

COMMENT

EPIDEMICS COLLIDE: THE OPIOID CRISIS IN PRISONS

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I. INTRODUCTION

This Comment explores the intersection of drug courts with the current opioid epidemic in the context of prisons. After explaining the nature of drug courts and treatment drugs for opiate addiction, I explore how punishment theory and case law support rehabilitation for violent and non-violent offenders. The overarching purpose of this Comment is to illustrate the need to incorporate drug courts into prisons as long-term solutions to opiate addiction under a rehabilitative justice theory.

A. The Problem

“She was basically sentenced to death before she even saw the judge.”¹ This is how Victoria Herr’s mother described her eighteen-year-old daughter’s 2015 death in a Pennsylvania jail after being arrested on drug charges and denied treatment for opioid withdrawal.²

“You go to bed at night and pray that your child will be arrested and taken care of. You hope this will be a second chance,

† To Tommy, Daniel, Randy, and Mark. “I have measured out my life with coffee spoons.” T.S. Elliot, *The Love Song of J. Alfred Prufrock*, POETRY, June 1915, at 130, 132.

1. Jeremy Galloway, *U.S. Jails Are Killing People Going Through Opioid Withdrawals*, HUFFINGTON POST (Mar. 29, 2016), http://www.huffingtonpost.com/the-influence/us-jails-are-killing-people-opioid-withdrawals_b_9563940.html (citing Melanie Orkins, *Police Investigating Lebanon County Woman’s Death After Collapsing Inside Prison*, FOX43 NEWS (Apr. 28, 2015), <http://fox43.com/2015/04/28/police-investigating-lebanon-county-womansdeath-after-collapsing-inside-prison>).

2. *Id.* (citing Tara West, *18-Year-Old Girl Dies in Jail After Suffering for Days, Police Thought She Was Faking Medical Emergency*, INQUISITR (May 5, 2015), <http://www.inquisitr.com/2093001/18-year-old-girl-dies-in-jail-while-suffering-for-days-police-thought-she-was-faking-medical-emergency>).

not a death warrant.”³ This is how Kellsie Green’s father described his twenty-four-year-old daughter’s 2016 death in an Alaska jail during heroin withdrawal.⁴

“An excruciatingly painful and slow death” is how the family of twenty-three-year-old David Stojcevski described his death from “acute withdrawal from chronic benzodiazepine, methadone, and opiate medications.”⁵ The victim was serving a thirty-day sentence in a Detroit jail for careless driving and was enrolled in a medication-assisted treatment program.⁶

B. *The Solution*

The first drug court began in 1989 in Miami-Dade County, Florida.⁷ It is hard to ignore the historical irony here, as the cocaine-crazed decade of the 1980s was coming to a close in this epicenter of the cocaine cowboy trade.⁸ This inaugural drug court’s goal was “to bring drug treatment more fully into the criminal justice system, treating offenders with a history of drug abuse for their addiction, while simultaneously ensuring supervision, and sanctions when needed, from the courts.”⁹ The drug court movement quickly spread to other jurisdictions. There were 492 drug courts ten years after the first Miami court, and by 2012, an estimated 2734 courts operated across the country.¹⁰ This exponential growth reflects how crime and drugs go hand-in-hand. In 2004, approximately fifty-three percent of offenders in state prison were drug dependent or abused drugs, but only fifteen percent received treatment.¹¹ Fast forward to 2016, where a

3. *Id.*

4. *Id.*

5. *Id.* (citing David Shortell, *Michigan Jail Death Leads to FBI Inquiry*, CNN (Oct. 21, 2015), <http://www.cnn.com/2015/10/21/us/michigan-jail-death-david-stojcevski>).

6. *Id.* (citing Alexander Smith et al., *Family of David Stojcevski Files Lawsuit Over His Death in Macomb County Jail*, NBC NEWS (Sept. 25, 2015), <http://www.nbcnews.com/news/us-news/addict-david-stojcevski-dies-after-16-dats-detroits-macomb-county-n433446>).

7. *Drug Court History*, NAT’L ASS’N DRUG CT. PROFS., <http://www.nadcp.org/learn/what-are-drug-courts/drug-court-history> (last visited Apr. 7, 2017).

8. *Miami Drug Wars*, FLASHBACK MIAMI (Sept. 10, 2014), <http://flashbackmiami.com/2014/09/10/miami-drug-wars/>.

9. RYAN S. KING & JILL PASQUARELLA, THE SENTENCING PROJECT, DRUG COURTS: A REVIEW OF THE EVIDENCE 1 (2009), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Drug-Courts-A-Review-of-the-Evidence.pdf>.

10. *Drug Court History*, *supra* note 7.

11. KING & PASQUARELLA, *supra* note 9, at 1.

new breed of drug epidemic emerged in the form of prescription and other opiate abuse.¹² With a two hundred percent increase in opioid-related deaths since 2000,¹³ drug courts, legislators, and health care professionals must quickly figure out a way to make drug courts part of the answer, instead of another obstacle to treatment.

II. DRUG COURTS

A. Theory and Methodology

Drug courts are a critical tool in providing a vital and viable alternative to a lengthy sentence for drug offenders striving to overcome addiction. As non-adversarial settings for holistic discipline and healing for non-violent offenders, drug courts apply a therapeutic jurisprudence theory to criminal law.¹⁴ The multidisciplinary teams that drive drug courts are comprised of legal professionals, law enforcement officers, and community workers, including judges, prosecutors, defense attorneys, social workers, treatment service professionals, and probation officers.¹⁵ Under the therapeutic jurisprudence model, the judge asks whether the court can help heal a “perceived pathology,” instead of asking whether the state has proven that a crime was committed.¹⁶ This is essentially a “disease model” that treats drug offenders as judicial patients with a chronic illness.¹⁷

While all drug courts generally “use the criminal justice system to address addiction [of low-level offenders] through an integrated set of social and legal services instead of solely relying upon . . . incarceration or probation,” they are primarily designed

12. *Rewrite the Prescription on Opioid Treatment*, ADVOCS. FOR OPIOID RECOVERY, <http://www.opioidrecovery.org> (last visited Apr. 7, 2017).

