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“PROPER SUBJECTS FOR MEDICAL TREATMENT?”

**ADDICTION, PRISON-BASED DRUG TREATMENT, AND THE
EIGHTH AMENDMENT**

*David Lebowitz**

ABSTRACT:

The Supreme Court has held that deliberate indifference to prisoners' serious medical needs violates the Eighth Amendment's prohibition on cruel and unusual punishment. This article argues that, because both courts and the medical community have consistently acknowledged that addiction is a disease, there may well be a basis in constitutional law for people in prison to claim a constitutional right to prison-based drug treatment.

“Even one day in prison would be a cruel and unusual punishment for the ‘crime’ of having a common cold.”

—Supreme Court Justice Potter Stewart, *Robinson v. California*¹

I. INTRODUCTION

As early as 1908, Dr. Charles W. Carter wrote in the *Journal of Inebriety* that morphine addiction “is not an immorality, but according to the most advanced medical thought a physical or psychophysical disorder, or a condition of disease”; he predicted “an approaching unanimity of opinion among the most diligent observers” concerning the characterization of drug addiction as a disease.² History has in large part

* J.D., Yale Law School, 2012. I am grateful to all of the teachers and classmates whose insights about criminal justice, prisoners' rights, and the law's treatment of drugs helped shape the views expressed in this essay. Special thanks to Professor Jeffrey Fagan for his thoughtful guidance. Any errors are exclusively my own.

1. *Robinson v. California*, 370 U.S. 660, 667 (1962).

2. Charles W. Carter, *What is the Morphine Disease?*, 30 J. INEBRIETY 28 (1908), reprinted in DAVID

vindicated Dr. Carter's prognostication. By 1961, the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs reported that "[t]he narcotic drug addict because of his physical and psychological dependence on drugs and because of his frequently abnormal personality patterns should be as much a subject of concern to medicine and public health as to those having to do with law enforcement."³ These two conceptions of addiction—as both an epidemiological and criminological concern—continue to co-exist in the American psyche, competing for predominance.

An immense proportion of individuals under the supervision of the criminal justice system in the United States are drug addicts or users. According to the Justice Department's Arrestee Drug Abuse Monitoring Program (ADAM), in half of reporting cities, 64% or more of the adult male arrestees had recently used cocaine, opiates, marijuana, methamphetamine, or PCP; New York had the highest rate at 80%.⁴ In surveys administered by the Bureau of Justice Statistics, approximately 70% of state and 57% of federal prisoners reported regular past drug abuse; this figure was up from about 62% and 42% respectively since 1991.⁵ Many of those in custody—about 57% of state prisoners and 45% of federal prisoners—reported using drugs in the month before their arrest.⁶ The Office of National Drug Control Policy reports that among male prisoners, 22.7% of federal inmates and 32.1% of state inmates report being under the influence of drugs when they committed their offense. For women prisoners the numbers are 19.3% of federal inmates and 40.4% of state inmates.⁷

Clearly, drug prohibition is bound up inextricably with the explosion of incarceration in the United States in recent decades. Approximately 6.3 million American adults, or just over 3% of the adult population, were under the supervision of the criminal justice system (i.e. either incarcerated, on parole, or on probation) as of 1999.⁸ Drug offenders

MUSTO, DRUGS IN AMERICA: A DOCUMENTARY HISTORY 239, 240 (2002).

3. JOINT COMM. OF THE AM. BAR ASS'N AND THE AM. MED. ASS'N ON NARCOTIC DRUGS, DRUG ADDICTION: CRIME OR DISEASE? 159-66 (1961), *reprinted in* MUSTO, DRUGS IN AMERICA, *supra* note 2, at 284.

4. *See generally* U.S. DEP'T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, ANNUAL REPORT 2000: ARRESTEE DRUG ABUSE MONITORING 7 (2000) [hereinafter ADAM REPORT].

5. U. S. DEP'T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, SUBSTANCE ABUSE AND TREATMENT, STATE AND FEDERAL PRISONERS, 1997 3-4 (1999), *available at* <http://bjs.ojp.usdoj.gov/content/pub/pdf/satsfp97.pdf>.

6. *Id.*

7. OFFICE OF NATIONAL DRUG CONTROL POLICY, DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM 2 (March 2001) [hereinafter ONDCP, DRUG TREATMENT].

8. *Id.* at 1.

comprised 21% of the state prison population and an impressive 59% of the federal prison population.⁹ By contrast, in 1980 drug offenders were only 6% of the state prison population and 25% of the federal prison population.¹⁰ This increase is the result of a steep uptick in enforcement, with drug arrests peaking at 1,889,810 in 2006.¹¹ It is not related to any dramatic increase in drug use among Americans, which has actually fallen since 1979 among many demographics and has risen only modestly in others.¹²

This paper will not comment on the justice of mass incarceration or prohibitionist policies. It is, however, premised upon the relatively uncontroversial claim that many Americans are in prison because they are addicted to drugs. While it is difficult to estimate how many individuals under the supervision of the criminal justice system are drug-dependent—both because a definition of exactly who is addicted is difficult to specify and because self-reporting about addiction is notoriously unreliable—studies suggest that many of the drug users in prison are addicts or at risk of addiction. Between a quarter and half of the arrestees at each ADAM site were found to be at risk for drug dependence.¹³ Many of those incarcerated in state or federal prisons committed property crimes and thefts committed for the purpose of obtaining drugs, a course of action considered indicative of drug addiction.¹⁴

Drug treatment in prison may be essential, precisely because those whose addictions lead to arrest are disproportionately poor and unlikely to have had access to effective treatment. Fewer than one in ten arrestees surveyed by ADAM said they had received inpatient drug or alcohol treatment—for example, detoxification, rehabilitation, therapeutic community admission, or treatment in a hospital—in the past year.¹⁵ Prison, then, may be the only place where severely addicted individuals can access help. Yet according to one estimate, drug and alcohol treatment was available in only about four of every ten federal, state, and local correctional facilities as of 1997, with 173,000 total inmates in

9. *Id.*

10. *Id.*

11. FEDERAL BUREAU OF INVESTIGATION, CRIME IN AMERICA: FBI UNIFORM CRIME REPORTS 2006 (2007), available at http://www2.fbi.gov/ucr/cius2006/data/table_29.html.

12. OFFICE OF NATIONAL DRUG CONTROL POLICY, DRUG USE TRENDS 1 (October 2002).

13. ADAM REPORT, *supra* note 4, at 23.

14. ONDCP, DRUG TREATMENT, *supra* note 7, at 2.

15. ADAM REPORT, *supra* note 4, at 25. Interestingly, in half the sites, at least 29% reported ever having been in inpatient treatment, a relatively high figure potentially attributable to time spent in detoxification programs. *Id.*

treatment.¹⁶ This number may seem substantial, but it pales in comparison to the number of individuals in prison who need treatment. One survey of state prison systems indicates that 70 to 85% of inmates “need some level of substance abuse treatment” while “less than 11% of the inmate population” is receiving treatment.¹⁷

While incarceration generally has an extremely poor record of deterring drug use,¹⁸ drug treatment in prison has been empirically shown to reduce recidivism.¹⁹ According to the Federal Bureau of Prisons, only 3.3% of residential drug treatment graduates are likely to be rearrested in the first six months after release, compared to 12.1% of inmates who did not receive treatment.²⁰ Among treatment graduates, 20.5% used drugs in the first six months after release, compared with 36.7% of those without treatment.²¹ Overall, “[r]eviews of hundreds of studies of in-prison rehabilitation programs reveal a small, but statistically reliable effect of approximately a ten percentage-point reduction in recidivism, reducing recidivism on average from 55% to 45%.”²² This figure, while modest, is significant. Furthermore, this ten percent drop in recidivism is attributable to drug treatment generally. Evidence suggests that in-prison drug treatment done correctly—with appropriate funding, effective treatment modalities, and proper administration—can reduce recidivism by up to 25% or 30%.²³ A society that views addicts as disease sufferers—or indeed, one that takes seriously the idea of using the criminal justice system to reduce crime—must surely heed the evidence of prison-based treatment’s effectiveness.

Yet jurisdictions around the country are cutting treatment in prisons rather than increasing it. The unprecedented growth in prison populations

16. ONDCP, DRUG TREATMENT, *supra* note 7, at 2.

17. *Id.* at 3. Available treatment modalities include residential therapeutic communities, pharmacological maintenance (methadone, naltrexone and others), outpatient and other forms of counseling, aftercare (including 12-step programs), and alternative approaches such as acupuncture. *Id.* at 3-4. For an overview of corrections-based treatment models, see Roger H. Peters, *Drug Treatment in Jails and Detention Settings*, in DRUG TREATMENT AND CRIMINAL JUSTICE 44 (James A. Inciardi ed., 1993).

18. See generally Dess Aldredge Grangetto, *Reducing Recidivism by Substance Abusers Who Commit Drug and Alcohol Related Crimes*, 10 J. CONTEMP. LEGAL ISSUES 383 (1999).

19. This discussion is limited to drug treatment in prison, and not treatment as an alternative to incarceration as administrated through drug courts or other alternative criminal justice institutions.

20. ONDCP, DRUG TREATMENT, *supra* note 7, at 4.

21. *Id.*

22. David B. Marlowe, *Symposium: New Voices in the War on Drugs: Effective Strategies for Intervening with Drug Abusing Offenders*, 47 VILL. L. REV. 989, 998 (2002).

23. *Id.* at 999. “These exemplary programs employ professionally trained staff, serve higher-risk offenders, provide structured behavioral or cognitive-behavioral treatments and focus on the specific attributes of offenders that bear directly on their risk for recidivism, such as antisocial attitudes, impulsivity, sensation-seeking behaviors and negative peer group associations.” *Id.*

nationwide has coincided with substantial declines in the availability of drug treatment. “Of the almost 1.4 million individuals in prison nationwide in 2001, only 120,687 were receiving drug treatment while incarcerated.”²⁴ The availability of prison-based treatment varies widely by state, with some jurisdictions having effectively eliminated it altogether. Only 0.5% of inmates in Louisiana were in treatment as of 2001, while “several other states had rates below 5%—including the largest state prison system, California, with only 3.9% in treatment.”²⁵ In 1992, around the height of the crack cocaine “epidemic,” 15.9% of American prisoners were in drug treatment; by 2001, the number had been almost halved to just 8.7%.²⁶ By 2006, the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated that only about 11% of prisoners with substance abuse problems were receiving needed prison-based treatment, and that most such treatment was not “evidence-based.”²⁷ Researchers at the National Institute on Drug Abuse and the National Development and Research Institutes have estimated somewhat more optimistically that “32% of state and 21% of federal substance-involved prisoners had participated in treatment while under correctional supervision,” but noted the severe need for the expansion of such programs.²⁸ In addition, although about 70% of state prisoners are in need of treatment for drug addiction, “45% of state prisons and 68% of jails have no treatment of any kind. Moreover, only 22% of all prisons provided treatment in segregated settings, the modality of treatment which research shows is the most effective.”²⁹ This suggests that access to treatment is heavily concentrated in a few places, with many prisoners lacking any addiction programming at all. State budget cuts during the recent recession have left prison-based treatment even sparser. As treatment in prison is often a precondition of parole for drug offenders, these cuts are likely to increase recidivism while simultaneously

24. William D. Bales et al, *Policy Research Bulletin: Substance Abuse Treatment in Prison and Community Reentry: Breaking the Cycle of Drugs, Crime, Incarceration, and Recidivism?*, 13 GEO. J. POVERTY L. & POL'Y 383, 387-88 (2006).

