November 13, 2014

The Opioid-Dependent Criminal: Improving the Criminal Justice System to Account for Their Needs

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By: Courtney Priolo

INTRODUCTION

Over the past twenty-five years national concern over the drug-crime relationship has been increasing.[1] This increase has led to growth of criminal justice penalties as opposed to therapeutic approaches such as medicated-assisted treatment, resulting in an expansion of the drug-involved criminal justice population.[2] Approximately 75% of individuals convicted of crimes each year require some form of substance abuse treatment.[3] Of those, about 25% are addicted to opioids, or pain medications.[4] Yet, less than 20% of people in prison and in pretrial detention battling addiction will be receiving treatment with medications for their addition.[5]

Evidence suggests that drug abuse and dependence is a chronic medical illness and should be assessed and treated like other chronic medical illnesses.[6] In addition, according to the United States Supreme Court, correctional institutions have a legal requirement of providing medically necessary health care.[7] In other words, as a medical illness, drug abuse and dependence must be treated within correctional institutions.[8] In fact, the American Society of

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[1] Peter D. Friedmann et al., *Medication-Assisted Treatment in Criminal Justice Agencies Affiliated with the Criminal Justice-Drug Abuse Treatment Studies (CJ-DATS): Availability, Barriers, and Intentions*, 33 Substance Abuse 9, 10 (2012).
[2] *Id.*
[3] Robert D. Bruce & Rebecca A. Schleifer, *Ethical and Human Rights Imperatives to Ensure Medication-assisted Treatment for Opioid Dependence in Prisons and Pre-trial detention*, 19 Int'l J. of Drug Pol'y 17, 17 (2008).
[4] *Id.* Opioids are medications that relieve pain by reducing the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes the effects of a painful stimulus. *Prescription Drug Abuse*, DrugAbuse.Gov, http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids (last visited April 9, 2014).
[5] Bruce & Schleifer, supra note 3, at 19.
[6] Carrie B. Oser et al., *Organizational-level Correlates of the Provision of Detoxification Services and Medication-based Treatments for Substance Abuse in Correctional Institutions*, 103 Drug and Alcohol Dependence 73, 74 (2008).
[7] *Id.*
[8] *Id.*

Addiction Medicine recommends that all offenders, upon entering jail or prison, should be screened for addiction and withdrawal symptoms, and that medically appropriate withdrawal systems be put into place upon finding of a diagnosis.[9] There is a need for detoxification services as the first step of substance abuse treatment; however, providing medical detoxification to the opioid-dependent criminal justice population is not a current part of the standard practice in correctional institutions within the United States.[10]

Opioid-dependence is a complicated medical condition that affects neurocognitive and physical functioning.[11] Because of how it affects the human body, forcefully or suddenly withdrawing from opioids will cause severe physical and psychological suffering that includes nausea, vomiting, diarrhea, extreme agitation, and anxiety.[12]

There is a well-studied pharmacological therapy to treat the medical condition of opioid dependence.[13] This therapy, medication-assisted treatment (MAT),[14] involves the addition of pharmacotherapy to the traditional substance abuse counseling that is already in existence for the opioid-dependent community.[15] MAT uses medication authorized by state and federal law, along with medical, rehabilitative, and counseling services.[16]

Medication-assisted treatment uses opiate agonists[17] to control withdrawal symptoms, cravings, and/or the reinforcing euphoria resulting from opioid use.[18] The most common opiate

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[9] *Id.*
[10] *Id.*
[11] Bruce & Schleifer, *supra* note 3.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] Friedmann et al. *supra* note 1, at 10.
[16] Fla. Stat. § 397.311(19) (West 2010).
[17] Carmen E. Albizu-García et al., *Assessing Need for Medication-Assisted Treatment for Opiate-Dependent Prison Inmates*, 33 Substance Abuse 60, 60 (2012). Opiate agonists are agents that have a high affinity for opiate receptors but do not activate these receptors by blocking the effects of exogenously administered opioids. Drugs.com, http://www.drugs.com/dict/opiod-anatogonists.html (last visited April 14, 2014).
[18] Friedmann et al. *supra* note 1, at 10.

agonists used in MAT are methadone or buprenorphine, both of which meet the standard of care for opiate dependence.[19] Nationally and internationally, MAT involving either methadone or buprenorphine decreases recidivism rates, improves adherence to antiretroviral medications, decreases human immunodeficiency virus (HIV) risk-taking behaviors, and improves mortality.[20]