13. *Id.*

14. Peggy Fulton Hora & William G. Schma, *Therapeutic Jurisprudence*, 82 JUDICATURE 8, 10–11 (July–Aug. 1998); *Drug Courts*, NAT’L INST. JUST., <http://www.nij.gov/topics/courts/drug-courts/pages/welcome.aspx> (last modified Jan. 10, 2017).

15. *Drug Courts*, *supra* note 14.

16. DRUG POLICY ALL., DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE 5 (2011), http://www.drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf. While this report critiques the effectiveness of drug courts, its description of drug courts as therapeutic jurisprudence is useful for this Comment. For a discussion of Drug Policy Alliance’s critique, see *infra* Section II.D (illustrating this Comment’s stance on drug courts).

17. DRUG POLICY ALL., *supra* note 16.

to serve the local population of the county or jurisdiction.¹⁸ This is a strength and a weakness in the drug court system. While it allows judges to tailor court strategies to best serve their community, it is difficult to compare drug courts across jurisdictions and come up with an objective set of criteria courts should follow.¹⁹ This diversity poses a challenge in the face of the opioid abuse cycle, as each court must individually formulate a plan to deal with powerful addiction while receiving general advice from other courts or local and state officials.

The relationship between the judge and the drug court participant is a unique feature of drug courts because the rehabilitative process humanizes the judge.²⁰ The participants' frequent and typically informal interaction with the judge seems to be a successful motivator, especially for higher risk participants.²¹ This success stems from the paternalistic role of the judge combined with an "accountability buddy" function that resonates with participants on a human level. Further, a drug court overseen by one judge who presides over weekly or monthly sessions appears to be more effective than a rotating panel of judges.²² Thus, drug courts should continue to emphasize hands-on and personalized judicial participation in formulating and enforcing individualized participant plans.

B. Practice and Procedure

Drug courts generally follow two programs: deferred prosecution or post-adjudication.²³ In deferred prosecution, defendants are diverted to drug courts before pleading to a charge if they meet the eligibility requirements.²⁴ If deferred prosecution defendants complete the program, they are not prosecuted; however, failure to graduate results in prosecution.²⁵ Under the post-adjudication model, defendants are required to plead guilty, but their sentences are suspended while they complete the drug

18. KING & PASQUARELLA, *supra* note 9, at 1–2.

19. *Id.* at 2.

20. Hora & Schma, *supra* note 14, at 12.

21. KING & PASQUARELLA, *supra* note 9, at 12–13.

22. *Id.* at 13–14.

23. *Id.* at 3.

24. *Id.*

25. *Id.*

court program.²⁶ If they graduate, their sentences are waived and sometimes the charge is expunged from their record, as opposed to returning to criminal court in the case of failure.²⁷

Practically speaking, a drug court is a specialized court docket.²⁸ The National Institute of Drug Court Professionals enumerates the five core components of drug courts as follows: (1) intensive treatment and services needed to stay clean and sober; (2) accountability via the drug court judge to “court, society, themselves and their families”; (3) regular, random drug testing; (4) frequent court appearances so the judge may monitor progress; and (5) rewards or sanctions depending on whether or not they fulfill their obligations.²⁹ If the individual has violated drug court protocol numerous times, sanctions can be as harsh as jail time or removal from the program, or as gentle as a scolding from the judge or writing essays.³⁰ This comprehensive model embraces the benefits reaped from the balancing act among judicial interaction, monitoring and supervision, and treatment and rehabilitation.³¹ Participants are usually required to complete one year—or as long as it takes for the treatment to work—in the program before graduating.³² This often means attending status meetings, remaining drug and arrest free, and sometimes finding employment or housing.³³

Drug courts accept participants struggling with all types of addiction. However, participants’ drugs of choice vary according to urban, suburban, or rural region.³⁴ In 2004, the most severe drug use appeared in suburban and urban courts. Forty percent of

26. *Id.*

27. *Id.*

28. *Drug Courts*, *supra* note 14.

29. *What Are Drug Courts?*, NAT’L ASS’N DRUG CT. PROFS., <http://www.nadcp.org/learn/what-are-drug-courts> (last visited Mar. 16, 2017).

30. KING & PASQUARELLA, *supra* note 9, at 3.

31. *Drug Court & Treatment Alternatives to Incarceration*, DRUGWARFACTS.ORG, http://www.drugwarfacts.org/cms/Drug_Courts (last visited Mar. 13, 2017) (citing JUSTICE POLICY INST., *ADDICTED TO COURTS: HOW A GROWING DEPENDENCE ON DRUG COURTS IMPACTS PEOPLE AND COMMUNITIES 3* (Mar. 2011), http://www.justicepolicy.org/uploads/justicepolicy/documents/addicted_to_courts_final.pdf).

32. *Id.*

33. *Id.*

34. WEST HUDDLESTON & DOUGLAS MARLOWE, *PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURT PROGRAMS IN THE UNITED STATES 31* (June 2011), <http://www.ndci.org/sites/default0/files/nadcp/PCP%20Report%20FINAL.PDF>.

urban courts and thirty percent of rural courts saw mostly cocaine and crack, heroin, or methadone users, as opposed to only ten percent of rural drug courts.³⁵ However, in a 2008 survey, the primary substances used by urban drug court participants were cocaine and crack (twenty-seven percent), alcohol (twenty-seven percent), cannabis (twenty-two percent), methamphetamines (sixteen percent), opiates (seven percent), and prescription drugs (two percent).³⁶ Those in suburban drug courts preferred alcohol (thirty-three percent), cannabis (twenty percent), cocaine and crack (eighteen percent), methamphetamine (eighteen percent), opiates (ten percent), and prescription drugs (three percent).³⁷ Finally, in rural drug courts methamphetamine was king, with thirty percent use, followed by alcohol (thirty percent), cannabis (fourteen percent), opiates (twelve percent), cocaine and crack (seven percent), and prescription drugs (seven percent).³⁸ These statistics show that opiate use currently affects rural drug areas more, as will be discussed further in this Comment.