25. *Id.*

26. *Id.*

27. NAT'L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIV., BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 40, 42 (February 2010), available at <http://www.casacolumbia.org/download.aspx?path=/UploadedFiles/tw0t55j5.pdf> [hereinafter CASA].

28. Bennet W. Fletcher & Harry K. Wexler, *National Criminal Justice Drug Abuse Treatment Studies (CJ-DATS): Update and Progress*, 23 THE JRSA FORUM 3,(2005), available at http://www.cjdats.org/Documents/CJDATS%20Article%20only_20060414.pdf.

29. H.K. Wexler, *The Promise of Prison-Based Treatment for Dually Diagnosed Inmates*, 25 J. SUBSTANCE ABUSE TREATMENT 223, 224 (2003).

lengthening prison terms.³⁰

This paper seeks to highlight the apparent incongruity of a society that imposes criminal punishment on hundreds of thousands of people whose crimes arise out of what is considered in the national culture to be an illness and then eviscerates the very programs that treat that illness. In examining this question, I focus on the narrower issue of drug treatment in prison in the context of federal Eighth Amendment jurisprudence. Arguing that the case-law concerning addiction treats it largely as a disease for legal purposes, I argue that the Supreme Court's "deliberate indifference to serious medical needs" standard for establishing cruel and unusual punishment prohibited by the Eighth Amendment may provide grounds for a constitutional challenge to the elimination of prison-based drug treatment.

Addiction presents an intriguing vehicle to examine the various theories that underlie the criminal justice system. Conventional wisdom considers addicts particularly difficult to deter, as their illness is thought to render them incapable of properly evaluating rational disincentives to commit crime. Even those who would justify mass incarceration of drug users with a rehabilitation-based theory of criminal justice surely bear the burden of proving that incarceration results in desistance from drug use—at least among some convicts. With these issues in mind, I will seek to address three broad questions in what follows. In Section II, I very briefly review the literature on addiction, seeking to situate in context (if not to answer) the question of whether addiction is a disease. Second, I trace the development of federal jurisprudence concerning addiction, noting that much of the relevant case law treats addiction as a disease. Third, I examine whether the predominant disease model of addiction implicates Eighth Amendment jurisprudence on the provision of medical care in prisons. Finally, I conclude with a discussion of the interplay between legal and medical understandings of addiction and of disease in general.

II. THE DISEASE CONCEPT OF ADDICTION

I begin with a brief overview of the theory of addiction that has risen to predominance in the United States over the past century: the so-called "disease concept." This review of the literature on addiction is necessarily brief as it covers a wide array of issues over a substantial period of time. As such, I have intentionally limited the discussion go into depth only

30. Jeff Carlton and Nigel Duara, *Budget Problems Forcing Prisons to Cut Counseling*, ASSOCIATED PRESS, April 15, 2010.

where necessary to illuminate the law's treatment of addiction, to which I turn in Section III.

A. Addiction, Drug Control, and the Disease Concept in America: A Brief History

America's history with drugs is long and complex, but the general trend in popular conceptions of drug use has been away from moralism, and toward medicalization. When drug addiction was first recognized as a social phenomenon in the United States, it was generally seen as a moral failure, in no small part because of the strong association between drugs and socially marginal populations.³¹ As David Musto notes, “[i]n the nineteenth century addicts were identified with foreign groups and internal minorities who were already actively feared and the objects of elaborate and massive social and legal restraints”—most notably “the Chinese and the Negroes.”³²

In the years preceding the passage of the first federal drug laws, both the popular media and medical publications commonly linked drug abuse—especially the “cocaine habit”—to the putatively morally dubious African-Americans population in the South, while viewing white drug use as presumptively medical. One physician wrote that while whites often insufflated cocaine “on account of its contractile effects on the nasal mucosa,” this medical use was unavailing for blacks “as the nasal passages of the negro are normally quite patulous;” black cocaine users in the South instead snorted the drug “on account of its exhilarating effects.”³³ In the first years of the twentieth century, the *Journal of the American Medical Association* repeatedly editorialized that Southern African-Americans were disproportionately addicted to cocaine.³⁴ The popular press, meanwhile, was rife with sensationalized accounts of a drug-fueled black-on-white crime wave engulfing the South. In 1903, the *New York Tribune* published a statement by anti-drug crusader Colonel J. W. Watson claiming that “many of the horrible crimes committed in the Southern States by the colored people can be traced directly to the cocaine habit.”³⁵ The *Atlanta Constitution* published claims by the police chief of Atlanta

31. This seems to be true of almost all substances now considered “drugs of abuse,” with the exception of alcohol, which has enjoyed a prominent place in American culture since the days of the Puritans. See MUSTO, *DRUGS IN AMERICA*, *supra* note 2, at 14.

32. DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* 5 (1987) [hereinafter MUSTO, *AMERICAN DISEASE*].

33. W. Scheppegrell, *The Abuse and Dangers of Cocaine*, 73 *THE MED. NEWS* 417, 421 (1898).

34. See, e.g., Editorial, *The Cocaine Habit*, 34 *JAMA* 1637 (1900).

35. MUSTO, *supra* note 32, at 282.

that seventy percent of crimes were caused by drug use among blacks.³⁶ Often, reports about rampant drug use among Southern blacks explicitly linked cocaine to the rape of white women. One physician testified before Congress that “most of the attacks upon white women of the South are the direct result of a cocaine-crazed negro brain.”³⁷ Even the New York Times got in on the act, publishing an essay claiming that “cocaine orgies” were leading blacks to commit “wholesale murders”—an especially alarming threat considering the author’s claims that cocaine use improves marksmanship and imparts resistance to bullets.³⁸

The reality is that technological advances such as the isolation of cocaine from coca in 1860, the synthesis of heroin from morphine in 1874, and the invention and perfection of the hypodermic syringe in the latter half of the nineteenth century had increased the availability of drugs at all registers of society.³⁹ As a result, “[b]y 1900 America had developed a comparatively large addict population, perhaps 250,000” that reached across divides of race and sex.⁴⁰ Nonetheless, expert testimony before Congress frequently focused on the racial dimension of drug addiction. In response to the growing fear of an addiction crisis, that mapped onto a crisis of the social order, Congress passed the Pure Food and Drug Act in 1906 and the Harrison Act in 1914.⁴¹ While use of many recreational drugs declined in subsequent decades, drugs returned with a vengeance in the 1960s and 1970s as marijuana became a staple of youth counter-culture, and many Vietnam veterans returned from abroad addicted to heroin.⁴² For much of the second half of the twentieth century, drug use gradually increased while penalties for drug infractions and enforcement of drug laws shot up dramatically.⁴³

The history of Americans’ conceptions of addiction is perhaps more complicated. The notion that frequent morphine users could develop a “habit” surfaced around 1870 in Great Britain.⁴⁴ By the turn of the century, addiction was firmly situated as a medical issue, with research in the United States and Europe focusing on tolerance and withdrawal.⁴⁵

36. *Id.*

37. Quoted in M. Schatzmann, *Cocaine and the Drug Problem*, 7 J. PSYCHEDELIC DRUGS 9 (1975).

38. Edward Huntington Williams, *Negro Cocaine “Fiends” New Southern Menace*, N.Y. TIMES, Feb. 8, 1914.

39. MUSTO, *supra* note 2, at 183.

40. MUSTO, *supra* note 32, at 5.

41. MUSTO, *supra* note 2, at 187.

42. *Id.* at 183-93.

43. *Id.* at 189-93.

44. MUSTO, *supra* note 32, at 77.

45. *Id.* at 75-7.

Proposed “cures” for addiction abounded, including the suggestion that sufferers drink a tea made from ash tree bark.⁴⁶ In the early 1920s the medical establishment briefly changed its tune and began to argue, under the influence of psychoanalytical theory, that addiction was merely a manifestation of psychic dysfunction.⁴⁷ By the late 1920s, however, the medical community had largely abandoned the psychoanalytical perspective toward addiction, focusing instead on a theory of physical chemical dependence. Around this time the federal government established institutions known as “narcotic farms” in Lexington, Kentucky, and Fort Worth, Texas, to provide treatment for addicts, who were beginning to overcrowd the federal prison system.⁴⁸ While these institutions were initially touted as potential testing grounds for innovative addiction treatments,⁴⁹ no very effective medical “cure” for addiction has been discovered, despite efforts at developing one that continue to this day.

B. The Disease Concept

The so-called “disease concept” of addiction has become the predominant theory of chemical dependence in the United States, both within the therapeutic community and in society at large. First elaborated by E.M. Jellinek in 1946, the “disease concept” theory refers simply to the notion that addiction is an illness.⁵⁰ Today, most scientists who ascribe to the disease concept characterize addiction as a “brain disease,” caused by disordered functioning of neurological reward systems. Recent scholarship has attempted to generalize the disease concept to arrive at a unified theory of addiction applicable to dependence on a wide range of chemical substances. Alan Leshner, for instance, writes that:

virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain—the mesolimbic reward system. Activation of this system appears to be a common element in what keeps users taking drugs. This activity is not unique to any one drug; all addictive substances

46. *Id.* at 81.

47. *Id.* at 83.

48. *Id.* at 85.

49. For a history of the Lexington narcotic hospital and a detailed discussion of the search for an addiction “cure” within the criminal justice model in twentieth century America, see generally NANCY D. CAMPBELL ET AL., *THE NARCOTIC FARM: THE RISE AND FALL OF AMERICA’S FIRST PRISON FOR DRUG ADDICTS* (2008).

50. E. M. Jellinek, *Phases in the Drinking History of Alcoholics*, 7 Q.J. STUD. ALCOHOL 88 (1946).

affect this circuit.⁵¹

Indeed, neuroscientists have mapped many of the ways in which addiction affects brain function. Many drugs appear to affect the neurotransmitter dopamine, which is involved in sensing pleasure and experiencing subjective feelings of reward.⁵² Addiction is thus thought to modify brain function both during acute drug use and after desistance: “The addicted brain is significantly different from the non-addicted brain as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues.”⁵³ Like any other illness, the disease concept adherents argue, addiction changes the physical functioning of the human body in harmful—but potentially treatable—ways.

