Palliative Exceptions: Substance Abuse, Mental Illness, and Drug Courts

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I have emphasized the centrality of human suffering, in both its intense and subtle varieties, as a powerful governing influence in the pursuit of, reliance on, and relapse to one's drug of choice.

– Dr. Edward Khantzian, Clinical Professor of Psychiatry, Harvard Medical School.[1]

INTRODUCTION

There are many individuals who are both severely mentally ill and addicted to illicit drugs.[2] The conventional response to this comorbid population is to treat their mental illness and substance abuse issues concurrently. Is this the best way for society to handle these individuals, though? Should every attempt be taken to stop their abuse of marijuana, cocaine, heroin, prescription painkillers, methamphetamine, or whatever their drug of choice is? Basically, the orthodox answer to this question by our legal and medical systems is *yes*. Even accepting the disease-model of addiction—and moving away from a perspective of drug use as immoral—the answer remains the same: addiction ravages its victims, and the mentally ill are no exception.[3] In fact, substance abuse can hamper, if not

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[1] Edward J. Khantzian, *The Self-Medication Hypothesis of Substance Use Disorders: A Reconsideration and Recent Applications*, 4 HARV. REV. PSYCHIATRY 231, 237 (1997).

[2] For the purposes of this Article, the terms "mental illness" and "drugs" will be used as follows:

"Mental illness" refers to diseases such as schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depression, but not substance abuse disorders. (This is to avoid confusion arising from the fact that "substance use disorder" is a diagnosable mental illness in the DSM-IV-TR.).

"Drugs" refers to substances such as marijuana, cocaine, heroin, ecstasy, methamphetamine, abused prescription painkillers, etc. I will refer to traditional psychiatric drugs (e.g., SSRIs or atypical antipsychotics), medication or pharmaceuticals. (This is to avoid confusion because some street drugs are legally prescribable in certain contexts, and many regular medications are illegal without a prescription.).

[3] According to Scott Burns, a senior official in the Office of National Drug Control Policy (ONDCP) under the Bush Administration, "the debate about whether drug use is a sin or right or wrong [is over]. Those who espouse that—me included for many years—lost out to those that said it is a disease." Scott Burns, *A Government Insider's Perspective on the War on Drugs*, 2009 UTAH L. REV. 207, 212 (2009). *See also* Stephen J. Morse, *Hooked on Hype: Addiction and Responsibility*, 19 LAW

null, the efficacy of psychiatric treatment.[4]

But, what about mental illness that is treatment resistant—the psychological torment that is not alleviated by psychopharmaceuticals or psychotherapy? Consider that many of these patients with a dual diagnosis are using illegal drugs to self-medicate their mental pain. If certain mentally ill individuals are getting some relief, which is unobtainable otherwise, from their substance use, should society still prohibit their use of these drugs? The appropriate answer may still be yes, but given the possibility of drug use actually helping certain individuals—a concept that is by and large considered disputable at best—a careful analysis of possible drug policies should be undertaken.[5] This Article will argue that existing models for dealing with drug addiction need to be more nuanced in order to accommodate the intricacies of comorbid mental illness.

Maybe it is possible to balance the myriad harms of illicit drug use and the possible palliative effects, and come up with a creative drug policy beyond the normal binary debate (i.e., drugs should be legal or drugs should stay illegal). Academics and policymakers should try to develop an optimal drug policy that would allow people to obtain pain relief while constraining and preventing the misery and dangers of addiction, as well as collateral consequences such as drug-related crime. Whether such an optimal policy is conceptually feasible requires a careful examination of addiction, mental illness, medical treatment, and possible responses by the legal system. This Article attempts such an examination and argues that drug policy can be improved—be made more humane—by allowing certain treatment refractory, mentally ill individuals lawful access to otherwise illegal narcotics through a modified drug court model.

In Part I, this Article will illustrate the background of contemporary drug policy and provide an overview of drug courts. In Part II, this Article will outline a problem with drug policy that becomes apparent when considering mental illness, self-medication, and treatment resistant mental illness. In Part III, this Article will lay out a possible solution to the problem and discuss implementing the solution through drug courts.

& PHIL. 3, 3 (2000) ("Even sophisticated people tend to think that the 'man with the golden arm' is somehow an automaton, a puppet pulled by the narcotic strings of a biological disease, and to think that therefore the addict is not responsible for behaviors associated with his addiction. Conversely, many people think that addiction is purely a result of moral weakness.").

[4] *See, e.g.*, Vivian B. Brown et al., *The Dual Crisis: Mental Illness and Substance Abuse*, 44 AM. PSYCHOLOGIST 565, 566 (1989) ("[A]lcohol and drug use has been found to hinder almost every aspect of care for [patients] with chronic mental illness. Use or abuse of such substances complicates diagnosis, interferes with treatment, rehabilitation, and community functioning, and appears to contribute to relapse.").

[5] For the sake of convenience and simplicity, this Article will commonly refer to drugs and drug use instead of identifying specific drugs. Note, however, that many of the arguments in this article do not apply to all street drugs which vary widely in their addictive potentials, acute and chronic toxicities, therapeutic potentials and mechanisms of action, among other factors.

Finally, in Part IV, this Article will address criticism and concerns about the therapeutic efficacy (or lack thereof) of illegal drugs. In addition, alternative legal regimes for implementing the proposed solution will be discussed.

I. BACKGROUND

There are many tensions in America's perspectives on drugs.[6] We hate drugs, but we love pharmaceuticals. Prescription drug abuse runs rampant. We have a culture of medicine and therapy but continue to fund a War on Drugs.[7] These apparent contradictions highlight the complex nature of drug policy.

Historically, the drug policy debate has taken place on the extremes of a spectrum of possible social responses to drugs. On one end is prohibition, rooted in paternalism, and on the other end is legalization, rooted in liberalism.[8] Legalizers have typically highlighted "drug prohibition's affront to civil liberties and the incentives it creates for black market crime and violence."[9] Prohibitionists, on the other hand, have generally underlined "the risks of addiction and its pernicious effects on families, neighborhoods, and the workplace."[10] In between on the range of possible drug policy regimes are more recent creations, such as intermediate medical and regulatory models. It is in this middle ground that this Article argues progress can be made regarding the "increasing numbers of dually diagnosed offenders in the criminal justice system" and the complicated "relationship between mental illness and substance abuse."[11]

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[6] For broad historical discussions of U.S. drug policy see generally PETER J. COHEN, DRUGS, ADDICTION, AND THE LAW: POLICY, POLITICS, AND PUBLIC HEALTH (2004); DAVID T. COURTWRIGHT, FORCES OF HABIT: DRUGS AND THE MAKING OF THE MODERN WORLD (2001); DRUGS IN AMERICA: A DOCUMENTARY HISTORY (David F. Musto ed., 2002); Mathea Falco, *U.S. Federal Drug Policy*, *in* SUBSTANCE ABUSE: A COMPREHENSIVE TEXTBOOK 21, 21–31 (Joyce Lowinson et al. eds., Lippincott Williams & Wilkins 4th ed. 2005)(1981) [hereinafter SUBSTANCE ABUSE]; David F. Musto, *Historical Perspectives*, *in* SUBSTANCE ABUSE, *supra*, at 1, 1–13.