C. Results and Recidivism

Drug courts appear to be effective in stemming participants from falling back into their old habits. A 2011 report found that adult drug court participation correlated with lower recidivism rates.³⁹ Some research also suggests that re-arrest reductions continue past the first few years after treatment.⁴⁰ Generally, the re-arrest record for drug court offenders is better compared with those going through the traditional criminal court system.⁴¹ However, the biggest success factor appears to be completion of the drug court program, rather than mere participation.⁴² Thus, although not all drug court programs have statistically significant success with regard to recidivism, in general these programs ward off participant recidivism, particularly if the participant dedicates

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.*

39. U.S. GOV'T ACCOUNTABILITY OFFICE, ADULT DRUG COURTS: STUDIES SHOW COURTS REDUCE RECIDIVISM, BUT DOJ COULD ENHANCE FUTURE PERFORMANCE MEASURE REVISION EFFORTS 19 (Dec. 2011), <http://www.gao.gov/assets/590/586793.pdf>.

40. KING & PASQUARELLA, *supra* note 9, at 6.

41. U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 39, at 8.

42. *Id.*

him or herself to successfully graduating from the program. Thus, jurisdictions seeking to improve re-arrest rates should focus on ways to improve graduation rates and taking into account the specific problems of participants, rather than focusing simply on enrollment.⁴³

D. Criticism

As celebrated as drug courts and their success stories seem to be, valid criticisms to the model also exist. While there is not room to enumerate every argument against drug courts, I will mention a few of the most salient points. First, critics have pointed out that drug courts essentially cherry pick participants expected to do well in the program.⁴⁴ Drug courts do not usually save offenders from long prison sentences because many offenders are in drug court for a small offense like possession of marijuana.⁴⁵ Second, some offenders end up spending more time in prison than their original sentences due to drug court failures.⁴⁶ This is because the penalty for failures, like failing a drug test or missing an appointment, often result in further incarceration.⁴⁷ Finally, critics argue that drug courts make the criminal system more punitive toward addiction.⁴⁸ The problem lies in trying to combine the disease model with the prevalent retribution model, meaning that relapses and failures are punished with incarceration or expulsion from the program.⁴⁹ It follows that those with the best chance of graduating are not actually addicts, and the truly drug addicted are essentially set up for failure.⁵⁰ While all these issues are true to some degree, they do not provide insurmountable proof that drug courts should be done away with altogether. Especially in the heroin and opioid context, it will be incumbent to change the drug court system to better handle deeply troubled and addicted participants.

43. KING & PASQUARELLA, *supra* note 9, at 4.

44. DRUG POLICY ALL., *supra* note 16, at 2.

45. *Id.* at 13.

46. *Id.* at 14.

47. *Id.*

48. *Id.* at 13.

49. *Id.* at 14.

50. *Id.* at 13.

III. THE OPIOID EPIDEMIC

A. Introduction

The sobering statistics on opioid use and deaths reflect the need to reprogram the drug court system to combat this vicious cycle. The Department of Health and Human Services issued a fact sheet stating, “Our nation is in the midst of an unprecedented opioid epidemic.”⁵¹ The fact sheet then recites that there were more deaths from drug overdoses in 2014 than in any other year on record, and more than six out of ten were opioid-driven.⁵² In fifteen years (1999–2014), the rate of opioid-related overdose deaths, including pain relievers and heroin, has quadrupled, and the number of heroin-related and synthetic opioid deaths increased in 2014.⁵³ Another source estimates that every nineteen minutes, a person dies from the “cycle of opioid addiction.”⁵⁴ In response to this epidemic, the Secretary of the Department of Health and Human Services announced a three-pronged plan: (1) improve prescribing practices, (2) expand access to and the use of medication-assisted treatment, and (3) expand the use of naloxone.⁵⁵ The second prong, access to medication-assisted treatment (“MAT”), is applicable to the drug court context. MAT is generally the use of medications in conjunction with counseling and behavioral therapy to treat substance abuse.⁵⁶ With evidence that medication is the most effective road to long-term recovery,⁵⁷ MAT provides a hopeful alternative to cold-turkey quitting, which has a high chance of relapse.

51. DEP’T OF HEALTH & HUMAN SERVS., THE OPIOID EPIDEMIC: BY THE NUMBERS 1 (June 2016), <https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf>.

52. *Id.*

53. *Id.*

54. ADVOCS. FOR OPIOID RECOVERY, <https://www.opioidrecovery.org> (last visited Apr. 7, 2017).

55. Press Release, U.S. Dep’t of Health & Human Servs., Fact Sheet: Medication Assisted Treatment for Opioid Use Disorders: Increasing the Buprenorphine Patient Limit (Mar. 28, 2016), https://www.legistorm.com/stormfeed/view_rss/982589/organization/69541.html.

56. *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment> (last modified Sept. 28, 2015).

57. *Buprenorphine*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine> (last modified May 31, 2016).

B. Opioids: The Pain of Pleasure

A basic knowledge of how opioids chemically affect the brain will aid in understanding why the opioid epidemic is such a threat and also why it is so difficult to treat. Opioids attach to and activate receptors in the brain because they mimic a natural neurotransmitter.⁵⁸ The opioids trick the receptors into allowing the drugs to activate the nerve cells.⁵⁹ Once this happens, the nerves send signals to the brain—the “opioid effect”—that then block pain, slow breathing, and generally have a calming effect.⁶⁰ Opioids target the brain’s reward system by flooding it with dopamine, a neurotransmitter that regulates feelings of pleasure, and, in turn, overstimulating this system results in the sought-after euphoric effect.⁶¹ Without drugs, the body itself is unable to produce enough “natural opioid” to stop chronic or severe pain.⁶² Opioids are so destructive, in part, because the human brain is “wired to ensure that we will repeat life sustaining activities by associating those activities with pleasure or reward.”⁶³ When the reward system is activated, the brain thinks something important is going on and tells us to repeat whatever activated it over and over, without thinking of consequences.⁶⁴ Since drugs activate this same pleasure and reward circuit, it is difficult for opioid users to stop.⁶⁵

C. A Necessary Evil or Godsend? Opioids to Treat Opioids

The most common methods of treating opioid addiction are methadone and buprenorphine.⁶⁶ These medications are opiates themselves and work by slowly weaning addicts off opioids without the euphoric high.⁶⁷ Methadone was the original opioid

58. *How Do Opioids Work in the Brain?*, NAT’L ALLIANCE ADVOCS. FOR BUPRENORPHINE TREATMENT (Dec. 2008), https://www.naabt.org/faq_answers.cfm?ID=6.

