

THE REAL ANTIDOTE: A CRITICAL REVIEW OF U.S. AND CANADIAN DRUG TREATMENT COURTS AND A CALL FOR PUBLIC HEALTH PREVENTION TOOLS AS A SOLUTION TO THE OPIOID EPIDEMIC

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I. INTRODUCTION

A. How Did We Get Here?

Over the past twenty years, both chronic pain and health care costs have tremendously increased.¹ In the background, was a rise in the consumption of (and eventual abuse of) prescription painkillers. The main reason put forth to explain this rise in prescription painkiller use and abuse was the increased access and availability of these prescriptions.² In the United States, from 1999 to 2015, more than 183,000 people died as a result of overdoses of prescription opioids.³ Over time, the nonmedical use of prescription opioids has become a “major public health issue in the U.S.”⁴

During this time, the laws that governed opiate and opioid prescriptions were greatly “liberalized.”⁵ This liberalization of the law led to a dramatic increase in the use of opiates and opioids in the medical profession for chronic non-cancer pain.⁶ Beginning in the second half of the 1990s, various state medical boards cut down on the strict restrictions that governed the prescribing practices of opiates and opioids for the treatment of chronic non-cancer pain, resulting in an unprecedented increase in the number of prescriptions written for chronic pain patients.⁷

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1. Laxmaiah Manchikanti et al., *Opioid Epidemic in the United States*, 15 PAIN PHYSICIAN J. ES9 (2012).

2. Karen Harris & Patrick Krill, *National Opioid Epidemic is Cause to Examine the Legal Profession's Own Problems with Addiction*, 13 ABA HEALTH E-SOURCE (Oct. 2016), https://www.americanbar.org/publications/aba_health_esource/2016-2017/October2016/addition.html [<https://perma.cc/E4SG-33SR>].

3. *CDC Launches Campaign to Help States Fight Prescription Opioid Epidemic*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Sept. 25, 2017), <https://www.cdc.gov/media/releases/2017/p0925-rx-awareness-campaigns.html> [<https://perma.cc/H62T-6EUK>].

4. Wilson M. Compton et al., *Relationship between Nonmedical Prescription-Opioid Use and Heroin Use*, 374 N. ENG. J. OF MED. 154 (2016), at 154.

5. Manchikanti et al., *supra* note 1, at ES9.

6. *Id.*

7. *Id.*

In the past twenty years, the amount of prescription opioids sold in the U.S. has increased almost four-fold. According to the Centers for Disease Control and Prevention (“CDC”), “health care providers wrote 259 million prescriptions for painkillers in 2012.”⁸ How much is that? Well, it is more than enough to give every American adult a personal bottle of pills.⁹ Despite these astronomically high amounts of drugs flooding American homes, there was not a significant change in the overall amount of reported pain.¹⁰

In some cases, tiny towns in the U.S. received more painkillers than residents could ever have medically needed.¹¹ The small town of Kermit in West Virginia coal country was one such place.¹² With a population of 392 people, this town received almost nine million highly addictive opioid painkiller tablets over a two-year period.¹³ These nine million pills were shipped from out-of-state drug companies to one single pharmacy.¹⁴ Do the math and this comes out to about 22,959 pills per person in Kermit. It was amongst these conditions that an opioid epidemic with deadly adverse consequences has risen to the forefront.¹⁵

As millions of people began to receive prescription after prescription of opioids for pain, many eventually became dependent on them.¹⁶ Once individuals became dependent on these medications, if they could not obtain these medications legally, they would often obtain them illegally or move on to illicit drugs, like the traditional street drug, heroin.¹⁷ A study of young injection drug users interviewed in 2008 and 2009 found that “86 percent had used opioid pain relievers nonmedically prior to using heroin.”¹⁸ Soon enough, a deeper crisis was

8. Opioid Painkiller Prescribing, Where You Live Makes a Difference, CENTERS FOR DISEASE CONTROL AND PREVENTION (July 2014), <http://www.cdc.gov/vitalsigns/opioid-prescribing> [perma.cc/G9VX-YB7W].

9. *Id.*

10. Hsien-Yen Chang, Matthew Daubresse, Stefan P. Kruszewski et al., *Prevalence and treatment of pain in emergency departments in the United States, 2000 – 2010*, 32 AM. J. OF EMERGENCY MED. 421-31 (2014); Matthew Daubresse, Hsien-Yen Chang, Yuping Yu, Shilpa Viswanathan et al., *Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000 – 2010*, 51 MED. CARE 870-78 (2013).

11. Eric Eyre, *Drug Firm Poured 780M Painkillers into WV amid Rise of Overdoses*, CHARLESTON GAZETTE MAIL (Dec. 17, 2016), https://www.wvgazettemail.com/news/cops_and_courts/drug-firms-poured-m-painkillers-into-wv-amid-rise-of/article_99026dad-8ed5-5075-90fa-adb906a36214.html [https://perma.cc/HN9U-7QBY].

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Opioid Overdose Crisis*, NAT'L INST. ON DRUG ABUSE (Mar. 2018), <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis> [https://perma.cc/4ARL-L3UL].

17. *Id.*

18. In some places, heroin is considerable cheaper to buy and easier to obtain than a prescription opioid, so some people begin using heroin instead due to this economic reality. See *Prescription Opioids and Heroin*, NAT'L INST. ON DRUG ABUSE (Jan. 17, 2018), <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>.

born.

The non-medical use of opiates and opioids continues to be a major public health issue in this country.¹⁹ Recently, the New York Times reported that the opioid crisis was only getting worse.²⁰ Data from the CDC supported this conclusion, as it reported drug overdoses have tripled between the years of 1999 and 2014.²¹ Currently, the U.S. is facing an epidemic with two facets. On one side, the U.S. is dealing with a crisis of addiction to prescription opiates/opioids, many of which were legally prescribed. The other side of this crisis involves a rising number of acute overdoses due to both illegally obtained opiates and opioids and legally prescribed drugs.²²

This crisis has reached far and wide; it has affected people of all ethnicities and socioeconomic statuses. Painkiller abuse has affected famous celebrities, some of whom received their medication legally through a prescription from their doctor, while others obtained them illegally through other means. In light of this epidemic, many professional organizations have performed evaluations to examine the true extent and reach of this crisis. One such profession is the legal one. The American Bar Association announced it is examining its own problems with addiction within the legal community.²³ Not only does this crisis present a public health issue, it presents an issue for the legal community as well. But that is not all. The opiate and opioid addiction and the acute overdoses associated with it also present serious legal issues for drug users themselves. With addiction, legal troubles often ensue. Despite such issues, it is important to keep in mind that these are not unsolvable problems. Although drug overdose has become a leading cause of death for American adults, overdose is unlike other causes of death, as

drugabuse.gov/publications/research-reports/relationship-between-prescription-drug-heroin-abuse/prescription-opioid-use-risk-factor-heroin-use [https://perma.cc/UEX9-S76C]. See also *Prescription Opioids*, NAT'L INST. ON DRUG ABUSE (Jun. 7, 2018), <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids> [https://perma.cc/6F9S-MJ23]. See also SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, RESULTS FROM THE 2012 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2013); Theodore J. Cicero, Matthew S. Ellis & Hilary L. Surratt, *Effect of abuse-deterrent formulation of OxyContin*, 367 N. ENG. J. OF MED. 187–89 (2012).

19. Compton et al., *supra* note 4, at 154–155.

20. Josh Katz & Abby Goodnough, *The Opioid Crisis is Getting Worse, Particularly for Black Americans*, N.Y. TIMES (Dec. 22, 2017), <https://www.nytimes.com/interactive/2017/12/22/upshot/opioid-deaths-are-spreading-rapidly-into-black-america.html> [https://perma.cc/25PS-BW3L].

21. Rose A. Rudd, Puja Seth, Felicita David & Lawrence Scholl, *Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Dec. 30, 2016), <https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm> [https://perma.cc/Q58P-3VQ2].

22. *Opioid Overdose*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 23, 2017), <https://www.cdc.gov/drugoverdose/index.html> [https://perma.cc/9H3E-GHJK].

23. Harris & Krill *supra* note 2.

death resulting from an opioid overdose can be prevented.²⁴

This Note will critically examine the opiate and opioid epidemic as it relates to public health initiatives and criminal law programs, specifically drug courts. The Note will examine Michigan's and Ontario's drug court programs and suggest a public health based solution to the opioid epidemic, focused on evidence based medicine, an expansion of telemedicine and medication assisted treatment, active provider participation, improved oversight in prescription monitoring programs, improved Good Samaritan Laws, and the use of epidemiologically based prevention strategies.²⁵ Michigan has taken action to prevent prescription drug and opioid deaths and increase access to treatment for people addicted to drugs.²⁶ This Note will suggest improvements to Ontario's programs and laws to curb this epidemic. This Note will also evaluate the successful strategies Ontario has implemented to improve public health.

The goal of this Note is not to suggest that the use of opiates/opioids is never medically necessary. This Note recognizes there are appropriate uses of opiates/opioids in medical settings. Neither is the point of this Note to advocate for the removal of drug court programs entirely. This Note serves to call attention to the fact that the medical community cannot continue as it is with current prescribing practices. This Note also argues that drug courts are not sufficient in their current form to serve offending individuals with drug addictions. The point of this Note is to draw attention to the current epidemic and to recognize that it is both a legal and public health issue. Therefore, it follows that the opiate/opioid and its accompanying legal issues should be dealt with according to legal and

24. Scott Burris, Leo Beletsky, Carolyn Castagna, Casey Coyle, Colin Crowe, Jennie M. McLaughlin, *Stopping an Invisible Epidemic: Legal Issue in The Provision of Naloxone to Prevent Opioid Overdose*, DREXEL L. REV. 273 (2009). See also Tinka Markham Piper et al., *Overdose Prevention for Injection Drug Users: Lessons Learned from Naloxone Training and Distribution Programs in New York City*, 4 HARM REDUCTION J. 1 (2007), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1797013/pdf/1477-7517-4-3.pdf> [<https://perma.cc/SG7P-Q95Q>]

25. Generally, prescription monitoring programs allow prescribers and dispensers to access an individual's monitored drug history. Law enforcement can also access patient profiles through a more formal request process. Licensing authorities can access prescriber, pharmacy and patient profiles. Prescribers can request a prescriber peer comparison report, which will compare their individual prescribing information with that of their peers in the same geographical region or the same scope of practice (e.g., pain clinics) or specialty (e.g., primary care, specialist). See Andrea D. Furlan et al., *Overview of four prescription monitoring/review programs in Canada*, 19 PAIN RES. MGMT. 102 (2014). Some jurisdictions require providers to search new patients in their respective prescription monitoring system before writing a controlled substance prescription. This allows providers to rule out the existence of "doctor shopping," which involves a patient visiting multiple practitioners for the sole purpose of gaining a prescription for a controlled substance. Prescription monitoring programs were designed to prevent this phenomenon, but many providers fail to utilize the programs, do not use them frequently enough, or ignore them altogether.