Medication-assisted treatment is unavailable to most prisoners despite the fact that prisons must provide at least the standard of care to prisoners as is available to the general population.[21] However, international health and drug agencies endorse the use of MAT for opioid dependent drug users,[22] and large, prestigious groups including the World Health Organization encourage MAT in correctional institutions.[23] They support it because evidence shows vast benefits associated with the treatment.[24] These benefits are prominent when medication-assisted treatment is given to prisoners prior to release and include reducing recidivism and unfortunate health and social consequences associated with drug use.[25]

Because of the illicit nature of opioids, the means through which they are obtained, and the behaviors associated with it, many opioid-dependent individuals intertwine themselves in the criminal justice system and correctional system.[26] Despite the evidence of MAT's success, and the large number of inmates who would benefit from it, around 75% of inmates with a drug-dependence or disorder in correctional facilities in the United States, never receive treatment

[19] Albizu-García et al., *supra* note 17, at 60.
[20] Sandra A. Springer & Robert D. Bruce, *A Pilot Survey of Attitudes and Knowledge About Opioid Substitution Therapy for HIV-Infected Prisoners*, 4 J. Opioid Manag. 81, 81 (2008).
[21] Bruce& Schleifer, *supra* note 3, at 17.
[22] *Id.*
[23] Albizu-García et al., *supra* note 17, at 60.
[24] Michelle McKenzie et al., *Overcoming Obstacles to Implementing Methadone Maintenance Therapy for Prisoners: Implications for Policy and Practice*, 5 J. Opioid Manag. 219, 227 (2009).
[25] *Id.*
[26] Bruce & Schleifer, *supra* note 3, at 17.

during incarceration or after release.[27] Therefore, upon release to the community, former prisoners are relapsing back into the cycle of drug use, associated with higher recidivism rates.[28]

Individuals who are opioid-dependent are vulnerable at the time of arrest, and at the time of their initial detention due to their chemical dependence and impairment of their neurocognitive functioning.[29] These individuals may be coerced into providing incriminating testimony as an effect of their impairments' affecting their ability to make informed legal decisions.[30] In addition, to avoid painful withdrawal symptoms individuals may even be driven to engage in risky behavior such as sharing needles.[31]

In sum, the denial of medication to inmates in order to alleviate withdrawal symptoms is stigmatizing, punishing, and potentially life-threatening.[32] Despite its effectiveness and expert consensus recommendations, MAT is underutilized in the treatment of the opioid-dependent criminal justice population in prisons and pre-trial detention.[33]

Part I of this paper constitutes a brief primer on MAT, including the obstacles to its use and how these can be overcome. Part II will explain the international human right of health as it relates to the underutilization of MAT domestically, including how the failure of prisoner access to this medical treatment violates the fundamental human rights of protection against cruel, inhuman or degrading treatment, and the rights to health and to life.[34] Part III will further detail the costs and benefits of MAT for the opioid-dependent criminal justice population in prisons and pre-trial detention and explain why the benefits outweigh the costs.

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[27] Albizu-García et al., *supra* note 17, at 60.
[28] Springer & Bruce, *supra* note 20, at 81
[29] Bruce & Schleifer, *supra* note 3, at 17.
[30] *Id.*
[31] *Id.*
[32] Oser et al., *supra* note 6, at 74.
[33] Friedmann et al. *supra* note 1, at 9.
[34] Bruce & Schleifer, *supra* note 3, at 17.

PART I: THE DEFINITION OF MEDICATION-ASSISTED TREATMENT

Opioid dependence is a chronic and relapsing neurobiological disease.[35] However, there are known effective medical treatments for this disease, including MAT with methadone or buprenorphine.[36] Research and clinical experiments show that both methadone and buprenorphine are successful in producing the desired and intended results for chronic opioid dependency.[37]Methadone and buprenorphine have many positive results, including preventing withdrawal symptoms and drug cravings, blocking the euphoric effect of opiates, reducing the risk of relapsing to the use of illicit opiates, reducing infectious disease transmission, and reducing the likelihood of death resulting from an overdose.[38]

MAT is the use of medications such as methadone and buprenorphine that are approved by the United States Food and Drug Administration (FDA), in combination with counseling and behavioral therapies.[39] This treatment is intended to provide a holistic approach to the treatment of substance abuse.[40] Once a patient on MAT is stable on a proper dose, he or she can function normally.[41] Part A below will discuss the definition and scope of MAT in further detail, while Part B will lay out the obstacles that MAT has to overcome.