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. Alice Park, *There’s a New Way to Treat Opioid Addiction, So Why Isn’t It Being Used?*, TIME (Mar. 30, 2016), <http://time.com/4276369/new-way-to-treat-opiate-addiction>.

67. *Id.*

treatment drug.⁶⁸ Methadone treats opioid use by lessening the painful withdrawal symptoms and blocking opiates' euphoric effects.⁶⁹ The downsides of methadone are its addictiveness and required daily use, which is why it works particularly well in controlled settings like prisons or hospitals.⁷⁰ However, upon release, or among those seeking treatment themselves, this drug is a riskier option considering that the typical treatment period using methadone is between two to three years.⁷¹

Buprenorphine, on the other hand, was the first opioid treatment medication to be prescribed by physicians at their offices instead of in a structured, controlled environment.⁷² Buprenorphine is used as part of a comprehensive MAT program that incorporates taking the drug while seeing counselors or behavioral therapists.⁷³ Several buprenorphine-naloxone combination drugs—Bunavail, Suboxone, and Zubsolv—are now Food and Drug Administration (“FDA”) approved as treatment for those who cannot comply with the strict methadone regime.⁷⁴ Buprenorphine works by raising the opioid effect with each dose and then levels off at a moderate dose even as more doses are taken.⁷⁵ Thus, this “ceiling effect” lowers dependency.⁷⁶ Further, the drug's long-acting agent means patients do not have to take it every day.⁷⁷

Naloxone is another approved opioid treatment used alone and also in combination with buprenorphine in a MAT setting.⁷⁸ Naloxone blocks opioid receptor sites and is given to patients showing signs of overdose because it reverses the effects of the overdose.⁷⁹ It is administered through injection or nasal spray.⁸⁰

68. *Methadone*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <http://www.samhsa.gov/medication-assisted-treatment/treatment/methadone> (last modified Sept. 28, 2015).

69. *Id.*

70. Park, *supra* note 66.

71. *Just What Is Methadone?*, RIVERWOOD GROUP, LLC, <http://www.methadonetreatmentcenter.com/just-what-is-methadone> (last visited Mar. 17, 2017); Park, *supra* note 66.

72. *Buprenorphine*, *supra* note 57.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

When added to buprenorphine, it decreases the chance of misusing the combination drug cocktail.⁸¹ Physicians can prescribe naloxone to patients in a MAT system, particularly if the patient has a high risk of overdosing, has taken high doses of opioids for chronic pain management, has taken extended-release opioid medication, or is participating in mandatory opioid abstinence in detoxification programs.⁸² Naloxone, while life-saving, has also been criticized for being a fallback or safety net drug that cuts against MAT goals.⁸³

Finally, naltrexone is the newest wonder drug in the treatment of opioid addiction. Approved in 2010, naltrexone can be taken as a monthly extended-release injectable or daily pill and is often used as part of a MAT plan that integrates counseling and social support.⁸⁴ It works differently than buprenorphine and methadone in that, instead of activating opioid receptors in the body to suppress cravings, naltrexone binds to and blocks opioid receptors, reducing cravings.⁸⁵ Further, if a person relapses, naltrexone prevents the euphoric feeling.⁸⁶ An article in *Time* reported that among incarcerated opiate abusers, after six months of using naltrexone, the relapse rate was only forty-three percent, compared with sixty-four percent of those receiving standard treatment, although that figure only held true as long as naltrexone was taken.⁸⁷

80. *Id.*

81. *Id.*

82. *Naloxone*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone> (last updated Mar. 3, 2016).

83. *See, e.g.*, Kevin Miller, *LePage Vetoes Bill Aimed at Increasing Access to Overdose Antidote*, PORTLAND PRESS HERALD (April 20, 2016), <http://www.pressherald.com/2016/04/20/lepage-vetoes-bill-aimed-at-increasing-access-to-heroin-anti-overdose-drug> (reporting that Maine Governor LePage vetoed a bill that would allow naloxone to be dispensed without a prescription, fearing that accessibility to naloxone “serves only to perpetuate the cycle of addiction”).

84. *Naltrexone*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone> (last updated Sept. 12, 2016); *see also* Park, *supra* note 66.

85. *Naltrexone*, *supra* note 84.

86. *Id.*

87. Park, *supra* note 66.

IV. THE OPIOID EPIDEMIC AND DRUG COURTS: A SLOW-RELEASE APPROACH

Drug courts have been slow to adopt the MAT method of treatment for participants addicted to opioids. An article in the *Psychiatric Times* makes the case that “[b]ecause addiction and mental health treatment falls increasingly into the justice system for underserved and indigent patients, the drug courts can serve as an example for thoughtful, evidence-based care focused on the individual’s needs rather than on preconceived notions”⁸⁸

In 2010, a representative sample of drug courts showed that only forty-eight percent of opioid addicts were offered buprenorphine and methadone in drug courts, although ninety-eight percent of the participants had an opioid addiction.⁸⁹ The reasons for this pushback against MAT therapies from drug courts were cost and court policy.⁹⁰ Courts are most concerned with dependence-forming medication like methadone and buprenorphine, but they do not object much to treatment drugs like naltrexone and naloxone except for the cost factor.⁹¹

A common mantra in drug courts with regard to MAT programs is that using opioid-based drugs to treat the addiction is just “replacing one addiction with another.”⁹² However, courts adopting this attitude ignore the unique nature of opioid addiction because the pharmacological properties of opioids allow recovering users to continue taking therapeutic doses of opioids to avoid withdrawal, but without the impairment of drugs like alcohol.⁹³ Thus, recovering opioid abusers can function in society and live life without the euphoria from a hit of heroin or the pain of withdrawal.⁹⁴ This presumption against addiction maintenance stems from the idea that only abstinence constitutes real recovery.⁹⁵ However, this false notion of real recovery is an

88. Laurence M. Westreich, *Medication-Assisted Treatment and Drug Courts*, PSYCHIATRIC TIMES (Nov. 27, 2015), <http://www.psychiatrictimes.com/psychopharmacology/medication-assisted-treatment-and-drug-courts>.