26. *Treatment Resources*, MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (2017), http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_79584---,00.html [<https://perma.cc/J9RN-QSZD>].

public health principles.

This Note proceeds in seven parts. Section I of this Note serves as an introduction to the issues and arguments. This section will provide a backdrop to the opiate/opioid crisis and define terms such as “epidemic.” Section II will provide a review of the medical literature. This section will spend time differentiating between opiates and opioids. It will also provide a scientific explanation into the nature of addiction and the mechanisms of opioid receptors. Section III will provide both a historical background and an overview of the current U.S. public health initiatives at the federal level. Discussion will begin by focusing on national discussions, then narrowing into Michigan and Ontario specific data. Discussion will revolve around the effectiveness of these existing programs. This historical overview is important as it will serve to help readers draw comparisons between the present and past in order to make better decisions for the future.

National discussion will focus on how the crisis originated from the aggressive marketing of prescription pain medication to physicians then to the overprescribing of prescription opioids then to the latest deadly wave of the crisis fueled by fentanyl and carfentanil laced heroin. Particular attention will be paid to the rural opioid epidemic. This section will also present information on medication assisted treatment involving Suboxone and the barriers to that care, first providing national data and figures.

Section IV will provide discussion on the public health response to the opioid crisis. Section V will describe U.S. and Canadian drug courts, with a focus on their origins and status in present day. This section will also narrow down the discussion to specifically address Michigan and Ontario drug courts and their successes/challenges. Discussion will revolve around the facts and figures of overdoses and will then move into a discussion of the history and design of each jurisdiction’s drug court programs. Section VI will provide analysis and recommendations to improve the already existing drug court programs in Ontario and Michigan. This section will also provide recommendations to improve each jurisdiction’s laws and public health initiatives. Section VII will provide conclusions as a result of analysis.

B. Overview of the Data

According to the CDC, an epidemic is “an increase, often sudden, in the number of cases of a disease above what is normally expected in that population or area.”²⁷ In the U.S., drug overdose deaths and opioid-involved deaths have continued to increase year after year.²⁸ In 2016, 46 people in the U.S. died every

27. *Epidemic Disease Occurrence*, CENTERS FOR DISEASE CONTROL AND PREVENTION (May 18, 2012), <https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson1/section11.html> [https://perma.cc/9P82-R2JR].

28. *Understanding the Epidemic*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 30, 2017), <https://www.cdc.gov/drugoverdose/epidemic/index.html> [https://perma.cc/U2QR-7P7S].

day as a result of prescription opioid overdoses.²⁹ Most recent data suggests more than 115 Americans die from an opioid overdose on a daily basis.³⁰ Research shows opioid addiction strikes every state, county, socio-economic group, ethnicity, and a wide range of ages.³¹ Today, 40% of all U.S. opioid death involve a prescription opioid.³²

Every day, American emergency rooms see approximately 1,000 visits for complications related to the misuse of an opioid prescription, resulting in approximately 91 overdose deaths per day.³³ In response to this epidemic, federal and state agencies have implemented a variety of policies and programs aimed at curbing inappropriate prescribing.³⁴ Meanwhile, individuals affected by inappropriate prescribing have turned to street drugs and black market channels to obtain opioids/opiates to prevent withdrawal. Unfortunately, many of these people have overdosed and died as a result.³⁵ Whereas other individuals have had issues with criminal courts and criminal charges related to drug possession.³⁶

As the opioid epidemic began to envelop the nation, arrests for drug related offenses became more common.³⁷ In 2015, the Federal Bureau of Investigation (FBI) reported a total of 1,488,707 arrests for all drug offenses.³⁸ Of these arrests, 1,249,025 were for the illegal possession of drugs.³⁹ Of these arrests, 296,252

29. *Prescription Opioid Overdose Data*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 1, 2017), <https://www.cdc.gov/drugoverdose/data/overdose.html> [<https://perma.cc/FGG2-SAT7>].

30. *Opioid Crisis*, NAT'L INST. ON DRUG ABUSE (Jun. 2017), <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-crisis> [<https://perma.cc/ZN6J-B9F5>].

31. *Opioid Addiction Disease*, THE AMERICAN SOCIETY OF ADDICTION MEDICINE (2015), <https://www.healhero.in.org/uploads/9/8/2/9/98294234/asam-facts-figures.pdf> [<https://perma.cc/7V3J-AYY8>].

32. *Prescription Opioid Overdose Data*, *supra* note 29.

33. The most common drugs associated with these emergency situations are methadone, OxyContin (oxycodone), and Vicodin (Hydrocodone). *See Prescription Opioid Overdose Data*, *supra* note 29; *See also* Elizabeth Y. Schiller & Oren J. Mechanic, *Opioid Overdose*, (Oct. 27, 2018), <https://www.ncbi.nlm.nih.gov/books/NBK470415/> [<https://perma.cc/DY5G-JPW8>].

34. Compton et al., *supra* note 4, at 154.

35. *See generally Prescription Opioids and Heroin*, NAT'L INST. ON DRUG ABUSE (Jan. 17, 2018), <https://www.drugabuse.gov/publications/research-reports/prescription-opioids-heroin> [<https://perma.cc/EPT3-7S3F>]. *See also* Richard J. Bonnie, Morgan A. Ford & Jonathan K. Phillips, *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*, 189 (2017). E-book available at https://www.ncbi.nlm.nih.gov/books/NBK458660/pdf/Bookshelf_NBK458660.pdf [<https://perma.cc/32WE-6AUQ>].

36. Shima Baradaran, *Drugs and Violence*, 88 S. CAL. L. REV. 227 (2015).

37. By 2009, about four out of every five arrests linked with a drug abuse violation was for possession or use. *See id.* at 40.

38. *Crime, Arrests, and Law Enforcement*, DRUG WAR FACTS (2018), http://www.drugwarfacts.org/chapter/crime_arrests [<https://perma.cc/86XF-EFBE>].

39. *Id.*

were related to heroin, cocaine and their derivatives.⁴⁰ Today, most inmates who are in prison are there, at least in part, due to issues with substance abuse.⁴¹ Best estimates show that approximately 80% of offenders abuse drugs or alcohol and almost half of jail and prison inmates are clinically addicted.⁴² Research has shown that imprisoning these individuals has little effect on drug abuse.⁴³ Estimates also provide that approximately 60-80% of drug abusers go on to commit a new crime.⁴⁴ Often these later crimes are drug-driven.⁴⁵ When it comes to addiction after incarceration, approximately 95% of offenders continue to abuse drugs.⁴⁶ Further research has suggested that providing treatment to offenders which lacks personal accountability is not an effective method.⁴⁷ What has resulted is an increase in the amount of crimes committed by drug abusers, with a limited amount of those offenders enrolling in judicial supervision and drug treatment courts.⁴⁸

Drug treatment courts are “judicially-supervised court dockets that strike the proper balance between the need to protect community safety and the need to improve public health and well-being.”⁴⁹ Drug courts aim to keep non-violent drug-addicted offenders in treatment for long periods of time, while supervise them strictly.⁵⁰ Offenders who qualify are able to receive the treatment the court

40. *Id.*

41. *The Facts on Drugs and Crime in America*, National Association of Drug Court Professionals, available at <https://www.nadcp.org/sites/default/files/nadcp/Facts%20on%20Drug%20Courts%20.pdf> [<https://perma.cc/NR8C-SRMV>]

42. *Behind Bars: Substance Abuse and America's Prison Population*, CENTER ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY (Jan. 1999), available at <https://www.centeronaddiction.org/addiction-research/reports/behind-bars-substance-abuse-and-america%E2%80%99s-prison-population> [<https://perma.cc/FP5H-LDQL>] (as cited by *The Facts on Drugs and Crime in America*, *supra* note 41).

43. *The Facts on Drugs and Crime in America*, *supra* note 41.

44. U.S. DEP'T OF JUSTICE, RECIDIVISM OF PRISONERS RELEASED IN 1994 (June 2002); *The effect of imprisonment on recidivism rates of felony offenders: A focus on drug offenders*, CRIMINOLOGY, 40, 329-357 (as cited by *The Facts on Drugs and Crime in America*, *supra* note 41).

45. U.S. DEP'T OF JUSTICE, *supra* note 44. See also *the effect of imprisonment on recidivism rates of felony offenders: A focus on drug offenders*, *supra*, note 44.

46. Thomas E. Hanlon et al., *The response of drug abuser parolees to a combination of treatment and intensive supervision*, 78 PRISON J., 31-44 (1998); Steven S. Martin et al., *Three-year outcomes of therapeutic community treatment for drug involved offenders in Delaware*, 79 PRISON J. 294-320 (1999); David N. Nurco et al., *Recent research on the relationship between illicit drug use and crime*, 9 BEHAVIORAL SCIENCES & THE LAW 221-49 (1991) (as cited by *The Facts on Drugs and Crime in America*, *supra* note 44).

47. U.S. DEP'T OF JUSTICE, *supra* note 44; *The effect of imprisonment on recidivism rates of felony offenders: A focus on drug offenders*, *supra*, note 47.

48. *The Facts on Drugs and Crime in America*, *supra* note 41.

49. *Id.*

50. *Id.*

approves, while recovering under supervision.⁵¹ Judges hold participating offenders highly accountable during this time.⁵² For offenders who participate in drug courts, regimens can be quite strict. Participating offenders are frequently and randomly tested for drugs in their urine, they are required to appear in front of a judge to review their progress, some receive rewards for doing well, but oftentimes offenders receive sanctions from the judge for lapses.⁵³ Drug courts have been criticized in recent years as to their effectiveness.⁵⁴ Whereas drug court proponents argue drug courts “work better than jail or prison, better than probation, and better than treatment alone.”⁵⁵ Supporters argue drug courts “significantly reduce drug use and crime and do it cheaper than any other justice strategy.”⁵⁶ However, this bold claim lacks significant evidence to conclude such a sweeping statement.

Of the almost approximately 1.5 million people charged with a crime in the U.S., who were deemed at risk for drug abuse or dependence, only 109,921 (or 7 percent) met the stringent eligibility requirements to participate in drug courts.⁵⁷ To put this number in perspective, this accounts for about seven percent of people arrested. This means that many people who need drug treatment do not have access to it, and those that do are choosing treatment over prison time. Offenders do not make a meaningful choice, they choose the lesser of two evils. Thus, it is the contention of this Note that drug courts should not be the main pipeline for addressing addiction and the possession of opiates and opioids.⁵⁸ The real solution to this epidemic (and opportunities for treatment and recovery) should not be predicated on involvement with the criminal justice system. If this crisis is termed an epidemic, then epidemiological principles and public health prevention strategies are where the true hope lies.

II. REVIEW OF THE MEDICAL LITERATURE

A. Opiates and Opioids

Opiates are a class of drugs derived from the opium plant.⁵⁹ Specifically,

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.*

55. *Id.*

56. *Id.*

57. *Offenders Eligible for Drug Courts Compared with Total At-Risk Arrestee Population*, DRUG WAR FACTS (2018), <http://www.drugwarfacts.org/node/1959> [<https://perma.cc/L67X-7JDK>].

