

# American Correctional Facilities Provide Inadequate Substance Use Disorder Treatment: Can the ABA Help?

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Incarcerated persons in the United States receive inadequate substance use disorder (“SUD”)<sup>1</sup> treatment. Insufficient treatment during incarceration is a major contributor to recidivism and overdose. Amending the American Bar Association

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1. Pronounced [suhd].

(“ABA”) Criminal Justice Standards may be an incremental step toward alleviating the consequences associated with the inadequacy of treatment in correctional facilities.

Part I of this Note will demonstrate that American correctional facilities<sup>2</sup> are not meeting the treatment needs of incarcerated persons with a SUD.<sup>3</sup> It will also discuss how inadequate treatment during incarceration leads to a greater likelihood of recidivism and overdose. Part II will provide some suggestions for how the ABA Criminal Justice Standards could be amended to lessen the harm caused by inadequate SUD treatment during incarceration. Specifically, this Note will suggest changes that may decrease over-incarceration and promote a harm reduction philosophy conducive to lasting recovery and treatment access.

## I. CORRECTIONAL FACILITIES’ INADEQUATE CARE, THE UNVIRTUOUS CYCLE OF RECIDIVISM, AND THE SUBSTANTIAL RISK OF OVERDOSE

Part A will present four fundamentals of optimal SUD treatment. Part B will examine whether correctional facilities incorporate these fundamentals into their offerings. Part C will highlight the consequences of recidivism and overdose that result from correctional facilities’ failure, and sometimes inability, to incorporate these fundamentals.

### A. FOUR FUNDAMENTALS OF OPTIMAL SUD TREATMENT

First, in order for a person undergoing SUD treatment to have the best chance at lasting recovery, the provider must take an individualized approach.<sup>4</sup> A hyper-individualized approach to curating care is necessary due to the broad range of factors that contribute to an active SUD.<sup>5</sup> The development of a SUD may be caused by, among other things, genetic predisposition,<sup>6</sup> neurological

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2. As used in this Note, “correctional facilities” incorporates jails and prisons at the state and federal level.

3. Substance use disorders are generally diagnosed based on the criteria laid out in the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FIFTH EDITION (DSM-5). See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013), cited in *Substance Use Disorders vs. Substance Abuse and Dependence: DSM-5 Changes*, U. OF FLA. DEP’T OF PSYCHIATRY IN THE COLL. OF MED., <https://addiction-certificate.psychiatry.ufl.edu/about-the-program/articles/substance-use-disorders-vs-substance-abuse-and-dependence-dsm-5-changes/> [<https://perma.cc/4ZKA-BBZL>] (last visited Feb. 26, 2025).

4. See JOCELYN GUYER ET AL., AM. SOC’Y OF ADDICTION MED., SPEAKING THE SAME LANGUAGE: A TOOLKIT FOR STRENGTHENING PATIENT-CENTERED ADDICTION CARE IN THE UNITED STATES 12 (2021), <https://www.asam.org/asam-criteria/implementation-tools/toolkit> [<https://perma.cc/GVM2-GJ2L>]; NAT’L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 2 (3d ed. 2018) (“No single treatment is appropriate for everyone.”).

5. See RICHARD J. BONNIE ET AL., PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH 117 (Nat’l Acad. Scis. ed., 1996).

6. See generally Alexander S Hatoum et al., *Multivariate Genome-Wide Association Meta-Analysis of Over 1 Million Subjects Identifies Loci Underlying Multiple Substance Use Disorders*, 1 NATURE MENTAL HEALTH 210, 216 (2023) (discussing genetic predisposition for addictive behavior due to a newfound common genetic architecture underlying multiple SUDs); NAT’L INST. ON DRUG ABUSE, COMMON COMORBIDITIES WITH SUBSTANCE USE DISORDERS RESEARCH REPORT 7 (2020) (discussing epigenetic influences that increase risk of addiction).

abnormalities,<sup>7</sup> mental disorders and serious mental illnesses (“SMIs”),<sup>8</sup> social determinants of health,<sup>9</sup> and psychological trauma.<sup>10</sup> The substance(s) being used, the extent of use, the user’s age, and other differentiating factors combine to form distinct effects on an individual’s brain,<sup>11</sup> body, and behavior.<sup>12</sup> The breadth and complexity of ways in which a SUD may take shape demands a multidimensional initial assessment that considers a “patient’s full biological, psychological, and sociocultural context.”<sup>13</sup> A thorough, individualized assessment will allow the provider to determine an individual’s specific needs and design a particular service plan for treatment across a structured continuum of care.<sup>14</sup>

Second, a successful SUD treatment program requires continuous monitoring and evaluation of treatment processes and outcomes.<sup>15</sup> A person with a SUD will have an optimal chance at recovery only if their treatment program has developed a quality assurance system.<sup>16</sup> Ideally, each phase of the treatment process should be documented with regard to its *fidelity* to not only the standards of care put in place at the outset of the provider’s overall scheme, but also its fidelity to a person’s individualized care plan.<sup>17</sup> *Process data* should then be collected and evaluated on a periodic basis so that program leaders can adjust procedures, modify

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7. See generally SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 2-2 (2016) (“Well-supported scientific evidence shows that disruptions in three areas of the brain are particularly important in the *onset*, development, and maintenance of substance use disorders: the basal ganglia, the extended amygdala, and the prefrontal cortex.” (emphasis added)); Nora L. Nock et al., *Neurobiology of Substance Use in Adolescents and Potential Therapeutic Effect of Exercise for Prevention and Treatment of Substance Use Disorders*, 109 BIRTH DEFECTS RSCH. 1711, 1714–15 (2017) (“Abnormal structural and functional brain development during childhood may increase the risk of substance misuse in adolescence.”).

8. See generally NAT’L INST. ON DRUG ABUSE, *supra* note 6, at 2–5 (describing strong correlation between mental disorders and SMIs and SUDs but noting the difficulty in discerning causality).

9. See generally Chunqing Lin et al., *A Scoping Review of Social Determinants of Health’s Impact on Substance Use Disorders Over the Life Course*, 166 J. SUBSTANCE USE & ADDICTION TREATMENT (2024).

10. See generally Lamya Khoury et al., *Substance Use, Childhood Traumatic Experience, and Posttraumatic Stress Disorder in an Urban Civilian Population*, 27 DEPRESSION & ANXIETY 1077, 1082–83 (2010) (finding strong relationship between childhood trauma and substance use).

11. See generally Victor Pando-Naude et al., *Gray and White Matter Morphology in Substance Use Disorders: A Neuroimaging Systematic Review and Meta-Analysis*, 11 TRANSNAT’L PSYCHIATRY, Art. No. 29, 15 (2021) (describing how neurological effects of addiction found from neuroimaging varied based on substance and extent of use).

12. See generally Antoine Bechara, *Decision Making, Impulse Control and Loss of Willpower to Resist Drugs: A Neurocognitive Perspective*, 8 NATURE NEUROSCIENCE 1458, 1462 (2005) (discussing the ways in which decisionmaking and daily functioning while having a SUD varies from person to person).

13. Maureen Boyle, PhD, Introduction to the Fourth Edition of the American Society of Addiction Medicine Criteria (June 13, 2023).

14. See GUYER, *supra* note 4, at 13-14.

15. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: GETTING STARTED WITH EVIDENCE-BASED PRACTICES 9 (2009).

16. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: EVALUATING YOUR PROGRAM 2 (2009).

17. See *id.* at 29–32.

training initiatives, and discern whether there is any missing data.<sup>18</sup> The practice of gathering data regarding outcome measures—codified milestones in the treatment process and an individual’s progress toward these goals at various points in time—should go hand-in-hand with process tracking.<sup>19</sup> Aggregating *outcome data* and evaluating the results should occur somewhere around every three months.<sup>20</sup> The provider should organize both process and outcome data into graphic form so that it may be seamlessly shared with all concerned staff.<sup>21</sup> Thorough accumulation and monitoring of process and outcome data ensures staff accountability and progression toward intermediate and long-term goals for SUD treatment quality.<sup>22</sup>

Third, medication-assisted treatment (“MAT”)<sup>23</sup> should be available for all persons with an opioid use disorder<sup>24</sup> (“OUD”).<sup>25</sup> “[Medications for opioid use

18. *See id.* at 10–12.

19. *See id.* at 13–16.

20. *Id.* at 16.

21. *See id.* at 18–21.

22. *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 15.

23. MAT uses medications for opioid use disorder (“MOUD”). *Medications for Substance Use Disorder*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Apr. 11, 2024), <https://www.samhsa.gov/medications-substance-use-disorders> [<https://perma.cc/22Y6-NZCQ>]. MOUD consists of three FDA approved medications whose generic names are buprenorphine, methadone, and naltrexone. *Id.* Opioid overdose reversal medications (“OORMs”) consist of naloxone and nalmefene. *Id.* Naloxone may be used in combination with buprenorphine under normal conditions not involving overdose. This combination product is known as Suboxone®. *See How Effective Are Medications to Treat Opioid Use Disorder?*, NAT’L INST. ON DRUG ABUSE (May 2017), <https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder> [<https://perma.cc/DPW3-DCGW>].

Methadone is the most senior of the MOUD group, having been invented in 1947 for the purpose of pain relief. *See Drug Fact Sheet: Methadone*, DRUG ENF’T ADMIN. (Apr. 2020), <https://www.dea.gov/sites/default/files/2020-06/Methadone-2020.pdf> [<https://perma.cc/EY6D-7463>]. Methadone is an “opioid agonist” that activates the same receptors in the brain as any other opioid and helps relieve opioid cravings, decrease withdrawal symptoms, and promote abstinence. *Suboxone v. Methadone v. Naltrexone in Opioid Addiction Treatment*, HAZELDEN BETTY FORD FOUND. (Dec. 11, 2019), <https://www.hazeldenbettyford.org/articles/methadone-vs-suboxone-opioid-treatment> [<https://perma.cc/D98F-XQ28>]. However, because Methadone is a ‘full’ opioid agonist, there is a risk of misuse, as consumption of the medication in large doses can have an intoxicating effect and lead to overdose. *See id.* Buprenorphine, on the other hand, is a “partial opioid agonist,” which activates the same receptors of the brain as other opioids but has a ceiling effect, meaning there is no additional intoxicating effect no matter how much of the medication is taken, and there is no risk of overdose. *See Comparing Medications to Treat Opioid Use Disorder*, HARV. HEALTH PUBL’G, HARV. MED. SCH. (Jan. 3, 2018), <https://www.health.harvard.edu/blog/comparing-treat-opioid-use-disorder-2018010313021> [<https://perma.cc/8H7H-9VBV>]. Finally, Naltrexone is a “pure opioid antagonist,” meaning it sticks to opioid receptors and blocks other opioids from having any effect. *See id.*

24. Opioid use disorder encapsulates use of synthetic opioids such as fentanyl; pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine; the illegal drug heroin; and many others. *See generally* NAT’L INST. ON DRUG ABUSE, *Opioids*, (Mar. 2024), <https://nida.nih.gov/research-topics/opioids> [<https://perma.cc/5M3R-CFH5>].

25. AM. SOC’Y OF ADDICTION MED., *THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE 32* (2020).

*All* FDA approved medications for the treatment of opioid use disorder should be available to *all* patients. Clinicians should consider the patient’s preferences, past treatment history, current state of illness, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone. . . . There is no recommended time limit for pharmacological treatment.