89. *Id.*

90. *Id.*

91. *Id.*

92. Maia Szalavitz, *The War on Methadone*, N.Y. TIMES, July 20, 2015, at A19.

93. *Id.*

94. *Id.*

95. *Id.*

impossible reality for opioid abusers because the very chemical nature of the drug almost destines them to relapse under this approach.

The Substance Abuse and Mental Health Services Administration (“SAMSA”) recognized the absurdity of this “replacing one addiction with another” mentality. Last year, SAMSA announced that drug court funding would be cut off if drug courts ordered participants to stop taking opioid medication.⁹⁶ In fact, SAMSA even allowed drug courts to use twenty percent of funding specifically for MAT grants:

Recognizing that [MAT] may be an important part of a comprehensive treatment plan, . . . grantees are encouraged to use up to 20 percent of the annual grant award to pay for FDA-approved medication (e.g., methadone, injectable naltrexone, noninjectable naltrexone, . . . buprenorphine, etc.) when the client has no other source of funds to do so.⁹⁷

The grant language goes on to explain that MAT is evidence-based and, since not all communities have access to MAT because of a lack of qualifying physicians, courts should step in to fill this need.⁹⁸ Further, the Office of National Drug Control Policy and the National Association of Drug Court Professionals also agree with this notion, making pro-MAT strategies the prevailing view in the field.⁹⁹

V. PRISON: TO “DE-METHADONE-IZE” OR NOT?

A. Pretrial Detainees: More Free Than Not

In *Abdul-Akbar v. Department of Corrections*, the United States District Court for the District of Delaware held, generally, that there is no right to prison drug rehabilitation programs and

96. See Alison Knopf, *SAMSA Bans Drug Court Grantees from Ordering Participants Off MAT*, ALCOHOLISM DRUG ABUSE WKLY. (Feb. 16, 2015), <http://www.alcoholismdrugabuseweekly.com/article-detail/samhsa-bans-drug-court-grantees-from-ordering-participants-off-mat.aspx>.

97. *Id.*

98. *Id.*

99. *Id.*

denied a plaintiff's claim alleging that his equal protection rights were violated when he was denied entrance into a drug rehabilitation program into which his friends were admitted.¹⁰⁰ The court explained that prisoners are not a suspect class and do not have a fundamental right to participate in prison rehabilitation programs.¹⁰¹ Further, prisons are places of limited resources, so prison officials may use their discretion to determine who needs rehabilitation programs the most in order to maintain order in the prison.¹⁰²

Decades before *Abdul-Akbar*, the Court of Appeals for the Third Circuit, in *Norris v. Frame*, held that depriving a pretrial detainee of methadone treatment prescribed prior to arrest was a constitutional violation.¹⁰³ The court began its opinion by recognizing the general purgatory-like status of individuals who have been criminally charged but not yet convicted or acquitted at trial: "Their status during this waiting period has been questioned ever since the time of Blackstone, who described the wait between arrest and trial as 'this dubious interval.'"¹⁰⁴ The plaintiff in this case was participating in a methadone treatment program prior to his arrest for a drug-related offense but was denied continued treatment once in prison.¹⁰⁵ The pain of withdrawal caused him to slash his wrist and then tear out the stitches, resulting in an infection.¹⁰⁶ For several months, he was given Benadryl and Valium, among other drugs, but was still denied methadone treatment.¹⁰⁷ The court found the plaintiff's pretrial status persuasive, determining that although a detainee "may not be punished at all," detainees are also not accorded all the rights of unincarcerated citizens.¹⁰⁸ In this no-man's land, the court ultimately opined that because the plaintiff had established that the prison had denied him the methadone treatment he was undergoing just prior to his arrest, and that the prison had notice of such treatment, he could properly assert a deprivation of a

100. *Abdul-Akbar v. Dep't of Corr.*, 910 F. Supp. 986, 1003 (D. Del. 1995).

101. *Id.* at 1004.

102. *Id.*

103. *Norris v. Frame*, 585 F.2d 1183, 1189 (3d Cir. 1978).

104. *Id.* at 1184 (quoting 4 WILLIAM BLACKSTONE, COMMENTARIES *297).

105. *Id.* at 1185.

106. *Id.* at 1185-86.

107. *Id.* at 1186.

108. *Id.* at 1187.

liberty interest.¹⁰⁹ However, the court ended with noting that there is no constitutional right per se to methadone.¹¹⁰

Just before *Norris*, a different federal court, in *Cudnik v. Kreiger*, also held that not allowing pretrial arrestees to continue methadone treatment that they received prior to incarceration was a due process violation.¹¹¹ Again, the court's opinion hinged upon the pretrial status of the individuals who benefit from the presumption of innocence: "A pretrial detainee . . . retains all the rights and liberties that his bailed counterpart enjoys, except those necessarily lost through the fact of confinement."¹¹² Thus, due process prohibits further punishment on top of the deprivation of liberty that pretrial detainees already experience.¹¹³ Further, the court noted that if pretrial detention conditions stem from theories of punishment—retribution, deterrence, involuntary rehabilitation—"then those conditions are suspect constitutionally and must fall unless also clearly justified by the limited purpose and objection of pre-trial detention."¹¹⁴ In conclusion, the court found that the two main objectives of pretrial detention—assuring appearance at trial, and the state's interest in orderly jails—were not furthered by denying the plaintiff methadone treatment.¹¹⁵

These three cases clearly demonstrate that courts have come down on the side of allowing addicts to continue treatment while awaiting trial. Using due process and punishment rationales for support, courts do not allow a criminal charge to overcome constitutionality with regard to treatment access.