58. This author is concerned with non-violent individuals who were arrested for possession, not those arrested for trafficking high amounts of opiates/opioids. That population is not the focus of this Note.

59. *Opiates/Opioids*, THE NAT'L ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT, https://www.naabt.org/education/opiates_opioids.cfm [<https://perma.cc/54AA-87DQ>].

opium comes from the opium poppy.⁶⁰ Opium is an “exudate” of *Papaver somniferum*.⁶¹ The term opioid traditionally referred to a synthetic opiate, however, opioid now encompasses all drugs derived from the opium plant, including synesthetic varieties.⁶² Drugs in the opioid class of drugs were originally created to mimic the effects of opiates, but opioids and opiates are chemically different from each other.⁶³ Traditionally, opiates were prescribed to treat pain, but more recently, opioids replaced opiates as the primary form of prescribed pain medication.⁶⁴ Opioids include such drugs as heroin, morphine, codeine, Vicodin (acetaminophen-hydrocodone), OxyContin (oxycodone), Dilaudid (hydromorphone), Duragesic (fentanyl), Percocet (acetaminophen-oxycodone), methadone, and buprenorphine.⁶⁵ Both opiates and opioids are considered analgesic (pain relieving) substances.⁶⁶ Traditionally, opiates were prescribed to treat pain, but more recently, opioids replaced opiates as the primary form of prescribed pain medication.⁶⁷

B. Mechanisms of Opiates and Opioids

Once an opiate or opioid enters the bloodstream it moves to the brain, causing the chemicals to attach to special proteins called “mu opioid receptors,” located on the surfaces of neurons that are especially sensitive to the drug.⁶⁸ During this process, they trigger “the same biochemical brain processes that reward people with feelings of pleasure when they engage in activities that promote basic life

60. Sonia Moghe, *Opioid History: From ‘Wonder Drug’ to Abuse Epidemic*, CNN (Oct. 14, 2016), <http://www.cnn.com/2016/05/12/health/opioid-addiction-history/index.html> [https://perma.cc/J9HP-SJ84].

61. Abraham. D. Krikorian & Myron C. Ledbetter, *Some Observations on the Cultivation of Opium Poppy (Papaver somniferum L.) for Its Latex*, 41 BOTANICAL REVIEW 30 (1975).

62. *Opiates/Opioids*, *supra* note 59.

63. *Id.*

64. Moghe, *supra* note 60. See also *The Strange History of Opiates in America: from Morphine for Kids to Heroin for Soldiers*, THE GUARDIAN (Mar. 15, 2016), <https://www.theguardian.com/commentisfree/2016/mar/15/long-opiate-use-history-america-latest-epidemic> [https://perma.cc/99KN-236L].

65. Asbjørn M. Drewes et al., *Differences between opioids: pharmacological, experimental, clinical and economical perspectives*, 75 BRITISH J. OF CLINICAL PHARMACOLOGY 60 (2013).

66. *Opioid Addiction Disease*, American Society of Addiction Medicine (2015), <https://www.healheroin.org/uploads/9/8/2/9/98294234/asam-facts-figures.pdf> [https://perma.cc/SAT3-LE9W].

67. Moghe, *supra* note 60. See also *The Strange History of Opiates in America: from Morphine for Kids to Heroin for Soldiers*, THE GUARDIAN (Mar. 15, 2016), <https://www.theguardian.com/commentisfree/2016/mar/15/long-opiate-use-history-america-latest-epidemic> [https://perma.cc/99KN-236L].

68. Thomas R. Kosten & Tony P. George, *The Neurobiology of Opioid Dependence: Implications for Treatment*, 1 SCIENCE & PRACTICE PERSPECTIVES 13, 14 (2002).

functions, such as eating and sex.”⁶⁹ In the appropriate medical setting, opioids are prescribed therapeutically to relieve pain.⁷⁰ However, when opioids are used in the absence of pain, they can “motivate repeated use of the drug simply for pleasure.”⁷¹

One of the “brain circuits” that is activated by opioids is the “mesolimbic (midbrain) reward system.”⁷² This system creates signals in a part of the brain called the “ventral tegmental area (VTA)” that “result in the release of the chemical dopamine in another part of the brain.”⁷³ This release of dopamine is responsible for the feelings of pleasure.⁷⁴ When opioids are used repeatedly, dopamine gets released over and over again, creating a “lasting record or memory that associates these good feelings with the circumstances and environment in which they occur.”⁷⁵ Over time, these memory associations lead to cravings for drugs by the abuser, causing them to seek out the drug in spite of obstacles or external factors.⁷⁶

Repeated exposure to escalating doses of opioids “alters the brain so that it functions more or less normally when the drugs are present and abnormally when they are not.”⁷⁷

C. Addiction and Opioid Use Disorder

According to the American Society of Addiction Medicine, addiction is a “primary, chronic disease of brain reward, motivation, memory, and related circuitry.”⁷⁸ Dysfunction in these “circuits” leads to “characteristic biological, psychological, social, and spiritual manifestations.”⁷⁹ Addiction is marked by an “inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response.”⁸⁰ Addiction has been clinically described as “a chronic disease, in which patients often go

69. *Id.*

70. *Id.*

71. *Id.*

72. Dopamine is a neurotransmitter “present in the brain regions that regulate movement, emotion, motivation, and the feeling of pleasure. See Kosten & George, *supra* note 68, at 14-15.

73. Kosten & George, *supra* note 68, at 14.

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. *Public Policy Statement: Short Definition of Addiction*, AMERICAN SOCIETY OF ADDICTION MEDICINE (Apr. 12, 2011), https://www.asam.org/docs/default-source/public-policy-statements/1definition_of_addiction_short_4-11.pdf?sfvrsn=6e36cc2_0 [https://perma.cc/E9MQ-SYLM].

79. *Id.*

80. *Id.*

through cycles of relapse and remission.”⁸¹ Addiction operates in a progressive manner, meaning that those who fail to seek treatment or recovery can ultimately experience death or a disability as they continue to use their substance of abuse.⁸²

One type of addiction is opioid use disorder, which demands satisfaction of several diagnostic criteria before a diagnosis can be made.⁸³ These criteria include: the use of an opioid in increased amounts or for longer than medically indicated, the insistent wish or unsuccessful effort to lower or control opioid use, a strong wish to take an opioid, opioid use interfering with important obligations and daily life activities, a continued opioid use despite personal or social problems as a result of the drug use, the elimination of or a decrease in important daily life activities due to opioid use, the use of an opioid during a physically demanding task, a need for higher and higher doses of opioids, and then withdrawal symptoms when the dose is ultimately lowered.⁸⁴

The 2013 edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association defines “opioid-use disorder” as “the repeated occurrence within a 12-month period of two or more of eleven criteria, including withdrawal, giving up important life events in order to use opioids, and excessive time spent using opioids.”⁸⁵ A combination of six or more of the diagnosis criteria indicates a severe problem.⁸⁶

The clinical progression of opioid-use disorders often involves periods of severity and remission, meaning that relapses are likely to occur during treatment.⁸⁷ These individuals often encounter many legal problems as well.⁸⁸

D. Overdose Deaths and the Demographics of Addicts and Overdose Victims

In 2014, close to two million Americans abused or were clinically dependent on prescription opioids.⁸⁹ In 2016, the CDC reported that 64,070 people died from drug overdoses.⁹⁰ Of these deaths, approximately three-fourths can be attributed

81. *Id.*

82. *Id.*

83. Marc A. Schuckit, *Treatment of Opioid-Use Disorders*, 375 N. ENG. J. OF MED. 357 (2016).

84. *Id.*

85. *Id.* at 357.

86. *Id.*

87. *Id.*

88. *Id.*

89. *Prescription Opioid Overdose Data*, *supra* note 29.

90. To put this number in perspective, this amount surpasses the number of Americans killed during the Vietnam or the total deaths due to motor vehicle deaths, or the amount of deaths due to AIDS in 1995, the worst year of the AIDS crisis. *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Aug. 6, 2017), https://www.cdc.gov/nchs/data/health_policy/monthly-drug-overdose-death-estimates.pdf [https://perma.cc/T3ZJ-D7EA]. See also, Ashley Welch, *Drug Overdoses Killed More Americans Last Year than the Vietnam War*, ABC NEWS (Oct. 17, 2017), <https://www.cbsnews.com/news/opioids-drug-overdose->

to opioids.⁹¹ While men are more likely to die from an overdose than women, individuals between 25 and 54 years of age are the most at risk for dying from a prescription overdose.⁹²

III. HISTORICAL BACKGROUND

A. America's History of Opiate Use and Subsequent Addiction

The use of opiates in America has a long history, as do their abuse.⁹³ America's experience with opiates goes back to the time of the Mayflower in 1620.⁹⁴ One of those Mayflower pilgrims was a physician named Samuel Fuller.⁹⁵ Dr. Fuller reportedly brought an early form of laudanum with him on his transatlantic journey.⁹⁶ Like other opiates, laudanum was a product originating from the opium poppy.⁹⁷ It was an effective pain reliever that helped to ease the pain of patients in early America who commonly suffered from ailments such as smallpox, cholera, and dysentery, though it did not directly treat these ailments.⁹⁸

By the late 1700s opium was a commonly used medical tool.⁹⁹ During the American Revolution, the Continental and British armies both used opium as an effective pain reliever to treat injured soldiers.¹⁰⁰ Opiate use was so far spread in society that several of our founding fathers reportedly relied on laudanum to ease their own pain.¹⁰¹ However, it was not until the Civil War that America's first opiate epidemic really reared its ugly head.¹⁰² The use of opiates by Union Army soldiers alone numbered ten million opium pills.¹⁰³ The Union Army also utilized

killed-more-americans-last-year-than-the-vietnam-war/ [https://perma.cc/XWA3-6NNQ].

91. *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, *supra* note 90.

92. *Prescription Opioid Overdose Data*, *supra* note 29.

93. James Nevius, *The Strange History of Opiates in America: from Morphine for Kids to Heroin for Soldiers*, THE GUARDIAN (Mar. 15, 2016), <https://www.theguardian.com/commentisfree/2016/mar/15/long-opiate-use-history-america-latest-epidemic> [https://perma.cc/3R5V-GPH7].

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.* See also DAVID DARY, FRONTIER MEDICINE 36 (2008).

99. Nevius, *supra* note 93.

100. Erick Trickey, *Inside the Story of America's 19th-Century Opiate Addiction*, SMITHSONIAN (Jan. 4, 2018), <https://www.smithsonianmag.com/history/inside-story-americas-19th-century-opiate-addiction-180967673/> [https://perma.cc/Z3DA-UAA5].

