

THE OPIOID CRISIS: A Federal Court's Response

Tonight, I bring to you a weighty topic. I wish I could come to you all lighthearted and happy and tell you about some great invention, like Sherm Poppen's snurfer. But I am here to discuss a much more somber subject. When I spoke with Marty Ferriby about what you might be interested in, she suggested that I talk about "restorative" justice. Well, I don't really have a whole lot of experience with the restorative justice movement, but I am involved in a drug court in Maine, which has some elements of restorative justice, and I want to talk about that in a bit.

Before I get to my drug court, I want to start by telling you what is happening in Maine (and in many places around the country, here as well, but Maine is an area that has been particularly hard-hit). Then I want to tell you how the problem got started. Next, I want to explain addiction and why it's a bad idea to stigmatize it. Then I am going to tell you what can be done about opiate addiction. Finally, I am going to tell you about my drug court and what I am doing in my own little corner of the world.

What is happening?

Before I start telling you some statistics, let me set the stage. The total population of Maine is only about 1.3 million people—roughly the population of Muskegon, Kent, Ottawa, and Kalamazoo counties combined. Geographically, Maine is about seven-eighths the size of the lower peninsula of Michigan. So Maine is a big, sparsely populated state.

Last year, there were 376 deaths from drug overdoses in Maine.¹ Twenty years ago there were only 34 drug overdose deaths in Maine.² In the last five years, overdose deaths have shot up. Zeroing in just on heroin/morphine & non-pharmaceutical fentanyl, overdose deaths in Maine went from a total of 10 in 2010 to a total of 313 in 2016, an increase of 3,030 percent in just six years.³ In 2016, 84 percent of overdose deaths involved at least one opioid.⁴

Nationally, in 2015, there were 52,404 drug overdose deaths, and 33,091 of them were attributed to opioids.⁵ Let me put that in perspective. More people died of drug overdoses than in car accidents in 2015. Almost 15,000 more. There were 50,786 deaths per year at the height of the HIV/AIDS epidemic.⁶ So in terms of the numbers of people

dying, the drug epidemic has outpaced the HIV/AIDs epidemic at its peak. From 2000 to 2014, nearly half a million people in the United States died from drug overdoses.⁷ These figures are staggering.

The numbers of recent drug overdose deaths has started to make people pay attention, but those statistics just shed light on the most extreme event associated with opioid abuse. Overdoses don't always end in death. In 2016, rescue workers used Narcan 2,380 times in Maine.⁸ Narcan is a medication used to block the effects of an opioid overdose. So that means that for every overdose death in 2016 there were roughly seven close calls.

Drug addiction affects more than just the person suffering from the addiction. There were 1,024 drug addicted babies born in Maine in 2016.⁹ The Department of Health and Human Service removed 411 children from Maine homes because they were at risk due to their parents' drug use in 2016.¹⁰ And for every child placed into foster care, an estimated 20 more are living with relatives other than their parents outside the foster care system.¹¹ Children who grow up in families ravaged by addiction or drug abuse are themselves more likely to

develop addiction.¹² That means we have a problem with the capacity to spiral even further out of control in the future.

Drug addiction takes a terrible toll not only on children but also on parents and other family members. Over and over, we read the stories of parents who have lost a child (some even two children) to drug overdoses in the papers. Their grief is crushing. These drugs touch every socio-economic group. They touch every county in Maine.

And the ripple effects of the opioid/heroin crises extend into the community at large. Although Maine's crime rates compare favorably to national crime rates and have been on a downward trend, drug arrests have been rising.¹³ In Maine, arrests related to heroin quadrupled from 2010 to 2014.¹⁴ Roughly 80,000 Americans are incarcerated for opioid-related crimes alone.¹⁵ People sell drugs in order to support their own habits, and people commit other crimes while under the influence of drugs.¹⁶

This epidemic is taking a huge financial toll as well. According to the Centers for Disease Control, prescription opioid abuse, dependence, and overdoses cost the public sector \$23 billion a year.¹⁷ Add to that

number \$55 billion for health care expenses and productivity loss, and the opioid problem alone is costing us \$78 billion per year.¹⁸

Now that you have an idea of the scope of the problem, you may be wondering:

How Did This Happen?