PART I.A: THE SCOPE OF MEDICATION-ASSISTED TREATMENT

Most individuals who relapse to substance abuse after incarceration do so within one month of their release.[42] Therefore, the time right before and right after release is the ideal time

[35] *Id.* at 18.
[36] *Id.*
[37] Ezechukwu Awgu et al., *Herson-Dependent Inmates' Experience with Buprenorphine or Methadone Maintenance*, 42 Journal of Psychoactive Drugs 339, 339 (2011).
[38] McKenzie et al., *supra* note 24, at 220.
[39] *Id.* § 397.311(19).
[40] *Id.*
[41] Bruce & Schleifer, *supra* note 3, at 18.
[42] McKenzie et al., *supra* note 24, at 221.

to introduce MAT as a system for relapse prevention.[43] In fact, evidence shows that beginning MAT prior to release from incarceration reduces substance use post-release and reduces recidivism.[44] Despite substantial evidence of its effectiveness, this therapy is underutilized in treating the opioid-dependent criminal justice population in the United States.[45]

Evidence also shows that providing prisoners with referrals to community-based MAT together with providing the treatment prior to the individual's release reduces recidivism and unfortunate health and social consequences associated with drug use.[46] This is because MAT is a proven link to the reduction of opioid use, criminal behavior, arrest, and human immunodeficiency virus (HIV) risky behavior.[47] Further, when prisoners who were receiving treatment before they were incarcerated are prohibited from continuing that treatment upon incarceration, they often resort to illicit drug use in prison.[48] The refusal of correctional systems to provide validated medical treatment that would prevent this from happening increases risk-taking behavior linked with unnecessary harm.[49]

Despite the evidence of MAT's many benefits, providing this therapy to inmates who want to begin or remain on it while incarcerated is not a general practice.[50] The criminal justice system's failure in meeting the treatment needs for all drug users does not relieve prison officials of their obligation to protect the lives and well-being of every individual in custody.[51] The

[43] *Id.*
[44] *Id.*
[45] Friedmann et al. *supra* note 1, at 9.
[46] McKenzie et al., *supra* note 24, at 219.
[47] Friedmann et al. *supra* note 1, at 9.
[48] Bruce & Schleifer, *supra* note 3, at 19.
[49] *Id.*
[50] Michelle McKenzie et al., *supra* note 24, at 221.
[51] Bruce & Schleifer, *supra* note 3, at 21.

criminal justice system should provide access to evidenced-based MAT for the opioid-dependent criminal justice population to satisfy these obligations, yet there are obstacles.[52]

PART I.B: OBSTACLES FACING MEDICATION-ASSISTED TREATMENT

There are significant obstacles to carrying out MAT for the opioid-dependent criminal justice population in prisons and pre-trial detention.[53] These include the stigma of pharmacological treatment, misconceptions regarding the nature of opioid addiction, the logistics of the control and storage of methadone, a resulting increase in workload for staff, and safety concerns.[54] These obstacles exist because substance abuse treatment in correctional institutions is a controversial social and political issue.[55]

Correctional institutions firmly believe that their primary goal is detaining criminal offenders in a humane and controlling way, not "healing" these individuals.[56] This belief pairs with the fact that detention without treatment is cost-efficient.[57] With detention as the standard primary goal, the sometimes secondary goal of rehabilitation is overshadowed.[58] An organization with traditional criminal justice goals operates on a basis of punishment, incapacitation, and deterrence principles.[59] When the organizational structure of a correctional institution is under

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[52] *Id.*
[53] Michelle McKenzie et al., *supra* note 24, at 219.
[54] *Id.*
[55] Oser et al., *supra* note 6, at 74. It is a contradiction to call it a correctional institution when the people in charge of the so-called correctional institution refuse to correct the problems, or at least what is causing the problems, *i.e.*, drug use linked with criminal behavior resulting in prison sentences. *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.* However, more progressive organizations are incorporating rehabilitation principles into their primary goals. *Id.*
[59] *Id.*

the control of traditional criminal justice values, that institution is not likely to invest in the welfare and health of offenders.[60]

Other obstacles exist because the operation of dispensing pharmacotherapies, required by MAT with methadone or buprenorphine, requires additional medical screening, supervision, and expense.[61] Significant preparation and education is necessary when dispensing methadone or buprenorphine in facilities that have no previous experience in handling and storing opiate agonists, as in correctional institutions.[62] This is challenging for these institutions, which must require additional training and education for their staff to produce a protocol and a routine accommodating the additional responsibilities of the treatment program.[63] Nurses and other staff members already trying to work within an understaffed environment hesitate to commit themselves to the extra work.[64]