*Id.* (emphasis added). The language above was considered a “Major Revision.” *Id.*

disorder (“MOUD”)] are the standard of care for OUD. They are associated with reduced risk of relapse, overdose deaths, infections, and criminal behavior and are more cost-effective than no OUD treatment or treatment with no medication.”<sup>26</sup> Despite MAT’s well-documented benefits,<sup>27</sup> many states make it difficult for people with an OUD to access MOUD and maintain a consistent regimen with the medications.<sup>28</sup>

Finally, the provider’s ability to plan for and execute the patient’s reintegration into greater society via *aftercare*<sup>29</sup> is a crucial factor in the success of SUD treatment. Ideally, the provider should have a case manager in place who is assigned overall responsibility for the patient.<sup>30</sup> Case managers should be involved with the patient throughout treatment, developing a thorough understanding of the patient’s particular circumstances and individualized needs so that they can most effectively use their linkages with partners in the greater community to guide the patient through a delicate transition back into society. This transition could involve finding “housing, a safe and drug-free home environment, a source of income, marketable skills, . . . a support system[,]” transportation, a less-intensive level of treatment, continued MAT,<sup>31</sup> or any combination of these.<sup>32</sup> Case managers’

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26. Nora D. Volkow & Carlos Blanco, *Medications for Opioid Use Disorders: Clinical and Pharmacological Considerations*, 130 J. CLINICAL INVESTIGATION 10, 10 (2019); see also *Prescribe with Confidence: Patients with Opioid Use Disorder Need You*, U.S. FOOD & DRUG ADMIN. (May 20, 2024), <https://www.fda.gov/drugs/drug-safety-and-availability/prescribe-confidence> [<https://perma.cc/2BHD-WAU8>] (“Research shows that treatment of OUD is most effective when medications are used.”).

27. See, e.g., Hillary Smith Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARV. R. PSYCHIATRY 63, 64 (2015) (“[M]ethadone maintenance remains the gold standard of care for OUD.”); Johan Kakko et al., *1-Year Retention and Social Function After Buprenorphine-Assisted Relapse Prevention Treatment for Heroin Dependence in Sweden: A Randomised, Placebo-Controlled Trial*, 361 LANCET 662, 665 (2003) (finding that 100% of participants with placebo failed treatment while only 25% of the buprenorphine group failed treatment and noting that four of the participants in the placebo group died during the treatment period while no deaths occurred for members of the buprenorphine group); HARV. HEALTH PUBL’G, *supra* note 23 (“Studies on extended-release naltrexone are more promising and have shown it to be better than no medication at all.”).

28. *Overview of Opioid Treatment Program Regulations by State: Restrictive Rules Put Evidence-Based Medication Treatment Out of Reach for Many*, THE PEW CHARITABLE TRS. (Sept. 19, 2022), <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state> [<https://perma.cc/6AAS-UN8C>]. See generally Matthew B. Lawrence, *Addiction and Liberty*, 108 CORNELL L. REV. 259, 286–90 (2023) (summarizing obstacles to MAT and dire consequences of lack of access).

29. “Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. . . . Client interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social sober lifestyle.” SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., TREATMENT IMPROVEMENT PROTOCOL 27: COMPREHENSIVE CASE MANAGEMENT FOR SUBSTANCE ABUSE TREATMENT 18 (2020).

30. See *id.* at 59.

31. See generally Allison J. Ober et al., *The Substance Use Treatment and Recovery Team (START) Study: Protocol for a Multi-Site Randomized Controlled Trial Evaluating an Intervention to Improve Initiation of Medication and Linkage to Post-Discharge Care for Hospitalized Patients with Opioid Use Disorder*, 17 ADDICTION SCI. & CLINICAL PRAC. Art. No. 39 (2022).

32. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 29, at 21.

continuous involvement with the patient throughout the treatment process helps them better monitor the patient's general functioning after discharge due to greater insight into the patient's personality and tendencies.<sup>33</sup> Their continuous involvement also allows them to develop a trusting relationship so that the patient is comfortable divulging relapses into addictive behavior.<sup>34</sup> If relapse should occur, the case manager can consult the patient and support staff to determine whether readmission is necessary. Due to the familiarity between the provider and patient, the transition back into treatment should be smooth if readmission is necessary.<sup>35</sup>

Another important part of aftercare is the provider's cultivation of peer support services and alumni networks. The benefits of peer support services include greater rates of abstinence, lower rates of overdose for people with an OUD, fewer rehospitalizations, and greater overall self-efficacy and stability in housing, employment, and emotional wellbeing.<sup>36</sup> Alumni networks have also been shown to confirm and maintain former patients' recovery-oriented identity.<sup>37</sup> A patient who actively participates within alumni programs will gain fulfillment by helping others, which in turn leads to a higher quality of life and an increased chance of maintaining sobriety.<sup>38</sup>

This list is not exhaustive. These four components of optimal SUD treatment should be considered fairly basic, and other treatment processes are certainly needed in order to maximize patients' chances of reaching lasting recovery. Nonetheless, it would be fair to say that a program lacking these fundamental characteristics would make for inadequate care.

## B. THE INADEQUACY OF TREATMENT IN CORRECTIONAL FACILITIES

"The U.S. has the highest incarceration rate of any independent democracy on earth—worse, *every single state* incarcerates more people per capita than most nations."<sup>39</sup> Per capita incarceration rates among founding NATO countries reveal that the United States' incarceration rate is four times higher than the United

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33. *See id.* at 22.

34. *See id.* at 23.

35. *See id.*

36. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., TREATMENT IMPROVEMENT PROTOCOL 64: INCORPORATING PEER SUPPORT INTO SUBSTANCE USE DISORDER TREATMENT SERVICES 99 (2023). Peer support is also encouraged during the treatment process. *See id.* See also Charlene Sunkel & Claudia Sartor, *Perspectives: Involving Persons with Lived Experience of Mental Health Conditions in Service Delivery, Development and Leadership*, 46 BJPSYCH BULL. 160, 162–63 (2022) for a discussion of incorporating those with *lived experience* into provider staff and its advantages.

37. *See* Jessica V. Linely & Keith L. Warren, *The Alumni Club: Interpersonal Contact and the Exchange of Recovery Oriented Helping in a Sample of Former Residents of a Therapeutic Community for Women*, 40 THERAPEUTIC CMTYS.: INT'L J. OF THERAPEUTIC CMTYS. Apr. 2019, 10.

38. *See id.*

39. Emily Widra, *States of Incarceration: The Global Context 2024*, PRISON POL'Y INITIATIVE (June 2024), <https://www.prisonpolicy.org/global/2024.html> [<https://perma.cc/2922-ETAG>] (emphasis in original). El Salvador overtook the United States as the country with the highest incarceration rate among all countries since the PRISON POLICY INITIATIVE published its last global context report in 2016. *Id.* at n.1.

Kingdom, the runner-up for highest incarceration rate in the group.<sup>40</sup> As of Spring 2024, 1.8 million people were incarcerated in jails and prisons in the United States.<sup>41</sup>

Studies estimate that 63% of incarcerated persons in jails and 58% of incarcerated persons in state and federal prisons have a SUD,<sup>42</sup> compared to 17.1% of the general American population.<sup>43</sup> There is reason to believe that the percentage of incarcerated persons who have a SUD is higher than the figures above due to inconsistent screening in correctional facilities.<sup>44</sup> Some correctional facilities do not offer any SUD treatment whatsoever.<sup>45</sup> However, the Federal Bureau of Prisons (“BOP”) has laid out a comprehensive framework for SUD treatment in its ninety-eight federal prisons,<sup>46</sup> including the Drug Abuse Education Course, Non-residential Treatment Program (“NRDP”), Residential Drug Abuse Programs (“RDAP”), Follow-up Treatment in general population, and Community Transitional Drug Abuse Treatment (“TDAT”).<sup>47</sup> At face value, it seems that BOP’s programming embraces most of the four fundamental characteristics of optimal SUD treatment discussed above.<sup>48</sup> However, the criteria for incarcerated persons to

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40. *Id.*

41. JACOB KANG-BROWN & JESS ZHANG, VERA INST. OF JUST., PEOPLE IN JAIL AND PRISON IN 2024 1 (2024). “The unprecedented decrease in incarceration witnessed from 2019 to 2020 has been sustained into 2024, but only in some places and only for some groups of people.” *Id.* at 3; see also Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2024*, PRISON POL’Y INITIATIVE (Mar. 14, 2024), <https://www.prisonpolicy.org/reports/pie2024.html> [https://perma.cc/2GEC-YUPR] (finding 1.9 million people were incarcerated in jails and prisons in the United States).

42. *About Criminal and Juvenile Justice*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS. (May 24, 2024) (citing LAURA M. MARUSCHAK ET AL., BUREAU OF JUST. STAT., DEP’T OF JUST., SURVEY OF PRISON INMATES, 2016: ALCOHOL AND DRUG USE AND TREATMENT REPORTED BY PRISONERS 9 (2021)), <https://www.samhsa.gov/criminal-juvenile-justice/about> [https://perma.cc/D9FZ-2R38]. There is much reason for frustration at the lack of recent data on this topic. The PRISON POLICY INITIATIVE estimates that 47% percent of people in state and federal prisons in 2022 had a substance use disorder. Emily Widra, *Addicted to Punishment: Jails and Prisons Punish Drug Use Far More Than They Treat It*, PRISON POL’Y INITIATIVE (Jan. 30, 2024), <https://www.prisonpolicy.org/blog/2024/01/30/punishing-drug-use/> [https://perma.cc/6ES9-MAE7].

43. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., HIGHLIGHTS FOR THE 2023 NATIONAL SURVEY ON DRUG USE AND HEALTH 2 (2023). Note that the data related to the proportion of incarcerated persons with a SUD is not contemporaneous with that of the general population.

44. See Widra, *supra* note 42 (“In 2019, only 64% of all people admitted to jail each month were screened for opioid use disorder . . .”). *But see* U.S. DEP’T OF JUST., FEDERAL PRISON SYSTEM FY 2024 PERFORMANCE BUDGET CONGRESSIONAL SUBMISSION 39 (2024) (“BOP currently screens all those entering and preparing to leave the BOP for OUD.”).

45. See, e.g., SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., BEST PRACTICES FOR SUCCESSFUL REENTRY FROM CRIMINAL JUSTICE SETTINGS FOR PEOPLE LIVING WITH MENTAL HEALTH CONDITIONS AND/OR SUBSTANCE USE DISORDERS 6 (2023).

46. Sawyer & Wagner, *supra* note 41.

47. FED. BUREAU OF PRISONS, U.S. DEP’T OF JUSTICE, PSYCHOLOGY TREATMENT PROGRAMS 2-1 (2016); see also *Residential Drug Abuse Treatment Program*, U.S. SENT’G COMM’N (July 22, 2024), <https://www.ussc.gov/education/residential-drug-abuse-treatment-program> [https://perma.cc/4TSG-FBEZ] (providing an interactive infographic for the RDAP process). RDAP stems from 18 U.S.C. § 3621(b), (e).