Relatedly, geneticists have recently increased their efforts to explain addiction as at least partially the result of genetic risk factors. Scientists generally qualify genetic research about addiction with some version of the caveat that “many genes contribute to complex traits, interacting with each other as well as the environments in which they are expressed.”⁵⁴ Nonetheless, human identical twin studies, animal genetic studies, and other genetic inquiries have suggested the existence of a strong genetic component to addiction.⁵⁵

As scientific understanding of the neurochemistry and genetics of addiction have advanced, the claims of disease concept theorists have become increasingly bold. Richard Bonnie argues, “[A]ddiction specialists have convincingly demonstrated why addiction is sensibly understood as a chronic disease similar to other chronic diseases—such as diabetes and hypertension—that are also characterized by intermittent remissions and relapses.”⁵⁶ The disease concept view maintains that addiction is largely the result of involuntary processes. O’Brien and McLellan echo Bonnie in comparing drug addiction to hypertension, adult-onset diabetes, and asthma: “Like substance-use disorders, the onset of

51. Alan Leshner, *Addiction is a Brain Disease and It Matters*, 278 SCI. 45, 46 (1997).

52. See generally A. Thomas McLellan, et al., *Drug Dependence, a Chronic Mental Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1691 (2000); Tabitha M. Powledge, *Addiction and the Brain*, 49 BIOSCIENCE 513 (1999); Mark A. Schuckit, *Science, Medicine and the Future: Substance Use Disorders*, 314 BRIT. MED. J. 1605, 1606 (1997).

53. Leshner, *supra* note 51, at 46.

54. John C. Crabbe, *Genetic Contributions to Addiction*, 53 ANN. REV. PSYCHOL. 435, 452 (2002).

55. While the genetics of addiction are beyond the scope of this paper (and beyond the expertise of the author), numerous studies have established genetic predictors and risk factors for drug addiction. Many recent studies are reviewed by Crabbe, *supra* note 54.

56. Richard J. Bonnie, *Addiction and Responsibility*, 68 SOC. RESEARCH 813, 814 (2001).

these three diseases is determined by multiple factors, and the contributions of each factor are not yet fully specified.”⁵⁷ While diabetes and hypertension are strongly genetically determined, “[p]arenting practices, stress in the home environment and other environmental factors are also important in determining whether these diseases actually get expressed, even among individuals who are genetically predisposed.”⁵⁸ Voluntary behaviors are also important both in addiction and in other chronic diseases:

[A]lthough a diabetic, hypertensive, or asthmatic patient may have been genetically predisposed and may have been raised in a high-risk environment, it is also true that behavioral choices such as the ingestion of high sugar and/or high-cholesterol foods, smoking, and lack of exercise also play a part in the onset and severity of their disorder.⁵⁹

The disease concept thus characterizes addiction as no different from other illnesses that result from a combination of genetic, environmental and behavioral factors.

The analogies to diabetes and hypertension, which recur repeatedly in the literature on drug dependence, are of great value in applying to the disease concept to an understanding of how the legal system should deal with addiction. Perhaps addiction is best understood as a disease whose contraction and exacerbation can, like those of many diseases, be the result of individual behavioral choices. As Stephen Morse notes, “A person who is overweight, does not exercise, and smokes surely is responsible for risking hypertension.”⁶⁰ Likewise, “[A] person who suffers from many diseases can ameliorate the consequences by intentionally adhering to a prescribed medical regimen.”⁶¹ Yet no one would argue that these illnesses constitute moral failures or are unworthy of treatment. Such analogies have led many drug specialists to conclude that the disease concept mitigates the culpability of addicts and entitles them to treatment:

Despite the potential contribution of human agency to the cause and maintenance of some diseases, no one denies that these are

57. Charles P. O’Brien and A. Thomas McLellan, *Myths About the Treatment of Addiction*, 347 THE LANCET 237, 237 (1996).

58. *Id.*

59. *Id.*

60. Stephen J. Morse, *Addiction, Genetics, and Criminal Responsibility*, 69 L. & CONTEMP. PROBS. 165, 169 (2006).

61. *Id.*

fundamentally diseases. Moreover, with many and perhaps most diseases, the sufferer is not responsible for contracting the disease, and for many diseases there is little or nothing the sufferer can do to help, other than to seek and cooperate with professional help and to wait for the disease to run its course. Although people sometimes can be complicit in their own diseases, the disease model is so powerful that people who are ill are not in general considered responsible for the signs, symptoms, and consequences. The dominant image of people with diseases is that they are the victims of pathological mechanisms who deserve sympathy and help and do not deserve condemnation.⁶²

The disease concept, then, frequently casts addicts more as victims of their own brain chemistry than as wrongdoers actualizing some depraved intent.

Of course, the disease concept is not entirely inconsistent with criminal punishment of addicts. Just as a hypertensive individual would doubtless still be culpable for stealing salt, an addict who commits acquisitive property crimes in order to obtain drugs remains subject to the criminal law. But the issue of prison-based drug treatment presents a distinct question from the simple culpability of an addict: that is, whether a drug dependent individual is entitled to treatment for an ailment that, while potentially contracted recklessly or exacerbated by voluntary behaviors, poses harm that may be difficult or impossible to prevent without treatment. Acceptance of the disease concept, then, surely suggests that prison-based treatment is at least logical, and likely wise.

C. Social Contagion Theory

Another model of addiction, related to the disease concept, is the notion of *social contagion*. Social contagion denotes the concept that emotions and behaviors spread through social networks in predictable ways.⁶³ This theory has been applied to various public health issues, most famously by Nicholas Christakis and James Fowler. Christakis and Fowler found, for example, that social networks influenced the spread of obesity “in a quantifiable and discernable pattern that depends on the nature of social ties.”⁶⁴ Even controlling for factors such as common

62. *Id.*

63. See generally Ronald S. Burt, *Social Contagion and Innovation: Cohesion versus Structural Equivalence*, 92 AM. J. SOCIOLOGY 1287, 1287 (1987).

64. Nicholas A. Christakis & James H. Fowler, *The Spread of Obesity in a Large Social Network Over 32*

genetic risk factors and common environmental factors, social ties with obese people were even more predictive of obesity than geographical or physical intimacy with obese people.⁶⁵ While Christakis and Fowler's study is limited in its ability to explain the mechanism by which obesity "spreads" through social networks, changes in norms regarding the acceptability of being overweight and effects on diet are possible explanations for how contact with obese people can increase one's own risk for obesity.⁶⁶ Social contagion theory, then, provides a first step in explaining the epidemiology of diseases with behavioral components.

The social contagion model has been applied to drug and alcohol consumption in numerous studies. A study of alcohol consumption by Christakis, Fowler and others found that "[a]lcohol consumption behavior among persons and those in their social networks is highly correlated."⁶⁷ The authors contend that while confounding and selection bias cannot be ruled out, their findings strongly suggest that drinking is *induced* through social networks; that is, alcohol consumption is caused by, and not merely correlated with, social linkages with drinkers.⁶⁸ Indeed, this seems logically consistent with the fact that "drinking cessation programs [such as Alcoholics Anonymous] that provide peer support—that modify the social network of the target—are more successful."⁶⁹ Christakis and Fowler conducted a similar study of smoking and found that both cigarette smoking and cessation spread from person to person within social networks.⁷⁰ Moreover, the study found that cessation "cascaded" through social networks, as "whole connected clusters within the social network stopped smoking roughly in concert" as a result of collective social pressure.⁷¹ Other researchers have published similar findings.⁷² Several studies published around the peak of the American heroin epidemic argued that "[d]rug use is. . .'contagious', and the routes for spread can be the same as those for disease, including friendship networks, neighbourhoods

Years, 357 NEW ENG. J. MED. 370, 377 (2007).

65. *Id.*

66. *Id.*

67. J. Niels Rosenquist et al., *The Spread of Alcohol Consumption Behavior in a Large Social Network*, 152 ANN. INT. MED. 426, 430 (2010).

68. *Id.* at 432.

69. *Id.*

70. Nicholas A. Christakis and James Fowler, *The Collective Dynamics of Smoking in a Large Social Network*, 358 NEW ENG. J. MED. 2249, 2256 (2008).

71. *Id.*

72. For a review of many studies regarding the diffusion of drug-related behaviors through social relationships, see Roberta Ferrence, *Diffusion Theory and Drug Use*, 96 ADDICTION 165 (2001).

and institutional settings such as schools, work-places or prisons.”⁷³ Initiation of new drug users takes place “through friendship networks of existing drug users, providing support for key determinants of diffusion, including compatibility and observability.”⁷⁴ The use of social contagion theory to explain both substance abuse and cessation provides a means of integrating behaviors traditionally conceived of as voluntary, autonomous actions into a “disease” model of addiction.

D. The Autonomy Model

Of course, the disease concept is not universally accepted, and even some theorists of addiction who do not dispute certain of its tenets nonetheless question its relevance to criminal law. Morse, for example, argues that addiction is essentially just a strong form of desire:

The primary behavioral signs of addiction - seeking and using substances - are intentional human actions, even if they are also signs of a disease that has genetic, anatomical, and physiological causes. Indeed, all intentional action has genetic, anatomical, and physiological causes, whether or not the action is the sign of a disease. The addict has an exceptionally powerful desire - a craving - to consume the addictive substance, believes that consuming it will satisfy that craving by avoiding pain, causing pleasure, or some combination of the two, and therefore forms and acts on the intention to seek and to use the substance. Such explanatory practical syllogisms are the mark of all intentional actions.⁷⁵

For Morse, then, the fact that an addict’s actions have biological, genetic or neurochemical underpinnings does not bear on the addict’s culpability. “To assume that the addict is not responsible for addiction-related behavior just because it has biological causes or because the action is the sign of a disease generally commits the fundamental psycholegal error and therefore begs the question of responsibility.”⁷⁶ According to this view, addicts are neither mechanistically coerced from within to behave in a certain way nor divested of their reasoning capabilities in a manner that prevents them from responding to rational incentives. “Even if addiction is

73. *Id.* at 167.

74. *Id.*

75. Morse, *supra* note 60, at 176.

76. *Id.* at 176.

properly and most usefully characterized as a disease, at the extreme its necessary behavioral signs are virtually all reward sensitive or reason-responsive. An addict threatened with instant death for seeking and using will not seek and use unless she already wishes to die at that moment or does not care if she does.”⁷⁷

The autonomy perspective thus pushes back against the disease concept insofar as it questions whether a condition that can be eliminated by voluntary desistance can truly constitute an illness. Jeffrey Schaler notes that “[h]eavy, habitual users of drugs, including alcohol, often moderate or cease taking the drug without help from anyone else.”⁷⁸ Schaler points out that a genetic predisposition to certain behavior does not automatically constitute a disease.⁷⁹ He also disputes the analogies advanced by disease concept adherents between addiction and chronic diseases like diabetes, noting that the “symptoms” of addiction (compulsive drug use) are coterminous with the definition of the disease itself. Whereas diabetes can be present (according to objective medical definitions of the condition) for some time without causing noticeable symptoms, “there is no such thing as asymptomatic addiction, and *logically there could not be.*”⁸⁰ In short, for critics of the disease concept:

A person starts, moderates or abstains from drinking because that person wants to. People do the same thing with heroin, cocaine, and tobacco. Such choices reflect the person’s values. The person, a moral agent, chooses to use drugs or refrains from using drugs because he or she finds meaning in doing so.⁸¹

Schaler, then, rejects altogether the notion that drugs constrain the free will of addicts.

Some critics of the disease concept criticize what they see as its overly deterministic view of behavior while still conceding that addiction can alter brain function and change individuals’ responses to various stimuli and incentives. For instance, a weaker form of the autonomy view maintains that although addiction clearly compromises an addict’s volition, addicts are still culpable for actions they take while under the influence or pursuing the acquisition of drugs, because the initial decision

77. *Id.* at 168-9.