The additional responsibilities include counting, recording, and storing the opiate agonists in a secure location, and administering each dose.[65] When administering each dose, it is important that the nurse observe each inmate taking his or her dose of methadone or buprenorphine to decrease the likelihood that the inmate is not swallowing it.[66] Any missed dose must be documented and returned back to the secured location where it is being stored.[67] Nurses will also have the responsibility of tracking each patient's response to the medication, coordinating with a physician to adjust the dose, and treating the side effects.[68]

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[60] *Id.*
[61] *Id.*
[62] McKenzie et al., *supra* note 24, at 225.
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*

Further obstacles arise because MAT is problematic in correctional institutions due to its involving the use of scheduled controlled substances (methadone or buprenorphine).[69] With the use of these substances comes a risk of liability.[70] There is substantial liability associated with storing methadone or buprenorphine because they are highly regulated, controlled substances.[71] When facilities are not familiar with handling such medication, nurses and other staff members are concerned about having enough secure storage space.[72]

Because of these obstacles, prisons offering MAT for opioid-dependence are few and far between.[73] Instead, many of these prisons prefer "cold turkey" as a so-called treatment for opioid-dependent inmates.[74] This "treatment" results from the failure of prisons to understand that opioid-dependence is a medical disorder resulting from complex neurobiological systems.[75] Some correctional systems believe that requiring an inmate to renounce opioids "cold turkey" is the appropriate thing to do because the inmate's societal misdeeds landed him or her in this situation, and as a result the inmate should experience the natural consequences of his or her actions, including painful opioid withdrawal.[76]

Overall, the general knowledge about MAT among correctional institutions staff has been reported as being shabby.[77] This results from correctional workers' and case-management referral workers' insufficient knowledge about MAT's ability to improve the health of their patients or about how it decreases opioid-dependence.[78] Correctional staff, especially nurses,

[69] Oser et al., *supra* note 6, at 74.
[70] *Id.*
[71] McKenzie et al., *supra* note 24, at 225.
[72] *Id.* at 224.
[73] Bruce & Schleifer, *supra* note 3, at 17.
[74] *Id.*
[75] *Id.* at 18.
[76] *Id.*
[77] Springer & Bruce, *supra* note 20, at 81.
[78] *Id.*

social workers, and case-managers, have considerable influence over whether inmates choose to accept or reject the treatment, and/or have treatment arranged for them upon their release from incarceration.[79] As a result of the correctional staffs' lack of knowledge, MAT remains the victim of social stigma and is under-utilized in correctional settings.[80]

Stigma is the experience of being "deeply discredited" due to one's "undesired differentness."[81] To be the victim of a stigma is to be held in contempt, shunned, or rendered socially invisible as the result of a socially disapproved status.[82] Being stigmatized involves the processes of labeling, stereotyping, social rejection, and exclusion.[83] To suffer from a stigma is to be discriminated against.[84]

The stigma attaching to MAT for the opioid dependent population, even greater than that imposed on the general criminal justice population is rooted deep within the culture of illicit drug use in the United States.[85] This is because of the social stigma associated with addiction,[86] which is a major obstacle to recovery.[87] A further obstacle resulting from this stigma is the limitation on the type and amount of cultural resources being distributed specifically for drug-related

[79] *Id.* at 84.
[80] Friedmann et al. *supra* note 1, at 16.
[81] William L. White, Office Phila. Bur., *Long-Term Strategies to Reduce the Stigma Attached to Addiction, Treatment, and Recovery within the City of Phila. (With Particular Reference to Medication-Assisted Treatment/Recovery)*, 1, 6 (2009).
[82] *Id.*
[83] *Id.* at 2.
[84] *Id.*
[85] *Id.* at 4. The stigma surrounding addiction influences how people and society view the role of choice versus compulsion relating to addiction. Simply put this stigma results from how people view the motivation for initial drug use, such as a search for pleasure, escape from pain, etc. *Id.*
[86] *Id.*
[87] *Id.* at 2. The stigma attaching to addiction is widespread in society depending on whether addiction is being viewed as a socially "good" or "bad" drug. *Id.*
[87] *Id.* When it comes to solving this problem and coming up with a solution, opioid addiction and treatment are stuck between criminal, medical, and moral ideals. *Id.*

problems.[88] Stigma also prevents treatment-seeking and contributes to early treatment termination.[89]