48. See *supra* Part I.A (multidimensional initial assessment, quality assurance program, MAT, aftercare).

qualify for these programs are quite strict<sup>49</sup> and there is an arduous admissions process.<sup>50</sup> These obstacles may contribute to the fact that only 11,817 inmates “participated” in RDAP<sup>51</sup> out of 158,637 total prisoners in 2022,<sup>52</sup> though the BOP projects increases in enrollment for the residential program in 2023–2025.<sup>53</sup> Unless the “58% of incarcerated persons in prisons have a SUD” figure is warped by a larger proportion of persons with a SUD being in state prisons, the BOP’s current performance is underwhelming. A further issue with the BOP’s SUD treatment regime is the lack of an evaluation plan for overseeing programming across prisons.<sup>54</sup> Additionally, less than 1% of the BOP’s prison population received MAT in 2021.<sup>55</sup>

Turning to state prisons, the vast majority of prisoners in the United States are incarcerated in state-operated prisons.<sup>56</sup> State prisoners with a SUD do not have the benefit of an idealized, uniform SUD treatment framework like the one designed by the BOP. This disuniformity in treatment frameworks across state prisons can be shown by Homans’ examination of states’ various positions on the use of MAT in correctional facilities.

Besides California, only 14 states offer comprehensive MAT services at either intake and/or release in a considerable number of its jails and prisons: Alaska, Arizona, Colorado, Connecticut, Delaware, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New Hampshire, Ohio, Pennsylvania, and Rhode Island. . . . Although not fully operational, some states like Arkansas, Connecticut, Hawaii, Nevada, North Carolina, Oregon, South Carolina, and Vermont piloted or are currently piloting a MAT program in at least one of their correctional facilities.<sup>57</sup>

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49. See, e.g., FED. BUREAU OF PRISONS, *supra* note 47, at 2–8–2–9 (“Inmates must meet all of the following criteria to be admitted into RDAP. . . . Ordinarily, have 24 months or more remaining on their sentence.”). Therefore, persons with a SUD who have committed less serious crimes are denied residential treatment, further delaying their opportunity for recovery.

50. See *generally id.* at 2–11–2–14.

51. U.S. DEP’T OF JUST., *supra* note 44, at 40. 20,163 inmates participated in the Non-residential Treatment Program, but the BOP projects decreases in this program’s enrollment for 2023–2025. *Id.*

52. BUREAU OF JUST. STAT., DEP’T OF JUST., FEDERAL PRISONER STATISTICS COLLECTED UNDER THE FIRST STEP ACT, 2023 at 5.

53. U.S. DEP’T OF JUST., *supra* note 44, at 40.

54. See *Bureau of Prisons: Improved Planning Would Help BOP Evaluate and Manage Its Portfolio of Drug Education and Treatment Programs*, U.S. GOV’T ACCOUNTABILITY OFFICE (May 26, 2020), <https://www.gao.gov/products/gao-20-423> [<https://perma.cc/BE9K-FWGE>]. Further discussion about the presence of an evaluation program could not be found. The BOP did conduct the TRIAD Drug Treatment Evaluation Project back in 2000, but a similar, more recent effort has not occurred. See *generally* OFFICE OF RSCH. AND EVALUATION, FED. BUREAU OF PRISONS, TRIAD DRUG TREATMENT EVALUATION PROJECT FINAL REPORT OF THREE-YEAR OUTCOMES (2000).

55. MARDET HOMANS ET AL., U. OF CAL., IRVINE, CENTER FOR EVIDENCE-BASED CORRECTIONS, A REVIEW OF MEDICATION ASSISTED TREATMENT (MAT) IN UNITED STATES JAILS AND PRISONS 3 (2023).

56. There are 1,071,000 people incarcerated in state prisons compared to just 208,000 who are incarcerated in federal prisons and jails as of Spring 2024. Sawyer & Wagner, *supra* note 41.

57. HOMANS, *supra* note 55, at 7.

Rhode Island appears to be a leader in delivering MAT and addressing the needs of its incarcerated population who have a SUD.<sup>58</sup>

Two scholars have recently called for state correctional systems to be more transparent and make public key data on their SUD treatment capabilities and outcomes.<sup>59</sup> They noted that thirty-nine states had “publicly accessible prison reports[,]” but forty-four states did not report an “estimated percent of [inmates] with substance addiction,” forty-five states did not report “bed counts for RDAPS[,]” and forty-nine states did not report “RDAP average attendance” nor “RDAP funding”.<sup>60</sup> The lack of publicly available data on these metrics raises suspicion that there is either insufficient tracking or that SUD treatment is not occurring. Data from 2019 reveals that only 10% of incarcerated persons in state prisons had received clinical treatment in the form of a residential treatment program, professional counseling, detoxification unit, or MAT.<sup>61</sup>

Turning to jails, 64% of local jails screen people for opioid use disorder during admission.<sup>62</sup> 54% provide MAT to people experiencing withdrawal; 41% provide behavioral or psychological treatment; 29% provide education on overdose; and 24% of jails continue MAT for people already on a regimen, while only 19% initiate MAT for those not currently on a regimen.<sup>63</sup> Considering the access issues already faced by the public outside of the correctional context,<sup>64</sup> initiation of MAT for incoming inmates in jails represents a major opportunity to expand treatment access. An inmate’s lack of an existing MAT regimen upon intake should not be an automatic means for exclusion from MAT. Furthermore, although jails do somewhat better than prisons on several metrics, such as screening and MAT access, they lag behind prisons in overdose prevention. 15% of deaths in jails in 2019 were attributed to overdose, a figure that used to be 4% in 2000.<sup>65</sup>

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58. See Beth Schwartzapfel, *A Better Way to Treat Addiction in Jail*, THE MARSHALL PROJECT (Mar. 1, 2017, 10:00 PM ET), <https://www.themarshallproject.org/2017/03/01/a-better-way-to-treat-addiction-in-jail> [<https://perma.cc/S5VC-DRZJ>] (“Because Rhode Island’s is a unified system — all the state’s prisons and county jails are located on a single campus — it is the only state where almost every opiate-addicted inmate, whether in prison or jail, has access to a range of medications to treat their drug addiction.”). Rhode Island is obviously an outlier in that its small geographic size makes it feasible to centralize its entire correctional system in one location.

59. Blake Beaton & Jurg Gerber, *Drug Addiction and Incarceration: A Call for Transparency Among Prison-Based Substance Abuse Treatment Programs*, INT’L J. OFFENDER THERAPY & COMPAR. CRIMINOLOGY June 2023, 12.

60. *Id.* at 10.

61. Widra, *supra* note 42.

62. *Id.*

63. *Id.*; see also *Fewer than Half of U.S. Jails Provide Life-Saving Medications for Opioid Use Disorder*, NAT’L INST. ON DRUG ABUSE (Sept. 24, 2024), <https://nida.nih.gov/news-events/news-releases/2024/09/fewer-than-half-of-us-jails-provide-life-saving-medications-for-opioid-use-disorder> [<https://perma.cc/GK2B-KNLA>].

64. See *supra* note 28.

65. Widra, *supra* note 42.

In sum, American correctional facilities are not following the four fundamentals of optimal SUD treatment laid out in Part I.A.<sup>66</sup>

First, state prisons and jails' failure to screen for SUDs indicates that incarcerated persons are not receiving an initial assessment that can be used to develop a plan for SUD treatment, let alone a multidimensional initial assessment that considers a "patient's full biological, psychological, and sociocultural context."<sup>67</sup> The BOP seems to succeed at screening for mental illnesses and SUDs upon intake.<sup>68</sup> However, the BOP accounts for a small minority of the total incarcerated population,<sup>69</sup> and it is unclear whether the BOP has an evaluation plan for overseeing screening and intake to ensure these procedures are taking place in federal prisons across the country.<sup>70</sup>

Second, the BOP's lack of an evaluation plan also raises concerns that it is not collecting process and outcome data to improve the care effectiveness of its unified scheme.<sup>71</sup> Beaton and Gerber's 2023 study on states' dissemination of SUD treatment data also raises doubts as to the accumulation and evaluation of process and outcome data by state prisons. This study found that the vast majority of states are not tracking the percentage of the incarcerated population who have a SUD, number of beds, and the funding set aside for residential treatment.<sup>72</sup> Without a quality assurance program in place, staff accountability, training, and overall SUD treatment quality are at risk.<sup>73</sup>

Third, the figures pertaining to the inaccessibility of MAT for incarcerated persons is disconcerting considering MAT's proven benefits.<sup>74</sup> "Methadone and buprenorphine medication treatment reduces the risk of overdose by more than 50% compared to treatment without medication."<sup>75</sup> All forms of MAT should be made available to incarcerated persons without a predetermined time limit for prescriptions.<sup>76</sup> The Drug Enforcement Administration ("DEA") has a hand in regulating all MAT but most stringently regulates methadone, making the medication only accessible through a licensed opioid treatment program ("OTP").<sup>77</sup> Traditionally, a patient could only maintain a methadone regimen by making

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66. See generally *supra* Part I.A (multidimensional initial assessment, quality assurance program, MAT, aftercare).

67. Boyle, *supra* note 13.

68. See U.S. DEP'T OF JUST., *supra* note 44, at 8, 39.

69. See *supra* note 56.

70. See U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 54.

71. See *id.*

72. See generally Beaton & Gerber, *supra* note 59.

73. See generally SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 16, at 10–12.

74. See generally *supra* notes 23, 25, 27.

75. *Treating Addiction in Jails and Prisons*, JOHNS HOPKINS UNIV. BLOOMBERG SCH. OF PUBLIC HEALTH (Aug. 23, 2021), <https://publichealth.jhu.edu/2021/treating-addiction-in-jails-and-prisons> [<https://perma.cc/G4WF-BKYM>]; see also Volkow & Blanco, *supra* note 26.

76. AM. SOC'Y OF ADDICTION MED., *supra* note 25.

77. JOHNS HOPKINS UNIV. BLOOMBERG SCH. OF PUB. HEALTH, *MEDICATIONS FOR OPIOID USE DISORDER IN JAILS AND PRISONS: MOVING TOWARD UNIVERSAL ACCESS* 7 (2021).

daily visits to an OTP.<sup>78</sup> In June 2021, the DEA promulgated regulations to permit OTPs to operate “mobile methadone programs which could serve jails and prisons.”<sup>79</sup> Still, correctional facilities tend to be geographically isolated, presenting excessive costs and logistical challenges when coordinating with community OTPs on a daily basis.<sup>80</sup> The DEA also required that only clinicians prescribe buprenorphine and only after they engaged in additional training and submitted an application to the DEA for a special prescriber identification number.<sup>81</sup> In 2021, the Department of Health and Human Services stepped in, announcing policy changes that would allow physicians, nurse practitioners, and physician assistants to prescribe buprenorphine, but only to a maximum of thirty patients if the prescriber had not received additional training.<sup>82</sup> In order for a correctional facility to administer a full suite of MAT while complying with applicable regulations and guidelines, it needs to either obtain OTP licensure or figure out a way to coordinate with a community OTP. Correctional facilities have proven unwilling to take these steps for years according to Homans’ work with the University of California, Irvine. Homans found that the majority of states in 2023 had not implemented MAT *in a single one* of their correctional facilities.<sup>83</sup>

Fourth, the BOP’s SUD treatment scheme recognizes the importance of after-care based on its Residential Reentry Centers, which hosted a daily population of 13,934 in November 2022.<sup>84</sup> However, the Substance Abuse and Mental Health Services Administration’s call to action for community case managers to “if possible” engage in “in-reach” at jails and prisons raises the suspicion that there is typically not a person working closely enough with incarcerated persons to build

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78. *Id.* Because it has been found that persons with a SUD are less likely to be successful in controlling their use if they are unable to move to an entirely new environment, the requirement of daily visits to the same clinic (depending on access elsewhere) is contradictory to promoting healthy behavioral change conducive to lasting recovery. See Anke Snoek et al., *Strong-Willed but Not Successful: The Importance of Strategies in Recovery from Addiction*, 4 ADDICTIVE BEHAV. REPS. 102, 106 (2016). This finding by Snoek also raises the question of whether correctional facilities are fundamentally incompatible with recovery due to its inherent restrictions on a person’s ability to cultivate a new environment.