78. JEFFREY A. SCHALER, ADDICTION IS A CHOICE 8 (2000).

79. *Id.* at 14.

80. *Id.* at 17. Schaler does not address the philosophy of 12-step programs, whose participants frequently refer to themselves as “recovering” addicts (i.e. presumably, at least in some cases, asymptomatic addicts).

81. *Id.* at 20.

to use was freely undertaken. As Morse notes, “[p]eople can, of course, be responsible for initially contracting or risking contracting diseases.”⁸² According to this perspective, “[w]hen the addict first uses addictive illegal drugs, it should be reasonably foreseeable to him that he could become drug dependent and consequently desire to possess and use illegal drugs in the future;” an addict should also be able to predict “that he might be tempted to engage in future illegal conduct in order to facilitate his continued drug use.”⁸³ Under this view, the traditional criminal law concepts of justification and excuse do not undermine the culpability of drug addicts because those defenses are generally unavailable to defendants who knowingly place themselves in a position from which they are likely to violate the law. “Actual or constructive foreseeability is generally required for culpability, and thus the addict would not be justified, nor properly excused, for that matter, for his later drug use or for the crimes he committed to facilitate his habit.”⁸⁴ Of course, this view does not consider the obviously imperfect information possessed by any potential addict at the instance of first use. Education about the potential addictiveness and other harms of various substances is not equally available to everyone, and most people can only guess their own susceptibility to addiction based on a sketchy understanding of family history or any number of other potential contributing factors to addiction, which are poorly understood even by scientists who study the issue.⁸⁵

Importantly, the autonomy perspective generally does not dispute that volition is compromised once addiction has taken hold. Moreover, only the most extreme proponents of this view dispute the empirical evidence that addiction treatment can be effective in reducing compulsive drug use, whether such use is ultimately the result of a brain disease or simply a strongly felt desire. The dispute among commentators, then, is most salient on the issue of whether the effects of drug addiction are sufficient to mitigate criminal culpability, and not whether drug addiction profoundly affects the behavior of addicts. Indeed, as discussed below, this debate is mirrored in the opinions of federal judges over the period since drug addiction became a fact of life in the United States.

Certainly, the extent of drug addicts’ culpability for acts that result in incarceration is an important question, and one that arguably bears directly

82. Morse, *supra* note 60, at 169.

83. Eugene R. Milhizer, *Justification and Excuse: What They Were, What They Are, and What They Ought To Be*, 78 ST. JOHN’S L. REV. 725, 870 (2004).

84. *Id.*

85. See generally DAVID A. PETERS, THE PROBABILITY OF ADDICTION: LEGAL, MEDICAL AND SOCIAL IMPLICATIONS 33-54 (1997).

upon the extent of services that prisoners deserve once behind bars. Yet, as the Supreme Court has held, imprisonment itself—albeit often under harsh conditions—is “the penalty that that criminal offenders pay for their offenses against society.”⁸⁶ Inhumane or degrading confinement conditions that do not serve legitimate penological interests cannot be justified on the basis that they are simply part of repaying a prisoner’s debt to the community. Thus, even if addicts are legally responsible for their criminal acts, the question of what is constitutionally protected once imprisoned is a distinct matter.⁸⁷ For the purposes of this paper, the important question then is not whether addicts possess free will, but whether they suffer from a harmful ailment that can and should be treated—and whether American prisoners are entitled to such treatment as a matter of law. As such, I turn next to the treatment of drug dependence in American law.

III. ADDICTION AS A TREATABLE DISEASE IN FEDERAL LAW

This section analyzes the treatment of both alcoholism and drug addiction in federal case law over the past century. First, I trace the adoption of a strong-form disease concept theory in several early cases. Next, I argue that courts have subsequently pulled back somewhat from the disease concept in decisions regarding criminal culpability, favoring a more autonomy-oriented view in cases involving insanity defenses. Finally, I note that upholding the criminal culpability of addicts does not inherently conflict with an understanding of addiction as a medical problem worthy of treatment.

86. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994).

87. This is not to suggest that the relationship between harm and punishment is irrelevant. The Federal Sentencing Guidelines suggest that up to six months in prison is an appropriate sentence for a defendant convicted of drug possession as a first offense; the guideline is progressively more severe for defendants with significant criminal histories, and defendants who possess opiates or crack cocaine start off at an “offense level” four steps higher than a defendant convicted for possessing cannabis or other or other putatively less harmful substances. U.S. SENTENCING GUIDELINES MANUAL §2D2.1 cmt. n.1 (2010), U.S. SENTENCING GUIDELINES Sentencing Table. In its findings and declarations regarding the Drug Abuse and Control Act, Congress noted that “possession and improper use of controlled substances have a substantial and detrimental effect on the health and general welfare of the American people.” 21 U.S.C. 801(2) (2006). This suggests that federal possession laws are intended to punish an individual’s decision to risk his or her own health, and that punishments are more severe for more harmful drugs because the health risks are greater. Failure to provide access to prison-based drug treatment is thus particularly illogical in the case of addicts who are in prison merely for possession of illegal drugs, since the stated justification for sanctioning possession is a concern for public health.

A. The Disease Concept in Federal Constitutional Jurisprudence

Federal court jurisprudence was no exception to the trend toward a disease concept of addiction in twentieth century America. Some of the Supreme Court's earliest decisions taking up the nature of addiction declared it unequivocally to be a disease. In *Linder v. United States*, the Court famously declared that addicts "are diseased and proper subjects for medical treatment."⁸⁸ Other decisions from the first years of the nation's struggle with addiction confirm this approval of the disease concept, frequently distinguishing between drug dealers and addict-consumers (the latter often being viewed as the hapless victims of the former). A federal judge in California during the Great Depression wrote with approval of the Harrison Act,⁸⁹ praising its innovation in drawing "the line between the addict who may be found with illegally obtained drugs in his possession and the peddler who, for a consideration, supplies the need and barter upon what has been here declared to be a disease."⁹⁰ As drug dependence spread from poor and immigrant communities to all strata of society, the legal system was quick to embrace a view of addiction that characterized addicts as victims of an illness while castigating drug suppliers as cynically profiting from an insidious disease.

Perhaps the most well-known and important treatment of addiction by an American court came in *Robinson v. California*.⁹¹ In *Robinson*, the Supreme Court unequivocally declared drug addiction to be a disease and declared unconstitutional a California law that criminalized the mere "status" of being an addict even in the absence of any requirement of *actus reus* (e.g. proof of drug possession or use).⁹² Speaking for the majority, Justice Stewart wrote that "in the light of contemporary human knowledge, a law which made a criminal offense of . . . a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments."⁹³ The Court unflinchingly applied this reasoning to the California statute at bar, noting

88. *Linder v. United States*, 268 U.S. 5, 18 (1925) (holding that a physician could not be criminally liable when he dispensed morphine or cocaine as treatment for an addiction).

89. Passed in 1914, the Harrison Narcotics Tax Act was among the first pieces of federal legislation to regulate the distribution of opiates. For an excellent review of the history of the Act's passage, see generally MUSTO, THE AMERICAN DISEASE, *supra* note 32 at 54-68.

90. *United States v. Anthony*, 15 F. Supp. 553, 555 (S.D. Cal. 1936) (stating "[a]nd in dealing out punishment I think the courts, as a rule, have distinguished between the two conditions, treating one as a diseased and unfortunate person and the other as a mercenary trafficker in drugs.")

91. 370 U.S. 660 (1962).

92. *Id.* at 665-66.

93. *Id.* at 666.

that “counsel for the State recognized that narcotic addiction is an illness. Indeed, it is apparently an illness which may be contracted innocently or involuntarily.”⁹⁴ In addition to describing addiction as a disease, the justices suggested that this designation was a matter of widespread consensus⁹⁵ and even appeared to embrace a form of the social contagion model.⁹⁶ The Supreme Court in *Robinson* thus built upon the foundation provided by *Linder*, seeming to set the stage for American courts’ wholesale adoption of the disease concept.

Yet the Supreme Court seemed to pull back from the disease concept, or at least qualify its adoption of a disease model, in the case of *Powell v. Texas*.⁹⁷ Decided just six years after *Robinson*, *Powell* involved a criminal defendant named Leroy Powell who challenged his conviction for violating a public drunkenness law. Powell argued that as an addict, his appearance in public while drunk was essentially involuntary.⁹⁸ In a 5-to-4 decision, the Court declined to extend *Robinson* to Powell’s case, distinguishing the “status” of addiction from the act punished by the Texas law: “The entire thrust of *Robinson*’s interpretation of the Cruel and Unusual Punishment clause is that criminal penalties may be inflicted only if the accused has committed some act, has engaged in some behavior, which society has an interest in preventing.”⁹⁹ Importantly, the justices did not completely jettison the disease concept. Nevertheless, the opinion clearly questions the wisdom of premising a judicial holding on a theory that was subject to widespread contention even within the clinical and medical communities:

[T]he inescapable fact is that there is no agreement among members of the medical profession about what it means to say that “alcoholism” is a “disease.” One of the principal works in this field states that the major difficulty in articulating a “disease concept of alcoholism” is that “alcoholism has too many

94. *Id.* at 667.

95. “Of course it is generally conceded that a narcotic addict, particularly one addicted to the use of heroin, is in a state of mental and physical illness.” *Id.* at 667, n8 (quoting Brief for Appellee).

96. “Drug addiction is more prevalent in this country than in any other nation of the western world.... It is sometimes referred to as ‘a contagious disease.’” *Id.* at 669 (internal citations omitted).

97. *Powell v. Texas*, 392 U.S. 514 (1968).

98. *Id.* at 518. Following *Robinson*, At least two U.S. Circuit Courts of Appeals had accepted a version of this argument based upon a strong form of the disease concept. *Driver v. Hinnant*, 356 F.2d 761, 764 (4th Cir. 1966); *Easter v. District of Columbia*, 361 F.2d 50, 53 (D.C. Cir. 1966).

99. *Powell*, 392 U.S. at 533. Interestingly, the Court’s opinion seems at least partially based on the “voluntary desistance” argument articulated by Schaler and others. Leroy Powell’s admission at trial that he had voluntarily limited his drinking on the day of his trial in order to be able to give testimony in his defense was taken at least implicitly as evidence that his earlier public drunkenness was the result of a voluntary act. *Id.* at 519-20.

definitions and disease has practically none.” This same author [Jellinek] concludes that “a disease is what the medical profession recognizes as such.” In other words, there is widespread agreement today that “alcoholism” is a “disease,” for the simple reason that the medical profession has concluded that it should attempt to treat those who have drinking problems. There the agreement stops.¹⁰⁰

Thus, while conceding that experts had reached a consensus that addiction is a disease, the Court highlighted the difficulty of extrapolating from that consensus a coherent legal theory of addiction given the ambiguity of the term “disease” itself.¹⁰¹ Crucially, however, the one premise of the disease concept that the majority accepted was the desirability of treatment for addiction. While the disease concept had been questioned as a mitigating factor for culpability,¹⁰² its corollary that addicts need help had not truly been undermined.