Well in the 1990's, there was a movement dealing with the under-treatment of pain. You may remember seeing those little charts with faces that measured pain if you visited an emergency room or walk-in care clinic. [slide] And doctors were being encouraged by some aggressive pharmaceutical marketing campaigns to prescribe various opioids to control pain. We started to see drastic increases in the number of prescriptions which were being written for opioids, like hydrocodone and oxycodone. The use of these types of drugs escalated from around 76 million prescriptions in 1991 to nearly 207 million in 2013.¹⁹ Doctors began prescribing opiates to control pain for a large and growing variety of symptoms.

With the rise of these drugs we also saw a corresponding rise in opiate abuse and its negative consequences—ER visits, people being

admitted to treatment, etc. As doctors started to realize the addictive qualities of these drugs, they began to reign in their prescribing practices. Patients who could no longer get pills from their doctors started looking for pills on the street. As the prescribing practices tightened, the supply of pills dropped, and the prices rose. Heroin dealers—mostly from Massachusetts and New York—saw an emerging market in Maine. As more drug dealers came into the state, they started to compete with one another. And heroin, sometimes laced with fentanyl, became cheaper, more lethal, and more widely available throughout Maine.

Now some of you out there might be wondering, ‘why should I care about drug addicts?’ So, I want to talk to you a bit about addiction.

What is Addiction?

I am no scientist, but I can explain to you what has been explained to me dozens of times by the addiction specialists who work with me. There are medical, genetic, behavioral, and environmental influences on addiction. Different drugs have different effects; and different people can respond differently. Developing an addiction is complicated, but it does boil down to a roughly consistent process.

Drug users get a rewarding or pleasurable feeling from the use of the drug. That pleasurable feeling reinforces their desire to repeat the experience. As time progresses (and it doesn't take much time with extremely addictive drugs like opiates), the user begins to build a tolerance to the drug. The same amount of drug that was used the last time no longer produces the desired response, and a higher dose is needed to achieve the same effect. The brain adapts as the user builds tolerance.

Some people reach the point where they can only function normally with the presence of the drug, and they call this "dependence." When the drug is removed, there is a physical disturbance called "withdrawal" that is very unpleasant. People in withdrawal can't sleep, can't eat, can't regulate their body temperature. It's often described as akin to a terrible flu, and it goes on for days or even weeks. People also describe a malaise or depression or sometimes an anxiety that goes along with withdrawal. Anhedonia, or the inability to feel joy, is often a symptom, and it frequently remains well after the physical symptoms have waned. As use continues, "dependence" can become "addiction."

“Addiction” is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders refers to this condition as “severe substance use disorder.” People who are addicted seek the reward offered by the drug (or seek to avoid withdrawal), and they lose the ability to control intake.

All this to say that a person addicted to drugs is going to do just about anything to get the next dose. They will beg, borrow, lie, cheat, and steal to get their next fix, which is why it comes as no surprise that addiction and crime are connected.

We have a tendency to ignore or look down on or shame people with addiction. We debate whether we should spend money to help people who use drugs. The theory goes that this is a choice—these people made their own beds. Well, there are a boatload of people who are in this predicament because they developed an addiction to painkillers that were prescribed by their doctor. There are also a boatload of people who become addicted because they have an underlying mental health disorder. And there are a boatload of people

who got into this at a very young age, often because their lives were broken in ways that many people in this room would find difficult to imagine.

While there may be some thrill-seekers who started down this road voluntarily, virtually nobody aspires to become a heroin addict. Remember that addiction is a disease characterized by compulsive behavior. The addiction is in control, not the person. Saying that someone chooses this lifestyle is like starting the book at Chapter 30 when the needle goes into the arm. Nobody starts there.

Stigmatizing addiction only exacerbates the problem. You can call addiction a moral failure or bad behavior, but that is not going to fix anything. Addiction compels people to seek the drug despite the negative consequences that will flow from it. Shaming or punishing them is ineffective. When you see addiction as a disease, you realize it is ridiculous to yell at or punish someone because they relapsed. Should we shame people who have diabetes because they ate too much sugar? Look, it might make *you* feel better, but it isn't going to fix *their* problem.