Finally, MAT involving methadone or buprenorphine is not yet fully accepted. It has yet to achieve full legitimacy as a medical treatment by health and medical professionals.[90] The public and the recovery community also tend not to consider this medical treatment as legitimate despite the scientific evidence supporting it.[91] Thus, individuals enrolled in MAT have yet to receive full "patient" status.[92] Not only is society refusing to view the medical treatment as legitimate, and to view the individual receiving it as a patient, but clinics providing MAT also have yet to receive full status as a place of healing on the same level as hospitals or outpatient medical clinics.[93]

PART II: FUNDAMENTAL HUMAN RIGHT TO HEALTH

Yet, the criminal justice system should incorporate MAT because implied within the context of the international human right to health is the fundamental human right to health, which is threatened when MAT is unavailable to prisoners.[94] Failing to provide prisoners with this treatment results in a threat to those individuals' fundamental human right of health.[95] The fundamental right to health is more than a moral obligation; it is a legal right.[96] The legal basis for use of MAT is best founded on international human rights law, despite the fact that the

[88] *Id.* at 4.
[89] *Id.*
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] Alicia Ely Yamin, *The Right to Health Under Int'l Law and Its Relevance to the U.S.*, 95 Am. J. Pub. Health 1156 (2005).
[95] Bruce & Schleifer, *supra* note 3, at 17.
[96] Steven D. Jamar, *The Int'l Human Right to Health, See also*, S. Univ. L. Rev. 1, 49 (Fall 1994).

United States has yet to sign onto these treaties.[97] The fundamental human right to health forces states to take appropriate steps to secure this right.[98]

There are few arguments for a legal right to MAT that can be made under United States domestic law.[99] Perhaps the most promising is founded on the constitutional protection against cruel and unusual punishment.[100] However, so far domestic law does not support the existence of an actual legal right to MAT.[101] Rather, the United States should stop trying to resist international authorities on this issue.[102]

The majority of the world's nations accept the international human right to health contained within the United Nations' and regional treaties.[103] In fact, when comparing the United States to other developed, democratic nations in regards to carrying out the international human right to health, the United States is flawed.[104] Although the United States has never made a full commitment to the identification and understanding of the international human right to health, it recently has been doing more to make health care services more available for its citizens.[105] Increasing the number of organizations using MAT to treat people suffering from opioid-dependence is both consistent with that trend and important to advance public health in the United States.[106]

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[97] Eleanor D. Kinney, *Recognition of the Int'l Human Right to Health and Health Care in the U.S.*, 60 Rutgers L. Rev. 335, 348 (Winter 2008).
[98] Jamar, *supra* note 95, at 49. *See also*, Kinney, *supra* note 96, at 348.
[99] U.S. Const. amend, VIII. *See also*, Bruce & Schleifer, *supra* note 3, at 17.
[100] *Id.*
[101] *Id. See infra* section II.A.
[102] *Id.*
[103] Kinney, *supra* note 96, at 364. *See infra* Section II.B.
[104] *Id.* at 368.
[105] *Id.* at 376. One way that the United States is making health care services more available to its citizens is with the implementation of Obamacare. *Id.*
[106] Oser et al., *supra* note 6, at 79.

Part A will explore arguments in favor of a domestic human right to health within the United States, as relating to the underutilization of MAT. Part B will explain the international human right of health relating to the underutilization of MAT.

PART II.A: DOMESTIC HUMAN RIGHT TO HEALTH

Correctional systems in the United States cannot refuse medically necessary treatments to prisoners with conditions such as diabetes or human immunodeficiency virus (HIV) because of the harm refusal can cause.[107] The same should be true for MAT.[108] To fulfill their duty and responsibility of providing treatment to the opioid-dependent, correctional systems should immediately reform their policies and procedures.[109] Such new policies and procedures would provide MAT so that opioid-dependent patients receive the benefits of this well-studied and validated medical treatment.[110] However, there is a need for greater national leadership in order to modernize these policies.[111]

The Supreme Court has held that deliberate failure of prison authorities to properly respond to the health care needs of an inmate establishes cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution.[112] It can be argued that failing to provide access to MAT, an effective medical treatment for opioid dependence, violates the basic obligation to protect prisoners from exposure to inhuman or degrading conditions.[113]

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[107] Bruce & Schleifer, *supra* note 3, at 21.
[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] Amy Nunn et al., *Methadone and Buprenorphine Prescribing and Referral Practices in US Prison Systems: Results from a Nationwide Survey*, 105 Drug and Alcohol Dependence 83, 88 (2009).
[112] Helling v. McKinney, 509 U.S. 25, 35 (1993). *See* Ginger Lerner-Wren, *Problem Solving Justice, Reducing Recidivism and Promoting Public Safety*, Nova Se. Univ.: Public Health Law Summit (2013).
[113] Bruce & Schleifer, *supra* note 3, at 20.