[7] *See*, JOSEPH A. CALIFANO, JR., HIGH SOCIETY: HOW SUBSTANCE ABUSE RAVAGES AMERICA AND WHAT TO DO ABOUT IT 1 (2007) ("Chemistry is chasing Christianity as the nation's largest religion. The millions of Americans, who *daily* take some kind of mood-altering, pain-killing or mind-bending prescription drug, abuse alcohol and illegal drugs, and smoke cigarettes likely exceeds the number who *weekly* attend religious services."). For a general discussion on the War on Drugs, see generally JONATHAN P. CAULKINS ET AL., RAND DRUG POLICY RESEARCH CTR, HOW GOES THE "WAR ON DRUGS"? AN ASSESSMENT OF U.S. DRUG PROBLEMS AND POLICY 1–43 (2005).

[8] *See* ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, AND PLACES 3–5 (2001).

[9] *Id*. at 102.

[10] *Id*. at 103.

[11] Leslie Paik, *Maybe He's Depressed: Mental Illness as a Mitigating Factor for Drug Offender Accountability*, 34 LAW & SOC. INQUIRY 569, 569 (2009).

A. Addiction and Modern Drug Policy

The extent to which the criminal justice system and drug addiction are closely intertwined cannot be overstated. "An immense proportion of alleged felons are under the influence of mind-altering substances when they are arrested, and many people arrested for drug offenses and other crimes are addicted."[12] To begin an exploration of legal and medical responses to addiction, it is important to first establish a familiarity with drugs and contemporary society. In particular, outlining the contours of the drug war and addiction itself provides a useful starting point for discussion.

1. Society and Drugs

Recent studies have shown that substance abuse in the United States is an epidemic: out of approximately 300 million Americans, about 125 million use, or abuse, alcohol, 50 million smoke, and 20 million use drugs illicitly.[13] According to the 2008 National Survey on Drug Use and Health, in the past year, approximately 850,000 Americans used methamphetamine; 1.1 million used crack cocaine; 5.3 million used cocaine; 453,000 used heroin; and 6.2 million abused prescription drugs.[14] Although, some people who have used even the most addictive drugs never become dependent on them,[15] the majority lose their lives, literally and figuratively, to addiction.

Our society views drug abuse as a both a crime and a disease.[16] Despite the medicalization of addiction, however, the central tenet of American drug policy is prohibition—law enforcement on the national and international fronts, ubiquitously termed the War on Drugs.[17] Other major

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[12] Stephen J. Morse, *Addiction, Genetics, and Criminal Responsibility*, 69 LAW & CONTEMP. PROBS. 165, 165 (2006) (citing ZHIWEI ZHANG, NAT'L INST. OF JUSTICE, DRUG AND ALCOHOL USE AND RELATED MATTERS AMONG ARRESTEES tbls. 3, 9 & 10 (2003)). In a study of arrestees in thirty-nine cities, approximately three-quarters of male adults tested positive for alcohol or a controlled substance and just under 40 percent were at risk for drug dependence. *Id*. at 165 n.2.

[13] Burns, *supra* note 3, at 208–09; OFFICE OF NAT'L DRUG CONTROL POLICY, WHAT AMERICANS NEED TO KNOW ABOUT MARIJUANA: IMPORTANT FACTS ABOUT OUR NATION'S MOST MISUNDERSTOOD ILLEGAL DRUG 1 (2003), *available at* http://www.ncjrs.gov/ondcppubs/publications/pdf/mj_rev.pdf [hereinafter MARIJUANA].

[14] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., RESULTS FROM THE 2008 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 244 tbl.G.3 (2009), *available at* http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.pdf.

[15] *See* Douglas N. Husak, *Addiction and Criminal Liability*, 18 LAW & PHIL. 655, 674 (1999)); Morse, *supra* note 3, at 19 ("[T]he majority of the regular users of any drug do not develop classic addictions.").

[16] Jennifer Broxmeyer, *Prisoners of Their Own War: Can Policymakers Look Beyond the "War on Drugs" to Drug Treatment Courts?*, 118 YALE L.J. POCKET PART 17 (2008), http://thepocketpart.org/2008/06/30/broxmeyer.html.

[17] Burns, *supra* note 3, at 208.

strategies employed by public and private entities include prevention, education, and treatment.[18] The rationale for government intervention is driven by paternalistic objectives (e.g., preventing citizens from becoming addicted) and public safety goals (preventing drug-related crime like gang violence).[19]

Researchers estimate that approximately 7 million of the 20 million illegal drug users are addicted in the clinical sense.[20] And, of the 7 million, only 2 million are in treatment.[21] This has resulted in one of the major therapeutic rationales for the criminalization of many drugs. Encountering the criminal justice system, being imprisoned, or having criminal sanctions leveraged to pressure treatment are all "rock bottom" methods by which current policy attempts to address the 5 million American addicts who are not in treatment.[22]

The modern phase of the drug war is commonly considered to have begun with the crack-cocaine epidemic that emerged in the 1980s and the concomitant passage of more severe drug laws.[23] It was primarily these factors that caused the criminal justice and corrections systems to focus heavily on the conviction and incarceration of drug offenders.[24] As time has passed, however, there has been a growing concern that the War has failed overall.[25] Despite the high burden of drug cases on criminal dockets and the overcrowding of prisons, drug abuse remains a major problem.[26]

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[18] *Id*.

[19] Husak, *supra* note 15, at 665.

[20] MARIJUANA, *supra* note 13.

[21] *Id*. Conventional wisdom states that addicts typically will not be receptive to treatment until they hit "rock bottom." The Partnership for a Drug-Free America, *13 Myths About Drug Abuse & Treatment*, DRUGFREE.ORG (Mar. 13, 2006, 10:39AM), http://www.drugfree.org/Intervention/WhereStart/13_Myths_About_Drug_Abuse.

[22] Burns, *supra* note 3, at 211.

[23] Broxmeyer, *supra* note 16.

[24] *Id*.

[25] *But cf*. Burns, *supra* note 3, at 210 (successes include cocaine shortages and methamphetamine shortages—"[t]he price is up and the purity is down"). Other milestones include:

> Marijuana abuse among twelve to eighteen year olds is down 24 percent since 2001. That's 860,000 fewer people smoking marijuana in the United States. Methamphetamine abuse is down 64 percent. Cocaine is down; steroids are down; alcohol and tobacco are down . . . [d]own, down, except in one category and that is prescription drug abuse.

Id. at 213.

[26] Broxmeyer, *supra* note 16. *See also* Robert W. Sweet, *Will Money Talk?: The Case for a Comprehensive Cost-Benefit Analysis of the War on Drugs*, 20 STAN. L. & POL'Y REV. 229, 233 (2009) ("Drug trafficking offenses have constituted the largest portion of the federal criminal docket for over thirty years. Between 1985 and 2002, the number of drug prosecutions brought in federal court increased by 144%. It is estimated that federal prosecutions and incarceration of drug offenders may alone cost approximately $5 billion annually.").

The United States is the global leader in imprisonment: there are about 2.3 million people incarcerated, and nearly half a million are there because of a drug offense.[27] Currently there are three times as many drug arrests as in 1980—more than 1.8 million in 2007, which is significantly higher than for any other type of criminal violation.[28] In addition, more than eight out of ten arrests on average are for possession, as opposed to distribution.[29] The average sentence length for a federal drug charge ranges from over ten years (129 months) for crack cocaine to more than three years (40 months) for marijuana.[30] Furthermore, five- and ten-year mandatory minimums apply to the majority of cocaine and crack offenders, even though there is no violence connected with over 90 percent of their drug crimes.[31]

Clearly, the effects and responses to addiction and other illegal drug use are a major domestic policy concern. Before delving into specific problems in U.S. drug policy, however, it is necessary to grasp what is meant by the word addiction, and how medical and legal scholars understand it.