101. Benjamin Franklin reportedly suffered from a bladder stone late in life. Franklin used opium to ease the pain associated with this condition. It was also reported that a physician administered laudanum to Alexander Hamilton after his fatal duel with Aaron Burr. See *id.*

102. *Id.*

103. *Id.*

2.8 million ounces of opium powders and tinctures.¹⁰⁴ It is not known how many soldiers returned home from the war addicted to opium, but it is widely agreed that this amount of opiates created a problem in society.¹⁰⁵

Laudanum and other forms of opiates continued to be a popular medication well into the Victorian era.¹⁰⁶ During this time, opium was virtually totally unregulated and physicians provided their patients with many doses.¹⁰⁷ Opiates were widely available and easily accessible, as they were sold over the counter in pharmacies and many other retail locations.¹⁰⁸ Around this time medical journals started to publish warnings about the dangers of morphine and its addictive properties.¹⁰⁹ Despite these warnings, physicians at this time were slow to change their prescribing habits in order to reverse the public's over-reliance on opiates.¹¹⁰ Part of the resistance of physicians to reduce opiate reliance involved financial interests.¹¹¹ Demands for morphine from affluent patients and competition from other doctors and pharmacies willing to provide the drugs to the public added to the pressures felt by physicians at the time.¹¹² Medicinal and recreational use of opiates remained relatively common by the mid-nineteenth century.¹¹³

By the late 1800s, more than 60% of opium addicts were women.¹¹⁴ In Boston by 1888, opiates accounted for 15% of all prescriptions distributed by the city's drug dispensers.¹¹⁵ By 1895, the overuse of morphine and opium powders had led

104. *Id.* A tincture is a "liquid medicinal preparation containing alcohol. The medicinal ingredient of a typical tincture is vegetable in origin" See "Tincture," ATTORNEY'S DICTIONARY OF MEDICINE (Sep. 2017).

105. Trickey, *supra* note 100. However, since the early years of the twentieth century, historians and physicians have used the term "army disease" to describe both Union and Confederate Soldiers addicted to morphine. Whether or not addiction was prevalent among veteran troops is under much debate, but one thing is firm, that after the Civil War, drug problems ran rampant. See Jonathan Lewy, *The Army Disease: Drug Addiction and the Civil War*, 21 SAGE J 102, 102 (2014).

106. Joe Schwarcz, *Opium and Laudanum History's Wonder Drugs*, CHEMICAL INSTITUTE OF CANADA (Jul./Aug. 2015), <http://www.cheminst.ca/magazine/columns/opium-and-laudanum-history%E2%80%99s-wonder-drugs> [<https://perma.cc/2724-XBRW>].

107. Trickey, *supra* note 100. See also Nevius, *supra* note 93.

108. Trickey, *supra* note 100.

109. *Id.*

110. *Id.*

111. *Id.*

112. *Id.*

113. Nevius, *supra* note 93.

114. Abuse by women has been attributed the fact that opium was frequently prescribed for uterine and ovarian conditions. Male doctors would frequently prescribe morphine to relieve menstrual cramps, morning sickness, and even "nervous character" complaints. See Trickey, *supra* note 100.

115. *Id.*

to an addiction epidemic that affected about 1 in 200 Americans.¹¹⁶ What proved most useful during this epidemic was the focus on educating physicians.¹¹⁷ During the 1890s, medical textbooks and medical school instructors provided strong messages of caution against overprescribing opiates.¹¹⁸ By the 1890s physicians began to recognize the extent of the problem and change their prescribing habits.¹¹⁹ Although physicians began to change their prescribing habits, this was not the end of America's reliance on opiates.¹²⁰ With the invention of the hypodermic needle came an increased use of opium drugs, specifically morphine.¹²¹ The hypodermic needle offered physicians and patients a "powerful new technique for administering morphine," allowing its effects to be "almost immediately felt."¹²²

In the late 19th century, several U.S. states began to regulate opiates.¹²³ These laws helped to cut off the ease of accessibility as opiates could no longer be procured as over-the-counter drugs.¹²⁴ However, despite increased regulation opiate abuse discretely continued into the early 20th century, particularly in the American South.¹²⁵ Southern whites had the highest addiction rate of any group in the U.S.¹²⁶ Part of southerners' heavy reliance on opium can be attributed to the high rates of diarrhea, dysentery, and malaria, all of which were endemic diseases to the area.¹²⁷ Because these endemic conditions were chronic and incapacitating, frequent dosing with opiates to treat the symptoms of these conditions led to dependence and addiction.¹²⁸

By 1914, the Harrison Narcotic Act was passed.¹²⁹ This law was designed to regulate the sale and distribution of narcotics (primarily opiates and cocaine).¹³⁰ This law primarily dealt with the financial implications associated with the

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. *Id.*

121. David T. Courtwright, *The Hidden Epidemic: Opiate Addiction and Cocaine Use in the South, 1860-1920*, 49 J. S. HIST. 57, 63 (1983).

122. *Id.*

123. Trickey, *supra* note 100.

124. *Id.*

125. Courtwright, *supra* note 121, at 72.

126. *Id.* at 57. Documenting exact patterns of drug use for this period has proved difficult as users of this time would often conceal their use out of fear of social stigma or legal trouble. This opinion also excepts the Chinese population in its consideration. *Id.*

127. *Id.* at 65 The term "endemic" refers to "the constant presence and/or usual prevalence of a disease or infectious agent in a population within a geographic area." See also *Epidemic Disease Occurrence*, CENTERS FOR DISEASE CONTROL AND PREVENTION (May 18, 2012), <https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson1/section11.html> [<https://perma.cc/FX9P-E74E>].

128. Courtwright, *supra* note 121.

129. *Id.* at 57.

130. *Id.*

distribution and sale of opiates.¹³¹ What the Act failed to do was deal with any maintenance issues between physician and patient.¹³² Specifically, it was ambiguous as to whether or not a physician could legally supply an individual with drugs “for the sole purpose of supporting his or her habit.”¹³³

The legal implications for physicians were left unaddressed until 1919.¹³⁴ The Supreme Court decided that physicians could not maintain addicted patients by prescribing them opiates.¹³⁵ As a result, many addicted individuals turned to the black market to obtain their much-desired opiates.¹³⁶ To combat this health crisis, many towns and cities actually set up “narcotic clinics,” places that supplied doses of narcotics to addicted persons.¹³⁷ People could also receive treatment at these clinics.¹³⁸ These clinics were met with success until federal action shut down almost all of them.¹³⁹

Part of what the Harrison Narcotic Act did was enable data collection related to southern opiate addicts attending narcotic treatment clinics.¹⁴⁰ According to 1924 data, approximately 2.567 per 1,000 residents of Atlanta were opiate addicts attending narcotic clinics.¹⁴¹ Approximately 4.809 per 1,000 opiate addicts in Shreveport, Louisiana, were attending clinics.¹⁴² In Memphis, Tennessee, about two in every 1,000 persons had attended an opiate clinic.¹⁴³ In Knoxville, Tennessee, approximately 2.364 per 1,000 persons were attending narcotic clinics.¹⁴⁴ On average, amongst southern states approximately 1.530 per 1,000 persons were attending narcotic clinics.¹⁴⁵

In 1924, in other parts of the country, the numbers told similar stories.¹⁴⁶ In San Diego, California, approximately 2.397 per 1,000 residents were attending opiate clinics.¹⁴⁷ In Oneonta, New York, approximately 3.195 per 1,000 persons

131. *Id.* at 58.

132. *Id.* at 57, 58.

133. *Id.* at 58.

134. *Id.*

135. *Id.*

136. *Id.*

137. *Id.*

138. *Id.*

139. The federal government was pursuing “anti-maintenance policies” during this time, meaning that federal policy was against providing narcotics to individuals, even to those who were highly addicted to opiates. *See id.*

140. *Id.*

141. *Id.* This number does not account for opiate addicts getting their supply from other sources.

142. *Id.*

143. *Id.*

144. *Id.*

145. *Id.*

146. *Id.*

147. *Id.* at 59.

attended narcotic clinics.¹⁴⁸ Corning, New York, residents who attended narcotic clinics totaled 1.391 per 1,000.¹⁴⁹ In terms of demographics, Caucasian individuals far surpassed African Americans when it came to opium and morphine addiction.¹⁵⁰ For example, in Jacksonville, Florida, approximately 75% of opium and morphine addicts were Caucasian, despite Caucasians accounting for less than half of the city's population.¹⁵¹

B. America's Most Recent American Opioid Epidemic

In the Western World, pain is the most common reason that an individual will seek out medical care.¹⁵² Chronic pain is defined as:

Any pain that continues beyond the period over which healing would normally occur (generally three to six months) and affects a person's function or quality of life.¹⁵³ Chronic pain includes persistent pain related to injury, surgery, or conditions such as arthritis, vascular insufficiency, cancer treatment-related neuropathy, or diabetic peripheral neuropathy.¹⁵⁴

According to a 2015 study by the National Institutes of Health's National Center for Complementary and Integrative Health, approximately 126 million American adults suffer from various degrees of pain, ranging from "some days" to "every day" in amounts described as "a little" to "a lot."¹⁵⁵ A reported 40 million of these people suffer from the most severe levels of pain.¹⁵⁶ This pain causes physical and mental harm, but is also a remarkable public health issue that affects personal finances, families, employers, and health care systems.¹⁵⁷

Opioids are very effective for their main prescribed uses of reducing acute pain and as anesthesia during surgery.¹⁵⁸ However, opioids also have a high potential for abuse, which can lead users who unable to obtain legal prescriptions to move on to more lethal opioids without accepted medical uses, such as heroin

148. *Id.*

149. *Id.*

150. *Id.* at 63.

151. *Id.* at 62, 63.

152. Drewes et al., *supra* note 65, at 60.

153. Risa Denenberg & Carol P. Curtiss, *CE: Appropriate Use of Opioids in Managing Chronic Pain*, 116 THE AM. J. OF NURSING 26 (2016).

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. THE COUNCIL OF ECONOMIC ADVISORS, EXEC. OFFICE OF THE PRESIDENT, THE UNDERESTIMATED COST OF THE OPIOID CRISIS (Nov. 2017), <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf> [<https://perma.cc/FZJ4-FPG3>].

or the often illicitly produced fentanyl.¹⁵⁹

Opioid prescriptions have increased considerably over the past two decades, which can largely be attributed to aggressive marketing by the pharmaceutical industry, rather than improved scientific knowledge.¹⁶⁰ Survey data indicated that 2.4 million Americans have an opioid-use disorder as of 2016.¹⁶¹ This encompasses the individuals who abuse prescription painkillers like OxyContin and Vicodin and individuals who abuse heroin or other illegal opioids.¹⁶²

Back in the 1990s, doctors were persuaded to treat pain as a serious medical issue.¹⁶³ As a result, opioids were increasingly used to treat different types of pain across many disciplines of medicine.¹⁶⁴ However, pharmaceutical companies took advantage of this and aggressively marketed drugs like OxyContin and Percocet to physicians so that they would prescribe these medications to patients with pain.¹⁶⁵

In the U.S., the amount of prescription opioids sold to pharmacies, hospitals, and doctors' offices nearly quadrupled from 1999 to 2010.¹⁶⁶ Yet, there had been no significant change to overall amounts of pain that Americans reported.¹⁶⁷ Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid.¹⁶⁸ From 2000 to 2015 over half a million people died from drug overdoses.¹⁶⁹ In 2014, 14,838 Americans died from overdoses involving drugs like oxycodone.¹⁷⁰ In 2015, more than 33,000 people died as a result of opioids,

159. *Opioid Overdose Crisis*, *supra* note 17.