The law should recognize a right to health, in part because health is a need and an interest in this country.[114] President Franklin D. Roosevelt identified health as one of the four essential human freedoms.[115] A right to health includes equal access to the health care system, including non-discrimination, basic sanitation, public health activities, and medical care.[116] According to the World Health Organization, "[h]ealth is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[117] While citizens cannot claim that they need to be made healthy because they have a right to health, they can claim that they need to have the necessary things done in order for them to be healthy because they have a right to health.[118] The right to health includes health care, healthy conditions, and involvement in decision-making affecting one's health.[119]

Legislative and judicial action on the national level is critical to applying and enforcing the right to health because constitutional law can and will change to match changes in public opinions and political philosophy.[120] Standards that relate to non-discrimination and equal protection are important to creating responsibility for the right to health in the United States.[121] For example, once a state begins to take steps towards enforcing health rights,[122] courts are required to ensure that it does so without discrimination.[123]

Therefore, although the United States has not affirmatively established a human right to health, it could begin to develop one by using the international right to health as a standard in

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[114] Jamar, *supra* note 95, at 16.
[115] *Id.* at 2.
[116] *Id.* at 9.
[117] *Id.* at 10.
[118] *Id.* at 27.
[119] Yamin, *supra* note 93, at 1157.
[120] *Id.* at 1159.
[121] *Id.* This in turn is creating another obstacle in the sense that MAT needs to be provided to everyone in order to satisfy these non-discrimination and equal protection standards, making it easier to just not do it. *Id.*
[122] *Id.* An example of taking steps towards enforcing health rights is through the application of Medicaid. *Id.*
[123] *Id.*

evaluating governmental conduct and degree of accountability.[124] Recognition on the national level of the right to health authorizes the state to ensure equality of access to care and to eliminate any systematic discrimination that exists.[125] State-imposed barriers to MAT for opioid-dependent prisoners interfere with the right to health and should not be tolerated.[126]

PART II.B: INTERNATIONAL HUMAN RIGHT TO HEALTH

Even if domestic law is not clear, failure to provide MAT for the opioid-dependent criminal justice population in prisons and pre-trial detention is a violation of the international human right of health.[127] International human rights law requires use of this treatment, so the United States should provide it – even if it hasn't technically signed on to the treaties providing for such rights.[128]

International human rights law guarantees that prisoners keep their fundamental rights and freedoms while incarcerated.[129] As noted earlier, the World Health Organization, health is the state of complete, physical, mental, and social well-being, as opposed to just the absence of disease or sickness.[130] The United Nations Charter includes language that promotes international health and solutions for related problems.[131] The Universal Declaration of Human Rights states that everyone has the right to a standard of living sufficient for the health and well-being of his

[124] Bruce & Schleifer, *supra* note 3, at 20.
[125] *Id.*
[126] *Id.*
[127] Jamar, *supra* note 95, at 3.
[128] *Id.* at 68.
[129] Bruce & Schleifer, *supra* note 3, at 21. The exception to international human rights law guaranteeing that prisoners keep their fundamental freedoms while incarcerated is the right to liberty of course. *Id.*
[130] Const. of the World Health Org., July 22, 1946, 62 Stat. 6349. *See* Kinney, *supra*note 96, at 338.
[131] Universal Declaration of Human Rights, Dec. 10, 1948, G.A. Res. 217A (III). *See*Kinney, *supra* note 96, at 334.

or her person and of his or her family, which includes medical care and necessary social services.[132]

In addition to these sources, Article 12 of the Covenant of Economic, Social, and Cultural Rights states that everyone has the right to health, in a non-discriminatory fashion, in accordance with principles of equality and universality.[133] Various international bodies have taken the stance that enjoyment of health is a human right.[134] These international bodies include the United Nations General Assembly; the United Nations Economic, Social and Cultural Council; the Human Rights Commission; the committee on Economic, Social and Cultural Rights, and the World Health Organization.[135]

By its nature, the right to health is universal and requires equal application of services and benefits.[136] Thus, there will be a violation of the right to health if the right is not universally available to the population.[137] The international human right to health guarantees all individuals the "enjoyment of the highest obtainable standard of physical and mental health."[138] This standard includes the freedom to acquire or reject medical treatment, the right to a healthy environment, and access to treatment facilities.[139]