B. Incarcerated Offenders: Abandon All Hope

As seen in the cases above, courts are hesitant to come out and rule that a constitutional right to methadone treatment exists. While courts err on the side of freedom in cases involving pretrial detainees, once convicted and housed as inmates in prison, these former detainees are at high risk of losing access to rehabilitation

109. *Id.* at 1188–89.

110. *Id.* at 1188.

111. *Cudnik v. Kreiger*, 392 F. Supp. 305, 313 (N.D. Ohio 1974).

112. *Id.* at 311.

113. *Id.*

114. *Id.* (quoting *Hamilton v. Love*, 328 F. Supp. 1182, 1193 (E.D. Ark. 1971)).

115. *Id.* at 311–12.

medications.¹¹⁶ In 2005, approximately eighty-five percent of jails surveyed did not continue methadone treatment for inmates who were previously participating in programs before incarceration.¹¹⁷ Further, not only do most prisons decline to provide MAT programs but around seventy-seven percent of prisons surveyed in 2004 did not even have a specific, standard protocol to treat opioid detox.¹¹⁸ These appalling statistics provide little to no hope for the estimated forty to sixty percent of inmates with substance abuse disorders and the estimated two hundred thousand heroin addicts passing through the criminal system every year.¹¹⁹ Whether because of the cost of MAT therapies or the old “addiction swapping” mentality, prisoners can essentially abandon all hope of treatment once on the inside.¹²⁰

VI. THE PROBLEM OF PREREQUISITES

So, where does all this information leave us? Do all these statistics reveal a burgeoning epidemic? Why are these drugs that promise so much so hard to administer? Why are pretrial detainees anxiously awaiting verdicts for their crime and addiction, while inmates are cut off from treatment and forced to detox or share needles? Such is the nature of opiate addiction right now: vast, pervasive, and indiscriminate.

As a product of one epidemic—cocaine in the 1980s—many are hopeful that drug courts will be the solution to the current opiate epidemic as well. Armed with evidence of effective MAT therapies on their side, drug courts, in theory, should be a leader in changing addiction and incarceration paradigms. However, despite all the merited praise and support, drug courts are still not as effective as they should be. And this is, in part, because of the pre-requisites drug courts impose for simply

116. John Lavitt, *Federal Prisons Deny Suboxone Access and Medication-Assisted Treatment Programs*, THE FIX (July 6, 2015), <https://www.thefix.com/content/federal-prisons-deny-suboxone-access-and-medication-assisted-treatment-programs>.

117. LEGAL ACTION CTR., LEGALITY OF DENYING ACCESS TO MEDICATION ASSISTED TREATMENT IN THE CRIMINAL JUSTICE SYSTEM 4 (Dec. 1, 2011), https://lac.org/wp-content/uploads/2014/12/MAT_Report_FINAL_12-1-2011.pdf.

118. *Id.*

119. Lavitt, *supra* note 116.

120. *Id.*

entering into a program. Particularly problematic is the prerequisite that the participant be a non-violent offender.

A. Violent Crime: An Overview

A Bureau of Justice Statistics survey found that over half of drug courts did not accept applicants with a history of violent crime, and two-thirds did not accept applicants with a history of sex offenses.¹²¹ However, only eleven percent of domestic violence courts and thirty-eight percent of veterans courts excluded applicants with a violent crime history.¹²² The Federal Bureau of Investigation (“FBI”) defines violent crime as offenses that involve force or the threat of force, specifically, “murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault.”¹²³ Aggravated assault was the most common violent crime in 2010, accounting for around sixty-two percent of total violent crime.¹²⁴

Interestingly, the FBI estimated that violent crime dropped more than thirteen percent from the years 2001–2010.¹²⁵ The average total sentence for violent crime is thirty-eight months, and for aggravated assault around forty-one months.¹²⁶ Further, a 2014 study revealed that only sixteen percent of incarcerated offenders in state prisons are doing time for nonviolent drug offenses.¹²⁷ Comparatively, around fifty-three percent are serving sentences for violent offenses.¹²⁸ In simple terms, these statistics indicate that in state prisons there are many more people serving sentences for violent crimes than there are for non-violent drug crimes,

121. SUZANNE M. STRONG & TRACEY KYCKELHAHN, BUREAU OF JUSTICE STATISTICS, CENSUS OF PROBLEM-SOLVING COURTS, 2012, at 1 (Oct. 12, 2016), <https://www.bjs.gov/content/pub/pdf/cpsc12.pdf>.

122. *Id.*

123. FED. BUREAU OF INVESTIGATION, UNIFORM CRIME REPORT: CRIME IN THE UNITED STATES, 2010, at 1 (Sept. 2011), <https://ucr.fbi.gov/crime-in-the-u.s/2010/crime-in-the-u.s.-2010/violent-crime/violentcrimemain.pdf>.

124. *Id.*

125. *Id.*

126. SEAN ROSENMERKEL ET AL., BUREAU OF JUSTICE STATISTICS, FELONY SENTENCES IN STATE COURTS, 2006—STATISTICAL TABLES 6 (Dec. 2009), <https://www.bjs.gov/content/pub/pdf/fssc06st.pdf>.

127. E. ANN CARSON, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2014, at 16 (Sept. 2015), <http://www.bjs.gov/content/pub/pdf/p14.pdf>.

128. *Id.*

rebutting a common myth that prisons are brimming with non-violent offenders.