79. JOHNS HOPKINS, *supra* note 77.

80. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 45, at 26.

81. . JOHNS HOPKINS, *supra* note 77.

82. *Id.*

83. See HOMANS, *supra* note 55 at 7. See generally BUREAU OF JUST. ASSISTANCE, U.S. DEP’T OF JUST., BJA FY24 IMPROVING SUBSTANCE USE DISORDER TREATMENT AND RECOVERY OUTCOMES FOR ADULTS IN REENTRY 7–8, 10–27 (2024) (soliciting grant proposals from non-profit organizations with the goal of increasing MAT access, among other things); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 45, at 23–36 (providing guidance on how community coalitions, local agencies, and behavioral health or social service organizations can solve problems related to case management, peer and patient navigation, and MAT in lieu of the accountability and competence of the correctional system). These potential community partners are expected to provide “in-reach” services to incarcerated persons, which has the potential added barrier of correctional facilities’ lack of cooperation. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 45, at 32, 36. At some point, we need to recognize that the correctional system has grossly neglected the dilemma addiction poses for the nation, and its unwillingness to step up to the occasion should be a means for excluding it from any contact with persons with a SUD as often as possible. See *infra* Part II.

84. U.S. DEP’T OF JUST., *supra* note 44, at 74.

a trusting relationship conducive to effective monitoring of the individual once they transition from the correctional facility.<sup>85</sup> Ineffective monitoring means warning signs of relapse may go undetected, which is especially dangerous for persons with an OUD after forced withdrawal and no MAT to sustain tolerance.<sup>86</sup> Additionally, SUD treatment in correctional facilities is incompatible with the prevalence of readmission, as it has been found that the majority of people who enter treatment end up relapsing at some point afterward.<sup>87</sup> In fact, “specialists say that most [persons with a SUD] relapse an average of five to six times before achieving full sobriety.”<sup>88</sup> Unlike with a community-based treatment center, where familiarity between the provider and the patient increases the likelihood of successful recovery the next time around,<sup>89</sup> it is inconceivable that a person with a SUD may voluntarily readmit herself to a correctional facility to garner that same benefit.<sup>90</sup>

### C. RECIDIVISM AND OVERDOSE AFTER RECEIVING INADEQUATE SUD TREATMENT DURING INCARCERATION

A person with a SUD may nonetheless be readmitted involuntarily into the correctional system for a bevy of reasons, most notably failed drug tests<sup>91</sup> due to the

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85. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 45, at 36.

86. See, e.g., Volkow & Blanco, *supra* note 26; JOHNS HOPKINS, *supra* note 75.

87. Eric Kabis et al., *Determinants and Prevalence of Relapse Among Patients with Substance Use Disorders: Case of Icyzere Psychotherapeutic Centre*, 16 SUBSTANCE ABUSE TREATMENT, PREVENTION, AND POL’Y Feb. 2021, 6 (noting that 58% of patients relapse between two weeks and three months, and as high as 90% when relapse is defined as a single drink, while also noting another study finding a 75% relapse rate in the 3–6-month period following treatment). See generally Dawinder S. Sidhu, *Criminal Law X Addiction*, 99 N.C. L. REV. 1083, 1129–31 (2021) for a discussion of how failed urine tests play out in various drug courts.

88. The Editorial Board, *If Addiction Is a Disease, Why Is Relapsing a Crime*, N.Y. TIMES (May 29, 2018), <https://www.nytimes.com/2018/05/29/opinion/addiction-relapse-prosecutions.html> [<https://perma.cc/M47W-EZUF>].

89. See *supra* p. 6.

90. The correctional system is antithetical to the reality and prevalence of relapse. It is also worth doing away with the potential argument that a formerly incarcerated person could benefit from familiarity if she were to return to the same correctional facility. There is little guarantee that a formerly incarcerated person will be placed in the same correctional facility after recidivating. For instance, 18 U.S.C. § 3621(b) governs where a person may be incarcerated at the federal level and gives great latitude to the BOP in its choice of location. See, e.g., § 3621(b) (“Notwithstanding any other provision of law, a designation of a place of imprisonment under this subsection is not reviewable in court.”).

91. See, e.g., Jacob Schuman, *America’s Shadow Criminal Justice System*, NEW REPUBLIC (May 30, 2018), <https://newrepublic.com/article/148592/americas-shadow-criminal-justice-system> [<https://perma.cc/7ESJ-VVXH>].

[U]nlike most defendants, people accused of violating the terms of their supervised release do not enjoy the rights to a speedy trial, a jury, confrontation of adverse witnesses, or proof beyond a reasonable doubt. The upshot is that in the federal system alone, over 100,000 men and women are now subject to arrest for minor infractions and to imprisonment without the protections of the Bill of Rights.

Recently, the restrictive conditions of supervised release have also collided with the national opioid epidemic, funneling [persons with a SUD] into prisons, rather than into treatment.

*Id.* (emphasis added); Emilia E. McManus, Note, *Beyond Bars: Rethinking Substance Use Criminalization in Federal Supervision*, 51 FORDHAM URB. L.J. 1181, 1218 (2024) (“A majority of people will relapse five to

near inevitability of relapse.<sup>92</sup>

[18 U.S.C. § 3583(g)] requires judges to revoke supervised release and impose a prison sentence whenever a defendant violates supervised release by possessing a drug, refusing a drug test, or testing positive for drugs more than three times in a year. Although a single positive drug test alone does not trigger mandatory revocation, it is considered enough evidence for the government to prove that the defendant possessed drugs, which does mandate revocation. In other words, whenever a defendant tests positive for drugs, probation officers and prosecutors can choose whether to invoke mandatory revocation by arguing . . . that the defendant *used* drugs and also *possessed* them. This power to decide if the defendant will face a mandatory prison sentence gives law enforcement significant procedural leverage to induce concessions.<sup>93</sup>

The community SUD treatment provider, who is more likely to have implemented the four fundamental characteristics of optimal treatment discussed above, has been found to boast a modest treatment success rate of around 42%.<sup>94</sup> Therefore, a person with a SUD, whose odds at reaching lasting recovery are already against them, is likely to have a tremendously difficult time complying with randomized drug tests during supervised release after being incarcerated at a correctional facility missing one or all of the fundamentals of SUD treatment or lacking SUD treatment whatsoever.<sup>95</sup> Further, accusations that certain parole officers are less interested in offering genuine support than policing violations, if true, contradict any assertion that supervised release is a form of aftercare.<sup>96</sup>

According to one study, “40% of state prisoners and jail inmates said they used drugs at the time they were arrested.”<sup>97</sup> If the crime that a person with a SUD is

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six times before sobriety, meaning incarceration . . . for testing positive for drugs fully stops recovery progress . . . . The overwhelming burden of drug supervision conditions puts people fighting addiction at a constant risk of returning to prison.” (footnotes omitted)). *But see* U. Kappl et al., *Relapses in Illicit Drug Use Among Probationers: Results in a Risk Group of Public Health Services in Bavaria*, 68 INT’L J. PUB. HEALTH OCT. 11, 2023, 7 (“The low overall rate of positive drug screenings speaks to the effectiveness of probation for people with narcotic offenses in helping them discontinue drug use.”).

92. Compare Nicholas Guenzel & Dennis McChargue, *Addiction Relapse Prevention*, NAT’L INSTS. OF HEALTH (July 21, 2023), <https://www.ncbi.nlm.nih.gov/books/NBK551500/> [<https://perma.cc/NW3W-LLS4>] (“Individuals recovering from various forms of addiction frequently encounter relapses that have gained acceptance as an inevitable part of the recovery process.”), with William L. White, *Relapse Is NOT Part of Recovery: A Brief Commentary*, (2010), <https://www.chestnut.org/resources/33827e78-6bbe-4259-9751-1f87dc612205/2010-Relapse-is-NOT-Part-of-Recovery.pdf> [<https://perma.cc/U4B5-WDGL>].

93. Jacob Schuman, *Drug Supervision*, 19 OHIO ST. J. CRIM. L. 1, 23–24 (2021).

94. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEPT. OF HEALTH & HUM. SERVS., TREATMENT EPISODE DATA SET (TEDS) 2019: ADMISSIONS TO AND DISCHARGES FROM PUBLICLY FUNDED SUBSTANCE USE TREATMENT 7 (2021). *See generally* Catherine E. Paquette et al., *Expanding the Continuum of Substance Use Disorder Treatment: Nonabstinence Approaches*, 91 CLIN. PSYCH. REV. Feb. 2022, 2, 7, 11, 13 (grappling with alternative metrics for success besides total abstinence).

95. *See* Brian Lovins, *General Practice or Evidence-Based? Exploring Drug Testing for People Without a Substance Use Disorder*, 36 FED. SENT. REP. 183, 185 (2024) (explaining that testing during supervised release has been more frequent and that randomized testing is the norm).

96. *See, e.g.*, Schulman, *supra* note 91.

97. *Drug Related Crime Statistics*, NAT’L CTR. FOR DRUG ABUSE STATISTICS, <https://drugabusestatistics.org/drug-related-crime-statistics> [<https://perma.cc/P6FA-ATEB>] (last visited Feb. 26, 2025).

convicted of involves more than just a drug offense, a correctional facility's inability to deliver adequate treatment may not effectively lower a person's propensity to commit non-drug-related crimes while intoxicated.<sup>98</sup> Thus, the failure to provide adequate treatment during incarceration is not only a disservice to formerly incarcerated offenders, but also represents a downstream risk to public safety.

A linchpin to combatting recidivism is recently incarcerated persons' ability to secure housing and employment.<sup>99</sup> SUDs are generally recognized as disabilities under three major statutes—Section 504 of the Rehabilitation Act, Americans with Disabilities Act (“ADA”), and the Fair Housing Act (“FHA”). These statutes protect against housing discrimination and impose a duty on landlords to make reasonable accommodations.<sup>100</sup> Although these protections apply to an “ongoing disability,”<sup>101</sup> Congress lifted these protections for persons with an active SUD during the War on Drugs in the late 1980s and early 1990s.<sup>102</sup> Because these exceptions to the general rule of anti-discrimination and reasonable accommodations are still intact today, tenants caught using illicit substances are categorically unprotected and unable to assert a “second chance” accommodation to an eviction or housing subsidy termination.<sup>103</sup> The second chance accommodation acts as an affirmative defense.<sup>104</sup> To illustrate the inequity here, persons with a mental illness who faces eviction for acting illegally, violently, so threateningly that they may represent a risk to the health and safety of the public, are consistently able to assert a second chance accommodation with success and maintain their housing.<sup>105</sup> Meanwhile, persons with a SUD who are caught using substances will be consistently unsuccessful in asserting the same defense.<sup>106</sup> Therefore, formerly incarcerated persons with a SUD face a substantial risk of losing their housing if they do not receive adequate treatment during incarceration as a result of their increased chance of relapse and the dire consequences relapsing can have due to disability law's shaky relationship with SUDs in the property context.

In the employment context, the ADA gives individuals with a SUD no protection against termination if their SUD is active.<sup>107</sup> Public stigma may also place an

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98. See Volkow & Blanco, *supra* note 26.