2. Legal and Medical Perspectives on Addiction

The central defining feature of addiction is the "loss of control over drug use."[32] Some individuals use drugs and develop a craving for them—i.e., "a very intense, insistent level of subjective desire for the substance that is apparently satisfied by use only temporarily."[33] Some people develop this craving soon after their first use of a drug; for others, the addiction manifests much later.[34] In general, the addict desires the "pleasure of intoxication" (often euphoric for "harder" drugs) and/or the avoidance of the psychological and, sometimes, physical pain of withdrawal.[35] "For some, the craving is so strong that seeking and using the substance becomes a central life activity and even central to the agent's identity."[36] Essentially and insidiously, the "search for and use of the drug

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[27] Sweet, *supra* note 26, at 230.

[28] *Id*.

[29] *Id*.

[30] *Id*. at 230–31.

[31] *Id*. at 231 In addition, more than half of state inmates "incarcerated for drug offenses have no history of violence or high-level drug trafficking activity." *Id*.

[32] Richard J. Bonnie, *Responsibility for Addiction*, 30 J. AM. ACAD. PSYCHIATRY & L. 405, 409 (2002), *available at* www.jaapl.org/cgi/reprint/30/3/405.pdf.

[33] Morse, *supra* note 3, at 19.

[34] *Id*. at 20.

[35] *Id*. at 28.

[36] *Id*. at 20.

become one's life."[37] Moreover, drug use often "threatens and causes negative social, health and legal consequences."[38] Withdrawal and the plethora of adverse medical and extrinsic effects of drug use combined with the hedonic qualities of drugs serve to create a vicious cycle. From a broad, basic psychological perspective, the addict's life is made worse by the addiction, so the addict uses drugs to cope, which makes the addict's life worse, which causes the addict to resort to drug use—this is continued ad nauseam.

Mainly as a result of continuing advances in neuroscience, the public health, medical, and scientific communities have characterized addiction as a "brain disease."[39] In their view, drug dependence is similar to other illnesses, such as heart disease.[40] This model does not view addiction as a moral failing, and further personal accountability is reduced (or obviated, in the view of many adherents to the disease-model, at least to the extent that there is less responsibility attached to commonly-compared diseases like obesity). But responsibility is still part of the general public's intuition about addiction, as well as theoretical formulations of addiction by medico-legal scholars.[41]

According to some legal theorists, even if drug addiction is appropriately viewed as a disease, there is still "an enormous and highly unusual amount of human agency involved."[42] First-time drug use is voluntary in almost all situations, even if it is influenced by external forces such as peer pressure or dreadful living conditions.[43] Moreover, even once

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[37] *Id*.

[38] *Id*. The problems associated with addiction "including loss of control, health, friends and relatives, and self-respect and even the threat of loss of life, fail to deter those caught in the consuming process of addiction." Khantzian, *supra* note 1, at 231.

[39] Bonnie, *supra* note 32, at 405.

[40] NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 5 (2007), *available at* http://www.nida.nih.gov/scienceofaddiction/sciofaddiction.pdf (last revised Aug., 2010).

[41] Bonnie, *supra* note 32, at 408. According to Bonnie, one reason why many doctors and the public-at-large "are unsympathetic toward the addict is that addiction is perceived as being self-[in]flicted: 'they brought it on themselves.'" *Id*. (quoting Charles P. O'Brien & A. Thomas McLellan, *Myths About the Treatment of Addiction*, 347 LANCET 237, 237 (1996)).

[42] Morse, *supra* note 3, at 20. Furthermore, responsibility for addiction can be conceptualized as having three major parts: responsibility for becoming an addict (onset phase), responsibility for behavior resulting principally from addiction (active addiction phase), and responsibility for obtaining treatment or abstaining from drug use (remission/relapse phase). *See* Bonnie, *supra* note 32, at 405–08.

[43] *See* Bonnie, *supra* note 32, at 407–08 ("[W]hen we say that the addict's drug use is 'involuntary' and symptomatic of disease, we mean something different from what is meant when we say that having a seizure is involuntary."); Michael Louis Corrado, *Addiction and Responsibility: An Introduction*, 18 LAW & PHIL. 579, 581 (1999) ("Whatever it means to say that the addict is not in control of her behavior, we must not lose sight of the fact that the addict purchases, possesses, and consumes her drug intentionally and deliberately."). Exceptions to the voluntary nature of initial drug

addicted, drug use is voluntary—just subject to much more extreme internal and external forces. That addicts cannot help but use drugs is a normative judgment—and perhaps a proper one—but not a "deeper insight into the metaphysics of free will and determinism."[44] In particular, "loss of control" means, due to neurobiological processes, the addict feels a powerful craving for the drug, a desire so strong that it is highly improbable that she will be able to resist it. In other words, the disease model actually describes addiction in terms of choice and compulsion, not mechanism and causation.[45]

The disease model is still a useful hermeneutic, even when acknowledging that it permits responsibility. The "characterization of addiction as a brain disease" has value because of its worth as a "political statement."[46] The medicalization of addiction helps "negate the common belief" that addiction is a moral shortcoming or a character flaw and, thus, helps negate stigmatization and promote the view that the proper policy response is rehabilitation and not punishment.[47] Other benefits of the propagation of the disease model include encouraging investment in treatment and addiction research, as well as fostering supportive and rehabilitative attitudes among doctors, families, insurers, and policymakers.[48] In sum, the disease model is not incompatible with concepts of personal accountability.[49]

B. Drug Courts

The drug court movement can be traced back to the 1989 creation of the first drug court in Miami.[50] A judge created that first court, and the trend has continued.[51] It is the judiciary, not the legislature that has been the vanguard driving the proliferation of drug courts.[52] Now, every state

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use include "crack babies" and people who become addicted to prescription drugs that they used as directed.

[44] Husak, *supra* note 15, at 662.

[45] Bonnie, *supra* note 32, at 407.

[46] *Id*. at 406.

[47] *Id*.

[48] Richard J. Bonnie, *Addiction and Responsibility*, 68 SOC. RESEARCH 831, 832–33 (2001).

[49] *Id*. at 833.

[50] Broxmeyer, *supra* note 16.

[51] *Id*.

[52] *Id*. *See also* C. West Huddleston, III et al., *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem-Solving Court Programs in the United States*, 2 NAT'L DRUG COURT INST. 2 (2008), *available at* http://www.ojp.usdoj.gov/BJA/pdf/12902_PCP_fnl.pdf ("Drug courts represent the coordinated efforts of justice and treatment professionals to actively intervene and break the cycle of substance abuse, addiction, and crime.").

has at least one drug court.[53] There are on the order of 2,000 drug courts in operation across the country.[54]

1. Definition, Objectives, and Justifications

In general, drug courts are diversionary criminal justice programs for nonviolent drug-addicted offenders.[55] They are set up as alternatives to conviction (pre-trial programs), alternatives or ways to reduce incarceration (post-conviction programs), or ways to reduce probation (reentry programs).[56] Drug courts are often described as problem-solving courts, which are largely based on therapeutic jurisprudence theory.[57] Specifically, drug courts focus on fixing or treating the root causes of drug-related crimes—addiction and its determinants—instead of punishing addicts.[58] There are three main goals of the drug court system: reducing

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[53] Broxmeyer, *supra* note 16. The Bureau of Justice Assistance defines an "Adult Drug Court" as:

> A specially designed court calendar or docket, the purposes of which are to achieve a reduction in recidivism and substance abuse among nonviolent substance abusing offenders and to increase the offender's likelihood of successful habilitation through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, community supervision, and use of appropriate sanctions and other habilitation services.

Huddleston et al., *supra* note 52, at 21.

[54] Huddleston et al., *supra* note 52, at 7 fig.6.