B. The Disease Concept, Culpability, and the Insanity Defense: What Role for Treatment?

In the wake of *Robinson* and *Powell*, the disease concept of addiction was firmly established in federal common law but was of questionable relevance in determining a defendant’s liability for a criminal act. As such, a significant amount of federal litigation followed seeking to determine the limits of the disease concept as an exculpatory factor. One of the first federal appeals courts to take up this question was *Brown v. United States*.¹⁰³ In *Brown*, the D.C. Circuit accepted the notion that the defendant, an addict, suffered from an illness and thus reversed and remanded his case to allow him to develop an insanity defense.¹⁰⁴ Similarly, another D.C. Circuit case that year, *Castle v. United States*, held that testimony relating to narcotic addiction provided a basis from which the jury, under proper instructions, could have found (but was not required to find) a causal relationship between the defendant’s drug-related

100. *Id.* at 522 (internal citations omitted).

101. For a contemporaneous review of the *Powell* decision questioning the “disease concept,” particularly as applied by the *Powell* dissenters, see generally Herbert Fingarette, *The Perils of Powell: In Search of a Factual Foundation for the “Disease Concept of Alcoholism,”* 83 HARV. L. REV. 793 (1970).

102. For instance, in *United States v. Moore*, the D.C. Circuit characterized the dynamic between *Robinson* and *Powell* as at once forbidding punishment of an individual for experiencing cravings but allowing punishment for acting upon them, including by illegally procuring prohibited drugs. “There is no Eighth Amendment defense for the addict-possessor.” 486 F.2d 1139, 1153-54 (D.C. Cir. 1973).

103. *Brown v. United States*, 331 F.2d 822 (D.C. Cir. 1964).

104. *Id.* at 823.

“abnormality” and the charged offenses of purchasing drugs without a tax stamp and facilitating the concealment and sale of drugs with knowledge that they were illegally imported.¹⁰⁵

Other courts were less accepting of addiction as a per se criminal defense. The Fifth Circuit, for instance, held in *Bailey v. United States* that conviction of an addict did not present an Eighth Amendment problem:

[T]he record contains no evidence probative of the contention that addiction eliminates the criminal intent of a narcotics offender. It would appear that an element of reasoned choice yet exists when an addict knowingly violates the law in acquiring and using drugs. One is not excused for offending simply because he wanted to very, very badly.¹⁰⁶

The autonomy view, equating addiction to any other strong desire, was thus alive and well even after *Robinson*. The Second Circuit, while observing that severe mental deterioration from years of drug use could constitute a “mental disease” for the purposes of the insanity defense, held that “[m]ere recidivism or narcotics addiction will not *of themselves* justify acquittal.”¹⁰⁷ The split in the courts thus mirrored debates that continue today between strong-form disease concept adherents and autonomy-oriented scholars like Morse: does drug dependence truly overcome individual volition?

After *Powell*, the answer to this question seemed increasingly to be “no,” at least for the purposes of courts applying the doctrines of *mens rea*. This proposition was perhaps most starkly stated by the Fifth Circuit in *United States v. Lyons*.¹⁰⁸ The *Lyons* court overruled a previous Fifth Circuit decision, *United States v. Bass*,¹⁰⁹ to the extent that the *Bass* decision could be read to hold that mere drug addiction, “voluntary or involuntary, [could] be a mental disease for legal purposes.”¹¹⁰ Importantly, however, the *Lyons* court, like the Supreme Court in *Powell*, did not completely repudiate the disease concept. The *Lyons* court held that with regard to questions of *culpability*, the courts are “not necessarily served by an uncritical application of definitions developed with medical

105. *Castle v. United States*, 347 F.2d 492, 494 (D.C. Cir. 1964).

106. *Bailey v. United States*, 386 F.2d 1, 4 (5th Cir. 1967).

107. *United States v. Freeman*, 357 F.2d 606, 625 (2d Cir. 1965).

108. *United States v. Lyons*, 731 F.2d 243 (5th Cir. 1984).

109. *United States v. Bass*, 90 F.2d 846 (5th Cir. 1976).

110. *Lyons*, 731 F.2d at 246.

considerations of diagnosis and treatment foremost in mind.”¹¹¹ But the opinion concedes that as to the classification of addiction as a disease because of the effect drugs have on the brain, “the medical model must have its day.”¹¹² Moreover, the decision embraces treatment as an appropriate and desirable response to addiction. In fact, one of the opinion’s justifications for punishing an addict who chooses to use drugs was that “he could instead have participated in an addiction treatment program.”¹¹³ Much like *Powell, Lyons* and similar decisions have questioned the utility of the disease concept as applied to the narrow issue of criminal responsibility for addicts,¹¹⁴ but have accepted the framework of addiction as a medical issue worthy of, and indeed requiring, treatment.

Contemporary federal statutory and administrative law reveals a general acceptance of the disease concept as appropriately characterizing the status of addicts, if not excusing them from criminal responsibility. Congress and federal agencies routinely treat drug and alcohol dependence as diseases. The Americans with Disabilities Act expressly classifies alcoholism as a protected disability, holding employers who do not make reasonable accommodations for alcoholic workers civilly liable.¹¹⁵ Importantly, the law is animated by an acceptance of the wisdom and desirability of treatment for addiction; for example, firing an employee who takes time off to enter rehabilitation for alcoholism is considered a paradigmatic violation of the ADA.¹¹⁶ And while the ADA does not explicitly protect the use of illegal drugs, it does apply to individuals who have successfully undergone treatment or who are currently participating in rehabilitation.¹¹⁷ In fact, the ADA terms drug addiction a “physical or mental impairment” entitled to antidiscrimination protection.¹¹⁸ “This

111. *Id.*

112. *Id.* at 247.

113. *Id.* at 245.

114. For an interesting application of these principles to a non-substance addiction, see *United States v. Torniero*, 735 F.2d 725 (2d. Cir. 1984) (holding that trial judge did not err in excluding as irrelevant evidence that defendant was a compulsive gambler despite conflicting testimony by psychiatrists as to whether gambling addiction constituted a “mental disease or defect” for the purposes of the insanity defense).

115. 42 U.S.C. 12114(a).

116. Joyce Krutick Barlow, *Alcoholism as a Disability under the Social Security Act – An Analysis of the History, and Proposals for Change*, 18 J. NAT’L ASS’N. ADMIN. L. JUDGES 273, 281 (1998); see also *Corbett v. National Products Company*, No. 94-2652, 1995 U.S. Dist. LEXIS 3949 (E.D. Pa., 1995).

117. 42 U.S.C. 12114(b).

118. See H.R. Rep. No. 101-485(II), at 51 (1990); 28 C.F.R. § 35.104(1)(ii) (2006) (“The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction,

congressional recognition of drug addiction as a disability demonstrates that drug addiction is to be treated as a medical problem, even if public policy remains somewhat schizophrenically committed to punitive prohibition.”¹¹⁹

Likewise, the Social Security Administration accepted, at least temporarily, the disease model. “From 1972 until 1994, addicts could, with certain qualifications, receive benefits under Social Security Disability Insurance (“SSDI”) or its sister program, Supplemental Security Income (“SSI”).”¹²⁰ Even proposed Federal Rule of Evidence 504, which would have set forth the parameters of the psychotherapist-patient privilege, implicitly adhered to the disease concept. The rule, though not enacted,¹²¹ would have protected communications between patients and those “engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction.”¹²² Again, proposed Rule 504 represents an implicit understanding on the part of Congress that addiction is an ailment for which treatment is appropriate.

Federal case law has thus largely embraced the disease concept of addiction, while evincing a clear reticence to extend that theory directly to the question of criminal responsibility. Statutory and administrative law have mostly followed suit in recent years. In this context, I turn next to the significance of the law’s adoption of the disease concept to contemporary Eighth Amendment doctrine, arguing that the disease model may lend support to the notion of constitutionally mandated drug treatment in prisons.

IV. PRISON-BASED TREATMENT AND THE EIGHTH AMENDMENT

This section will trace the trajectory of federal jurisprudence concerning the Constitution’s prohibition on the infliction of “cruel and unusual punishments.”¹²³ I begin by analyzing how the federal courts have applied the Eighth Amendment to the provision of medical care in prisons,

and alcoholism.”).

119. Andrew Brunsten, *Hepatitis C in Prisons: Evolving Toward Decency Through Adequate Medical Care and Public Health Reform*, 54 UCLA L. REV. 465, 477 (2006).

120. Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOKLYN L. REV. 185, 185 (2002).

121. Congress opted to allow the courts to develop testimonial privileges through their common-lawmaking authority instead of codifying them legislatively. Thus, its decision not to adopt the rule was unrelated to any judgment about the accuracy of the disease model of addiction.

122. Proposed FED. R. EVID. 504 (not enacted).

123. U.S. CONST. amend. VIII.

highlighting the potential applicability of Eighth Amendment doctrine to the context of prison-based drug treatment. I then construct a brief case study, using several federal cases regarding methadone maintenance treatment (MMT) in correctional settings. I argue that the protections afforded to inmates against “deliberate indifference to serious medical needs” should extend to the context of drug treatment programs.

A. The Development of the Deliberate Indifference Standard

In *Estelle v. Gamble*,¹²⁴ the United States Supreme Court held that inadequate medical care for prisoners could implicate the Cruel and Unusual Punishment Clause of the Eighth Amendment. In order to state a claim against corrections officials, inmate-plaintiffs must show both that their medical needs are severe and that prison staff were intentionally heedless:

Deliberate indifference to serious medical needs of prisoners constitutes the “unnecessary and wanton infliction of pain,” proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a cause of action under § 1983.”¹²⁵

For a prisoner to claim successfully that prison-based drug treatment is constitutionally mandated, she would have to make a two-part showing. First, she would be required to show that she have been deprived of a basic human need. Food, clothing, shelter, exercise, reasonable safety, and—most importantly here—medical care, have all been found to be clear examples of basic human needs.¹²⁶ Demonstrating the deprivation of a basic human need is sometimes referred to as the “objective element” of the Eighth Amendment standard. The “subjective element,” which is often considerably more difficult to prove in court, requires that one or more defendants acted with a culpable state of mind—deliberate indifference—toward the plaintiff.¹²⁷ In other words, “[p]rison officials are deliberately indifferent to a prisoner’s serious medical needs when they deny, delay, or

124. 429 U.S. 97, 104 (1976).

125. *Estelle*, 429 U.S. at 104-5.

126. See *Helling v. McKinney*, 509 U.S. 25, 32 (1993).

127. See *Wilson v. Seiter*, 501 U.S. 294, 303 (1991).

intentionally interfere with medical treatment.”¹²⁸

Of course, both the word “serious” and the phrase “deliberate indifference” are ambiguous, and the courts have generally applied them narrowly and with a reluctance to expand liability for discretionary acts by prison officials.¹²⁹ Nonetheless, the development of case law since the *Estelle* decision could provide a constitutional basis for claims to prison-based drug treatment by prisoners suffering from addiction. A close examination of the “deliberate indifference to serious medical needs” standard shows that there is no legally principled distinction between drug treatment and other forms of medical care that are constitutionally mandated in prison settings, given the extensive support in case law for a disease conception of addiction.