99. See SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 45, at 6–7.

100. See Hailey Adams, *A Public Health Approach to Addiction Starts at Home*, 135 HARV. L. REV. F. 391, 395–97 (2022) (citing 42 U.S.C. §§ 3603(h), 12102(1); 29 U.S.C. § 705(20)).

101. Adams, *supra* note 100, at 397, n.43.

102. See *id.* at 402.

103. *Id.* at 403.

104. *Id.* at 398.

105. See *id.* at 399–400.

106. *Id.*

107. The applicable implementing regulation for the ADA reads, “The terms disability and qualified individual with a disability do not include individuals currently engaging in illegal use of drugs.” 29 C.F.R. § 1630.3(a).

additional barrier to employment that persons with a SUD have to overcome, even if they have maintained sobriety for an extended period.<sup>108</sup>

Several times this Note has touched on the increased chance of overdose for persons with a SUD who are reentering the community after incarceration.<sup>109</sup> “Recently incarcerated people are over 40 times more likely to die from an opioid overdose [than the general population].”<sup>110</sup> This dramatic disparity in the likelihood of death by overdose reinforces the conclusion that correctional facilities are not providing optimal SUD treatment.

## II. AN INCREMENTAL SOLUTION: CAN THE ABA HELP?

There are two ways to approach the dilemma of inadequate SUD treatment in correctional facilities. The first approach is to improve upon correctional facilities’ current SUD treatment offerings with an eye toward, at the very least, implementing the four fundamentals of SUD treatment from Part I.A of this Note.<sup>111</sup>

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108. See Jenifer Wogen & Maria Teresa Restrepo, *Human Rights, Stigma, and Substance Use*, 22 HEALTH & HUM. RTS. J. 51, 54 (2020). *But see, e.g.*, BUREAU OF JUST. ASSISTANCE, DEP’T OF JUST., BJA FY24 SECOND CHANCE ACT IMPROVING REENTRY EDUCATION AND EMPLOYMENT OUTCOMES 6 (May 6, 2024) (“With this solicitation, BJA seeks to fund reentry services and programs focused on strengthening education and employment outcomes for individuals returning to their communities [after incarceration].”); *Workplace Supported Recovery*, NAT’L INST. FOR OCCUPATIONAL SAFETY & HEALTH, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 21, 2023), <https://www.cdc.gov/niosh/substance-use/workplace-supported-recovery/index.html> [<https://perma.cc/9T7E-2K5U>]; *Thousands of Businesses Pledge to Hiring Those with a Criminal Record*, SOC’Y FOR HUM. RES. MGMT. (Apr. 28, 2020), <https://www.shrm.org/about/press-room/thousands-businesses-pledge-to-hiring-criminal-record> [<https://perma.cc/28SB-VZ4L>].

109. See, e.g., *supra* pp. 4–6, 10–13.

110. Maddy Troilo, *We Know How to Prevent Opioid Overdose Deaths for People Leaving Prison. So Why Are Prisons Doing Nothing?*, PRISON POL’Y INITIATIVE (Dec. 7, 2018), <https://www.prisonpolicy.org/blog/2018/12/07/opioids/> [<https://perma.cc/WET3-5REC>] (looking specifically at North Carolina). Other outlets pose a lesser but still substantial disparity. However, note that the figure produced by the PRISON POLICY INITIATIVE measures death by overdose not just instances of overdose. See, e.g., Nicole Rideout, *Opioid Overdose Risk Is 10 Times Greater for Those Recently Released from Prison*, OR. HEALTH & SCI. U. (Mar. 10, 2023), <https://news.ohsu.edu/2023/03/10/opioid-overdose-risk-is-10-times-greater-for-those-recently-released-from-prison> [<https://perma.cc/LA5D-QLSX>] (“The research . . . also found that risk of overdose is highest among women and in the first two weeks following incarceration.” (citation omitted)).

111. Examples of litigation related to SUD treatment in correctional facilities: *Smith v. Aroostook Cnty.*, 376 F. Supp. 3d 146, 161 n.20 (D. Me. 2019) (“The evidence presented in this action suggests that a scientific consensus is growing that refusing to provide individuals with their prescribed MAT is a medically, ethically, and constitutionally unsupportable denial of care. Cognizant of the principle of judicial restraint and given my ruling that the Plaintiff is likely to succeed on her ADA claim, I sidestep the constitutional issue . . .” (citations omitted)), *aff’d*, 922 F.3d 41 (1st Cir. 2019); *Strickland v. Delaware Cnty.*, No. 21-4141, 2022 WL 1157485, at \*1, \*4, \*6 (E.D. Pa. Apr. 19, 2022) (involving a challenge to a jail policy limiting methadone treatment to pregnant individuals with OUD and upholding claims based on the ADA, Rehabilitation Act, Fourteenth Amendment, and professional negligence); *Johnson v. Dixon*, No. 23-cv-23021-ALTMAN, 2023 WL 6481252, at \*1 (S.D. Fla. Oct. 5, 2023) (recognizing ADA and deprivation of civil rights claims based on state prison’s refusal to administer Suboxone); *Chamberlain v. Virginia Dep’t of Corrs.*, No. 7:20-cv-00045, 2021 WL 4100354, at \*13–14 (W.D. Va. Sept. 9, 2021) (granting summary judgment in favor of state correctional system on plaintiffs’ MAT-related ADA, Rehabilitation Act, and equal protection claims, but not on plaintiffs’ Eight Amendment claim for cruel and unusual punishment). See generally U.S. ATT’Y’S OFF. E.D. KY., DEP’T OF JUST., *U.S. Attorney’s Office Reminds Correctional Facilities of Obligation to Ensure Access to Treatment*

The second approach is to decrease the number of people with a SUD who are incarcerated.<sup>112</sup> This Note will focus on the second approach.

One defense of this decision to focus on decreasing the number of persons with a SUD who are incarcerated rather than improving treatment offerings in correctional facilities is that this Note has already discussed ways in which correctional facilities are incompatible with recovery, such as the correctional system's inability to account for the prevalence of relapse and readmission.<sup>113</sup> It is not unreasonable to question whether correctional facilities could ever provide optimal SUD treatment.

Another concern with focusing on treatment in correctional facilities is that litigation appears to be limited to the issue of access to MAT, without concern for the other three fundamentals of optimal SUD treatment.<sup>114</sup> Even on the MAT front, it is unreasonable to expect that litigation alone can vindicate the needs of incarcerated persons with a SUD across all fifty states and beyond, nor is it desirable that litigation be the sole trailblazer for widespread reform due to the exponential time and money involved in fighting cases.<sup>115</sup> Thus, a substantial overhaul of the correctional system's SUD treatment offerings requires voluntary action by individual states. An obvious barrier to voluntary state action would be fiscal

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for Opioid Use Disorder, (Apr. 10, 2024), <https://www.justice.gov/usao-edky/pr/us-attorneys-office-reminds-correctional-facilities-obligation-ensure-access-treatment> [<https://perma.cc/946C-JHSW>] (“Since 2022, the office has entered three settlement agreements to resolve allegations of discrimination against individuals with OUD . . . .”); Lawrence, *supra* note 28, at 268–70, 300–06 (formulating freedom from addiction as a fundamental liberty protectable by the Fourteenth Amendment, which would be an outgrowth of the freedom of thought, an existing fundamental liberty embedded in the First Amendment).

Virtually all litigation against correctional facilities regarding SUD treatment revolves around MAT. But what about addiction to other substances that are not currently treatable by FDA approved medications? Is it sensible or desirable that receiving treatment for one's SUD can only be legally required if there is a medication that bridges the SUD with treatment and recovery? Litigation for more 'abstract' forms of SUD treatment would be desirable. Professor Lawrence's more robust constitutional argument for freedom from addiction may be a way to reach these forms of treatment in litigation. See Lawrence, *supra* note 28, at 268–70, 300–06. However, one need only look to *Aroostook County* as an example of judges' reluctance to reach the constitutional question should the government not settle. See 376 F. Supp. 3d at 161; ATT'Y'S OFF. E.D. KY., *supra*.

112. For an example of this approach in action, see Meredith Cusiak, Note, *Mens Rea and Methamphetamine: High Time for a Modern Doctrine Acknowledging the Neuroscience of Addiction*, 85 FORDHAM L. REV. 2417 (2017), which endeavors to counter the seemingly immovable doctrine that “voluntary” intoxication, even intoxication due to a SUD, cannot negative the *mens rea* of a criminal defendant. See generally MODEL PENAL CODE § 2.08 (AM. L. INST. 2021).

113. See *supra* note 90; see also *supra* note 77.

114. See *supra* note 111.

115. *But cf.* *Bounds v. Smith*, 430 U.S. 817, 828 (1977) (“We hold, therefore, that the fundamental constitutional right of access to the courts requires prison authorities to assist inmates in the preparation and filing of meaningful legal papers by *providing prisoners with adequate law libraries* or assistance from persons trained in the law.” (emphasis added)), *abrogated by* *Lewis v. Casey*, 518 U.S. 343, 355 (1996); VIBEK LEHMAN, PRISONERS' RIGHT OF ACCESS TO THE COURTS: LAW LIBRARIES IN U.S. PRISONS (1994), <https://origin-archiv. ifla.org/IV/ifla60/60-lehv.htm> [<https://perma.cc/59SF-ENX8>] (“[T]he 1977 landmark Supreme Court decision . . . led to the establishment of law libraries in most major U.S. prisons.”).

conservatives' reluctance to spend money on prisoners when funding is desperately needed for others who have not broken the law.<sup>116</sup>

Notwithstanding the available arguments countering that line of thinking,<sup>117</sup> fiscal conservatives cannot argue that the current costs of incarceration are desirable or insubstantial.<sup>118</sup> Opting to amend the ABA Criminal Justice Standards with the goal of not only lessening the incarceration of persons with a SUD, but also expressly recognizing the inadequacy of SUD treatment in correctional facilities, would play an incremental role in strengthening the moral concern for persons with a SUD so that it may ultimately override monetary reservations.

One may also argue that there is no guarantee a person with a SUD who eludes incarceration will be admitted into treatment, whether by their own will or that of the government. That is not the point. The point is that many persons with a SUD are entirely precluded from any possibility of adequate treatment if they are incarcerated. They are precluded from acting on the realization that they need help.<sup>119</sup> They remain free to choose the path of recovery and benefit from a lesser risk of overdose when they are not incarcerated.<sup>120</sup>

#### A. WHY AMEND THE ABA CRIMINAL JUSTICE STANDARDS?

The ABA Criminal Justice Standards ("the Standards") are a respected part of the legal landscape that has been in place for sixty years.<sup>121</sup> In 1974, then-Chief

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116. Email from Lawrence O. Gostin, Founding O'Neill Chair in Glob. Health L. Geo. Univ., to author (Nov. 21, 2024) (on file with author). The contention that funding optimal SUD treatment for incarcerated persons is an undesirable expense has a simple counterargument. Providing adequate SUD treatment during incarceration is better conceptualized as a downstream cost-cutter rather than a gratuitous immediate expense because it should prevent spells of recidivism. *See supra* pp. 14–17. Each instance of incarcerating someone represents a greater expense than if that person were not incarcerated. *See* Erica Bryant, *Why Punishing People in Jail and Prison Isn't Working*, VERA INST. OF JUST. (Oct. 24, 2023), <https://www.vera.org/news/why-punishing-people-in-jail-and-prison-isnt-working> [<https://perma.cc/8ZAL-CWHR>]; *see also* Peter Wagner & Bernadette Rabuy, *Following the Money of Mass Incarceration*, PRISON POL'Y INITIATIVE (Jan. 25, 2017), <https://www.prisonpolicy.org/reports/money.html> [<https://perma.cc/P29W-CQ86>]. In theory, the eventual savings of adequate SUD treatment may mean more funding for other causes than what is currently available. Additionally, remember that a noteworthy percentage of inmates have admitted to being intoxicated at the time of their arrest. NAT'L CTR. FOR DRUG ABUSE STATISTICS, *supra* note 97. If the propensity to commit crimes beyond mere drug offenses is not lessened by decreasing instances of intoxication, then the public bears avoidable expenses related to those crimes, whether it be physical injury, property damage, lost wages, or other expenses.