The duty to impose the right to health is to act in order to avert a threat to health, as opposed to just acting in response to danger.[140] The right to health forces the government to supply its citizens with clean water, air, and streets, along with clean hospitals, drugs, and

[132] *Id.* at art. 25. *See* Kinney, *supra* note 96, at 338.
[133] Int'l Covenant on Econ., Social and Cultural Rights, opened for signature Dec. 16, 1966, 993 U.N.T.S 12. *See* Kinney, *supra* note 96, at 340.
[134] *Id*. at 342.
[135] *Id.* at 338.
[136] Jamar, *supra* note 95, at 27.
[137] *Id.* at 16.
[138] Int'l Covenant on Econ., Social and Cultural Rights, *supra* note 132.
[139] *Id*.
[140] Jamar, *supra* note 95, at 60.

doctors. When MAT is unavailable to the criminal justice population, the supply of drugs guaranteed under the right to health is as well.[141]

PART III: MEDICATION-ASSISTED TREATMENT IS A GOOD COST-BENEFIT CHOICE

Finally, perhaps more important to policy making, MAT is a good policy choice because its benefits outweigh its costs.[142] Despite the obstacles, there is strong public policy favoring the use of MAT for the opioid-dependent criminal justice population in prisons and pre-trial detention, based on a cost-benefit analysis.[143] Given the United States' reluctance to latch onto the international human right to health, it is necessary to focus on another reason why the legal system should be incorporating MAT.[144] Specifically, this therapy is a good cost-benefit choice.[145] Part A will go into further detail on the costs associated with MAT for the opioid-dependent criminal justice population in prisons and pre-trial detentions, while Part B will discuss the benefits and show why the benefits of MAT outweigh the costs.

PART III.A: COSTS ASSOCIATED WITH MEDICATION-ASSISTED TREATMENT

The costs of not providing MAT include the fact that upon incarceration many opioid-dependent prisoners are being forced to undergo abrupt opioid withdrawal.[146] This sudden and unexpected withdrawal causes them to suffer extreme physical and mental pain, with serious medical consequences.[147] These consequences exist because individuals who are opioid-

[141] Int'l Covenant on Econ., Social and Cultural Rights, *supra* note 132.
[142] Paul G. Barnett & Sally S. Hui, *The Cost-effectiveness of Methadone Maintenance*, 67 Mt. Sinai J Med 365, 374 (2000).
[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] Bruce & Schleifer, *supra* note 3, at 17.
[147] *Id.*

dependent have changed the neurobiology of their brains through the ingestion of the drug, placing themselves at risk.[148]

Risks abound. For example, the opioid-dependent individual assumes risks in hopes of avoiding painful physical and mental withdrawal symptoms.[149] Such risks include self-mutilation and needle-sharing.[150] Moreover, sharing needles can lead to contracting HIV.[151] When an individual already experiencing the trauma of imprisonment also experiences severe opioid withdrawal, there is an increase in the risk of suicide.[152]

Physical and psychological symptoms relating to withdrawal also may impair the individual's ability to make informed legal decisions.[153] As a result, an individual experiencing withdrawal is vulnerable at the time of arrest and pretrial detention.[154] At this time he or she may be intimidated into self-incrimination, giving information which he or she would never give if his or her brain was functioning normally.[155] That individual may be vulnerable to police pressure, resulting in admission to false charges or confession to guilt before having access to counsel, standing before a judge, or being able to break down and understand potential criminal charges and consequences.[156]

Another cost associated with MAT arises because of the poor general knowledge about this treatment among correctional institutions.[157] Therefore, there is the actual financial cost of

[148] *Id.* at 18.
[149] *Id.* at 17.
[150] *Id.* at 19. The risks among the opioid-dependent individual who seeks to avoid painful physical and mental withdrawal symptoms multiply as individuals attempt to avoid detention or to secure release from confinement. *Id.*
[151] *Id.*
[152] *Id.*
[153] *Id.* at 17.
[154] *Id.*
[155] *Id.*
[156] *Id.* at 19.
[157] Springer & Bruce, *supra* note 20, at 81.

providing education to the staff and outsiders.[158] Financial costs also arise because establishing disbursing pharmacotherapies (methadone or buprenorphine) requires additional expense,[159] both literally and in the sense that there is substantial liability associated with storing the highly regulated controlled substances used in MAT: methadone or buprenorphine.[160]