Stigmatizing addiction creates resistance to action. It's an excuse for people to look the other way. Treatment facilities don't get built, jails get completely overrun with non-violent offenders who deal drugs to support their habits, addicted babies keep being born, and children continue to live in hopeless situations. Nothing changes, except the problem gets worse. As a society we can't afford to keep stigmatizing addiction.

So that's where we are, how we got there, and what it is. And now you may be wondering:

What Can Be Done?

Let's start with what we know.

We know that addiction is a complex, chronic brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. Let that sink in a minute.

We know that the right treatment in the right doses works to interrupt compulsive use. Treatment is not a panacea, and it takes a long time. But it does work. We know that treatment saves lives.

We know that for every dollar we spend on treatment we save at least three dollars in crime reduction. And we of course save even more when you consider regained productivity and health care costs.

A number of law enforcement agencies—local police departments especially—have taken up the cry that we need more resources for treatment. Now, I have worked with police officers for over 20 years, and when law enforcement tells you that they want to put someone in treatment rather than jail, we ought to listen.

So, Why Don't We Put People in Treatment?

The Office of the Surgeon General estimates that only 10 percent of people living with addiction get treatment.²⁰ In Maine, that's an estimated 25,000 to 30,000 people who cannot get the help that they need.²¹ There are multiple barriers to treatment.

First, some people don't want it. They are not ready for it. They think that they can handle it themselves.

Second, in order for an active user to start a treatment program, they have to get past the withdrawal stage. Remember how bad withdrawal feels? The responsible way to help someone get clean is to

put them in a detox center and wean them off opiates, usually with Suboxone, which helps control their cravings. Even in a detox center, withdrawing from opioids is an unpleasant experience. We have one detox center in Portland, Maine that has 16 beds. We have another planned in Bangor that hasn't opened yet. When you only have 16 detox beds in the entire state, people who desperately want to stop using continue to use to avoid withdrawal. Sometimes they buy Suboxone on the street and try to limp along that way. With people who are addicted to opiates, there is a small window of opportunity. They may be ready for treatment, but if you put them on a three month wait list, just forget it. You may never see them again.

Third, there are huge financial barriers to treatment. Detox is just the beginning. Typically, the least that is needed is an intensive outpatient program and medication-assistance. An intensive outpatient program typically costs \$100 per day for 3 to 5 days a week for 4 to 5 weeks. Medication management costs \$145 per week. Methadone treatment costs \$300 per month for the medication alone.²² Suboxone treatment costs \$600 per month for the medication alone.²³ A promising new drug, Vivitrol, is given in the form of a monthly shot, but it costs

\$800–\$1,000 per shot.²⁴ And you may well have someone who needs residential treatment. Residential treatment costs about \$3,500 for a 30 day program. Long term residential can cost \$25,000 for a six month program. You get the idea. This stuff is beyond the means of most people.

In order to afford treatment, you need to either: 1) be wealthy, 2) have a very good insurance plan, or 3) be on Mainecare, which is Maine's Medicaid program. There are only 200 Medicaid-eligible treatment beds in residential programs, and only a third of those are available for women.²⁵ Maine was one of 19 states that opted not to expand Medicaid under the Affordable Care Act. So at a time when our need for treatment was skyrocketing, our admissions to treatment were declining and we were spending less on treatment.²⁶

For the uninsured, access to treatment is nearly impossible. And of the people who need treatment, about 40 percent are uninsured.²⁷ So those folks have to compete for the scholarship beds, which are as rare as hens' teeth.

The fourth barrier to treatment in Maine comes from our geography. We are a very large state with limited public transportation.

As I mentioned, the only detox facility is in Portland. There are methadone clinics in the major cities, and 4,000 Mainers receive methadone treatment,²⁸ but if you live in rural regions, you could have to drive hours every day just to get methadone. Suboxone can be prescribed by primary care providers if they receive a DEA waiver, but only 5 percent of primary care providers have that waiver.²⁹

There are other barriers as well. People with children fear losing their kids if they seek help. People with criminal records sometimes can't get into sober living houses. The list goes on. The more barriers there are to treatment, the more use we will see. More use means more crime, more chaos, more overdoses, more deaths.