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Huddleston et al., *supra* note 52, at 21. *See generally* Nahama Broner et al., *Criminal Justice Diversion of Individuals with Co-Occurring Mental Illness and Substance Use Disorders: An Overview*, *in* SERVING MENTALLY ILL OFFENDERS: CHALLENGES AND OPPORTUNITIES FOR MENTAL HEALTH PROFESSIONALS 83 (Gerald Landsberg et al. eds., 2002); Broxmeyer, *supra* note 16; Eric J. Miller, *Drugs, Courts, and the New Penology*, 20 STAN. L. & POL'Y REV. 417, 452–53 (2009).

[56] *See* Huddleston et al., *supra* note 52, at 4–5. "Unlike the first generation of adult drug court programs, which tended to be diversionary or pre-plea models, today only 7% of adult drug courts are diversionary programs compared to 59% which are strictly post conviction." *Id*. However, some critics, such as the National Association of Criminal Defense Lawyers, have argued that the pre-trial model is the most fair because it allows successful participants to avoid a criminal record, which can impede job prospects and other factors for successfully maintaining recovery. Dina Fine Maron, *Courting Drug-Policy Reform: A Bipartisan Drug Policy 20 Years in the Making?*, NEWSWEEK, Oct. 7, 2009, *available at* http://www.newsweek.com/id/216866.

[57] Huddleston et al., *supra* note 52, at 4.

[58] Miller, *supra* note 55, at 422 ("Two lines of argument predominate: that the failure to treat offenders properly does nothing to ameliorate the rate of drug abuse; and that the arrest and conviction rates for drug crime pose a range of managerial problems for an overloaded criminal justice system."). Another practical reason is that drug courts are potentially cost-effective. Morse, note 3, at 204.

recidivism, reducing substance abuse, and rehabilitating offenders.[59]

In order to accomplish these goals, drug courts leverage criminal sanctions to coerce addicts into rehabilitative programs; despite the coercive aspect, however, these programs are generally seen as helping the addicts instead of punishing them.[60] After all, these programs eschew punishment in the form of prison as long as offenders meet treatment goals. Overall, drug courts are typically viewed as a progressive and enlightened response to addiction because they emphasize rehabilitation over retribution.[61] Moreover, the "tough love" approach—threatening prison or other penalties—is an effective therapeutic tool for helping addicts overcome their substance dependence.[62]

2. Architecture and Operation

The primary goals of drug courts—freeing participants of drug dependency and reducing drug-related criminal activity—are achieved by frequent court meetings, drug testing, substance abuse counseling, education, and vocational programs, among other methods.[63] Drug courts also often make available other services such as mental health treatment and other forms of therapy.[64] The overall rehabilitative scheme can be categorized into three phases: (1) detoxification, (2) stabilization via counseling, and (3) social reintegration through education and job programs.[65] Program compliance is enforced through court supervision and sanctions.[66] The courts employ behavior modification techniques such as graduated penalties if the participants fail to reach treatment goals, such

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[59] Vickie Baumbach, *The Operational Procedure of Drug Court: Netting Positive Results*, 14 TRINITY L. REV. 97, 99 (2007).

[60] Bonnie, *supra* note 32, at 410–11. *See also* Broxmeyer, *supra* note 16 ("Drug treatment courts are largely rehabilitative in nature and are founded on the belief that drug offenders are 'sick' and in need of treatment. They treat drug abuse as a socio-medical problem in need of a socio-medical solution (rehabilitation, education, employment). The War on Drugs, on the other hand, treats drug offenders as criminal wrongdoers who 'deserve' punishment.").

[61] *See* Broxmeyer, *supra* note 16. *See also* Miller, *supra* note 55, at 447 ("This disciplinary aspect of the drug court has august and beneficent antecedents and is embraced from genuinely therapeutic motivations. It seeks to maximize a certain form of liberty—positive liberty—by freeing the offender from 'obsessions, fears, neuroses, irrational forces.'").

[62] *See* Bonnie, *supra* note 32, at 411 (noting that threats of negative consequences are "not only useful as a clinical stratagem but is also a fair professional response"); Miller, *supra* note 55, at 448 (describing short terms of incarceration as "'shock therapy,' 'motivational jail,' and 'not really punishment at all, but a therapeutic response to the realistic behavior of drug offenders in the grip of addiction or the restructuring of the defendant's lifestyle.'").

[63] *See* Broxmeyer, *supra* note 16; Huddleston et al., *supra* note 52, at 2.

[64] Huddleston et al., *supra* note 52, at 2.

[65] Broxmeyer, *supra* note 16.

[66] Miller, *supra* note 55, at 448.

as brief intervals of "shock incarceration."[67]

Drug court participation begins with defendants volunteering for the program. Offender eligibility for the drug court program is based largely on enumerated disqualification categories and judicial discretion.[68] Specifically, offenders are typically ineligible if they are charged with or have a history of violent offenses, or if they are charged with sale of drugs or possession with intent to sell.[69] Federal drug courts, and state courts receiving federal funds, are subject to strict guidelines for establishing entrance criteria.[70]

Drug courts are nonadversarial to a large extent.[71] The judge, prosecutor, defense counsel, as well as probation officers, treatment providers, and others, function in a cooperative and collaborative environment, with a mutual goal of rehabilitating the addict.[72] The primary advantage drug courts share over comparable probation programs is the authority and expertise of the drug court judge.[73] Direct oversight of participants by judges "demands responsibility in a manner that medical or social work professionals cannot."[74]

While the profiles of particular drug court participants vary, there are some broad demographic statistics available. Participants are usually male and have low educational levels, poor employment histories, considerable criminal records, and histories of failed drug treatment.[75] The drugs to which participants are addicted differ substantially by court and geographic area; however, this is likely more a function of local drug use patterns and law enforcement strategies, rather than entrance determinations.[76] In general, though, cocaine/crack is the drug of choice in urban drug courts, marijuana is the drug of choice in suburban drug courts, and

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[67] *See* Broxmeyer, *supra* note 16; Miller, *supra* note 55, at 448. There is evidence that addicts are more likely to be deterred by this style of sanctions, as opposed to low probability but more severe punishment. Mark A. R. Kleiman, *Controlling Drug Use and Crime with Testing, Sanctions, and Treatment*, *in* DRUG ADDICTION AND DRUG POLICY: THE STRUGGLE TO CONTROL DEPENDENCE 168, 168, 177–80 (Philip Heymann & William Brownsberger eds., 2001) [hereinafter DRUG ADDICTION AND DRUG POLICY].

[68] Baumbach, note 59, at 115. In some jurisdictions the defendant may also need a referral from the state prosecutor's office. *Id*.

[69] *Id*. at 115–16.

[70] *Id*. at 115.

[71] Broxmeyer, *supra* note 16.

[72] *Id*.

[73] Miller, *supra* note 55, at 424.

[74] *Id*. at 447.

[75] Steven Belenko, *Research on Drug Courts: A Critical Review 2001 Update* THE NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., 19 (2001), *available at* www.drugpolicy.org/docUploads/2001drugcourts.pdf.

[76] *Id*.

methamphetamine is the drug of choice in rural drug courts.[77]

There is general consensus that drug courts lower recidivism and drug use, and are more cost-effective than incarceration.[78] In particular, "[f]our independent meta-analyses have now concluded that drug courts significantly reduce crime rates an average of approximately 7 to 14 percentage points."[79]

II. THE PROBLEM

A. Mental Illness and Addiction

The comorbidity of addiction and severe mental illness is prevalent and compounds treatment outcomes.[80] One study of drug treatment programs found that 68 percent of patients qualified for a psychiatric diagnosis besides substance dependency.[81] The most common co-occurring mental disorders were anxiety disorders (45 percent), antisocial personality disorder (36 percent), and affective disorders (27 percent).[82] There is also evidence that shows that addiction is especially endemic in schizophrenic populations.[83] Individuals with schizophrenia are six times

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[77] Huddleston et al., *supra* note 52, at 8.