160. Drewes et al., *supra* note 65.

161. THE COUNCIL OF ECONOMIC ADVISORS, *supra* note 160.

162. *Id.*

163. Pain is a serious medical issue. According to a 2011 report from the Institute of Medicine about 100 million U.S. adults suffer from chronic pain. See German Lopez, *Drug Overdose Deaths Skyrocketed in 2016 and traditional opioid painkillers weren't the cause*, VOX (Sep. 5, 2017), <https://www.vox.com/policy-and-politics/2017/9/5/16255040/opioid-epidemic-overdose-death-2016> [<https://perma.cc/WYX9-GMCC>]. See also THE INST. OF MED., RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION, AND RESEARCH 1 (2011), available at <https://www.nap.edu/download/13172> [<https://perma.cc/R38T-8UGQ>].

164. Drewes et al., *supra* note 65.

165. Lopez, *supra* note 163. See INST. OF MED., *supra* note 163.

166. *Understanding the Epidemic*, *supra* note 28. See *Automation of Reports and Consolidated Orders System (ARCOS)*, U.S. DEP'T OF JUSTICE (2011), <https://www.deadiversion.usdoj.gov/arcos/> [<https://perma.cc/HP9H-HVGV>]. See Leonard J. Paulozzi, Christopher M. Jones, Karin A. Mack, Rose A. Rudd, *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999—2008*, CENTERS FOR DISEASE CONTROL AND PREVENTION (2011), <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm> [<https://perma.cc/LGF2-QRLL>].

167. *Understanding the Epidemic*, *supra* note 28.

168. *Prescription Opioid Overdose Data*, *supra* note 29.

169. *Understanding the Epidemic*, *supra* note 28.

170. Shefali Luthra, *Opioid Crisis in Rural Areas May be Tackled through Telemedicine*, WASH. POST (Sep. 27, 2016), https://www.washingtonpost.com/news/to-your-health/wp/2016/09/27/opioid-crisis-in-rural-areas-may-be-tackled-through-telemedicine/?utm_

more than any year on record.¹⁷¹ As of January 2016, the amount of U.S. drug overdose deaths totaled 52,898.¹⁷² As of January 2017, the number of deaths was 64,070.¹⁷³ To put these numbers into perspective, consider that more than 58,000 U.S. soldiers died in the entire Vietnam War.¹⁷⁴

So why have overdoses continued to dramatically increase? Drug overdose deaths skyrocketed in 2016 due to the introduction of fentanyl into the drug chain.¹⁷⁵ In 2016, fentanyl overtook both heroin and prescription painkillers in terms of overdose deaths.¹⁷⁶ Fentanyl is particularly dangerous as it is anywhere from fifty to one hundred times more potent than morphine.¹⁷⁷ In the U.S. the opioid epidemic is at its worst in rural areas.¹⁷⁸

In Michigan, “from 1999 to 2016, the total number of overdose deaths involving any type of opioid increased more than 17 times in Michigan, from 99 to 1,689 per year.”¹⁷⁹ Data from the Michigan Automated Prescription System (MAPS) for 2015 reported 11.4 million prescriptions for painkillers were written.¹⁸⁰ To put these numbers in perspective, this amounted to “about 115 opioid prescriptions per 100 people in Michigan.”¹⁸¹ In 2016, 2,335 people died of drug overdoses; this was more than deaths due to car accidents.¹⁸² The opioid crisis has many costs, not the least of which has been the loss of life.

C. Overview of Treatment

For almost 100 years, federal regulations made it illegal for physicians, specifically psychiatrists, to manage drug dependence in an office-based setting using prescription opioids.¹⁸³ In 2000, the Drug Addiction Treatment Act of 2000

term=.b9bbbead714 [https://perma.cc/8VUT-RJ6E].

171. *Opioid Overdose*, *supra* note 22.

172. *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, *supra* note 90.

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. *Opioid Overdose: Fentanyl*, Centers for Disease Control and Prevention (Aug. 29, 2017), <https://www.cdc.gov/drugoverdose/opioids/fentanyl.html> [https://perma.cc/S2ZY-PMCJ].

178. Luthra, *supra* note 170.

179. *Prescription Drugs and Opioids in Michigan*, MICH. DEP'T OF HEALTH & HUM. SERVICES (2017), http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_79584---,00.html [perma.cc/ZC2Z-BDQU].

180. *Treatment Resources*, MICH. DEP'T OF HEALTH & HUM. SERVICES (2017), http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_79584---,00.html [perma.cc/ZC2Z-BDQU].

181. *Id.*

182. *Id.*

183. Christopher Welsh & Adela Valadez-Meltzer, *Buprenorphine: A (Relatively) New Treatment for Opioid Dependence*, 2 PSYCHIATRY (EDGMONT) 29 (2005), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994593/> [perma.cc/5M94-EUE7]. See generally *What Is 'Treatment' for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and*

was passed into U.S. law.¹⁸⁴ This Act made it possible for all physicians to prescribe a drug called buprenorphine to their patients in the office setting.¹⁸⁵ Buprenorphine, is a partial “*mu*-opioid receptor agonist,” meaning that it has “unique pharmacologic properties that distinguish it from methadone and other medications used in the treatment of opioid dependence.”¹⁸⁶ Medical opinion states that buprenorphine has been shown to be “as effective as methadone and is generally safe and well-tolerated.”¹⁸⁷ *It is available in two sublingual¹⁸⁸ formulations: Subutex, which contains only buprenorphine, and Suboxone, which also contains naloxone.*¹⁸⁹ In order to prescribe for these medications, doctors must either obtain a special waiver from the U.S. government and have a limit as to how many patients they may write the medication for in treatment.¹⁹⁰

From a medical perspective, opioid maintenance treatment using methadone and buprenorphine is the “first-line approach” to treat opioid dependence.¹⁹¹ Both methadone and buprenorphine are licensed to treat opioid dependence.¹⁹² However, treatment can be lengthy as dependence often involves relapse on a chronic basis.¹⁹³

Today, in rural areas, the problems of prescription opioid abuse have far surpassed the capacity of psychiatrists and addiction providers to treat patients who became addicted.¹⁹⁴ Complicating treatment options is the fact that access to medication assisted treatment is not widely available,¹⁹⁵ and not enough providers are credentialed and trained in addiction.¹⁹⁶ Providers must be highly credentialed to provide drugs like Suboxone.¹⁹⁷ Additional training and an additional DEA

Veterans Courts, 13 STAN. J.C.R. & C.L. 189 (June 2017).

184. *Id.*

185. *Id.*

186. *Id.*

187. *Id.*

188. Under the tongue administration. The drug dissolves quickly in the mouth.

189. Welsh & Valadez-Meltzer, *supra* note 183.

190. Originally under the 2000 legislation, this number was set to 30 patients. The Obama Administration increased this limit to 275 patients per year. Welsh & Valadez-Meltzer, *supra* note 183. See *Obama Administration Takes More Actions to Address the Prescription Opioid and Heroin Epidemic*, WHITE HOUSE ARCHIVE (Jul. 6, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/07/05/obama-administration-takes-more-actions-address-prescription-opioid-and> [perma.cc/9DPP-V5AB].

191. Michael Soyka, *Treatment of Opioid Dependence with Buprenorphine: current update*, 19 DIALOGUES IN CLINICAL NEUROSCIENCE 299, 305 (Sep. 19, 2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5741113/> [perma.cc/2FWR-LMQC].

192. *Id.*

193. *Id.*

194. Luthra, *supra* note 170.

195. *Id.*

196. *Id.*

197. Suboxone is widely accepted as the drug of choice to treat opioid addiction, whether dependence was to prescription opioids or illegal ones. Suboxone is a prescription medication that

drug license is required for a prescriber to provide this drug.¹⁹⁸

D. The Recent Canadian Opioid Epidemic

The U.S. is not alone in this epidemic. The U.S.' neighbor to the north, Canada, has the second highest rate (just over nineteen percent of Canada's entire population) for opioid consumption in the world.¹⁹⁹ In 2016, more than 2,800 people died as a result of opioid-related overdoses.²⁰⁰ In 2017, Canada's Chief Public Health Officer Theresa Tam said that an average of eight people die every day in Canada as a result of an opioid-related overdose.²⁰¹

Fentanyl is largely to blame for Canada's recent epidemic.²⁰² Street dealers routinely cut fentanyl into their heroin and cocaine.²⁰³ However, Canada is also seeing large amounts of carfentanil enter the country.²⁰⁴ Carfentanil was developed in the 1970s as a tranquilizer for large animals like elephants, and can be 100 times more toxic than fentanyl and 10,000 times more toxic than morphine; a lethal amount is as small as a grain of sand.²⁰⁵

In Canada's most populated province, Ontario, opioid abuse is a serious problem. In the 2015-2016 fiscal year, two million Ontarians (or about 14% of the Ontario population) filled prescriptions for opioids.²⁰⁶ As one physician stated, "There are simply more opioids being prescribed than ever before."²⁰⁷ In 2012, Ontario saw about 140 deaths linked to fentanyl. In 2013, deaths totaled a

contains the active ingredient buprenorphine and naloxone. See *What is Suboxone Film?*, INVIDOR, INC. (2016) <https://www.suboxone.com/Treatment/Suboxone-film> [perma.cc/D3J2-Y6EJ].

198. Luthra, *supra* note 170.

199. Adam Miller & Allison Vuchnich, 'Staggering': Ontario filled more opioid prescriptions than ever before amid overdose 'crisis,' GLOBAL NEWS (May 17, 2017), <https://globalnews.ca/news/3458335/staggering-ontario-filled-more-opioid-prescriptions-than-ever-before-amid-overdose-crisis/> [perma.cc/7ZLQ-8KXH].

200. Karen Howlett, *Opioid-related overdose figures show grim reality of Canadian epidemic*, GLOBE AND MAIL (Sep. 14, 2017), <https://www.theglobeandmail.com/news/national/opioid-related-overdose-figures-show-grim-reality-of-canadian-epidemic/article36257932/> [perma.cc/JT2Z-6S8Q].

201. *Id.* See *Canada vs. United States*, INDEXMUNDI (Jul. 2016), <https://www.indexmundi.com/factbook/compare/canada.united-states/demographics> [perma.cc/F6EB-F5FL].

202. Howlett, *supra* note 200.

203. *Id.*

204. The U.S. has had issues with carfentanil too. In a six-day period, 17 people overdosed in Cincinnati, Ohio. Carfentanil was partially responsible. Ashifa Kassam, 'Dose as small as a grain of sand can kill you': alarm after Canada carfentanil bust, THE GUARDIAN (Nov. 12, 2017), https://www.theguardian.com/world/2017/nov/12/carfentanil-bust-canada-fentanyl-opioid-crisis-dangers?CMP=Share_iOSApp_Other [perma.cc/GC49-8VBE].