There has been some recent progress. Congress recently passed the Comprehensive Addiction and Recovery Act (CARA), which was designed to increase access to medication-assisted treatment by allowing nurse-practitioners to prescribe Suboxone.³⁰ And the 21st Century Cures Act, which designated \$1 billion in grants, is beginning to help states build their capacity to provide treatment.³¹ Anything we can do to improve access to treatment is great, but these efforts are not enough to solve the problem.

Well, I have taken you through the first four sections of my talk, so we are almost to the finish line, and you probably are asking,

‘When is She Going to Talk about Her Drug Court?’

I am getting there. Let me first give you a little history about drug courts. The first drug court in the United States was established in Miami, Florida, in 1989. Faced with a vexing crack-cocaine problem and feeling that the system for dealing with non-violent drug offenders was broken, Judge Stanley Goldstein decided to combine drug treatment with the structure and authority of the judge. Judge Goldstein had the support of the prosecutor and the public defender, and as a team, they were able to get many drug court participants to change their behavior.³² The Miami-Dade drug court was deemed a success. Less than 30 years later, we have approximately 3,000 drug courts in operation nationwide.³³ Drug courts refer more people to treatment than any other system in America, and annually drug courts are serving more than 145,000 seriously addicted people.

The vast majority of drug courts are state courts. There are a lot of variations in drug courts, but probably the most common model is a diversionary model or a “front-end” drug court. The participant is given

a choice: complete drug court or go to jail. This gives the drug court judge a lot of leverage over the participants, and it gives the participants strong external incentives to beat their addiction.

While the number of drug courts in the federal judiciary has been increasing, there has been a reluctance by some in the federal system to take on this mission. But a growing number of federal judges are taking action and starting drug courts. Why? Because we are fed up with seeing offenders come out of prison, return to their homes, reconnect with old associates, resume their involvement in drugs, violate their conditions of supervised release (also known as probation), only to be brought back before us and returned to prison, to start the cycle all over again.

In federal court, the drug court model that first emerged was a “re-entry court.” People with a history of addiction who are coming out of prison are identified and referred to the re-entry court. The United States Probation Office and the federal drug court support that person’s “re-entry” into the community.

For the past five years, I have been the head of a Federal Re-entry Court in Portland, Maine, called SWiTCH, which is an acronym for

Success with the Court's Help. This is not my full-time job. I spend only about 5 percent of my time on the SWiTCH program. The remainder of my hours are consumed with the other tasks of a federal judge—civil and criminal cases and administrative work.

My drug court team consists of the United States Attorney for the District of Maine, an Assistant United States Attorney, the Federal Defender for the District of Maine and a support person from his office, two United States Probation Officers, a Treatment Provider, a Deputy Clerk of the Court, and my law clerk. This inter-disciplinary team comes together with one purpose: to help people on supervised release beat their addiction and get their lives heading in a positive direction.

Most people who are coming out of a federal penitentiary and onto supervised release have pretty lengthy criminal histories. Their federal convictions can vary, and may include drug trafficking, firearms offenses, and even bank robberies. Often they have amassed numerous state convictions for offenses that were related to their substance use. Whereas the state front-end drug courts often catch people before they embark on lives of crime, the mission of my drug court is to get people

who have already racked up serious criminal records to turn their lives around.

In addition to having federal criminal histories, all of the participants in SWiTCH have serious substance use disorders. In the last couple years, we have seen that opiates are the drug of choice for most of my participants. We regularly deal with people who have co-occurring mental health disorders or who have a whole lot of dysfunction in their pasts: people who were abandoned by parents, people who suffered physical and emotional trauma, people who have been sexually abused; people who dropped out of school, people who started using drugs in their early teens (or earlier). In short, people whose lives are a complete mess.

Drug Court is hard. It takes at least a year to complete, though most participants take longer, and at least a couple of my participants have actually gone through the program twice. Those who make it through the SWiTCH program are rewarded with a year off of their supervised release term. But it takes some people so long to get through the program that they don't have a year left on their supervised release. The real reward is getting a chance to break the cycle.