[78] *See* Broxmeyer, *supra* note 16. According to a United States Government Accountability Office study, "adult drug court programs substantially reduce crime by lowering re-arrest and conviction rates among drug court graduates well after program completion, and thus, greater cost/benefits for drug court participants and graduates than comparison group members." Huddleston et al., *supra* note 52, at 2.

[79] Huddleston et al., *supra* note 52, at 6.

[80] *See* NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., COMORBIDITY: ADDICTION AND OTHER MENTAL ILLNESSES 1–2 (2008), *available at* http://www.drugabuse.gov/researchreports/comorbidity/; PRINCIPLES OF ADDICTION MEDICINE 1137–1274 (Richard Ries et al. eds., Lippincott Williams & Wilkins 4th ed. 2009) (1993). "Higher levels of substance abuse have been associated with . . . antisocial behavior, unipolar depression, bipolar disorder, attention-deficit hyperactivity disorder, borderline personality disorder, and suicide . . . [as well as] heavy involvement in deviant activities and depressive mood . . . anxiety disorders, antisocial personality, and affective disorders . . . [and] schizophrenia and conduct disorder . . . " Bryan Neighbors et al., *Co-Occurrence of Substance Abuse with Conduct, Anxiety, and Depression Disorders in Juvenile Delinquents*, 17 ADDICTIVE BEHAVIORS 379, 380 (1992) (citations omitted). *See also* John R. DeQuardo et al., *Patterns of Substance Abuse in Schizophrenia: Nature and Significance*, 28 J. PSYCHIATRIC RES. 267, 268 (1994) ("Studies focusing on the effect of substance abuse on outcome in schizophrenia generally suggest poorer outcome in substance-abusing patients.").

[81] Neighbors et al., *supra* note 80, at 379–80 (citing H. Ross et al., *The Prevalence of Psychiatric Disorders in Patients with Alcohol and Other Drug Problems*, 45 ARCHIVES GEN. PSYCHIATRY 1023 (1988)).

[82] *Id*.

[83] R. Andrew Chambers et al., *A Neurobiological Basis for Substance Abuse Comorbidity in Schizophrenia*, 50 SOC'Y BIOLOGICAL PSYCHIATRY 71, 71 (2001) ("Schizophrenic populations commonly use one or more of several substances, including nicotine, alcohol, cannabis, cocaine, and amphetamines.")(citation omitted).

more likely to abuse illicit drugs than persons without mental illness.[84]

Moreover, certain drugs addictions are associated with particular mental illnesses. In one study, between one-third and one-half of patients addicted to opiates met criteria for major depression.[85] Other studies have indicated that cocaine addiction is strongly associated with affective disorders (especially bipolar disorder), attention-deficit disorder, and personality disorders (e.g., borderline personality disorder).[86] There is also data evincing higher rates of alcoholism among patients afflicted by anxiety or affective disorders compared to the general population.[87]

B. Rational Addiction and Pain Management

There are many reasons why someone with mental illness might become a drug addict, including environmental, social, and hereditary characteristics, among other explanations and contributing factors. Furthermore, in some cases, mental illness might be a product of the addiction. However, one of the predominant psychological explanations, discussed below, is that for many cases substance abuse among the mentally ill is essentially a coping mechanism. There is a perception, however, that substance abuse is fairly irrational.[88] Yet some legal theorists have argued that drug addiction can be a completely rational choice in some circumstances.[89]

For instance, Professor Stephen J. Morse relates the circumstances of a not-so-hypothetical person "who has lived an extraordinarily deprived life and therefore has little human capital and few prospects."[90] If there was a high improbability of the person being able to acquire resources, education, or other skills to ameliorate her situation, then "a life of intermittent 'highs' or 'oblivion'"—even with the threat of disease or prison—might be better than a "clean, straight life" encompassed in constant misery.[91] Obviously, as Morse notes, society should attempt to effect broad changes so that such individuals are not faced with the conclusion that a life of drugs is the best (least worst) option.[92] But consider when the triggering

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[84] *Id*.
[85] Khantzian, *supra* note 1, at 235.
[86] *Id*.
[87] *Id*.
[88] Morse, *supra* note 3, at 25–26.
[89] *Id*. at 26.
[90] *Id*.
[91] *Id*.
[92] *Id*. at 26 n.51.

conditions are less environmental and social than biological.[93] In other words, consider drug abuse as a rational response to some illnesses.

This concept is neither novel nor foreign to most people—at least regarding physical illnesses. The public is quite familiar with, and accepting of, substance use in response to some physical illnesses, such as medical marijuana and cancer or HIV/AIDs.[94] But it is important to consider substance use in response to psychological pain as well, especially since drug courts encounter comorbid offenders quite often. To better understand addiction's relation to mental illness—drug abuse's relation to mental suffering—it is essential to examine a main psychiatric explanation for comorbidity: the self-medication hypothesis.

C. Self-Medication

It is widely accepted in the psychiatric community that substance use by many mentally ill individuals constitutes self-medication, "an attempt by patients to alleviate . . . adverse symptoms, cognitive impairments, or medication side effects."[95] The self-medication hypothesis, advanced primarily by Edward Khantzian and David Duncan, is grounded in clinical observations that drugs are used to assuage or alter a variety of painful emotional states.[96] In other words, patients with substance use disorders often "suffer in the extreme with their feelings, either being overwhelmed with painful affects or seeming not to feel their emotions at all."[97] Drug use is an attempt by these individuals "to relieve painful affects or to experience or control emotions when they are absent or confusing."[98] This should not be conflated, however, with seeking pleasure from drug use.[99]

For those who suffer from mental illness, drug use is initially a

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[93] *Id*. at 43–44 ("For those who have lived lives of abuse or who *suffer from psychological miseries for any reason*, substances can be a welcome escape.") (emphasis added).

[94] "Virtually no one thinks it is reasonable to initiate criminal prosecution of patients with cancer or AIDS who use marijuana on the advice of their physicians to help them through conventional medical treatment for their disease." George J. Annas, *Reefer Madness—The Federal Response to California's Medical-Marijuana Law*, 337 NEW ENG. J. MED. 435, 436 (1997).

[95] Chambers, *supra* note 83, at 71. *See also* Khantzian et al, *Psychodynamics*, *in* SUBSTANCE ABUSE, supra note 6, at 97, 98–100; EDGAR P. NACE & JOYCE A. TINSLEY, PATIENTS WITH SUBSTANCE ABUSE PROBLEMS 180 (2007).

[96] *See* Khantzian, *supra* note 1, at 231. *See generally* Edward Khantzian, *The Self-Medication Hypothesis of Addictive Disorders: Focus on Heroin and Cocaine Dependence*, 142 AM. J. PSYCHIATRY 1259 (1985).

[97] Khantzian, *supra* note 1, at 231.

[98] *Id*.