B. Drugs & Crime: A Symbiotic Relationship

It is a matter of common sense, life experience, and awareness of the world that drug users often commit more crimes than non-users and that criminals use more drugs than non-criminals. The relationship between the two is symbiotic. Thus, it follows the chicken-or-egg paradigm in that it is impossible to separate which phenomena came first. The Department of Justice (“DOJ”) categorizes the relationship of drugs and crime into three categories: drug-defined offenses, drug-related offenses, and drug-using lifestyle.¹²⁹

The first, drug-defined offenses, are defined as “violations of laws prohibiting or regulating the possession, use, distribution, or manufacture of illegal drugs.”¹³⁰ The second, drug-related offenses, are “offenses in which a drug’s pharmacologic effects contribute; offenses motivated by the user’s need for money to support the continued use; and offenses connected to drug distribution itself.”¹³¹ Finally, drug-using lifestyle means “the likelihood and frequency of involvement in illegal activity is increased because drug users may not participate in the legitimate economy and are exposed to situations that encourage crime.”¹³² The DOJ further reported that arrestees frequently test positive for recent drug use, incarcerated offenders were often under the influence of drugs when they committed the crime, and offenders often commit crimes to support their drug habit.¹³³ However, the DOJ concludes by cautioning against interpreting the drug and crime cycle too simply as most crimes result from a multitude of factors in an individual’s life, and “drug-related” is interpreted differently across studies.¹³⁴

129. BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, FACT SHEET: DRUG-RELATED CRIME 1 (1994), <https://www.bjs.gov/content/pub/pdf/DRRC.PDF>.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 3.

134. *Id.*

*C. Putting Two and Two Together: The Drug Court
Loophole*

Applying these violent offense and drug and crime statistics to the drug court scenario, it is clear that most offenders heading for prison will not even qualify for pre-prosecution drug court rehabilitation programs. The ironic distinction drawn between violent and non-violent offenders in terms of drug court qualification reflects a sad double standard and fundamental misunderstanding of addiction. Society's determination that nonviolent offenders are capable of being rehabilitated and deserve a second chance while violent offenders—the majority of the prison population—are undeserving of a shot at rehabilitation makes a black-and-white issue out of a complicated mess of converging factors. And, at the heart of this attitude, there often lies a desire for eye-for-an-eye justice. As a recent *New Yorker* article so aptly stated:

One might contend, and quite legitimately, that someone who has been murdered by another person will never have the opportunity to grow, heal, or change. This opportunity has been taken away from the victim, thus it should also be taken away from their murderers. The place from which this sentiment arises is certainly understandable. But, as a matter of public policy, we should ask whether or not we want to be the type of country that allows people who demonstrate no legitimate threat to public safety the opportunity to move beyond what they have previously done.¹³⁵

While I am not advocating for drug court in lieu of jail time, I am arguing that drug court rehabilitation should be an integral part of the prison paradigm as a form of punishment. Statistics show that in most criminal cases, violent and non-violent, drugs play a role.¹³⁶ All things remaining equal, drug courts should not just be an exception to the rule of punishment but should instead be incorporated into punishment as the norm.

135. Clint Smith, *The Meaning of Life Without Parole*, NEW YORKER (Feb. 8, 2016), <http://www.newyorker.com/news/news-desk/the-meaning-of-life-without-parole>.

136. See generally BUREAU OF JUSTICE STATISTICS, *supra* note 129.

VII. WHY THIS MATTERS MORE NOW THAN EVER

A. Changing Addiction Paradigm, Stagnant Punishment Paradigm

The opioid epidemic mandates a new punishment paradigm that includes drug court and MAT therapies as a rule, not an exception. As discussed earlier, the unique chemistry of opiates makes battling addiction that much more unique. Its properties that deliver a dangerous façade of functionality, while underneath forming an unbreakable addiction, must be matched with an equally formidable punishment plan. To gain an understanding of the mindset and lifestyle opiate users develop during the course of their addiction, consider the following:

Heroin is a wonder drug. Heroin is better than everything else. Heroin makes me who I wish I was. Heroin makes life worth living. Heroin is better than everything else. Heroin builds up a tolerance fast. Heroin starts to cost more money. I need heroin to feel normal. I don't love anymore. Now I'm sick. I can't afford the heroin that I need. How did \$10 used to get me high? Now I need \$100. That guy that let me try a few lines the first time doesn't actually deal. Oh I need to find a real dealer? This guy is a felon and carries a gun—he can sell me the drug that lets me find love in the world. No this isn't working, I need to quit.¹³⁷

This downward spiral demonstrates what the FBI characterizes as drug-related offenses and drug-using lifestyle in the drug-crime matrix.¹³⁸ The likelihood of drastic measures to gain access to opiates, and short-sighted goals aimed at scoring the next fix: these are the risks of addiction that fuel chronic crime. These chronic issues necessitate solutions that do not simply have an end date—such as a prison sentence—but rather embrace a long-term rehabilitation theory—like MAT treatment.

137. Luke Lewis, *700 Words That Explain Exactly What It Feels Like to Do Heroin*, BUZZFEED (Feb. 5, 2014), https://www.buzzfeed.com/lukelewis/700-words-that-explain-exactly-what-it-feels-like-to-do-heroin?utm_term=.kpLWnd4ND#.nqRXxPzYM.

138. See generally BUREAU OF JUSTICE STATISTICS, *supra* note 129.

B. Punishment Theories: Academia in Action

Let us take a moment to examine why the traditional theories of punishment justify making MAT treatment and drug court a part of the wider sentence for violent opiate-using offenders. Generally, there are two broad categories of punishment philosophy: utilitarian and retributive.¹³⁹

The former, utilitarian theory, aims to punish offenders in order to deter future crime.¹⁴⁰ Utilitarian theory believes that laws should be used to further the well-being of society and that the positive effect of criminal law should outweigh the negative.¹⁴¹ Deterrence operates on a specific and general level. Specifically, jail time will practically deter the person from committing more crime, and the unpleasant experience will also deter him or her from returning to crime.¹⁴² Generally, the individual's incarceration serves to deter the general public away from crime.¹⁴³

Rehabilitation is another utilitarian punishment rationale.¹⁴⁴ It aims to prevent crime by giving offenders another chance, or "an ability to succeed within the confines of the law."¹⁴⁵ Drug courts that aim to treat chemical dependency and mental illness and educational programs that equip offenders with practical skills are two common rehabilitative measures.¹⁴⁶ Rehabilitation is the only punishment theory whose premise is one of affirmative progress instead of retrospective regression.