205. *Id.*

206. Miller & Vuchnich, *supra* note 199.

207. *Id.*

little under 140.²⁰⁸ In 2014, deaths linked to fentanyl totaled 170.²⁰⁹ Ontario saw 865 deaths related to opioids in 2016 and 1,965 “opioid poisonings” that required hospitalization.²¹⁰ Of these 865 deaths, 412 occurred in the first six months of the year, which constituted an 11% increase from 2015.²¹¹

According to Ontario’s Ministry of Health and Long-Term Care, Ontario has a Narcotic Strategy in place.²¹² This policy promotes the “proper use, prescribing and dispensing of prescription narcotics and other controlled substance medications, while ensuring that people who need them continue to have access.”²¹³

Ontario also has a narcotic monitoring system to collect information and track the dispensing of prescription narcotics and other controlled substances.²¹⁴ Recent studies have shown that the existence of a prescription monitoring system does not necessarily mean lower prescription rates or lower rates of usage of controlled substances.²¹⁵

IV. PUBLIC HEALTH RESPONSE

A. The U.S. Public Health Response and Effectiveness

Because opioid overdoses and deaths have increased at such alarming rates, several public health initiatives have come into effect to reduce these drug poisonings.²¹⁶ On the acute overdose front, one initiative that gained support was to expand access to the opioid antidote Narcan (generic is naloxone).²¹⁷ Since

208. Kassam, *supra* note 204.

209. *Id.*

210. Howlett, *supra* note 200.

211. *Id.* See also Allison Jones, *Ontario urged to declare emergency over opioid overdoses, deaths*, GLOBAL NEWS (Aug. 28, 2017), <https://globalnews.ca/news/3700495/opioids-emergency-ontario/> [perma.cc/BCQ7-DVGL].

212. *Ontario’s Narcotics Strategy*, ONTARIO MINISTRY OF HEALTH AND LONG-TERM CARE, <http://www.health.gov.on.ca/en/public/programs/drugs/ons/> [perma.cc/8DUT-P9VC].

213. *Id.*

214. *Id.* In March 2013, the Canadian Centre on Substance Abuse released a report entitled ‘First Do No Harm: Responding to Canada’s Prescription Drug Crisis.’ One of the recommendations is to establish prescription monitoring programs in each province and territory to share information about prescribing and dispensing practices across disciplines and jurisdictions on a timely basis and take timely action. See Furlan et al., *supra* note 25, at 106.

215. *Id.* at 105-06.

216. Daniel P. Wermeling, *Review of naloxone safety for opioid overdose: practical considerations for new technology and expanded public access*, 6 THERAPEUTIC ADVANCES IN DRUG SAFETY 20, 20 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4308412/> [perma.cc/C5ET-CMN2].

217. Naloxone has a long history of “safe and effective” use in institutionalized healthcare settings. It used to be that only medical providers could administer it, such as paramedics,

1971, naloxone has been approved as a prescription medication.²¹⁸ Naloxone is FDA approved for emergency treatment of known or suspected opioid overdose with respiratory depression.²¹⁹ Naloxone is a “competitive antagonist” to opioids in the central nervous system.²²⁰ Naloxone is a preferred overdose reversal drug as it is generally harmless unless opioids are present in the body.²²¹

During an overdose, respiratory depression is a significant problem.²²² Naloxone works within the body by binding to opioid receptor sites within the brain, sending signals to the rest of the body to continue breathing.²²³ Naloxone is now more widely available, obtainable over the counter so it can be administered by bystanders, whether that bystander is a person who also uses opioids, a family member, a friend or acquaintance, or even an emergency responder, like a police officer.²²⁴ While naloxone is quite effective at treating acute overdoses in emergency situations, it is a “bandage” at best.²²⁵ Naloxone does not offer any long-term treatment options to a repeated opioid abusing individual. Naloxone has also been criticized because some believe that it encourages repeated drug use.

Critics of naloxone argue the rescue drug gives opioid users a “safety net,” allowing people to take continue to take more risks and seek higher highs.²²⁶ Indeed, many drug users do overdose more than once, and each time, naloxone rescues them from an overdose death.

Critics have said that government action has been slow to address the opioid epidemic, despite the current administration’s view that it has “moved quickly” to address the growing drug addiction and opioid crisis within this United States.²²⁷ In particular, President Donald Trump has been criticized for both his

emergency medicine physicians, and anesthesiologists. Early criticisms of naloxone expansion included concerns that non-medical providers would be administering it in non-medical settings. Concerns of adverse effects and withdrawal ultimately were outweighed by the reduction in deaths. Wermeling, *supra* note 216, at 20.

218. *Id.*

219. Todd Kerensky & Alexander Y. Walley, *Opioid overdose prevention and naloxone rescue kits: what we know and what we don’t know*, 12 ADDICTION SCIENCE & CLINICAL PRACTICE 1, 1 (2017).

220. Wermeling, *supra* note 216, at 21.

221. *Id.*

222. Critley King, *EMS Director Says Naloxone is a ‘Bandage Not a Cure,’* EMERGENCY MANAGEMENT (Aug. 1, 2017), <http://www.govtech.com/em/health/EMS-Director-Says-Naloxone-is-a-Bandage-Not-a-Cure.html> [perma.cc/SZC6-N6E6].

223. *Id.*

224. Kerensky & Walley, *supra* note 219.

225. King, *supra* note 222.

226. Katharine Q. Seelye, *Naloxone Saves Lives, But Is No Cure in Heroin Epidemic*, N.Y. TIMES (Jul. 27, 2016), <https://www.nytimes.com/2016/07/28/us/naloxone-eases-pain-of-heroin-epidemic-but-not-without-consequences.html> [http://perma.cc/97CY-XESU].

227. *President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis*, WHITE HOUSE (Oct. 26, 2017), <https://www.whitehouse.gov/briefings-statements/president-donald->

inaction and his empty promises regarding this topic despite his public comments describing the current epidemic “the worst drug crisis in American history.”²²⁸

In March 2017, President Trump established the President’s Commission on Combating Drug Addiction and the Opioid Crisis.²²⁹ The mission of this Commission was “to study the scope and effectiveness of the Federal response to drug addiction and the opioid crisis and to make recommendations to the President for improving that response.”²³⁰ As of October 26, 2017, President Trump was “eagerly await[ing] the Commission’s final report.”²³¹

On September 25, 2017, the CDC launched a new campaign called “Rx Awareness.”²³² This program is a communication campaign that features true accounts from both individuals recovering from opioid use disorder and those who have been affected by someone else’s overdose.²³³ The primary goal of this campaign is to increase awareness among Americans about the risks of prescription opioids and to help curtail medically inappropriate uses of them.²³⁴

On October 26, 2017, the U.S. Department of Health and Human Services Acting Secretary, Eric D. Hargan, issued a public health emergency in response to the U.S. national opioid crisis.²³⁵ This decision was criticized by many on account of the fact that the directives provide no additional funding on their own to deal with the epidemic.²³⁶ Without funds, action is not likely. Without funding for programs, progress will be halted and the problems outlined above could potentially get worse.

B. Canada’s Public Health Response and Effectiveness

The Government of Canada has publicly provided that “Canada is facing a

j-trump-taking-action-drug-addiction-opioid-crisis/h [perma.cc/3YUB-W79H].

228. Jenna Johnson & John Wagner, *Trump Declares the Opioid Crisis a Public Health Emergency*, WASH. POST (Oct. 26, 2017), https://www.washingtonpost.com/news/post-politics/wp/2017/10/26/trump-plans-to-declare-the-opioid-crisis-a-public-health-emergency/?utm_term=.83beffa4ccc2 [perma.cc/75CA-QSPE].

229. *President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis*, *supra* note 227.

230. *Id.*

231. *Id.*

232. *CDC Launches Campaign to Help States Fight Prescription Opioid Epidemic*, *supra* note 3.

233. *Id.*

234. *Id.*

235. *HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis*, DEPT. OF HEALTH AND HUMAN SERVICES (Oct. 26, 2017), <https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html> [perma.cc/SQC4-A7QR].

236. Julie Davis, *Trump Declares Opioid Crisis a ‘Health Emergency’ but Requests No Funds*, N.Y. TIMES (Oct. 26, 2017), <https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html> [perma.cc/K5Z8-EHT9].

national opioid crisis. The growing number of overdoses and deaths caused by opioids, including fentanyl, is a public health emergency. This is a complex health and social issue that needs a response that is comprehensive, collaborative, compassionate and evidence-based.”²³⁷ Canada recognized that its increasing number of overdoses and deaths caused by opioids has reached national public health crisis status.²³⁸ The Minister of Health has stated publicly it is a top priority for the federal government.²³⁹

On November 18th and 19th, 2016, the Minister of Health gathered various health partners to commit to a “joint action on the opioid crisis.”²⁴⁰ This outlined “the combined commitment of over 30 partner organizations to respond to this crisis.”²⁴¹ As a result of an Opioid Conference and Summit, this joint action plan was implemented.²⁴² This Summit gathered qualified speakers and participants for a discussion on a national level regarding the harm of opioids and how to address these harms.²⁴³ Part of the statement that came about from this Summit included plans for harm reduction, public health emergency response, supporting access to treatment, and preventing the abuse of drugs.²⁴⁴

The Canadian Government is also committed to solving the long-term complications of drug abuse as seen from the following statement pertaining to legal changes:

Supporting a range of tools and harm reduction measures for communities, including supervised consumption sites. This will include: proposing any necessary amendments to the Controlled Drugs and Substances Act to remove any undue barriers introduced through the Respect for Communities Act; continually supporting potential applicants to complete the application process through proactive engagement; and keeping the public up to date on the status of applications that have been submitted to Health Canada, including their stage in the review process.

Canada also included several points in its commitment to federal action.²⁴⁵ The

237. *Responding to Canada's Opioid Crisis*, GOVERNMENT OF CANADA, <https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/responding-canada-opioid-crisis.html> [perma.cc/45GN-KJ26].

238. *Federal Action on Opioids*, GOVERNMENT OF CANADA, <https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/federal-actions.html> [perma.cc/TVN8-MVZD].

239. *Id.*

240. *Id.*

241. *Id.*

242. *Id.*

243. *Opioid Conference*, GOVERNMENT OF CANADA, https://www.canada.ca/en/health-canada/services/substance-abuse/opioid-conference.html?utm_source=canada-ca-opioids_en&utm_medium=vanity_url&utm_campaign=opioids [perma.cc/D27A-2B4Y].