[99] *Id*. Moreover, these patients are not "simply seeking escape, euphoria, or self-destruction." Khantzian, *supra* note 96, at 1263.

successful way to relieve psychiatric suffering.[100] However, it is not the mental illness *per se* that the patient self-medicates, but rather a broad range of "subjective symptoms and states of distress" that are often, but not necessarily, a product of a psychiatric illness.[101] The relief is short-term at best, though, and, as discussed below, the attendant complications of drug use can easily outweigh any benefits.[102]

The patient's specific "drug of choice" depends on the psychopharmacological properties of the drug and the agonizing "feelings with which they struggle."[103] Patients often experiment with different types of drugs until they discover one that dulls such painful states.[104] The main appeal of various drugs can be generalized. For example, the calming and normalizing effects of opiates, like heroin, can have a "powerful muting action on the disorganizing and threatening affects of rage and aggression."[105] Central nervous system depressants, like alcohol and benzodiazepines, are poor antidepressants, but they can provide illusory relief by "temporarily soften[ing] rigid defenses and ameliorat[ing] states of isolation and emptiness that predispose to depression."[106] Stimulants, like cocaine, can counteract "deenergiz[ation] and bored[om], and [provide relief] to those who suffer from depression."[107] Additionally, they can "act as augmentors for hypomanic, high-energy individuals as well as persons with atypical bipolar disorder."[108] Paradoxically, stimulants can "calm and counteract hyperactivity, emotional lability, and inattention in persons with attention-deficit/hyperactivity disorder."[109]

It is crucial to understand that the self-medication hypothesis does not imply that substance use is an efficacious method of treating mental illness. Most efforts at self-treatment are "doomed, given the hazards and complications of long-term, unstable drug use."[110] It is also important to recognize that the self-medication hypothesis does not account for all dual

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[100] *See* Khantzian, *supra* note 1, at 231; Khantzian, *supra* note 96, at 1263 ("[A]ddicts discover that the short-term effects of their drugs of choice help them to cope with distressful subjective states and an external reality otherwise experienced as unmanageable or overwhelming.").

[101] Khantzian, *supra* note 1, at 235–36. "For example, the painful affects and subjective states associated with depression could be predominantly anger, sadness, anergy, or agitation, and it is these specific inner states that one self-medicates." *Id*. at 236.

[102] *See generally* Khantzian, *supra* note 96.

[103] *Id*. at 1259.

[104] *See* Khantzian, *supra* note 1, at 232.

[105] Khantzian, *supra* note 96, at 1259. *See also* Khantzian, *supra* note 1, at 232.

[106] Khantzian, *supra* note 1, at 233.

[107] *Id*.

[108] *Id*.

[109] *Id*. *See also* Khantzian, *supra* note 96, at 1263.

[110] Khantzian, *supra* note 96, at 1263.

diagnosis cases. There are four clinical explanations for the development of comorbidity: (1) mental illness that results in substance abuse; (2) substance abuse that causes mental illness (e.g., rebound depression from cocaine, psychoses induced by amphetamine); (3) dual primary diagnosis (i.e., two initially unrelated disorders); and (4) common etiology (e.g., the possible hereditary link between alcoholism and affective disorders).[111] The self-medication hypothesis is consistent with the first theory. It should be noted, however, that no matter the etiology, the relationship between mental illness and substance abuse is likely transactional in nature: "once the two disorders emerge, each will influence the other, leading to a spiraling effect for both disorders."[112] Moreover, there is substantial evidence that for many cases, mental illness precedes substance abuse.[113]

In sum, the self-medication hypothesis explains that many cases of comorbidity occur when the afflicted individuals use drugs to cope with the pain of their illness. Whether it is ever appropriate for society to allow patients to continue using illicit drugs depends largely upon the nature and incidence of treatment-resistant mental illness.

D. Treatment-Resistant Mental Illness

Psychopharmacology has made great advances in the past several decades; however, some instances of mental illness remain refractory to medication or other therapeutic interventions.[114] Treatment-resistance is defined broadly as the failure of patients to respond to particular therapies that are generally expected to be successful.[115] Recent statistics on the

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[111] *See* Anthony F. Lehman, C. Patrick Myers & Eric Corty, *Assessment and Classification of Patients with Psychiatric and Substance Abuse Syndromes*, HOSP. & COMMUNITY PSYCHIATRY (Oct. 1989), *reprinted in* 51 PSYCHIATRIC SERVICES 1119, 1121–23 (2000) *available at* http://ps.psychiatryonline.org/cgi/reprint/51/9/1119.

[112] Neighbors, *supra* note 80, at 384.

[113] *See* Khantzian, *supra* note 1, at 236 ("[Some] investigations provide evidence of high lifetime prevalence rates of psychopathology in patients with a substance use disorder and a psychiatric disorder preceding the substance abuse.") (citations omitted); Khantzian, *supra* note 96, at 1263 ("Clearly, there are other determinants of addiction, but I believe a self-medication motive is one of the more compelling reasons for overuse of and dependency on drugs."). Note, however, "drug and alcohol abuse occurs before the onset of psychosis and neuroleptic treatment in 14 to 69% of cases of schizophrenia," but "it is difficult to distinguish the initiation of drug use from the onset of prodromal symptoms." Chambers, *supra* note 83, at 72 (citations omitted).

[114] *See* Keith Rasmussen et al., *Electroconvulsive Therapy and Newer Modalities for the Treatment of Medication-Refractory Mental Illness*, 77 MAYO CLINIC PROC. 552, 552, 555 (2002) *available at* www.mayoclinicproceedings.com/content/77/6/552.lonb ("Severe mental illnesses often remain chronic and refractory to medication, leading to substantial morbidity and mortality.").

[115] *See* NANCY C. ANDREASEN & DONALD W. BLACK, INTRODUCTORY TEXTBOOK OF PSYCHIATRY 592 (4th ed. 2006). *See also* B. B. Sheitman & J. A. Lieberman, *The Natural History and Pathophysiology of Treatment Resistant Schizophrenia*, 32 J. PSYCHIATRIC RES. 143, 143–44 (1998), *available at* http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T8T-3VVTN92-5&_user=669286&_coverDate=05%2F01%2F1998&_rdoc=1&_fmt=high&_orig=search&_origin=sea

prevalence of treatment-resistant mental illness are not readily available. Yet, research from the 1970s to the 1990s indicates that there was a general consensus that 5 to 25 percent of schizophrenics were partially or completely unresponsive to antipsychotic drug therapy.[116]

A binary definition of treatment-resistance, such as whether the medication is successful or unsuccessful in alleviating symptoms, is insufficient to the extent that it does not capture fully the reality of mental illness or treatment. Specifically, a robust definition of treatment-resistance would acknowledge whether *any* orthodox treatments are successful, the partial responsiveness of many disorders to many medications, the range of illness severity, and the fact that many mentally ill patients still have some suffering and disability even once they have been successfully treated.[117] Accordingly, some academics have argued that a continuum of responsiveness-refractoriness to medication is the most appropriate way to conceptualize treatment-resistance in mental illness.[118]

Before addressing the alternatives to traditional therapies for patients with treatment-resistant mental illness, it is important to examine briefly the severity of the problem caused by treatment-resistant mental illness. In cases of more severe mental illness, "[s]uicide attempts, suicidal ideation, self-mutilation, and other self-destructive phenomena are a serious source of concern."[119] Moreover, many of these patients' illnesses are resistant to treatment, "including chronic or recurrent depressive disorders and personality disorders, especially borderline personality disorder. . . ."[120] As shown in one study, while aggressive treatment can lead to improvement (85 percent of patients), there is still a substantial fraction that do not

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rch&_sort=d&_docanchor=&view=c&_acct=C000036298&_version=1&_urlVersion=0&_userid=669286&md5=fee8b4bf5f35d7bccb6aae3d0c3e10b6&searchtype=a. Therefore the term "treatment resistance," as used in this paper, does not mean the refusal of patients to take the prescribed course of medications.