The first step is the screening. We want only high risk/high needs participants. We want the people who have at least moderate to high prognostic risk factors. By that I mean people who are predicted to fail and commit more crime. If someone has a lower risk of recidivism, they can probably do this without drug court, and we turn those people away. We don't want to mix lower risk people with this high risk/high needs group. We also want people who have disorders or conditions that cause or exacerbate crime. People with co-occurring mental health disorders, criminal thinking patterns, impulsivity, difficult family and peer associations are fine. That's who we want. A diagnosis of substance use disorder is a must. Mixing people with lower needs into this group is also not good—lower needs people are considered to be abusing drugs, but not addicted. They can stop if they want to. Putting people in SWiTCH who are not addicted is demoralizing to those who are addicted and compelled to use.

We know that, in order to succeed, these people will need 300 hours of drug treatment. They need cognitive behavioral treatment to address their criminal thinking patterns. They may need to learn basic

life and social skills. It's important to give the right type of treatment, in the right dose, to the right cohort.

If a candidate for SWiTCH is accepted, he or she meets with the Federal Defender who goes over a contract with the rules. It's a dense agreement, and participants probably aren't absorbing much at the beginning. The drug-addled brain needs time to recover. At the first court session, I try to keep it simple. The two most important rules: "Don't Use." "Be Honest." Participants must appear before me in court every two weeks until they graduate from the program.

We put participants into the appropriate level of treatment, and they are expected to attend. Usually it starts with Intensive Outpatient Treatment which involves groups and counseling at a level of about nine hours a week for five weeks.

They are screened by a medical doctor for Medication Assisted Treatment. Some get it, some don't. It depends on the circumstances. We don't allow methadone, but Suboxone and Vivitrol are used. If they get medication, they attend the 36-week long Medication Assisted Treatment Group.

Where we suspect an underlying disorder, we provide the participant with a psychological evaluation. It is so important to get to the bottom of whatever problems started the person down this path. Many of my participants need treatment for anxiety, depression, or ADHD. Without the right medications, the chance of them returning to self-medication is high.

We drug test. It's random, it's observed, it's frequent. Tests occur at least once a week, but usually more, and in the early phases it can be much more frequent. It's important that the participant not know when they will be tested. I had one probation officer who liked to wake them up at 5:00 a.m. "to catch a fresh stream."

Before each court appearance, the team members meet and discuss the status of each participant. At every court session, each participant takes the podium and checks in with me. If they have done well, they are praised. "I'm proud of you." "Good job." The power of praise especially from a judge is extraordinary, but, remember, some of these people have never received praise. If they have slipped up, I ask them what they were thinking and what they have learned from the

mistake. Depending on the slip up, they may be sanctioned as well. And then I encourage them to get back on the horse.

We understand relapse. Forty to sixty percent of people in treatment for opioid addition are going to relapse.³⁴ If we have relapse, we reassess whether they are getting the right level of treatment. Often, we will stop and send someone into residential treatment for a couple of months. When they get through that, they come back and try again.

We also understand dishonesty. These people are practiced in deceit. It's how they have learned to get along in the world. Although many judges will overlook dishonesty at the early stages, I am less forgiving. If a participant tests positive in a preliminary urine screen and denies use, we send the test to a lab for confirmation. If it comes back positive, they receive a sanction, not for the new use but for the dishonesty.

I have learned the language of the treatment providers: If a participant fails to achieve a distal goal (that is, something that they may not be able to do now, such as remaining sober), then we use a low magnitude sanction. If the participant fails to achieve a proximate goal

(that is, something that they are able to do now, such as, in my view, being honest), then a moderate or higher level sanction is imposed. Sanctions start out light but build if a person has multiple infractions or is in a later phase of the program where more is expected of them. Lower level sanctions include imposing curfews, making the participant observe a sentencing, or assigning life skills homework. Moderate sanctions may require a day in the U.S. Marshal's lock-up, an increased reporting requirement, or community service. And higher level sanctions might be electronic monitoring or up to seven days of incarceration.

In Phase I, we work on establishing basic, safe housing. We can use the halfway house in Portland, which is run by the Bureau of Prisons, but it's important that people get out of there as soon as possible and start living on their own. This is tough, as lots of people in the program don't have money or a job yet. Sometimes they qualify for assistance and can get some social services help. Sometimes they have family that will take them in. Sometimes they get a job and can afford a room in a sober house. The probation office has resources to help them develop job skills, write a resume, or make calls. There are some

employers that will hire federal felons. Some actually like hiring our people because they know that we are keeping a close eye on them.