B. “Serious”

Ailments that constitute a “serious” harm to a free person may not always be “serious” in the eyes of the law when that same affliction befalls a prisoner. The Supreme Court has held that when “conditions are restrictive and even harsh, they are part of the penalty that criminal offenders pay for their offenses against society.”¹³⁰ However, no court has gone so far as to hold that prisoners can legally be made to suffer from treatable medical or mental health disorders as part of their sentence.

Courts have diverged on the difficult issue of defining seriousness. In the Second Circuit, for example, courts consider several factors, including “whether a reasonable doctor or patient would perceive the medical need in question as important and worthy of comment or treatment. . . [and] whether the medical condition significantly affects daily activities.”¹³¹ In the Ninth Circuit, by contrast, “[a] serious medical need is present whenever the failure to treat a prisoner’s condition could result in

128. *Hallett v. Morgan*, 296 F.3 732, 744 (9th Cir. 2002) (internal quotation marks omitted).

129. This paper does not address issues of qualified immunity, which generally shields government officials in a discretionary capacity from liability if their actions, even if subsequently found unlawful, did not violate “clearly established statutory or constitutional rights of which a reasonable person would have known.” *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982). Although some courts have recognized prisoners’ right to continuation of certain drug dependence treatments (see methadone discussion, *infra* Part E), it is unlikely that any court in the status quo would hold an official liable for damages for failure to provide drug treatment, given the paucity of legal precedents supporting drug treatment as a constitutional right. However, equitable relief—such as an injunction or declaratory judgment—would likely be an appropriate remedy for an inmate who successfully alleged that the inaccessibility of prison-based drug treatment violated her constitutional rights.

130. *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).

131. *Brock v. Wright*, 315 F.3d 158, 162 (2d Cir. 2003) (internal quotation marks omitted).

further significant injury or the unnecessary and wanton infliction of pain.”¹³² The Court of Appeals for the Eighth Circuit, meanwhile, has held that “[a] serious medical need is one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a layperson would easily recognize the necessity for a doctor’s attention.”¹³³

In determining seriousness, then, it might be said that courts generally look to both the professional judgment of the medical community and to the potential that a given condition, if left untreated, will cause further harm. The scientific and medical communities largely agree that addiction is rightly considered and treated as a disease.¹³⁴ The World Health Organization¹³⁵ and the American Medical Association¹³⁶ consider addiction to be a treatable illness. Likewise, it is clear that when untreated, addiction can be expected to cause future harm. According to the National Institutes of Health, untreated drug addiction can lead to increased mortality, unemployment, criminal activity, and increased exposure to health risks like hepatitis and AIDS, among other health harms.¹³⁷

C. “Medical”

As we have seen, the federal courts have widely accepted the notion that addiction is a medical disease. Thus, the notion that prison-based treatment should address a medical issue should be uncontroversial. Nonetheless, some commentators have argued that as far as the law is concerned, drug addiction should be treated no differently than other cravings or desires (including a greedy person’s craving for money).¹³⁸

However, the federal courts have unanimously concluded that, as in

132. *Clement v. Gomez*, 298 F.3d 898, 904 (9th Cir. 2002).

133. *Coleman v. Rahija*, 114 F.3d 778, 784 (8th Cir. 1997).

134. Ellen M. Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631, 638-39 (2005) (“Twenty years of scientific research...has convinced the majority of the biomedical community – if not the public generally – that addiction is a brain disease: a condition caused by persistent changes in brain structure and function.”).

135. See, e.g., U.N. OFFICE ON DRUGS AND CRIME & WORLD HEALTH ORG., PRINCIPLES OF DRUG DEPENDENCE TREATMENT I (2008), available at http://www.who.int/substance_abuse/publications/principles_drug_dependence_treatment.pdf (“Drug dependence is considered a multi-factorial health disorder that often follows the course of a relapsing and remitting chronic disease.”).

136. See, e.g., AM. MED. ASSOC., ACCESS TO AND PAYMENT FOR TREATMENT SERVICES, available at <http://www.ama-assn.org/resources/doc/alcohol/access.pdf> (AMA policies treat alcoholism and substance abuse disorders as diseases);

137. Nat’l Institutes of Health, Nat’l Consensus Dev. Panel on Effective Med. Treatment of Opiate Addiction, *Effective Medical Treatment of Opiate Addiction*, 280 JAMA 1936, 1938-39 (1998).

138. See Stephen J. Morse, *Excusing the Crazy: The Insanity Defense Reconsidered*, 58 S. CAL. L. REV. 777, 813-14 (1985).

the words of the Fifth Circuit, “mental health needs are no less serious than physical needs.”¹³⁹ Even a condition that is wholly neurological or even psychological can constitute a “serious medical need” for the purposes of the Eighth Amendment.¹⁴⁰ Many courts have utilized a test similar to the one articulated in *Tillery v. Owens*, which held that the Eighth Amendment covers mental ailments that cause “significant disruption in an inmate’s everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself.”¹⁴¹ No definition of drug addiction would fail to satisfy this test.

Moreover, courts have shown a willingness to look outside “traditional” models of illness in defining medical needs. For instance, a transsexual woman forced to terminate her hormone treatments upon entering a sex-segregated male prison—and to go through painful breast reduction and other physical repercussions as a result—was found to have suffered from deliberate indifference to a serious medical need.¹⁴² Clearly, then, public acceptance of a treatment or of the morality of the individuals who need it is not a prerequisite for a deliberate indifference claim.¹⁴³ Likewise, numerous courts have held that failure to protect inmates from their own self-harming tendencies constitutes deliberate indifference. The most common context for such decisions has been when prison officials fail to follow up or provide treatment when an inmate displays credible risk factors for suicide.¹⁴⁴ The same logic has also been extended to cases

139. *Gates v. Cook*, 376 F.3d 323, 332 (5th Cir. 2004) (citing *Partridge v. Two Unknown Police Officers of City of Houston, Texas*, 791 F.2d 1182, 1187 (5th Cir. 1986)). See also *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (“deliberate indifference to an inmate’s serious mental health needs violates the eighth amendment”); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) (“[t]reatment of the mental disorders of mentally disturbed inmates is a serious medical need”) (internal quotation marks omitted); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982) (internal quotation marks omitted); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (internal quotation marks omitted).

140. See, e.g., *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2d Cir. 2000) (quoting *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987)) (observing that “[c]ourts have repeatedly held that treatment of a psychiatric or psychological condition may present a serious medical need”); *Langley v. Coughlin*, 888 F.2d 252, 254 (2d Cir. 1989) (“We think it plain that from the legal standpoint psychiatric or mental health care is an integral part of medical care. It thus falls within the requirement of *Estelle v. Gamble*, [429 U.S. 97, 103 (1976)], that it must be provided to prisoners.”)

141. 719 F. Supp. 1256, 1286 (W.D. Pa. 1989), *aff’d*, 907 F.2d 418 (3d Cir. 1990).

142. *Phillips v. Mich. Dep’t of Corr.*, 731 F. Supp. 792, 800 (W.D. Mich. 1990), *aff’d* 932 F.2d 969 (6th Cir. 1991).

143. See also *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995) (finding gender dysphoria to give rise to a serious medical need).

144. See, e.g., *Conn. v. City of Reno*, 591 F.3d 1081 (9th Cir. 2010) (failure of officers to recognize legitimate threats of suicide); *Woodward v. Corr. Med. Servs.*, 368 F.3d 917 (7th Cir. 2004) (failure to respond to signs that prisoner was suicidal); *Olsen v. Bloomberg*, 339 F.3d 730 (8th Cir. 2003) (failure to take reasonable steps to prevent prisoner suicide); *Cavaliere v. Shepard*, 321 F.3d 616, 621-22 (7th Cir. 2003) (failure to respond to warnings that prisoner was suicidal); *Comstock v. McCrary*, 273 F.3d 693 (6th Cir. 2001) (failure to respond to warnings that prisoner was suicidal); *Sanville v. McCaughtry*, 266 F.3d

where a prison failed to treat an inmate's compulsion to self-mutilate.¹⁴⁵ Like addiction, suicidal ideation and self-mutilation might be seen as in some sense "chosen" behaviors on the part of the sufferer. That some in the public view addiction as an existential weakness provides no legally principled support for the notion that it is less "serious" or less "medical" than other afflictions whose treatments courts have deemed to be constitutionally mandated.¹⁴⁶

In addition to recognizing medical needs that are wholly neuropsychological, courts have also recognized that illnesses with behavioral components are "medical" conditions. In *Hunt v. Uphoff*, for example, the Tenth Circuit held that an inmate had properly stated a deliberate indifference claim by alleging that medical complications he had suffered were caused by inadequate treatment in prison for diabetes and hypertension.¹⁴⁷ Likewise, the court in *Taylor v. Anderson* rejected the argument that because adult-onset diabetes differs from person to person, failure to provide a special diet did not constitute deliberate indifference.¹⁴⁸ If this argument fails in the context of diabetes, it must also fail in the context of addiction: the lack of any failsafe method to medically treat addiction effectively in all individuals does not relieve prison officials of their duty to make a good-faith effort at providing treatment. Moreover, as noted above, drug dependence is frequently analogized to diseases like diabetes and hypertension—both by disease concept adherents and some autonomy-oriented critics—because these diseases are the result of a combination of behavioral, genetic, and environmental factors.¹⁴⁹ "Drug addiction is similar to other chronic illnesses such as diabetes, heart disease, and lung cancer in that voluntary, yet socially conditioned, behaviors, such as diet or smoking, can lead to the onset and development

724, 738 (7th Cir. 2001) (same); *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir. 1989) (failure to respond to warnings that prisoner was suicidal); see also *Mombourquette v. Amundson*, 469 F. Supp. 2d 624, 655 (W.D. Wis. 2007) (deliberate indifference to risk that plaintiff would attempt suicide); *Arnold v. Lewis*, 803 F. Supp. 246, 257-58 (D. Ariz. 1992) (failure to respond to warnings that prisoner was suicidal).
145. *De'Lonta v. Angelone*, 330 F.3d 630 (4th Cir. 2003).

146. In *Farmer v. Brennan*, the Supreme Court provided further support for the notion that the Eighth Amendment covers ailments that are entirely internal to the sufferer's brain. The Court in *Farmer* recognized transsexualism as a "rare psychiatric disorder in which a person feels persistently uncomfortable about his or her anatomical sex, and...typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change." 511 U.S. 825, 829 (1994). Despite being internal to an individual's brain, in other words, transsexualism might indeed give rise to "serious medical needs," attention to which would constitutionally be mandated by the Eighth Amendment.

147. 199 F.3d 1220, 1224 (10th Cir. 1999).

148. 868 F. Supp. 1024, 1026 (N.D. Ill. 1994).

149. See, e.g., J. Thomas Payte, *The Use of Insulin in the Treatment of Diabetes: An Analogy to Methadone Maintenance*, 2 J. MAINTENANCE ADDICTIONS 95 (2003).

of the disease.”¹⁵⁰ As such, if diabetes and hypertension are cognizable under the Eighth Amendment because they may give rise to future harm, surely addiction fits the mold of a serious medical condition requiring treatment.