[116] Hans D. Brenner et al., *Defining Treatment Refractoriness in Schizophrenia*, 16 SCHIZOPHRENIA BULL. 551, 551 (1990) *available at* http://schizophreniabulletin.oxfordjournals.org/content/vol16/ issue4/index.dtl. Given subsequent advances in neuroleptics, however, these statistics should be taken with a grain of salt.

[117] Sheitman & Lieberman, *supra* note 115, at 144. ("[A] definition of treatment resistant schizophrenia that dichotomizes patients into those who are fully remitted versus those with persistent symptoms not alleviated by antipsychotic medication, would not be adequate."). *See also* Herbert Y. Meltzer, *Commentary: Defining Treatment Refractoriness in Schizophrenia*, 16 SCHIZOPHRENIA BULL. 563, 563 (1990) ("[A] more liberal definition [of treatment refractoriness] should be considered to better appreciate the limitations of current therapies . . . ."). *See generally* Brenner et al., *supra* note 116.

[118] Sheitman & Lieberman, *supra* note 115, at 144.

[119] Christopher J. Perry et al., *Improvement and Recovery From Suicidal and Self-Destructive Phenomena in Treatment-Refractory Disorders*, 197 J. NERVOUS & MENTAL DISEASE 28, 28 (2009), *available at* http://journals.lww.com/jonmd/Abstract/2009/01000/Improvement_and_Recovery_From_Suicidal_and.6.aspx (follow "view this article on OvidSP" hyperlink).

[120] *Id*.

improve (15 percent).[121] Generalizing these results, it is clear that even with psychiatry's best efforts, there is still a number of mentally ill individuals who cannot obtain relief from profoundly devastating symptoms.

In extreme cases, some psychiatrists have resorted to less traditional methods in an effort to help treatment resistant patients. Doctors and patients have used drastic "last resort" treatments to try to alleviate suffering from treatment resistant mental illness. More well-known examples include psychosurgery and electroconvulsive therapy (ECT).[122] Unfortunately, but logically, recommendations for the care of treatment-resistant mental illness cannot be guided by a strong evidence base and often rely on "open studies and case series, and on expert opinion."[123] Less well-known examples of *ultima ratio* treatment include experimentation with illicit drugs, in particular psilocybin ("magic mushrooms"), 3,4-methylenedioxymethamphetamine (MDMA or "ecstacy"), and lysergic acid diethylamide-25 (LSD or "acid"). Psychiatric research on psychedelics is not a new phenomenon—in the 1960s, there was substantial interest in the possible clinical applications of these types of drugs, but research died off due to a variety of factors.[124] There has been a recent revival of interest in researching whether some of these illicit drugs

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[121] *Id*. at 33.

[122] Georg Juckel et al., *Psychosurgery and Deep Brain Stimulation as* Ultima Ratio *Treatment for Refractory Depression*, 259 EUR. ARCHIVES PSYCHIATRY & CLINICAL NEUROSCIENCE 1, 1–2 (2009*), available at* http://www.springerlink.com/content/u622n79682543005/fulltext.pdf. "For decades, the most severe, protracted and therapy-resistant forms of major depression have compelled clinicians and researchers to look for last resort treatment." *Id*. at 1. "The past decade, however, has witnessed the resurgence of surgical strategies as a result of refined techniques and advances such as high frequency stimulation of deep brain nuclei." *Id*. *See also* Rasmussen et al., *supra* note 114, at 555 (discussing less invasive methods of neuropsychiatric treatments using brain stimulation); Thomas A. Mellman et al., *Evidence-Based Pharmacologic Treatment for People with Severe Mental Illness: A Focus on Guidelines and Algorithms*, 52 PSYCHIATRIC SERV'S 619, 622 (2001), *available at* http://ps.psychiatryonline.org/cgi/reprint/52/5/619 (select "Begin Manual Download") (discussing combination drug therapy for severe mental disorders).

[123] Mellman, *supra* note 122, at 622. After all, if the alternative therapy were an evidence-based next-best practice, then the illness would not be considered altogether treatment-resistant.

[124] "By the early 1960s more than 1,000 studies on LSD and other hallucinogens discussing the experiences of 40,000 patients had been published in reputable medical journals." Linda Marsa, *Acid Test*, DISCOVER, June 16, 2008, 52, 55. But a "[l]ack of scientific standards in many of the early studies" rendered their results somewhat useless. *Id*. Furthermore, drugs like LSD

> became a symbol of the dark side of the '60s counterculture. Unhinged people on bad acid trips who had taken bootleg or adulterated street drugs began showing up in emergency rooms in the throes of severe panic attacks or psychotic breakdowns. Psychedelics, and LSD in particular, were held responsible for suicides, permanent brain damage, and cult thrill killings. In response to the hysteria . . . by 1972 legitimate scientific research [using LSD] had ground to a halt.

Id. at 55.

have any useful medicinal properties.[125] This research has not been relegated to fringe psychiatry, either. Indeed, prominent institutions and researchers, including groups at UCLA and Johns Hopkins, have been at the forefront of this renaissance.[126]

Two anecdotes from a recent UCLA study on the effects of psilocybin on treatment resistant anxiety disorders are helpful in illustrating the research interest in these drugs. One patient, a fifty-four year old neuropsychologist with ovarian cancer, was afflicted by "obsessive thoughts that [she] would suffer horribly while going through the dying process."[127] But after the psilocybin sessions, her despair evaporated:[128]

> She was able to come to terms with her eventual death, concentrate on all the joy in her life, and stop ruminating about all the awful things that might happen in the future. The drug's influence endured for about six months.[129]

Another participant in the study, a thirty-seven year old man with metastatic colon cancer, was plagued by intense anxiety that was ameliorated by administration of psilocybin.[130]

There is a wide variety of current research regarding hallucinogens and mental illness. For instance, a group in Switzerland is exploring the

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[125] "[A]fter a four-decade hiatus, psychedelic research is undergoing a quiet renaissance. . . ." *Id*. at 53. Scientists are revisiting the powerful mind-altering drugs of the 1960s in hopes of making them part of our therapeutic arsenal. Hallucinogens such as psilocybin, MDMA (better known as Ecstasy), and the most controversial of them all, LSD, are being tested as treatments for maladies that modern medicine has done little to assuage, such as post-traumatic stress disorder, drug dependency, obsessive-compulsive disorder, cluster headaches, and the emotional suffering of people with a terminal illness. *Id*. at 53–54.

[126] Research into the therapeutic potentials reemerged in 2006 when a study was conducted at Johns Hopkins "using psilocybin in 36 health adults. . . ." *Id*. at 56. "Especially significant was the experiment's rigorous design, which proved that this type of research can be safely done under scientifically standardized conditions." *Id*. Note well, however, that researchers stress the importance of not interpreting their research as a green light for recreational drug use. *Id*. at 57.

[127] *Id*, at 57.

[128] *Id*.

[129] *Id*.

[130] Marsa, *supra* note 124, at 52.

> Other early test results are equally encouraging. University of Arizona scientists recently fed psilocybin to nine volunteers whose obsessive-compulsive disorder (OCD) was so disabling that many could not hold down a job or leave the house; they would observe elaborate cleaning rituals or shower for hours until they felt comfortable. Conventional treatments such as psychotherapy and medication had failed. In each of the nine patients in the study, psilocybin drastically diminished or melted away their compulsions for up to 24 hours, and several remained symptom-free for days.