244. *Id.*

245. *Id.* See also *Actions on Opioids*, GOVERNMENT OF CANADA, <https://www.canada.ca/>

Canadian Government specifically stated it would take action to improve consumer education. For example, Canada pledged to better inform Canadians about the risks of opioids by mandating new warning stickers and patient information sheets for all dispensed opioids, conducting targeted public awareness activities, and disseminating youth prevention tools that reflect best practices.²⁴⁶

Each Canadian province joined this Summit and contributed to the Statement that was published.²⁴⁷ Ontario committed to implement its first “comprehensive opioid strategy to prevent opioid addiction and overdose by enhancing data collection, modernizing prescribing and dispensing practices, and connecting patients with high quality addiction treatment services.”²⁴⁸ Ontario also committed to modernizing its opioid prescribing and monitoring systems.²⁴⁹ Specifically, it committed to creating Ontario’s first “Provincial Overdose Coordinator,” to developing new, evidence-based training and academic programs that will “provide modernized training to all health care providers who prescribe or dispense opioids.”²⁵⁰ Ontario committed to improving patient education as well. Specifically, Ontario committed to including a patient guide to all patients who are prescribed opioids to help them better understand risks.²⁵¹

V. DRUG COURTS HOME AND ABROAD

A. Overview of American Drug Courts

In 1989, the first drug court was established in Miami, Florida to supervise revolving door non-violent, substance-abusing offenders.²⁵² In theory, drug courts were designed to provide nonviolent offenders with substance abuse issues the opportunity to tackle their addictions in a process that involves judicial supervision, drug treatment, drug and alcohol testing, and community services tailored to each participant’s circumstances instead of lengthy incarceration.²⁵³

content/dam/hc-sc/documents/services/publications/healthy-living/actions-opioids-2016-2017/Opioids-Response-Report-EN-FINAL.pdf

246. *Opioid Conference*, *supra* note 243. See also *Actions on Opioids*, *supra* note 245.

247. *Id.* See also *Recommendations for Adoption: Opioid Prescribing for Acute Pain*, HEALTH QUALITY ONTARIO, <http://www.hqontario.ca/Portals/0/documents/evidence/quality-standards/qs-opioid-acute-pain-recommendations-for-adoption-en.pdf> [https://perma.cc/3C3Y-ZGB7].

248. *Id.*

249. *Id.*

250. *Id.*

251. *Id.*

252. *Toronto Drug Treatment Court Program Policy and Procedures Manual*, ONTARIO COURT OF JUSTICE (Aug. 2008), <https://www.tdtc.ca/sites/default/files/pages/2018%20Policy%20and%20Procedure%20Manual%20PDF.pdf> [https://perma.cc/FN9B-5TEN].

253. *Michigan Drug Court Recidivism: Definitions and Methodology*, MICH. SUP. CT., <http://courts.mi.gov/Administration/admin/op/problem-solving-courts/Documents/RecidivismExplanation.pdf> [https://perma.cc/L7TE-2YZR].

However, if drug court participants do not successfully complete the drug court program, they have to serve their original sentences.²⁵⁴ But for participants who successfully complete the process, incarceration is avoided and long-term sobriety is more likely.²⁵⁵

The first drug court in the U.S. was instituted over 20 years ago in response to an increasing numbers of drug-related court cases entering and re-entering the criminal justice system.²⁵⁶ As of December 31, 2014, an estimated 3,057 of these “problem-solving courts” existed nationwide, serving approximately 127,000 people per year.²⁵⁷ Nationally, 1,540 problem-solving courts were adult drug courts, 407 were hybrid adult and DUI courts and 262 were DUI courts.²⁵⁸ Drug Courts have grown at a remarkable rate nationally, growing in aggregate number by 24 percent in the past five years.²⁵⁹ The number of drug courts has grown dramatically in the last decade. In 2012, the U.S. had approximately 2,734 drug courts in operation.²⁶⁰

Drug treatment courts, often referred to as “problem-solving courts” now “permeate the legal landscape.”²⁶¹ As of 2014, over 3,000 of these courts were active across the U.S.²⁶² These courts are unique in that “unlike regular courts whose primary duty it is to arbitrate civil and criminal issues, problem-solving courts focus on solving underlying problems of communities through the rehabilitation of offenders in the criminal justice system.”²⁶³ Drug courts are called “problem-solving courts” because they seek to “rehabilitate drug offenders through the provision of social and therapeutic services, such as treatment for drug addiction.”²⁶⁴

Often times though, when offenders are freed from incarceration, they return to their old habits.²⁶⁵ Judges have referred to this as the “Revolving Door” effect.²⁶⁶ Drug courts have been shown to reduce recidivism when compared to

254. *Id.*

255. *Id.*

256. Douglas Marlowe, Carolyn Hardin & Carson Fox, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Courts in the United States*, NAT'L DRUG COURT INSTITUTE (2016), <http://www.ndci.org/wp-content/uploads/2016/05/Painting-the-Current-Picture-2016.pdf> [<https://perma.cc/ST8F-JXTD>].

257. *Id.* at 44.

258. *Id.* at 35.

259. *Id.*

260. *Id.* at 34.

261. Barbara Andracka-Christou, *What Is 'Treatment' for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and Veterans Courts*, 13 STAN. J.C.R. & C.L. 189, 191 (June 2017).

262. *Id.*

263. *Id.*

264. *Id.*

265. *Michigan Drug Court Recidivism: Definitions and Methodology*, *supra* note 253, at 2.

266. *Id.*

traditional criminal justice interventions.²⁶⁷ Adhering to evidence based practices that have been shown to be associated with improved outcomes for participants can enhance the effectiveness of drug courts in reducing recidivism.²⁶⁸ Anecdotal evidence has suggested that drug courts are effective and life changing, but national scientific studies of the impact of these programs and recidivism are lacking.²⁶⁹ The trouble with measuring drug courts' effectiveness due in part to there the fact that there is no nationally accepted definition for recidivism.²⁷⁰ Equally problematic is the long amount of time between initial arrest and drug court treatment.²⁷¹

U.S. drug courts only serve a limited population. Of the over 2,000 drug courts in America, only 55,000 people participated in them in 2008, but more than 1.6 million people are arrested on drug charges every year.²⁷²

B. Overview of Michigan Drug Courts

The Michigan Community Corrections Act was enacted in 1988 to investigate and develop alternatives to incarceration.²⁷³ Four years later, the first female drug treatment court in the nation was established in Kalamazoo, Michigan.²⁷⁴ Since 1992 Michigan has implemented 84 total "problem-solving courts," offering alternatives to incarceration for adults, juvenile offenders, and driving under the influence (DUI) offenders.²⁷⁵

Michigan's problem-solving courts were developed locally in response to needs at the local level. There are five goals outlined by statute for Michigan's drug treatment courts. These goals are: (1) to reduce drug addiction and drug dependency among criminal offenders; (2) to reduce recidivism among offenders; (3) to reduce drug-related court dockets; (4) to increase personal, familial, and societal responsibility among offenders; and (5) to promote effective preparation and use of resources among criminal justice system and community agencies.²⁷⁶

Michigan drug treatment courts enabling statutes define a drug court as "a court supervised treatment program for individuals who abuse or are dependent

267. *Michigan's Sobriety Courts Recidivism Analysis*, NATIONAL CENTER FOR STATE COURTS (May, 2017), <http://courts.mi.gov/Administration/admin/op/problem-solving-courts/Documents/NCSC-SobrietyRecidivismAnalysis.pdf> [<https://perma.cc/7RWU-Y8HA>].

268. *Id.* at 13.

269. *Michigan Drug Court Recidivism: Definitions and Methodology*, *supra* note 253, at 2.

270. *Id.*

271. *Michigan's Sobriety Courts Recidivism Analysis*, *supra* note 267.

272. *Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use*, DRUG POLICY ALLIANCE (Mar. 2011), http://www.drugpolicy.org/sites/default/files/Drug%20Courts%20Are%20Not%20the%20Answer_Final2.pdf [<https://perma.cc/ALJ9-LNKX>].

273. *Michigan Courts: One Court of Justice*, MICH. SUP. CT., <https://courts.michigan.gov/pages/default.aspx> [<https://perma.cc/SNP6-9KV3>].

274. *Id.*

275. *Id.*

276. *Michigan's Sobriety Courts Recidivism Analysis*, *supra* note 267, at 10.

upon any controlled substance or alcohol.”²⁷⁷ These courts are specially designed to reduce recidivism and substance abuse among nonviolent substance-abusing offenders and to increase the offenders’ likelihood of successful habilitation through early, continuous, and intense judicially-supervised treatment, mandatory periodic drug testing, and use of appropriate sanctions.²⁷⁸

Drug court participants face lengthy periods of time from arrest to program treatment. In Michigan, the average number of days from arrest to program entry was ninety days and participants spent an average of 14 days between program entry and treatment entry.²⁷⁹ In Michigan the most favored drug of choice among sobriety court participants was alcohol.²⁸⁰

C. Canadian Drug Courts

In the summer of 1997, in response to its own revolving door problem, a committee was formed comprising of representatives from Canada’s Federal Department of Justice, defense bar, legal aid, Toronto Public Health, and various community agencies to discuss the possibility of establishing a drug court in Toronto.²⁸¹ Many months of discussions went into Canada’s response, as developed as part of its commitment under Canada’s Drug Strategy, with the goal being to reduce both the social and financial costs of substance abuse, Canada’s federal government agreed to fund a four-year pilot via the National Crime Prevention Centre.²⁸²

In 1998, Canada’s first drug treatment court was established in Toronto, Ontario.²⁸³

D. Ontario Drug Courts

Ontario’s first drug treatment court was also Canada’s first drug treatment court.²⁸⁴ Drug treatment courts in Ontario offer an alternate to imprisonment to non-violent offenders who are addicted to cocaine, methamphetamine, heroin, and/or other opiates/opioids.²⁸⁵ Ontario currently has drug courts in London, Ottawa, Hamilton, Halton and Toronto, with each tailored to the needs of the community in which it is located.²⁸⁶

277. Mich. Comp. Laws Serv. § 600.1060 (LexisNexis, Lexis Advance through 2017 Public Act 117).

278. *Michigan’s Sobriety Courts Recidivism Analysis*, *supra* note 267, at 9. *See also Michigan’s Sobriety Courts Recidivism Analysis*, *supra* note 267.

279. *Michigan’s Sobriety Courts Recidivism Analysis*, *supra* note 267, at 31.

280. *Id.*

281. *Toronto Drug Treatment Court Program Policy and Procedures Manual*, *supra* note 252.