117. *See, e.g.*, Gary A. Zarkin et al., *Benefits and Costs of Substance Abuse Treatment Programs for State Prison Inmates: Results from a Lifetime Simulation Model*, 21 HEALTH ECON. 633, 648 (2011) ("Our results clearly demonstrate positive net benefits to society and the criminal justice system (as measured by cost-savings) of enhancing in-prison substance abuse treatment and community-based treatment aftercare.").

118. Bryant, *supra* note 116.

119. For discussion of harm reduction and deflection, see generally *infra* note 128. *See also* Benjamin F. Henwood et al., *Provider Views of Harm Reduction Versus Abstinence Policies Within Homeless Services for Dually Diagnosed Adults*, J. 41 BEHAVIORAL HEALTH SERVS. & RSCH. 80, 89 (2014) ("Harm reduction has become widely used beyond its origins in needle exchange and its incorporation into services for homeless adults . . . . The invariance of abstinence approaches opens the door to program dropout . . . . Recovery from substance abuse is rarely a linear all-or-nothing proposition . . . .").

120. *See supra* note 110.

121. *See* MARTIN MARCUS, *THE MAKING OF THE ABA CRIMINAL JUSTICE STANDARDS: FORTY YEARS OF EXCELLENCE* 1 (2009).

Justice Warren Burger said of the Standards: “[It is] the single most comprehensive and probably the most monumental undertaking in the field of criminal justice ever attempted by the American legal profession in our natural history . . . . Everyone connected with criminal justice . . . [should] become totally familiar with [its] substantive content.”<sup>122</sup> In 1986, then-Justice Sandra Day O’Connor said that she “frequently finds [the Standards] helpful.”<sup>123</sup> The Standards continue to play a role in federal and state courts today<sup>124</sup> as a driver of “prevailing professional norms.”<sup>125</sup>

There could be tremendous value in amending the Standards. For example, unlike with federal legislation, amending the Standards would not involve the burdensome process of persevering through numerous vetogates.<sup>126</sup> It should be a relatively efficient and feasible way to move the needle on a pressing issue that is costing lives. Amending the Standards could also make for a nudge toward more impactful changes in the Sentencing Guidelines governing incarceration terms.<sup>127</sup> The Standards’ use in state and federal courts across the nation may also make its amendments a much needed unifying force for prosecutors and criminal courts.<sup>128</sup>

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122. *Id.* (citing Warren E. Burger, *Introduction: The ABA Standards for Criminal Justice*, 12 AM. CRIM. L. REV. 251 (1974)).

123. MARCUS, *supra* note 121 (citing *Moran v. Burbine*, 475 U.S. 412, 440–41 (1986) (O’Connor, J., dissenting)).

124. *See, e.g.*, *State v. Rolls*, 211 A.3d 695, 701 (Vt. 2020); *Bd. of Pro. Resp., Wyoming State Bar v. Manlove*, 527 P.3d 186, 199 (Wyo. 2023); *Commonwealth v. Berry*, 323 A.3d 641, 652–53 (Pa. 2024); *United States v. Mulrenin*, No. 20-cr-00152-PAB, 2021 WL 5759164, at \*3–4 (D. Colo. Dec. 3, 2021); *In re Ethics Investigation of Allegations Raised by UDF*, No. 4:22-MC-01-O, 2023 WL 3327251, at \*6–9 (N.D. Tex. Feb. 6, 2023).

125. *Padilla v. Kentucky*, 559 U.S. 356, 367 (2010).

126. “Vetogates” refers to separate stages in the legislative process where a bill may be killed. *See* William N. Eskridge Jr., *Vetogates and American Public Law*, 31 J. L. ECON. & ORG. 756, 757–61 (2015).

127. *See generally* U.S. SENT’G COMM’N, OVERVIEW OF THE FEDERAL SENTENCING GUIDELINES, [https://www.uscc.gov/sites/default/files/pdf/about/overview/2022\\_Guidelines-Basics-Trifold.pdf](https://www.uscc.gov/sites/default/files/pdf/about/overview/2022_Guidelines-Basics-Trifold.pdf) [<https://perma.cc/N2C9-QTRB>] (last visited Jan. 7, 2025); NEAL B. KAUDER & BRIAN J. OSTROM, NAT’L CTR. FOR STATE CTS., STATE SENTENCING GUIDELINES: PROFILES AND CONTINUUM (2008).

128. *See generally* Saba Rouhani et al., “What I Should Be Doing Is Harm Reduction, If I’m Doing My Job Right”: Engagement with Harm Reduction Principles Among Prosecutors Enacting Drug Policy Reform in the United States, 131 INT’L J. DRUG POL’Y 104541, 7 (2024).

Ultimately, whether participants specifically referred to harm reduction principles did not correlate with adoption of any particular *prosecutorial declination policy*. Despite some prosecutors explicitly discussing or defining harm reduction, their drug policy details remained fundamentally at odds with its principles. Specifically, conditions of diversion that included coerced treatment sometimes featured in policies [were] being discussed as progressive and public health or harm-reduction aligned. This incongruity points to the perils of [the] divorcing of harm reduction philosophies from harm reduction interventions; when interventions alone are taken up by policymakers, they may be adapted to the same carceral logics and structures that generate harms for [people who use drugs] in the first place. These provisions directly contradict the principle and practice of meeting people where they are at and ensuring that treatment and/or abstinence is a *choice*, which are core tenets of harm reduction.

*Id.* (first emphasis added). “Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a

Additionally, the ABA has recently demonstrated its willingness to use its influence to promote a more progressive approach to criminal justice, having added the Criminal Justice Standards on Diversion in 2022.<sup>129</sup>

## B. IDEAS FOR AMENDMENTS

This Note will provide general points of direction for the ABA should it decide to further amend the Standards. This Note is a call to action rather than a cut-and-paste set of proposals. It will make suggestions for the Prosecution Function, Sentencing, Mental Health, and Diversion sections of the Standards.

### 1. THE PROSECUTION FUNCTION

Prosecutorial discretion may be described as forming the center of the universe of criminal law.<sup>130</sup> Prosecutors' discretionary power is shaped by their freedom to decide when and against whom to bring charges,<sup>131</sup> their ability to negotiate plea deals,<sup>132</sup> and their authority to suggest sentencing to the judge if a case should progress through trial.<sup>133</sup> In practice, judges accord a fair amount of deference to a prosecutor's sentencing suggestions following a conviction.<sup>134</sup>

Prosecutorial discretion is mentioned throughout the Prosecution Function section. It is first mentioned in Standard 3.1-2(b): "The prosecutor serves the public interest and should act with integrity and balanced judgment to increase public safety both by pursuing appropriate criminal charges of appropriate severity, and by *exercising discretion to not pursue criminal charges in appropriate circumstances.*"<sup>135</sup>

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belief in, and respect for, the rights of people who use drugs." *Principles of Harm Reduction*, NAT'L HARM REDUCTION COAL., [https://harmreduction.org/about-us/principles-of-harm-reduction/\[https://perma.cc/QX85-Y5XB\]](https://harmreduction.org/about-us/principles-of-harm-reduction/[https://perma.cc/QX85-Y5XB]) (last visited Jan. 7, 2025). See generally Conrad Wilson & Michelle Wiley, *After Rolling Back Ballot Measure 110, Oregon's Drug Recriminalization Plans Come into Focus*, OR. PUB. BROAD. (Aug. 21, 2024), [https://www.opb.org/article/2024/08/29/measure-110-drug-law-deflection-possession-crime-law-oregon-recriminalization-decriminalization/\[https://perma.cc/JC5J-8SU3\]](https://www.opb.org/article/2024/08/29/measure-110-drug-law-deflection-possession-crime-law-oregon-recriminalization-decriminalization/[https://perma.cc/JC5J-8SU3]) (discussing the variance among approaches of Oregon county prosecutors as they adapt to recriminalization, some attempting to carry out 'deflection'). "Deflection, the practice of moving a person away from the criminal legal system *entirely* and toward community-based services, is a key—and often preferable—tool for shrinking the footprint of the criminal legal system, promoting reinvestment in the community, and reducing police violence." Miriam Krinsky & Liz Komar, "Victims' Rights" and Diversion: *Furthering the Interests of Crime Survivors and the Community*, 74 SMU L. REV. 527, 534 (2021) (footnote omitted) (emphasis added).

129. STANDARDS FOR CRIMINAL JUSTICE, Diversion (Am. Bar Ass'n 2022).

130. See, e.g., Peter L. Markowitz, *Prosecutorial Discretion Power at Its Zenith*, 97 B.U. L. REV. 489, 501 (2017).

131. See STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-4.4 (Am. Bar Ass'n 4th ed. 2017).

132. Andrew Yablonsky, *Runaway Prosecutorial Discretion*, 102 TEX. L. REV. ONLINE 1, 19 (2023).

133. See *id.*

134. See STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-7.2(d) (Am. Bar Ass'n 4th ed. 2017). But see Adam M. Gershowitz, *The Myth of the All-Powerful Federal Prosecutor at Sentencing*, 95 ST. JOHN'S L. REV. 581, 583 (2021).

135. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-1.2(b) (Am. Bar Ass'n 4th ed. 2017) (emphasis added).

When deciding whether appropriate circumstances exist for exercising prosecutorial discretion, prosecutors should consider the (in)adequacy of SUD treatment in correctional facilities that serve as the foreseeable hosts of a given defendant based on jurisdiction. “[A]ppropriate circumstances” as used in the Standard may be described as a case where the defendant has an active SUD, the crime for which she has been charged reflects minimal danger to public safety, and the correctional facilities where she is most likely to be sent are geographically isolated from MAT and a PTO, lack a quality assurance program, or are understaffed. If the ABA could codify further detail into the “appropriate circumstances” inquiry, details which, for instance, reflect a harm reduction philosophy,<sup>136</sup> it may be helpful to the cause of reducing recidivism and overdose.

The best place in the Prosecution Function section for express recognition of the (in)adequacy of SUD treatment in correctional facilities may be Standard 3-4.4(a), as it lists “the factors which the prosecutor may properly consider in exercising discretion . . . .”<sup>137</sup> Subsection (v) already makes mention of the offender’s previous “efforts at rehabilitation”<sup>138</sup> but adding a factor that reads something like “the behavioral health treatment capabilities of potential facilities for incarceration” would make for a richer calculus in deciding whether to exercise prosecutorial discretion.

Two other parts of the Prosecution Function section could be altered. Standard 3-1.6, Improper Bias Prohibited, could include persons with an active SUD as a class that should be protected from a prosecutor’s potential bias in subsection (a).<sup>139</sup> This recommendation is pertinent given SUD’s attenuated relationship with the term “disability,”<sup>140</sup> which is currently part of the Standard and is the only included term that would theoretically reach persons with an active SUD. The express inclusion of persons with an active SUD may also further the protection against racial bias already mentioned in the Standard<sup>141</sup> given the country’s history of racial favoritism in its response to certain substance addictions.<sup>142</sup>

Subsection (b) of Standard 3-1.13, Training Programs, lists subject matter that should be part of a prosecutor’s training curriculum.<sup>143</sup> The listed areas of training

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136. See generally *supra* note 128.

137. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-4.4(a) (Am. Bar Ass’n 4th ed. 2017).

138. *Id.* at Standard 3-4.4(a)(v).

139. See generally *id.* at Standard 3-1.6(a).

140. See, e.g., 29 C.F.R. § 1630.3(a).

141. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-1.6(a) (Am. Bar Ass’n 4th ed. 2017).

142. See, e.g., Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 791–93, 815–20 (2020) (comparing the inhumane response to the crack cocaine scare of the 1980s to the more compassionate public health response to the contemporary opioid epidemic and highlighting that this disparate response is the product of the race of the affected population and white privilege).

143. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-1.13(b) (Am. Bar Ass’n 4th ed. 2017).

already go beyond substantive skills-based training, including matters like “sentencing alternatives” and “appreciation of diversity”.<sup>144</sup> Due to the prevalence of SUDs within the population who encounter the criminal justice system,<sup>145</sup> perhaps it would be valuable if the ABA suggested that prosecutors be trained on SUD treatment matters, particularly the care capabilities of correctional facilities within their jurisdiction.

## 2. SENTENCING

Subsection (b) of Standard 18-3.5, Criminal History; Recidivism, includes “time elapsed since an offender’s most recent prior conviction” as an unqualified “[standard] for enhancement . . . .”<sup>146</sup> Yet, in the context of a person with a SUD, a shorter duration between a prior conviction and recidivating could be more appropriately viewed as the result of an undertreated SUD, or potentially a relapse into addictive behavior,<sup>147</sup> rather than a source of greater moral blameworthiness fitting for a sentencing enhancement. Considering the prevalence of the inadequacy of treatment in correctional facilities,<sup>148</sup> it is not desirable for a person with an active SUD to again be incarcerated and precluded from adequate treatment for a longer duration.<sup>149</sup> In the case of people currently receiving community-based treatment, their progress may be frustrated to a greater degree, the longer their sentence. When the Standard in its current form is literally applied, it seems to plunge defendants into the next phase of an unvirtuous cycle of recidivism due to their SUD.<sup>150</sup> Adding an exception to the current blanket statement, or adopting some other formulation that incorporates the principle that closer proximity between the current and prior conviction is not always indicative of greater moral blameworthiness, may be desirable.

In a similar vein, Standard 18-3.2, Mitigating Factors, could be altered.<sup>151</sup> In its current form, there are no examples or suggestions for what a mitigating factor may be, while Standard 18-3.3, Definition of Offenses; Aggravating Factors, explicitly suggests “violence” and “amount of money or quantity of goods [stolen]”

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144. *Id.*

145. *See, e.g.,* Widra, *supra* note 42.

146. STANDARDS FOR CRIMINAL JUSTICE, Sentencing, Standard 18-3.5(b) (Am. Bar Ass’n 3d ed. 1994).

147. An inevitable part of recovery. *See, e.g.,* Guenzel & McChargue, *supra* note 92.

148. *See supra* Part I.A, B.

149. An “enhancement” connotes that there will be no inquiry into *whether* a defendant should be incarcerated again if she was already incarcerated for the prior conviction.

150. *See supra* Part I.C. The only apparent way in which a sentencing enhancement may positively contribute to a person with a SUD’s path to recovery would be if she were charged federally and the enhancement pushed her over the threshold of “24 months or more remaining on [her] sentence[.]” which would generally be required to become eligible for the BOP’s RDAP. *See* FED. BUREAU OF PRISONS, *supra* note 47, at 2-8-2-9. Still, given the other qualification criteria for RDAP and its admissions process, *see supra* notes 49, 50, this potential payoff feels too uncertain to override consideration of an amendment to subsection (b) of Standard 18-3.5.

151. *See generally* STANDARDS FOR CRIMINAL JUSTICE, Sentencing, Standard 18-3.2 (Am. Bar Ass’n 3d ed. 1994).

as aggravating factors that a legislature should consider.<sup>152</sup> Therefore, it would be sensible if the Mitigating Factors Standard also contained prescriptive examples, such as a defendant having an ongoing SUD or the (in)adequacy of SUD treatment capabilities of the correctional facilities in the relevant jurisdiction.

Finally, the “mental health evaluation” touched on throughout the Criminal Justice Standards on Mental Health<sup>153</sup> should be woven into Standard 18-3.4, Personal Characteristics of Individual Offenders.<sup>154</sup> Standard 18-3.4 could expressly say that the findings of the mental health evaluation should color the current use of “mental” as a personal characteristic, or that the findings of the mental health evaluation themselves could be deemed personal characteristics.<sup>155</sup> This change is important because “personal characteristics” are to be considered by the sentencing court in determining “the appropriate types of sanctions to impose” in 18-3.4(c);<sup>156</sup> they are a part of the “presentence report”<sup>157</sup> used for “sentence determination and system accountability[;]”<sup>158</sup> and “personal characteristics” can be found in the bedrock Standard of the Sentencing section, Standard 18-6.1, General Principles, which reads, “The sentence imposed in each case should be the minimum sanction that is consistent with the gravity of the offense, the culpability of the offender, the offender’s criminal history, and the *personal characteristics* of an individual offender . . . .”<sup>159</sup> Incorporating the “mental health evaluation” into Standard 18-3.4 may create greater textual continuity across the Standards’ separate sections while also concretely bringing to the forefront consideration of a person’s SUD or other mental health conditions during sentencing due to the near ubiquity of “personal characteristics” throughout the section.

### 3. MENTAL HEALTH

As mentioned above, there seems to be a lack of continuity across the separate sections of the Standards. This shortcoming is especially apparent when viewing the Criminal Justice Standards on Mental Health. Though the Mental Health section cites to other sections,<sup>160</sup> the Prosecution Function, Sentencing, and Diversion sections do not cite to the Mental Health section once.<sup>161</sup> The lack of

152. *Id.* at Standard 18-3.3(a)(i), (ii).

153. *See e.g.*, STANDARDS FOR CRIMINAL JUSTICE, Mental Health, Standard 7-1.1(c) (Am. Bar Ass’n 4th ed. 2016).

154. *See generally* STANDARDS FOR CRIMINAL JUSTICE, Sentencing, Standard 18-3.4 (Am. Bar Ass’n 3d ed. 1994).

155. *See generally id.* at Standard 18-3.4(a).

156. *Id.* at Standard 18-3.4(c).

157. *Id.* at Standard 18-5.4(b)(iii).

158. *See id.* at Standard 18-5.1.

159. *Id.* at Standard 18-6.1(a) (emphasis added). Notice how “personal characteristics” seems to take on extra importance due to it being the final item on the list. *See id.*

160. *See, e.g.*, STANDARDS FOR CRIMINAL JUSTICE, Mental Health, Standard 7-8.2 (Am. Bar Ass’n 4th ed. 2016) (citing to STANDARDS FOR CRIMINAL JUSTICE, Sentencing, Standard 18-5.4 (Am. Bar Ass’n 3d ed. 1994)).

161. *See* STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function (Am. Bar Ass’n 4th ed. 2017);

cross-references to the Mental Health section in these other sections contributes to not only a lack of continuity, but a lesser likelihood that practitioners will go to the Mental Health section when surveying the substantive content of these other sections. The Mental Health section should play a more prominent role across the Standards given the prevalence of SUD and other mental health conditions within the population who encounter the criminal justice system.<sup>162</sup>

One thing left to be desired in the Criminal Justice Standards on Mental Health is a more affirmative stance on how SUD is to be treated within the criminal justice system. In the very first provision, “mental disorder” is defined as “*most likely to encompass* mental illnesses such as . . . substance use disorders that develop from repeated and extensive abuse of drugs or alcohol or some combination thereof.”<sup>163</sup> It is not necessary to have this equivocal, noncommittal language in the definition of the term that acts as a placeholder for SUD throughout the Mental Health section. Additionally, lumping SUD in with all other mental illnesses may not be the most effective way to address particular issues relating to SUD and the criminal justice system.

More narrow adjustments can also be made. Standard 7-1.5, Role of the Judge and Prosecutor in Cases Involving Defendants with Mental Disorders, contains several laudable positions, including “[j]udges and prosecutors should consider treatment alternatives to incarceration for defendants with mental disorders that might reduce the likelihood of recidivism and enhance public safety.”<sup>164</sup> This call to action may have a greater impact if the statement, or at least a cross-reference to this section, were included in Standard 3-4.4(a) of the Prosecutorial Function section, Discretion in Filing, Declining, Maintaining, and Dismissing Criminal Charges,<sup>165</sup> and other pertinent standards in the Sentencing section and beyond. Including mention of Standard 7-1.5 in more places throughout the Standards may help to reinforce the ABA’s more recent goals set out in the Criminal Justice Standards on Diversion, such as “reduce collateral consequences; address over-criminalization; reduce incarceration”<sup>166</sup> and “mitigating systemic harms, like over-criminalization and over-incarceration.”<sup>167</sup>

Most importantly, Standard 7-8.2, Contents of Presentence Report, lists five components that should make up the report submitted to a sentencing court in accordance with Standard 18-5.4 of the Sentencing section.<sup>168</sup> Subsection (b) asks

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Standards for Criminal Justice, SENTENCING (AM. BAR ASS’N 3D ED. 1994); STANDARDS FOR CRIMINAL JUSTICE, DIVERSION (AM. BAR ASS’N 2022).

162. See, e.g., Widra, *supra* note 42.

163. STANDARDS FOR CRIMINAL JUSTICE, Mental Health, Standard 7-1.1 (Am. Bar Ass’n 4th ed. 2016) (emphasis added).

164. *Id.* at Standard 7-1.5(a).

165. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-4.4(a) (Am. Bar Ass’n 4th ed. 2017).

166. STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 1.1(a) (Am. Bar Ass’n 2022).

167. *Id.* at Standard 1.1(b).

168. STANDARDS FOR CRIMINAL JUSTICE, Mental Health, Standard 7-8.2 (Am. Bar Ass’n 4th ed. 2016).

for “[a] description of programs or resources, such as treatment centers, residential facilities, vocational training services, educational and rehabilitative programs, and, in particular, community-based mental health services, that would be appropriate for the offender’s condition.”<sup>169</sup> The current set of “[c]ontents” makes no request for the report to describe the “appropriate[ness]” nor the “programs or resources” of correctional facilities within the relevant jurisdiction.<sup>170</sup> The Mental Health section already finds the expert writer of the presentence report qualified to evaluate community-based treatment programs, so there should be no issue with her evaluating the treatment capabilities of correctional facilities. Without mention of the (in)adequacy of treatment in correctional facilities, sentencing courts that are expected to use the report according to Standard 18-5.2, Requirement of Report,<sup>171</sup> and “exercise substantial discretion to determine sentences[.]”<sup>172</sup> are missing half of the equation. Adding an evaluation of correctional facilities’ treatment capabilities to the presentence report would cause sentencing courts to have a fuller picture when deciding the fate of a defendant with a SUD.