In order to proceed to Phase II of the Program, the participant must achieve 30 consecutive days of sobriety. As they proceed through Phases II, III and IV, we expect more of them and require longer periods of sobriety, 60 days, 90 days and six months, respectively. In later phases, they continue in treatment. Both individual counseling and groups are required. We assign groups based on what the participant needs. A woman who has suffered trauma will participate in Seeking Safety for Women; someone with a short fuse may be required to complete an Anger Management program. Most participants are expected to attend Early Recovery, Moral Reconation Therapy (MRT), and Responsible Choices groups. They must maintain stable housing. They are expected to get appropriate medical or dental treatment where needed. They must either get a job or enroll in school. They must pay off any criminal penalties. They work on personal goals, like getting a GED, getting a license restored, buying a car, rebuilding relationships with family members or kids. Brick by brick they build the foundation

for a better life. If they relapse at any point, they return to the beginning of the phase.

We have a token economy, and we award points for staying sober, going to treatment, check-ins with Probation, creating a resume, applying for a job, getting a job, maintaining employment, doing pro-social activities, attending AA or NA meetings, and getting a sponsor. We encourage participants to engage in the recovery community outside of treatment, because they need to have a pro-social support network in place before they graduate. As points build up, they earn small gift cards—\$5, \$10, and \$20.

As they work their way through the program, you watch people grow. Often they are initially defiant. Many have been ordered to complete the program if accepted. At the outset, they relapse and often lie their faces off. You think that they are never going to make it; and many don't. But some of them, almost despite themselves, start to realize that life is better when they aren't using. They learn from the participants who are ahead of them in the program. As they accomplish the goals of the program, you see them gain confidence. You see them build empathy. They offer encouragement and advice to someone else in

the program who is struggling. They celebrate each other's successes. They emerge as leaders for the newer participants.

As they get near their commencement from the program, they are given the assignment of writing an after-care plan. They present that to their Probation Officer and drug treatment counselor and summarize it at their final session.

At each graduation, we make a big circle, and we go around the circle and each member of the team and each participant gets to speak. Usually the family (sometimes the extended family) of the graduate attends the ceremony. Often the lawyer who handled the underlying criminal case comes back to celebrate. It is a joyous occasion, and you watch as the participant soaks up the glory.

I want to save some time for questions, and I have droned on a long time, but I do want to share our results. For about every one participant who makes it through, two drop out. Our participants are drug tested more frequently and have a lower percentage of positive drug tests (4.5 percent) than our Control Group (17 percent) of high-risk/high-needs offenders who are on federal supervision but not in SWiTCH. That is a satisfying result, particularly when I consider how

dangerous it is to inject heroin. So far, I have not lost a drug court participant to an overdose.

We also consistently beat the supervised release revocation rate as compared to our Control Group—over the years that has ranged from a 5 percent difference to a 50 percent difference. We need to improve the way we collect and analyze the data, and we are working on that. I feel confident, however, in saying that the SWiTCH program has saved lives and a fair bit of money.

I would be the first to concede that we are putting an awful lot of time, energy and resources into a very few people. But I like to look at it this way: when you are working with this particular cohort, if you can turn even one life around, you have saved much more than one life. You have saved a community from a walking crime-spree; you have saved the cost of incarceration (which in the federal system runs \$30,000 a year); and you may have saved a child or two as well. I have three participants involved right now who have each welcomed a healthy baby into the world within the last six weeks.

I would be foolish to think that all the SWiTCH graduates have turned their lives around forever. Addiction, like any chronic disease,

has to be managed for the rest of a participant's life. As one of my drug court participants put it, "the beast is always at the door." But even if there is relapse after they are off supervision, these graduates have put together a significant string of sober days. They have been educated and treated. They will be in a far better position to get back on the wagon and keep going having had the benefit of SWiTCH.

When I send them off, I tell them that they can always come back. If they still need us, they know where to find us. Sometimes they do come back for a time or two or to see a fellow participant graduate. But eventually, they are on their own. And I can only hope that they are doing well and remembering their lessons. I can only hope that they have made the SWiTCH.

I want to thank you so much for giving me this honor. I would be happy to take questions.

¹ Marcella H. Sorg, *Expanded Maine Drug Death Report for 2016* (Margaret Chase Smith Policy Center at the University of Maine, 2017).