282. *Id.*

283. *Id.*

284. *Id.*

285. *Id.*

286. Susan Clairmont, *Court Offers Chance for Drug Offenders to Get Help, Avoid Jail*, HAMILTON SPECTATOR (Jan. 9, 2014), <https://www.thespec.com/news-story/4305854-clairmont->

In Ontario drug treatment court programs, criminal offenders become “clients” who then participate in a structured outpatient drug treatment program where their cases are followed with all-encompassing case management services.²⁸⁷ After clients complete the one-year program, they receive a non-custodial sentence, and thus avoid prison or jail time. To participate in these courts, participants must plead guilty, but they have the option to reverse their plea within 30 days if they decide they do not want to participate.²⁸⁸ Treatment for clients starts with an “introductory phase,” where clients are often still abusing drugs, but are made stable.²⁸⁹ Client participants attend court two days per week and then attend group and individual sessions at the Centre for Addiction and Mental Health (CAMH) three days every week.²⁹⁰ Client participants then enter an “intensive phase.”²⁹¹ In this part of the treatment, client participants can stay in housing at CAMH or a participate in a five-day-a-week program that “kick-starts turning the corner into more abstinence.”²⁹² After this phase, client participants enter a “maintenance phase,” which consists of one day a week of court and two days at CAMH.²⁹³

VI. ANALYSIS & RECOMMENDATIONS

Addressing existing physician prescribing practices is of the utmost importance in order to prevent another epidemic. Medical ethics bodies and institutions should consider improving physician re-education. For example, expanding the use of practice guidelines could help strengthen physician awareness of proper opioid prescribing doses.²⁹⁴ Clinical practice guidelines encourage safer, often more effective options for chronic pain treatment.²⁹⁵ These guidelines help to reduce the misuse of opioids and prevent future overdoses.²⁹⁶

From a public health perspective, Canada has done a better job identifying the

court-offers-chance-for-drug-offenders-to-get-help-avoid-jail/ [https://perma.cc/9MAN-U2J2].

287. *Drug Treatment Court Services*, CENTRE FOR ADDICTION AND MENTAL HEALTH, <https://www.camh.ca/en/your-care/programs-and-services/drug-treatment-court-services> [https://perma.cc/HVM7-ZJGP].

288. Vanessa Milne, Joshua Tepper & Christopher Doig, *Drug Treatment Courts Offer an Alternative to Jail for People with Addictions*, HEALTHY DEBATE (Nov. 13, 2014), <http://healthydebate.ca/2014/11/topic/drug-treatment-courts> [https://perma.cc/79PY-54AJ].

289. *Id.*

290. *Id.*

291. *Id.*

292. *Id.*

293. *Id.*

294. *Improving Opioid Prescribing*, NAT’L INST. ON DRUG ABUSE (Mar 30, 2017), <https://www.drugabuse.gov/improving-opioid-prescribing> [https://perma.cc/NK8N-H3C8].

295. *Id.*

296. One study cited indicated that when Washington State introduced voluntary opioid guidelines in 2007, prescription opioid-related overdose deaths among injured workers dropped by half. *Id.*

problem and contributing both federal and local action and support for preventing more overdoses. But even in Canada, most drug treatment courts have done a poor job of addressing participants' needs by insisting upon abstinence only programs.²⁹⁷ Canadian drug courts should expand their treatment programs to include long-term drug-assisted maintenance that provides transition to CAMH treatment options even after drug court treatment ends. Suboxone should be added to drug court mandated treatment. Reliance upon abstinence only programs should be phased out of the normal procedure. Inherently, drug treatment courts have deficiencies regarding the health needs of client participants and have not meaningfully reduced client participants' chances of imprisonment.²⁹⁸ A key problem with drug treatment courts is that little is known about the nature of the courts' substance abuse treatment programs, including their policies and how decisions are made during the whole process.²⁹⁹

The issue is not whether drug courts do good works for people, but whether their proliferation promotes good social and health policy, at least in comparison to other available approaches to addressing drug use.³⁰⁰ Drug treatment do not provide that many benefits over incarceration.³⁰¹ It is true that alternatives to incarceration are essential to improve the justice system, but better alternatives must be adopted and punishment for drug law violations should be reduced through sentencing reform.³⁰²

It would be highly impractical do away with drug treatment courts. While their reach may be limited, they do provide treatment opportunities to people in society who would otherwise likely go without. States should increase funding to drug treatment courts so that treatment costs for low-income participants can be lowered, increase training opportunities and requirements for court treatment providers regarding medication-assisted treatment, and improve funding for physician participation.³⁰³ Concerned judges have suggested that increased funding would be ideal to help pay for residential treatment centers, halfway houses, and transportation for court participants.³⁰⁴ What really needs to be adopted in drug courts is medication-assisted treatment using drugs containing buprenorphine, like Suboxone. Abstinence only treatment programs should not be a feature of drug courts if the goal is long-term maintenance and recovery.

A move to more restorative forms of justice are beginning to become more and more popular in the legal community. Restorative justice focuses on healing

297. *Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use*, *supra* note 272; See *Drug Treatment Court Services*, *supra* note 295.

298. *Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use*, *supra* note 272.

299. Andracka-Christou, *supra* note 261, at 189.

300. *Drug Courts Are Not the Answer: Toward a Health-Centered Approach to Drug Use*, *supra* note 272, at 3.

301. *Id.*

302. *Id.*

303. Andracka-Christou, *supra* note 261, at 189.

304. *Id.*

the underlying issues behind the crimes committed. Restorative justice characterizes the “commission of crime in terms of interpersonal or community conflict, so that the goal of restorative justice is the resolution of the conflict.”³⁰⁵

Concepts of restorative justice should be applied in a re-working of both U.S. and Canadian drug courts. In this case of drug courts, court ordered treatment could include drug offenders making a concerted effort to heal themselves through community-based volunteering.

When it comes to treatment options, the past offers a lesson for the future. During America’s first opiate epidemic, the treatment centers where patients could go to be dosed with opiates are not all that dissimilar from the medication assisted treatment options of today. Public health programs should advocate the use of medication-assisted treatment methods.

When it comes to public health initiatives, Canada’s example has set out specific targeted initiatives and set deadlines. U.S. public health agencies could benefit from this same kind of commitment and structure. Strategies already put forth include opioid use policy reforms.³⁰⁶ Borrowing from Canada for consumer awareness would be beneficial. For example, mandating that all opioid prescriptions come with a clearly legible warning sticker about the addictive properties should be utilized here in the U.S. Specifically, prescribers write prescriptions in accordance with opioid prescribing guidelines, mandating the use of prescription drug monitoring programs to identify problematic prescribers, increasing medical and inter-professional education, increasing law enforcement training, and introducing more drug take-back programs to return leftover and extra medication to law enforcement for destruction.³⁰⁷

Despite public policy initiatives the number of overdoses due to opioids continues to increase.³⁰⁸ Not a lot of evidence shows that providing education on safe opioid prescribing will impact opioid overdoses and deaths, but it is better than ignoring prescribing practices.³⁰⁹ Thus, other initiatives may be more suitable to address providers prescribing habits.³¹⁰ Increasing the use of prescription monitoring programs would be a good start.

Financial recommendations begin with the allocation of funds. The U.S. should follow Canadian examples by pledging more financial aid to public health programs aimed at treating the epidemic. The U.S. government failed to allocate funds when President Trump declared the opioid crisis a public health emergency. In Canada, an increase in the allocation of funds for public health programs and drug court treatment programs should also be considered.

Educating the public will thus be paramount. In Ontario, national public education campaigns could be utilized to reach broad audiences. Speaking

305. Patricia Hughes & Mary Jane Mossman, *Re-Thinking Access to Criminal Justice in Canada: A Critical Review of Needs and Responses*, 13 W.R.L.S.I. 1, 17 (2002).

306. Wermeling, *supra* note 216, at 20.

307. *Id.*

308. *Id.*

309. Kerensky & Walley, *supra* note 219, at 1.

310. *Id.*

specifically of acute overdoses, the “evolving practice” emerging in other countries around the world is to treat opioid overdoses before they happen.³¹¹ This includes providing first responders with naloxone and physicians identifying patients who they have reason to believe are at risk of opioid overdoses and prescribe naloxone to those individuals at risk so that they have the medication in the event of an overdose.³¹² This newly evolving practice is intended to “move the continuum of care forward.”³¹³

An increasing amount of “harm reduction organizations” in the U.S. now offer “overdose prevention programs that provide injection drug users with resuscitation training and take-home doses of naloxone.”³¹⁴ This practice should be expanded in Michigan and Ontario in order to prevent further acute overdoses. In more and more locations, opioid users and their friends/family have access to naloxone rescue kits and training, including needle syringe access programs, inpatient and outpatient addiction treatment programs, preventative care, and support meetings.³¹⁵ Access to naloxone is not universally accessible, but it is clear that at least in the short-term naloxone acts as a valuable tool in emergency overdoses.³¹⁶

VII. CONCLUSION

Drug treatment courts in their current form are clearly an insufficient means alone to combat the opioid epidemic. Drug treatment courts should be expanded to include treatment of more offenders. A re-evaluation of current screening conditions should be considered. Loosening the requirements to allow more offenders to be eligible for drug court participation could be a good starting step. Current criminal justice programs aimed at treating addiction, specifically drug court programs fall short and are inadequate to handle an epidemic of national proportions.³¹⁷ While helpful to some, drug treatment courts enter an offender’s life too late in the process, so are considered too downstream a tool to be considered an effective public health intervention.³¹⁸

311. Wermeling, *supra* note 216, at 21.

312. *Id.*

313. *Id.*

314. Burris et al., *supra* note 24. See also Daniel Kim, Kevin S. Irwin & Kaveh Khoshnood, *Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality*, 99 AM. J. PUB. HEALTH. 402 (Mar. 2009) (manuscript at 4), <http://www.ajph.org/cgi/doi/10.2105/AJPH.2008.136937>.

315. Kerensky & Walley, *supra* note 219, at 2.

316. Burris et al., *supra* note 24.

317. Christine Mehta, *How Drug Courts Are Falling Short*, MEDIUM (Jun. 8, 2017), <https://medium.com/@PHR/how-drug-courts-are-falling-short-6b92e993cc3b> [<https://perma.cc/8JLF-D7P2>].

318. *Upstream Opportunities for Reducing the Harm of Alcohol and Drug Use*, BRANDEIS UNIVERSITY HELLER SCHOOL FOR SOCIAL POLICY AND MANAGEMENT (Sept. 13, 2013), <https://sihp.brandeis.edu/ibh/pdfs/OSI-Final-Report-10302013-MJL.pdf>.

Drug court programs are only available to people who are arrested and charged with a crime. After someone is charged, she or he becomes faced with two “choices,” treatment or incarceration. Treatment should be available to individuals before they are charged with a crime. Resources and efforts should be focused on preventing overdoses by providing access to medication assisted treatments with addiction providers. Drug courts offer valuable treatment options to nonviolent criminal offenders with drug or alcohol substance use disorders that trigger their involvement with the criminal justice system.³¹⁹ The reasoning behind drug courts revolves around the assumption that involvement in the criminal justice system is an indicator of addiction and that by treating indicators of addiction with incarceration will not cure criminal offenders of their underlying addiction issues.³²⁰

As made evident in this Note, costs are a major point of concern. While implementing changes to already existing programs will add financial costs, ultimately these costs should not outweigh the health of the people. Clearly, the cost of doing nothing is absolutely unacceptable, from both a legal and public health perspective. This epidemic has already incurred high costs, but if left untreated the effects of opioids will continue to wreak havoc both in Canada and the U.S.

319. *Michigan Drug Court Recidivism: Definitions and Methodology*, *supra* note 253, at 2.

320. *Id.*