#### 4. DIVERSION

The ABA’s online version of the Criminal Justice Standards on Diversion says, “Commentary for the Standards is forthcoming.”<sup>173</sup> One suggestion for the Commentary would be descriptions of what “harm reduction” and “deflection” mean.<sup>174</sup> The Standards’ inclusion of “harm reduction” is commendable even though it is used only once in the entirety of the Standards.<sup>175</sup> The term “harm

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169. *Id.* at Standard 7-8.2(b). Based on the language in Standard 7-1.3(a)(i), it may be assumed that a mental health professional external to the criminal justice system would be the person to write this report. *Id.* at 7-1.3(a)(i) (“Mental health professionals serve the administration of criminal justice by . . . evaluating and offering legally relevant expert opinions and testimony about . . . the effects of interventions, treatments, services or supports on the person’s condition, capacities, function or behavior . . .”).

170. *Id.* at Standard 7-1.3(v).

171. *See generally* STANDARDS FOR CRIMINAL JUSTICE, Sentencing, Standard 18-5.2 (Am. Bar Ass’n 3d ed. 1994).

172. *Id.* at Standard 18-2.6(a).

173. *Diversion*, AM. BAR ASS’N, [https://www.americanbar.org/groups/criminal\\_justice/resources/standards/diversion/](https://www.americanbar.org/groups/criminal_justice/resources/standards/diversion/) [<https://perma.cc/DL8W-WCTR>] (last visited Mar. 28, 2025).

174. *See, e.g.*, STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 4.2(7)(i) (Am. Bar Ass’n 2022) (“On-going training that: [f]acilitates an understanding of diversion objectives, *harm reduction*, addiction science, crisis intervention, training, behavioral health, and evidence-informed or evidence-based practices . . .” (emphasis added)); Standard 1.2(c)(2) (“‘Law enforcement diversion programs’ are programs that include diversion opportunities such as ‘pre-arrest,’ ‘pre-booking’ ‘*deflection*,’ and ‘post-arrest’ programs in which alleged unlawful conduct is intercepted and addressed before referral to prosecution.” (emphasis added)). *See generally supra* note 128.

175. *See* Regina LaBelle, Director, Addiction and Pub. Pol’y Initiative, O’Neill Inst. Geo. Univ., Looking to the Future of Drug Trafficking and the Drug Supply: Fentanyl and Other Synthetic Drugs (Oct. 30, 2024) (“The Biden administration was the first administration to use the term ‘harm reduction’ in a federal document.”); Maggie Nardi, Deputy Assistant Sec’y, Bureau of Int’l Narcotics and L. Enf’t Affs., U.S. Dep’t of State, Looking to the Future of Drug Trafficking and the Drug Supply: Fentanyl and Other Synthetic Drugs (Oct. 30, 2024) (“We just had a resolution that the U.S. put forward at the last U.N. commission on narcotic

reduction” and the progressive philosophy it entails should be highlighted more prominently in the Diversion section’s main text as well as its Commentary.<sup>176</sup>

Subsection (c) of Standard 7.1, Summary of Part VII. Post-Plea Programs, is a notable part of the Diversion section, as it states:

The Standards strongly encourage early diversion programming. Post-plea diversion programs, where the case is so close to the issuance of a final judgment, do not deviate significantly from the traditional criminal legal system. As a result, these programs occur in the presence of features of the criminal system that are often contrary to the objectives of diversion. For example, empirical study of post-plea diversion reveals a significant number of participants are subject to more severe penalties than similarly situated individuals who are not subject to diversion, particularly when the participant is a person of color . . . .<sup>177</sup>

A similar reservation is not found in Part VI., pre-plea programs,<sup>178</sup> but it seems most of the Standards’ critique of post-plea programs would be applicable to pre-plea programs, where “the prosecutor agrees to dismiss charges in exchange for the accused’s successful participation in a program.”<sup>179</sup> The accused will be deemed to have not been “successful” once the “accused has violated a condition of the program contract . . . .”<sup>180</sup> As a result, the pre-plea program appears to be an offshoot of supervised release, imposing all of the associated challenges that supervised release presents for persons with a SUD.<sup>181</sup> One relapse into addictive behavior would set a defendant back to square one, at the mercy of the prosecutor’s choice of “whether the contract should be maintained without change, modified with the agreement of the parties, or terminated.”<sup>182</sup> It is difficult to uncover an extra layer of protection for a defendant making a pre-plea agreement versus a post-plea agreement. It is also difficult to discern a pre-plea agreement’s greater “deviation” from “the traditional criminal legal system”<sup>183</sup> compared to a post-plea agreement, as is implied by not including a disclaimer in Part VI like the one in Standard 7.1.

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drugs, which for the very first time in an international resolution, used the term ‘harm reduction.’ Which, in the U.S., had been problematic.”)

176. See generally *supra* note 128.

177. STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 7.1(c) (Am. Bar Ass’n 2022).

178. *Id.* at Standards 6.1–6.4.

179. *Id.* at Standard 6.1.

180. *Id.* at Standard 6.4(a) (emphasis added).

181. See *supra* pp. 14–15.

182. STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 6.4(b)(3) (Am. Bar Ass’n 2022).

183. *Id.* at Standard 7.1(c).

The pre-plea agreement, like a regular plea agreement, may involve a waiver of rights.<sup>184</sup> California's preguilty drug court program may act as an example of a pre-plea program similar to the one articulated in the Standards, and it imposes a \$100–\$1000 fee for participation.<sup>185</sup> Failure to pay may be a violation of the pre-plea agreement.<sup>186</sup> Not to mention, the cost associated with hiring counsel to represent the defendant during pre-plea negotiations may also be a burden. Further, in California, failure to complete the program is recorded and made publicly available.<sup>187</sup> There is also no telling what the evidentiary implications are for failing to successfully complete the plan should the pre-plea agreement not have as a term the automatic imposition of a guilty or no-contest plea, which the Standards do not preclude.<sup>188</sup> There is virtually no case law on the particular question of whether violation of a pre-plea contract may be used as evidence against the defendant once charges are re-implemented. The apparent nonexistence of case law discussing the particular question of the evidentiary implications of violating a "pre-plea agreement" is most likely the result of prosecutors' strong reluctance to both offer a diversionary plan and allow for a full trial should the accused fail to successfully complete that plan. At bottom, these pathways lack a meaningful distinction if the accused were to fail, and they appear to be a sort of bizarre supervised release.<sup>189</sup> The only added benefit of a pre-plea agreement over a post-plea agreement is that if the accused is successful in the pre-plea agreement, the charges are dismissed, period.<sup>190</sup> Meanwhile success with a post-plea agreement entails "dismissal or vacation of the conviction, *in reduced charges, or in a sentence that is modified or reduced.*"<sup>191</sup> At a minimum, Part VI should include a disclaimer similar to the one found in Standard 7.1(c),<sup>192</sup> which would point practitioners toward pathways that are not merely supervised release in reverse.

The Standards include two other pathways: Part IV, Early Diversion: Law Enforcement Programs<sup>193</sup> and Part V, Early Diversion: Pre Filing Programs.<sup>194</sup> The law enforcement pathway occurs when "unlawful conduct is addressed

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184. *See id.* at Standard 6.2(c) ("The accused should have the opportunity to consult with defense counsel before waiving any constitutional or statutory right or accepting or rejecting an offer to participate in the program.")

185. Cal. Penal Code § 1001.90(b). *See generally* *A Second Chance—If You Can Pay for It*, COLLATERAL CONSEQUENCE RES. CTR (Dec. 19, 2016), <https://ccresourcecenter.org/2016/12/19/a-second-chance-if-you-can-afford-it/> [<https://perma.cc/96FB-ZET8>].

186. Cal. Penal Code § 1000.3(e).

187. *See* Cal. Penal Code § 1000.4(b).

188. *See* STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standards 6.1–6.4 (Am. Bar Ass'n 2022).

189. *See supra* pp. 14–15. The one major positive of these two diversionary pathways is that it may give a person with a SUD a concrete way to access treatment before incarceration. *See* Joy Radice, *The Reintegrative State*, 66 EMORY L.J. 1315, 1363 (2017). However, "[a] person may feel compelled to take a deferred prosecution if it is required for publically funded drug treatment or mental health programs." *Id.*

190. *See* STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 6.1(a) (Am. Bar Ass'n 2022).

191. *Id.* at Standard 7.1(a) (emphasis added).

192. *See id.* at Standard 7.1(c).

193. *See generally id.* at Standards 4.1–4.6.

194. *See generally id.* at Standards 5.1–5.4.

before referral for charging.”<sup>195</sup> This program appears to be true, unadulterated deflection.<sup>196</sup> However, Part V, which takes the form of “prosecutorial-managed diversion,”<sup>197</sup> includes a whole standard dedicated to pre-filing contracts<sup>198</sup> that is almost directly preceded by “diversion through declination[,]”<sup>199</sup> with no prescriptive language calling for declination over the use of a pre-filing contract, nor any language differentiating the two.<sup>200</sup>

The Diversion section includes absolutely no mention of “prosecutorial discretion,”<sup>201</sup> which seems to be the true key to ameliorating the consequences of the inadequacy of treatment in correctional facilities.<sup>202</sup> In all likelihood, prosecutorial discretion is meant to be baked in to the use of “declination.” But considering the confusion that could result from “[d]iversion through declination[’s]” tight proximity with Standard 5.3, Entering into a Pre-Filing Contract,<sup>203</sup> and the confusion surrounding harm reduction, declination, and deflection that is already present in the field,<sup>204</sup> it may be worth expressly including an ethical duty that prosecutors consider the inadequacy of treatment in correctional facilities and exercise prosecutorial discretion in “appropriate circumstances.”<sup>205</sup> This type of a strong, unmistakable assertion may better serve the Diversion section’s visionary goals set out in Standard 1.1.<sup>206</sup>

## CONCLUSION

This Note has endeavored to demonstrate the particular reasons why SUD treatment in correctional facilities is inadequate and why it is important to address this inadequacy. The ABA Criminal Justice Standards is a forward-looking set of guidelines with a firm footing in the legal landscape. Amending the Standards to promote various procedures and standards that reflect more of a harm reduction philosophy could be a stepping stone toward valuable criminal justice reform that would improve outcomes for people battling SUDs. If the ABA declines to adopt some or any of the suggestions made in this Note, hopefully this Note can at least spark ideas for beneficial changes in how the criminal justice system approaches substance use.

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195. *Id.* at Standard 4.1(a).

196. *See* Krinsky & Komar, *supra* note 128.

197. STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 5.2(b)(1) (Am. Bar Ass’n 2022).

198. *Id.* at Standard 5.3.

199. *See generally id.* at Standard 5.2(b)(2)(i)–(ii).

200. This Note assumes that the consequences of an accused’s failure to complete a pre-filing contract is no different than for pre-plea and post-plea agreements. *See supra* pp. 28–29. The confusion that could result from practitioners conflating pre-filing contracts and declination seems a lot like the dilemma posed in footnote 128 of this Note. *See* Rouhani, *supra* note 128. Perhaps providing further explanation of what declination truly means in the forthcoming Commentary could be a solution.

201. *See* STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standards 1.1–7.5 (Am. Bar Ass’n 2022).

202. *See supra* pp. 22–23.

203. *See* STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standards 5.2–5.3 (Am. Bar Ass’n 2022).

204. *See supra* note 128.

205. STANDARDS FOR CRIMINAL JUSTICE, The Prosecution Function, Standard 3-1.2(b) (Am. Bar Ass’n 4th ed. 2017).

206. *See generally* STANDARDS FOR CRIMINAL JUSTICE, Diversion, Standard 1.1 (Am. Bar Ass’n 2022).