The general category of retributive justice punishes offenders because they deserve it.¹⁴⁷ This eye-for-an-eye theory rests upon the premise that crime upsets the peaceful balance of society, and punishment helps to rectify the balance.¹⁴⁸ The major difference between the retributive and utilitarian theories is one of perspective: retributive justice looks backward at the crime itself

139. *Punishment—Theories of Punishment*, JRANK.ORG, <http://law.jrank.org/pages/9576/Punishment-THEORIES-PUNISHMENT.html> (last visited Mar. 20, 2017).

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.*

148. *Id.*

as the reason for punishment, whereas the utilitarian theory “looks forward by basing punishment on societal benefits.”¹⁴⁹

C. Utilitarian Rehabilitation: Addiction’s Long-Term Foe

In the context of opiate addiction, rehabilitation is the only feasible and logical punishment method. The reason for this is twofold. First, the nature of this addiction is such that users allow the short-sighted goal of the next high to supersede long-term goals like long life, happiness, and healthiness. Imprisoning an offender, even a violent offender, who suffers from opiate addiction without any rehabilitative measures will only cause her to focus even more on short-term problems like trying to obtain opiate contraband in prison. Imposing prison sentences for opioid addicts without any effort to divert and reset their decision-making calculus and personal goals is tantamount to making alcoholics and smokers quit cold turkey but leaving them in a liquor store or cigarette warehouse in handcuffs and telling them not to think about it.

The second reason that rehabilitation is the only long-term solution to crime involving opiate addiction is due to the age range of most criminals. Brain development, particularly in the prefrontal cortex, which controls decisions, risk calculation, and impulse control, is not complete until the mid-twenties.¹⁵⁰ After prefrontal cortex development is complete, the likelihood of someone committing another violent offense decreases significantly.¹⁵¹ Right now, only ten percent of incarcerated offenders are over fifty-five years old, but that number is expected to increase to one-third of the prison population by 2030.¹⁵² This cerebral science, combined with the obvious problem of already-overcrowded prisons, favors a heavy rehabilitation effort through MAT treatment and drug court in conjunction with shorter prison sentences to actually remedy the opioid drug and crime cycle. However, the prerequisite problem continues to impede this becoming a reality.

149. *Id.*

150. Smith, *supra* note 135.

151. *Id.*

152. *Id.*

D. Pretrial Detainees: Rights by Analogy

While it is well-settled that there is no constitutional right to methadone treatment during incarceration, and courts have so far declined to find an Eighth Amendment violation with regard to methadone, it can be argued that constitutional discussions bypass the heart of the opioid epidemic and thus fail to actually consider it in a real way. In *Cudnik*, the court stated that, with regard to pretrial detainees, due process concerns prohibit overly-harsh punishment in the form of methadone deprivation on top of liberty deprivation.¹⁵³ This statement posits opiate therapies within the realm of punishment rather than the realm of a chronic disease. Even though the court found for the detainee,¹⁵⁴ it failed to explain why methadone may be used as a punishment too. Thus, the first step courts should take is to reexamine the narrative surrounding MAT therapies for both pretrial and convicted offenders.

The *Cudnik* court also uses the two objectives of pretrial detention to frame its decision for the detainee.¹⁵⁵ In finding that the denial of methadone would not help assure the detainee's appearance for trial or the state's interest in orderly jails, the court opened up a more pragmatic way to examine MAT therapies in the context of punishment theories.¹⁵⁶ This approach is applicable to incarcerated offenders as well. While retributive justice seems to have been readily accepted as the preferred punishment theory in the past, the opioid epidemic is turning that paradigm on its head. Because chronic addiction to heroin or prescription painkillers is unsolvable absent chronic maintenance, quid-pro-quo punishment under the retributive model no longer works to further the overarching goal of punishment theories, which is to stop the offender from committing a repeat offense. The new paradigm is indeed a complicated one involving brain science and statistics, but one that highly favors continued rehabilitative measures for violent and nonviolent offenders alike in order to further orderly prisons and societies.

153. *Cudnik v. Kreiger*, 392 F. Supp. 305, 311 (N.D. Ohio 1974).

154. *Id.* at 313.

155. *Id.* at 311.

156. *Id.*

VIII. SOLUTIONS

It is impossible to propose a one-solution-fits-all model for the issues discussed in this Comment. Using heroin and abusing prescriptions are criminal acts, and those who fall into the cycle of use and abuse must answer to the law. However, how they answer to the law is the key to restoring balance in both individual lives and opioid-ravaged communities. While it is often true that the root problem of the drug and crime phenomena is cyclical poverty and desperation, the opioid epidemic transcends socioeconomic status, race, and geography. Because of the epidemic's indiscriminate nature, the criminal justice system must discriminate more carefully in its punishment. With a myriad of promising slow-release and Lazarus-effect drugs now available and accepted by society as legitimate forms of MAT treatment, prisons and courts have no excuse.

My contention is that drug court should be a constant in the punishment algorithm for non-violent *and* violent drug-related offenses. And by drug court, I am referring to all aspects of drug court, not just the MAT component. The effect of the positive reinforcement from judges and peers is difficult to quantify, but from my limited observation of drug courts, it seems to be a significant, impactful factor. Additionally, sentencing for violent offenders should be reduced in proportion to their participation and hopeful success in drug court. Further, drug court should not end with incarceration. Instead, the offenders in prison should continue to attend and receive MAT therapy through the drug court. While funding is one of the biggest barriers to implementing a solution like this, ideally the money saved by letting an offender out on parole early because of successful treatment would help compensate for the cost of the drugs and court personnel. In conclusion, rehabilitative justice through drug court expansion and open participation is a key component in solving the opioid crisis, and it is a component that courts and legislators should adopt and implement for the health of the nation.