Finally, drug dependence is indistinguishable from constitutionally recognized “medical” needs in terms of treatability. The American Medical Association has adopted an authoritative resolution “end[ing] the proposition that drug dependencies, including alcoholism, are diseases and that their treatment is a legitimate part of medical practice.”¹⁵¹ It is beyond dispute that this represents the consensus of the mainstream medical community. Moreover, notwithstanding the widespread belief that drug addicts cannot be reformed, drug treatment can be quite effective when a treatment modality is chosen that is appropriate to the circumstances and is administered properly. Alan Leshner suggests that “[d]rug treatment reduces drug use by 40% to 60% and significantly decreases criminal activity during and after treatment.”¹⁵² Drug treatment, importantly, has been empirically proven to be “as successful as treatment of other chronic illnesses.”¹⁵³ Drug addiction is thus no less “medical” in nature than other ailments recognized in Eighth Amendment jurisprudence.

D. “Needs”

Perhaps the most intuitive understanding of a “need” is the most restrictive one: something without which a person cannot survive. Fortunately, however, numerous court decisions have clarified that a prisoner’s medical condition need not be life-threatening to state a deliberate indifference claim. The Second Circuit, for instance, has defined a “serious medical need” as present whenever “the failure to treat a prisoner’s condition could result in further significant injury or the unnecessary and wanton infliction of pain.”¹⁵⁴ Medical conditions that are

150. Brunsden, *supra* note 119, at 476; see also Brian R. Edlin et al., *Overcoming Barriers to Prevention, Care, and Treatment of Hepatitis C in Illicit Drug Users*, 40 CLINICAL INFECTIOUS DISEASES S276 (2005) (noting the medical consensus that “[d]rug use is a complex behavior with multidimensional determinants, including social, psychological, cultural, economic, and biological factors”).

151. AM. MED. ASS’N, DEFINITIONS, H-95.983 Drug Dependencies as Diseases (Nov. 24, 2003), available at http://www.ama-assn.org/ama1/pub/upload/mm/388/alcoholism_treatable.pdf

152. Alan I. Leshner, *Science-Based Views of Drug Addiction and Its Treatment*, 282 J. AM. MED. ASS’N 1314, 1316 (1999).

153. *Id.*

154. *Harrison v. Barkley*, 219 F.3d 132, 136 (2d Cir. 2000) (quoting *Chance v. Armstrong*, 143 F.3d 698, 702 (2d Cir. 1998)). Meanwhile, some courts have held that “a medical need is sufficiently serious ‘if it is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay

not life-threatening can nevertheless constitute “serious medical needs” for constitutional purposes. This generally occurs if the conditions result in pain or loss of function. Examples have included severe heartburn with frequent vomiting,¹⁵⁵ painful keloid scars,¹⁵⁶ contact with errant pepper-spray directed at another inmate,¹⁵⁷ a swollen and painful knee,¹⁵⁸ the denial of medication prescribed for a seizure disorder,¹⁵⁹ post-surgical care for an inmate’s hand,¹⁶⁰ back pain,¹⁶¹ a lacerated lip,¹⁶² hemorrhoids,¹⁶³ and boils.¹⁶⁴

Indeed, federal courts have expressly held that the *Estelle* test covers even ailments that present a risk of causing future harm. The Supreme Court aptly noted that “[i]t would be odd to deny an injunction to inmates who plainly proved an unsafe. . . condition in their prison on the ground that nothing yet had happened to them.”¹⁶⁵ It was on this basis that the court in *Harrison v. Barkley* held that an untreated dental cavity could constitute a serious medical need: “a tooth cavity is a degenerative condition, and if it is left untreated indefinitely, it is likely to produce agony and to require more invasive and painful treatments. . .”¹⁶⁶ The consequences of untreated addiction are at least as serious. Like a cavity, addiction may be seen as a “degenerative” ailment. While no treatment is certain to work, left untreated addiction is essentially guaranteed to snowball into various second-order harms. Treatment has the potential to decrease drug use, recidivism, and health problems resulting from drug dependence.¹⁶⁷

Drug addiction, then, is logically indistinguishable from other ailments already covered under the “deliberate indifference to serious medical needs” test. The Eighth Amendment has to date been held to require prisons to treat illnesses defined exclusively by reference to the sufferer’s brain functionality; diseases to which the sufferer has

person would easily recognize the necessity for a doctor's attention.” *Gutierrez v. Peters*, 111 F.3d 1364, 1373 (10th Cir. 1997).

155. *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005).

156. *Brock v. Wright*, 315 F.3d 158, 163- (2d Cir. 2003).

157. *Clement v. Gomez*, 298 F.3d 898 (9th Cir. 2002).

158. *Ellis v. Butler*, 890 F.2d 1001, 1003 (8th Cir. 1989).

159. *Pulliam v. Shelby County*, 902 F. Supp. 797, 801 (W.D. Tenn. 1995).

160. *Chaney v. City of Chicago*, 901 F. Supp. 266, 270 (N.D. Ill. 1995).

161. *Bouchard v. Magnusson*, 715 F. Supp. 1146, 1148 (D. Me. 1989).

162. *Smallwood v. Renfro*, 708 F. Supp. 182, 187 (N.D. Ill. 1989).

163. *Henderson v. Harris*, 672 F. Supp. 1054, 1059 (N.D. Ill. 1987).

164. *Case v. Bixler*, 518 F. Supp. 1277, 1280 (S.D. Ohio 1981).

165. *Helling v. McKinney*, 509 U.S. 25, 33 (1993).

166. 219 F.3d 132, 137 (2d Cir. 2000).

167. See generally *Grangetto*, *supra* note 18, at 390-3.

contributed through voluntary behavior; ailments considered by mainstream society to be unworthy of treatment; diseases for which treatment is not guaranteed to succeed due to the variety of symptom permutations seen across various individual sufferers; and diseases which present relatively little cause for medical concern in the present but threaten to degenerate and cause severe future harms. Indeed, as we shall see, courts have already begun recognizing the need for drug treatment in prisons under the existing case law. In what follows, I argue that the constitutional mandate for prison-based treatment should be explicitly recognized and expanded.

E. The Methadone Cases: A Case Study of “Serious Medical Need”

In this section, I highlight the jurisprudence surrounding methadone maintenance and the Eighth Amendment. Methadone maintenance, or MMT, is the modality of corrections-based drug treatment that has most explicitly prompted courts to address Eighth Amendment issues surrounding drug addiction in prison and jails. Much of the litigation around methadone maintenance in correctional settings has been initiated by pre-trial detainees who were denied methadone in jail while awaiting trial. Because pre-trial detention is viewed as a means of preventing flight from criminal charges and not as punishment *per se*, these cases have tended to be decided under the due process clause of the Fourteenth Amendment rather than under the Eighth Amendment.¹⁶⁸ Before 1979, courts applied a due process balancing test to determine whether a given practice toward pre-trial detainees was justified by a sufficient state interest. Under this test, the Third Circuit determined that the denial of methadone to a detained MMT patient violated the constitutional guarantee of due process “unless the state can demonstrate that a legitimate security concern, or a genuine fear of substantial administrative disruption, warrants this interference with plaintiff’s medical care.”¹⁶⁹ The court further held that “the record [did] not demonstrate a connection between the security interest justifying the incarceration of a pretrial detainee and the deprivation of liberty complained of” by a patient whose methadone had been terminated.¹⁷⁰ Importantly, the court both recognized that a heroin addict had a cognizable medical need for methadone and

168. *Cf.* *Hampton v. Holmesburg Prison Officials*, 546 F.2d 1077 (3d. Cir. 1976) (holding that “[i]t would be anomalous to afford a pretrial detainee less constitutional protection than one who has been convicted”); *Id.* at 1079-80.

169. *Norris v. Frame*, 585 F.2d 1183, 1185 (3d. Cir. 1978).

170. *Id.*

found that legitimate penological objectives did not justify termination.

However, the federal courts changed course after the Supreme Court handed down its decision in *Bell v. Wolfish*.¹⁷¹ In *Bell*, the justices held that pretrial detainees must show that their treatment was punitive in order to state a due process claim.¹⁷² Although *Bell* was not itself a methadone case, it influenced subsequent methadone-related decisions because it seemed to narrow the grounds on which an addict could successfully sue corrections officials. As such, the Third Circuit retreated from its holding in *Norris* when it decided *Inmates of Allegheny Jail v. Pierce*.¹⁷³ In *Allegheny Jail*, the court found that maintaining a drug-free prison environment was a sufficient rationale for withholding methadone.¹⁷⁴ The Fourth Circuit followed suit in *Fredericks v. Huggins*, declining to find that detainees had a right to methadone treatment or even to comfortable detoxification.¹⁷⁵

Not all of the existing case law is so unfavorable to methadone treatment in correctional settings, however. In *Cudnik v. Kreiger*, the Sixth Circuit held that denying methadone to detainees who had been prescribed the treatment before their incarceration violated their constitutional rights.¹⁷⁶ The *Cudnik* opinion correctly repudiates the logic of the *Allegheny Jail* court, which justified a methadone ban for the purpose of ensuring a contraband-free jail. The court concluded that methadone patients could be isolated from the rest of the inmate population to minimize disruptions and that the possibility that a black market for methadone would spontaneously generate in the jail was “at best highly remote.”¹⁷⁷ Methadone could be (and indeed was) stored outside the facility and administered only in the presence of medical personnel.¹⁷⁸ The court declined to take the logical next step and hold that banning methadone from a facility to maintain a drug-free environment is nonsensical because methadone is not actually a drug of abuse.¹⁷⁹

171. 441 U.S. 520 (1979).

172. *Id.* at 560-61.

173. 612 F.2d 754 (3d. Cir. 1979).

174. *Id.* at 761.

175. 711 F.2d 31, 33 (4th Cir. 1983).

176. 392 F. Supp. 305, 312-3 (6th Cir. 1974).

177. *Id.* at 312.

178. *Id.*

179. The overwhelming consensus of experts is that methadone is not properly viewed as a recreational drug and does not produce a high as traditionally associated with drugs of abuse. Vincent P. Dole, *What Have We Learned from Three Decades of Methadone Maintenance Treatment?*, 13 DRUG & ALCOHOL REV. 3, 3 (1994); see also DRUG POLICY ALLIANCE, ABOUT METHADONE 10 (2d ed. 2003) (“When used in proper doses in maintenance treatment, methadone does not create euphoria, sedation, or an analgesic effect.”), available at <http://drugpolicy.org/docUploads/aboutmethadone.pdf>.

However, it nevertheless rejected corrections officials' claim that methadone could constitutionally be prohibited as contraband.

These methadone cases are, of course, not dispositive of the larger issue of whether prison-based drug treatment is constitutionally required. This is true not only because their outcomes are mixed but also because they concern pre-trial detainees and not convicted inmates (and thus did not apply the *Estelle* standard). Furthermore, they contemplate only one relatively unique drug treatment modality (methadone maintenance). These cases are important, however, because they illustrate the struggle between the lay understanding of drug treatment as a supererogatory luxury (or potentially a pretext for recreational drug use) and scientific understandings of addiction as a medical disorder requiring treatment. Unsurprisingly, more recent precedent suggests that as scientific understanding of addiction advances, the courts may be growing more amenable to integrating addiction into the law of the Eighth Amendment. For instance, in *Messina v. Mazzeo*,¹⁸⁰ the court held that an allegation that methadone was withheld from a prisoner who had previously been prescribed methadone maintenance was sufficient to survive a motion to dismiss. “[I]f, based on plaintiff’s condition, it was a medical necessity that he receive methadone immediately, then plaintiff has alleged. . . that [prison staff were] deliberately indifferent to Messina’s medical needs.”¹⁸¹ Such a determination is only possible given the premise that drug dependence is a medical condition worthy of treatment.