² Eric Russell, *A Deadly Epidemic: Addiction to Opioids Has Put an Entire Generation at Risk*, PORTLAND PRESS HERALD, March 26, 2017.

³ Sorg, *supra* note 1.

⁴ *Id.*

⁵ Russell, *A Deadly Epidemic*, *supra* note 2.

⁶ *Id.*

⁷ Rose A. Rudd, et al., *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014* (U.S. Centers for Disease Control and Prevention, 2016), available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>.

⁸ *Id.*

⁹ Megan Doyle, *The Children Left Behind: As One Generation Dies, the Next One's in Peril*, PORTLAND PRESS HERALD, March, 29, 2017.

¹⁰ *Id.*

¹¹ *Id.*

¹² Eric Russell, *Families Hit Hard: For Some Caught in Crisis, Tragedies Multiply*, PORTLAND PRESS HERALD, March 27, 2017.

¹³ Eric Russell, *Crime in Maine on the Decline, but Still Driven by Drug Abuse*, PORTLAND PRESS HERALD, September 26, 2016.

¹⁴ Darren Fishell, *Surge in Heroin Overdoses Spurs Portland to Try New Treatment Program*, BANGOR DAILY NEWS, August 5, 2015.

¹⁵ Austin Frakt, *Spend a Dollar on Drug Treatment, and Save More on Crime Reduction*, NEW YORK TIMES, April 24, 2017.

¹⁶ Over half of violent offenders and about one-third of property offenders commit crimes while under the influence of alcohol or drugs. *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Nora Volkow, *America's Addiction to Opioids: Heroin and Prescription Drug Abuse*, May 14, 2014 (National Institute of Health, National Institute on Drug Abuse, 2014), available at https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftnref5. "The number of prescriptions for opioids (like hydrocodone and oxycodone products) have escalated from around 76 million in 1991 to nearly 207 million in 2013, with the United States their biggest consumer globally, accounting for almost 100 percent of the world total for hydrocodone (e.g., Vicodin) and 81 percent for oxycodone (e.g., Percocet)."

²⁰ Russell, *A Deadly Epidemic*, *supra* note 2.

²¹ Eric Russell, *Treatment Dilemma: No Consensus on Cure as Demand for it Explodes*, PORTLAND PRESS HERALD, March 30, 2017.

²² *Id.*

²³ *Id.*

²⁴ See Eric Russell, *Fragile Recovery: Shannon Long's Story Illustrates How Difficult Sobriety Can Be*, PORTLAND PRESS HERALD, March 31, 2017.

²⁵ Russell, *Treatment Dilemma*, *supra* note 21; Noel Gallagher, *Women in Peril" Female Addicts Face Distinct—and Deadly—Disadvantages*, PORTLAND PRESS HERALD, April 3, 2017.

²⁶ In 2013, there were 7,453 admissions to treatment. After the Mainecare cuts went into effect, treatment admissions dropped by more than 1,000 to 6,372 in 2015. In 2011, \$ 76.7 million was spent on substance abuse treatment. In 2015, that number had fallen to \$ 71.6 million. Russell, *Treatment Dilemma*, *supra* note 21; see also Eric Russell, *Disease or Bad Behavior: Does Addiction Call for Compassion or Punishment?*, PORTLAND PRESS HERALD, March 28, 2017.

²⁷ Joe Lawlor, *Waking Up: As State Response Lags, Communities Step Up to Fight Addiction*, PORTLAND PRESS HERALD, April 4, 2017.

²⁸ *Id.*

²⁹ *Id.*

³⁰ Comprehensive Addiction and Recovery Act (CARA), Pub. L. 114-198, 130 Stat. 695, July 22, 2016.

³¹ 21st Century Cures Act, Pub. L. 114-255, 78 Stat. 1033, December 13, 2016.

³² Ronald Smothers, *Miami Tries Treatment, Not Jail, in Drug Cases*, NEW YORK TIMES, February 19, 1993.

³³ Quick Facts on Drug Court, NADCP, www.allrise.org/sites/default/files/2014/DrugCourtFacts.

³⁴ Russell, *Fragile Recovery*, *supra* note 24 (citing the Centers for Disease Control).