Despite the challenges, these obstacles can be overcome through proper and ongoing staff education, relying on staff outside of the specific correctional institution in disbursing the medication and providing compensation for the staffs' additional time.[161] These changes along with having executive leadership that sets a good example, setting the tone for the implementation of MAT in correctional settings within the criminal justice community, will help overcome the challenges.[162]

PART III.B: BENEFITS ASSOCIATED WITH MEDICATION-ASSISTED TREATMENT

The benefits of MAT for the opioid-dependent criminal justice population in prisons and pre-trial detention are similar to those in community settings.[163] For example, MAT presents prisons with an opportunity to recruit problem opioid users into treatment because they do not have anywhere to go to escape it.[164] The failure to execute effective MAT programs in prisons and pre-trial detention represents an important missed opportunity to recruit high-risk drug users in treatment.[165] Another benefit is that, overall, MAT has a positive influence within the criminal

[158] *Id.* at 81. The financial cost of providing education to outsiders is important in combating and hopefully overcoming the social stigma associated with MAT. When outsiders no longer stigmatize MAT, the likelihood of support by the public will increase. *Id.*
[159] Oser et al., *supra* note 6, at 74.
[160] McKenzie et al., *supra* note 24, at 225.
[161] *Id.*
[162] *Id.* at 227.
[163] Dagmar Hedrich et al., *The Effectiveness of Opioid Maintenance Treatment in Prison Settings: A Systematic Review*, 107 Addiction 501, 501 (2011).
[164] *Id.*
[165] *Id.*

justice system.[166] This positive influence includes reducing opioid injection, syringe sharing, HIV prevalence, and drug violations.[167]

Additionally, nationally and internationally, MAT involving either methadone or buprenorphine decreases recidivism rates, improves adherence to antiretroviral medications, decreases HIV risk-taking behaviors, and improves mortality.[168] The drugs themselves have many positive effects, including preventing withdrawal symptoms and drug cravings, blocking the euphoric effect of opiates, reducing the risk of relapsing to the use of illicit opiates, reducing infectious disease transmission, reducing the likelihood of death resulting from an overdose,[169] and allowing the individual to function normally (when stable on a proper dose).[170]

Along with these benefits, the impact of pre-release MAT on post-release outcomes is positive.[171] The positive influence that pre-release MAT has on post-release behavior includes significantly higher levels of treatment entry and retention, reduction in opioid and cocaine use, minimal risks of overdose on release, less criminal activity, and lower rates of re-incarceration.[172] MAT given to prisoners prior to their release also reduces recidivism and unfortunate health and social consequences associated with drug use.[173] Cost-effectiveness, in fact, is part of the reason the World Health Organization recommends that MAT be the model for treatment systems involving opioid dependence in all countries with problem opioid-user populations.[174]

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[166] *Id.*
[167] *Id.*
[168] Springer & Bruce, *supra* note 20, at 81.
[169] McKenzie et al., *supra* note 24, at 219.
[170] Bruce & Schleifer, *supra* note 3, at 18.
[171] Hedrich et al., *supra* note 160, at 502.
[172] *Id.* at 510.
[173] McKenzie et al., *supra* note 24, at 219.
[174] *Id.* at 514.

CONCLUSION:

Currently MAT for the criminal justice population remains underutilized.[175] Including this therapy within the criminal justice system will produce an opportunity to recruit problem opioid users into the treatment that they need.[176] However, current policies deny addiction treatment services to individuals within the criminal justice population,[177] resulting in a missed public health opportunity.[178] Failing to engage opioid-dependent drug-users in treatment while they are within the criminal justice system results in substantial costs not only to the individual but also to the community, now and in the future.[179]

There is a need for greater national leadership in order to modernize these policies.[180] Political opposition to the pharmacological medication-assisted treatment of opioid-dependence suggests that educating policymakers about the benefits of this treatment, medically and socially, along with encouraging a higher standard of treatment within the correctional system, should be important public health priorities.[181] Unfortunately at this time they are not.[182] Hopefully addressing inadequate knowledge and the negative attitudes towards MAT in the criminal justice system, will produce an increase in its adoption.[183]

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[175] Friedmann et al. *supra* note 1, at 9.
[176] Hedrich et al., *supra* note 160, at 501.
[177] Nunn et al., *supra* note 110, *at* 88.
[178] Hedrich et al., *supra* note 160, at 501.
[179] *Id*.
[180] Nunn et al., *supra* note 110, at 88.
[181] *Id*.
[182] *Id*.
[183] Bruce & Schleifer, *supra* note 3, at 21.