Of course, methadone maintenance is only one modality of drug treatment, and is somewhat unique in that it spares the addict the extreme discomfort and pain of experiencing withdrawal. As such, it is admittedly easier to see an Eighth Amendment injury when an inmate has been denied methadone (especially if she was previously prescribed a maintenance regimen) than where other forms of treatment have been withheld.¹⁸² The Supreme Court relied on a version of this logic when it held in 1974 that a defendant’s constitutional rights were not violated when he was excluded from a diversion-to-treatment program because “there is no generally accepted medical view as to the efficacy of presently known therapeutic

180. 854 F. Supp. 116 (E.D.N.Y. 1994).

181. *Id.* at 140.

182. Indeed, a potential reading of the current state of federal law is that corrections officials are constitutionally required to treat the symptoms of withdrawal but not addiction itself. *See, e.g., United States ex rel. Walker v. Fayette County*, 599 F.2d 573 (3d Cir. 1979); *Pedraza v. Meyer*, 919 F.2d 317 (5th Cir. 1990). However, while these cases clearly establish a constitutional “floor” requiring officials *at least* not to ignore the discomfort of an opioid-addicted inmate experiencing the withdrawal syndrome, they do not pass on the question of whether addiction itself constitutes a “serious medical need.”

methods of treating addicts and the prospect for the successful rehabilitation of narcotics addicts thus remains shrouded in uncertainty.”¹⁸³ As a matter of constitutional law, the importance of this holding is strongly diminished by the fact that it pre-dates *Estelle* and the development of the “deliberate indifference to serious medical needs” standard. More importantly still, it pre-dates a wealth of scientific evidence that various treatment modalities can be effective. Empirical evidence supports the effectiveness of an array of treatments, from cognitive therapies to training in coping skills to behavioral and motivational therapies, provided the treatments adhere to proven standards.¹⁸⁴ As such, while the suffering prevented by methadone maintenance may be vivid, other treatment modalities are equally valid responses to the medical harms of addiction. In short, “[c]ourts should not be afraid to step out of narrow methadone precedent and examine. . . dependence disorder in a new light, as a medical illness requiring [treatment] rather than a moralist debate.”¹⁸⁵

All evidence-based drug treatment modalities are ultimately assimilable to the “deliberate indifference” view of Eighth Amendment rights for prisoners. First, as noted above, the likelihood that a medical omission in prison will result in future harm is sufficient to state a deliberate indifference claim. Eliminating or refusing to implement prison-based treatment constitutes a deliberate choice by officials to deny treatment for a condition that is legally considered a disease and which has been scientifically shown to escalate and cause immense harm when left untreated. Second, the elimination of treatment programs is frequently analogous to withholding methadone from a maintenance patient because it amounts to the termination of treatment that a patient was already receiving. The simultaneous decrease in prison-based treatment availability and increase in imprisonment in the United States leads inexorably to the conclusion that inmates who once received drug treatment in the community or while incarcerated are denied it today.¹⁸⁶ Finally, because the federal courts have widely recognized addiction as a disease (even while questioning its exculpatory value with regard to criminal intent), the Eighth Amendment should undermine objections to prison-based treatment that cast it as a luxury. The logical conclusion from both the case law on addiction and the science of drug treatment is

183. *Marshall v. United States*, 414 U.S. 417, 426 (1974).

184. *CASA*, *supra* note 27, at 42-43.

185. Rebecca Boucher, *The Case for Methadone Maintenance Treatment in Prisons*, 27 VT. L. REV. 453, 482 (2003).

186. *See Bales*, *supra* note 24, at 387-88.

that addiction is a threat to health and is possible to treat. Maintaining prison-based treatment programs might thus be seen as equally a matter of constitutional law as it is one of public policy.

V. CONCLUSIONS

This paper has provided an overview of several competing models of addiction, arguing that the American federal judiciary has largely embraced the so-called “disease concept” while taking a more autonomy-oriented view on the narrower issue of addicts’ criminal culpability. It has argued that given our legal system’s understanding of addiction, current jurisprudence regarding the Eighth Amendment’s prohibition on cruel and unusual punishment suggests that failure to provide addicted inmates with prison-based drug treatment may well be constitutionally problematic. It has not yet, however, grappled with the important question of why so few imprisoned addicts have access to needed treatment.

The decision as to which services are available in correctional settings is foremost the province of legislators and administrators. In the face of ever-diminishing government resources and continually growing budgetary pressures, the notion that the Constitution contains a command that prisoners receive drug treatment while incarcerated may seem far-fetched and unrealistic. Both for those in charge of prisons and those inside them, the question of prison-based treatment is less a question of constitutional law than of utilitarianism. However, even from the perspective of a pure cost-benefit analysis, treating addiction in correctional settings makes sense. Numerous empirical studies have demonstrated that drug treatment in jails and prisons, when properly implemented, is cost-effective from a policy standpoint.¹⁸⁷ Moreover, addicts who need help and do not get it—especially those most likely to interact with the criminal justice system—are likely to suffer and die. In fact, drug overdose is the number one killer of convicts released from prison.¹⁸⁸ Why, then, does there seem to be relatively little political will in favor of prison-based treatment?

187. See generally, e.g., Kathryn E. McCollister et al, *Long-term Cost Effectiveness of Addiction Treatment for Criminal Offenders*, 21 JUST. Q. 659 (2004); Kathryn E. McCollister, et al., *Is in-prison treatment enough? A cost-effectiveness analysis of prison-based treatment and aftercare services for substance abusing offenders*, 25 L. & POL’Y 62 (2003); J. D. Griffith, et al., *A cost-effectiveness analysis of in-prison therapeutic community treatment and risk classification*, 79 PRISON J. 352 (1999); see also CASA, *supra* note 27, at 6 (claiming that “for each additional year that a former inmate stays substance free, employed and out of prison, society would receive an economic benefit of approximately \$90,953, and that therefore if treatment is effective for 10% of addicts, investing in treatment would pay for itself in about a year).

188. CASA, *supra* note 27, at 60.

Given the terrible suffering endured by many addicts, the social and economic costs of addiction and drug-related crime to the public at large, and the long history of the “disease concept” in America, we may wonder why the provision of drug treatment to prisoners is at all controversial. The answer lies in the profound stigma that continues to attach to drug addiction in the United States. Despite the century-long history of the “disease concept” in America, the idea that drug addicts bring upon themselves all the misery they suffer continues to endure. The scientific and medical community recoil at this characterization, arguing that advances in genetics, neurochemistry, and social epidemiology show convincingly that addiction is a disease logically indistinguishable from diabetes or hypertension. A leading advocate of methadone maintenance, for instance, has written:

On the issue of heroin addiction being “self-inflicted” and not worth treating, it is useful to provide an analogy. A significant number of cardiologists treat a large number of middle-aged men who require coronary bypass operations. These individuals are generally overweight, eating unhealthy food, and drinking unhealthy amounts of alcohol in addition to smoking several packs of cigarettes everyday [sic]. Should the cardiac surgeon deny treatment to these individuals because their cardiac disease is “self-inflicted” through years of neglecting their own health? If an inmate in any system required critical health care for his disease, should the officials deny him access to such care based on perception of “self-infliction”?¹⁸⁹

Such advocates are motivated by a passionate desire to extract from science a normative influence on society and the law.

But can science truly tell us who is morally blameworthy and who is not? Strong critics of the disease concept like Schaler who claim that “addiction is a choice” are surely partly reacting in disgust to the presumptuousness of the scientific establishment, which they view as attempting to prove moral culpability (or lack thereof) with empirical studies. This tension has long been present in the law, and indeed might well explain why most courts have stopped short of permitting addiction to suffice as a “mental disease or defect” defense in criminal trials. But does it bear on the question of prison-based drug treatment? If addiction is indeed a serious but treatable medical condition, then the issue of whether

189. Boucher, *supra* note 184, at 459 (quoting Mark W. Parrino, *Methadone Treatment in Jail*, AM. JAILS, May/June 2000, at 10 (2000)).

addiction is “self-inflicted” seems to be of little relevance. Even autonomy-oriented critics of the strong-form “internal coercion” theory of addiction can allow for the possibility that addiction is a disease while severing this theoretical characterization from the conclusion that addicts are not responsible for their actions. Indeed, “most mental and physical diseases suffered by people who violate the criminal law, even severe diseases, do not have. . . exculpating effects because they do not affect agency concerning criminal activity.”¹⁹⁰ How addiction bears on culpability, in other words, may not be a question that science alone can answer in a vacuum devoid of input from the law and social norms. But this conclusion alone may not answer the right questions.

Perhaps, then, determining whether addiction is a disease *simpliciter* is not the most fruitful approach to understanding whether withholding treatment constitutes cruel and unusual punishment. After all, disease is merely the subjective experience of “dis-ease” on the part of the sufferer:

‘Diseases’ are not things awaiting discovery by researchers and physicians. Instead, they are convenient short-hand descriptions of illnesses experienced by patients that facilitate investigating and selecting possible courses of treatment. But conceptions of illness do not serve only medical purposes; scholars and physicians alike have recognized that diseases are socially constructed and mutable. Nosology and diagnosis can describe a patient’s health or illness experience only imperfectly. As with language and other systems of classification, disease categories are context-dependent and subject to manipulation.¹⁹¹

The legal definitions and social implications of pain, hardship, and illness are thus perhaps not the province of any objective science. But this does not mean that the suffering of addicts, and the ability of treatment to alleviate such suffering, is not a matter of empirical fact. Whether the Constitution permits the government to turn a blind eye to this fact is a question that implicates how seriously we take the guarantees of the Eighth Amendment. As Justice Stevens wrote, concurring in one of the Supreme Court’s most recent elucidations of the Cruel and Unusual Punishment Clause: “Society changes. Knowledge accumulates. We learn, sometimes, from our mistakes. Punishments that did not seem cruel and unusual at one time may, in the light of reason and experience, be found

190. Stephen J. Morse, *Hooked on Hype: Addiction and Responsibility*, 19 L. & PHIL. 3, 6 (2000).

191. Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L. J. 241, 243 (1999). Noah offers a far more in-depth discussion of the various ways in which medical and legal concepts of illness are intertwined than can be developed here.

cruel and unusual at a later time.”¹⁹² More than a century’s worth of reason and experience have taught us that addiction can be torture and that prison-based drug treatment can work. In Justice Stevens’ words, “unless we are to abandon the moral commitment embodied in the Eighth Amendment,”¹⁹³ our society must bring such reason and experience to bear on the law.

192. *Graham v. Florida*, 130 S. Ct. 2011, 2036 (2010) (Stevens, J., concurring).

193. *Id.*