Id. at 54.

potential therapeutic properties of LSD on the "intense anxiety experienced by patients with life-threatening disease."[131] Similarly, researchers at the University of California, Berkeley are investigating the "changes in neural activity" accompanying use of [LSD].[132]

Another group is testing the effects of MDMA "on people suffering from severe post-traumatic stress disorder (PTSD), including rape victims and Iraq War veterans who have not gotten any relief from conventional treatments such as antidepressants and therapy."[133] Most participants in this study have "experienced statistically significant reductions in the severity of their condition after two months, compared with a control group."[134] The researchers hypothesize that MDMA's therapeutic mechanism of action lies in its ability to help the patient open up and participate meaningfully in psychotherapy.[135] Again, however, it must be emphasized that these drugs are not to be handed out freely to people suffering from mental illness—rather, precautions must be taken and researchers stress the need for the drugs to be administered in a controlled, clinical setting.[136]

E. Perils of Substance Use

Drug addiction is devastating. It wreaks havoc on the lives of addicts, their families, their friends, and countless others. It causes unimaginable suffering and kills many users.[137] Therefore, when contemplating highly controlled and limited socially approved uses for some of these drugs, it

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[131] Gary Stix, *LSD Returns—For Psychotherapeutics*, SCIENTIFIC AMERICAN, September 24, 2009, *available at* http://www.scientificamerican.com/article.cfm?id=return-of-a-problem-child.

[132] *Id*.

[133] Marsa, *supra* note 124, at 54.

> The symptoms of PTSD usually strike within three months of a person being involved in a disturbing event, such as sexual assault, torture, warfare, or witnessing a severe accident. The condition can lead suffers to become withdrawn, depressed and unable to function because of powerful flashbacks that repeatedly expose the victim to the debilitating emotions of the original event.

Arran Frood, *Illegal Drug Shows Promise in Treating Trauma Symptoms*, NATURE (November 13, 2008), http://www.nature.com/news/2008/081113/full/news.2008.1229.html. "[U]p to 20% of patients do not respond to any conventional treatments." *Id*.

[134] *Id*.

[135] It is theorized "that MDMA tends to decrease levels of fear and defensiveness and increase levels of trust when used in a clinical setting. 'It can remove some of the obstacles in therapy and act as a catalyst to the therapeutic process,' [the study's main author said]." *Id*.

[136] "Taken in haste, without proper regard for their effects and in chaotic conditions, the effects can be really awful and frightening." Marsa, *supra* note 124 (internal quotations omitted).

[137] Peter A. Clark, *The Ethics of Medical Marijuana: Government Restrictions vs. Medical Necessity*, 21 J. PUB. HEALTH POL'Y 40, 54 (2000) ("The fight against drug abuse is important because many lives are lost to drug addiction.").

must be done with an awareness of the harm these drugs can cause.

There are a panoply of drug-related harms, but, for the purposes of brevity, it is adequately instructive to look briefly at an academic view of the harmfulness of addiction, subjective accounts of addiction, and statistics on drug addiction.[138] First, the clinical description is characterized by the intense cravings and dysphoria that the addict suffers. In between spells of drug use, the addict often "experiences a build up of tension, irritation, anxiety, boredom, depression, or other dysphoric states."[139] These symptoms become "more persistent, more intense, and more demanding" the longer the addict persists without using the drug.[140] The craving for the drug is explained as "sheer desire" or "sheer wanting."[141] The addict can think virtually of nothing else except the drug; this addiction is akin to an extreme version of dehydration or starvation.[142]

Second, accounts of the miseries of drug addiction are found throughout our popular culture. One anti-drug program, the Montana Meth Project, shows documentary-like television commercials depicting the horrors of methamphetamine addiction.[143] Other accounts are more personal. Addicts have written memoirs about the grim realities they have faced. One recovered addict recalls a typical experience:

> Drugs clutched in my fist, I ran to a Shell gas station on Park Avenue in Newark and locked myself in the filthy bathroom—piss and dirt all over the floor, toilet stopped up and overflowing, a broken mirror and something smeared across the wall that I didn't even want to identify.
>
> I shot up as fast as I could and the dope knocked me out so quickly, all I could do was sink down onto the floor and lie there, the needle still sticking out of my arm as I fell asleep, my face resting in a cold puddle of sludge, a foul-smelling mixture of bodily fluids and the dirt from other people's shoes.

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[138] For a detailed taxonomy of drug-related harms, see MACCOUN & REUTER, *supra* note 8, at 106–07. Categories of harm include health, social and economic functioning, safety and public order, and criminal justice. *Id*. Risk-bearers include users, dealers, society, families, and others. *Id*. Moreover, the source of drug-related harms varies, but can generally be categorized as either stemming from drug use itself, law enforcement, or the illegal status of the drug. *Id*.

[139] Morse, *supra* note 3, at 39.

[140] *Id*.

[141] *Id*.

[142] *Id*.

[143] MONTANA METH PROJECT, http://www.montanameth.org/View_Ads/index.php (last visited Jan. 10, 2010).

> A guy who lived like that should be in the ground. And yet, here I am, telling this story of how I escaped such a horrible fate.[144]

Another book, written by Beverly Conyers, a mother whose daughter was an addict, relates descriptions of addiction:

> John, a recovering crack addict whose grown children were fighting their own battles with addiction, described how hard quitting for good had been for him thirteen years earlier: "Their mother, my wife, had walked out on us, and I knew I was in danger of losing my kids if I didn't get clean. I was in danger of losing my kids if I didn't get clean. I was scared and motivated to stop using. I can't tell you how many times I'd get off work and tell myself, 'I'm not going to use. I'm not going to use.' Then I'd call my dealer and drive over to his housing thinking, 'I'm not going to use.' I'd give him the money for the stuff, cook it up, and put it in the pipe, all the time telling myself, 'I'm not going to use.' Then I'd light it up [and] smoke it . . . . My daughter described a similar feeling one night, crying, "Sometimes I feel like there's a beast inside me."[145]

Death even fails to deter many addicts. Conyers writes further:

> [M]y daughter described attending the funeral of a heroin addict who had died of an overdose. I asked if seeing the effects of heroin had frightened her into wanting to get clean. She calmly replied, "Mom, when addicts hear that someone has OD'd, they think, 'That must have been good stuff. Where can I get some?'"[146]

Conyers continues:

> Another addict, who OD'd many times, described [an] incident: "My friends had shot me full of salt water, because that's supposed to bring you back, but it didn't. So they called 911. The EMTs were working on me when

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[144] STEPHEN J. DELLA VALLE, RISING ABOVE THE INFLUENCE 217 (2008).

[145] BEVERLY CONYERS, ADDICT IN THE FAMILY 39 (2003).

[146] *Id*. at 52.

> I came to. I thought, 'No, no.' They were wrecking my high, and I wanted them to leave me alone. They took me to the hospital anyway."[147]

Finally, data on drug addiction paints a dark picture. According to the founder of the National Center on Addiction and Substance Abuse (CASA) at Columbia University, Americans account for 4 percent of the world's population but consume more than two-thirds of the planet's illicit drugs.[148] The suffering that this drug use causes is hard to quantify. Some figures are available, however. One study estimates the number of annual drug-related deaths at just under 40,000.[149]

Juxtaposing the death tolls and personal accounts of struggles with drug addiction with the information laid out above regarding treatment-resistant mental illness, it is clear that any attempt to change policies regarding either topic should be done with great caution. But it is equally clear that such changes should be contemplated. Even though addiction is terrible, controlled use of illegal drugs may be a last chance at peace for some people with treatment resistant illness.

III. A POTENTIAL SOLUTION

What should we do with people suffering from severe mental illness who have not responded to conventional treatments? Should we prevent them from using drugs that *may* provide some palliative relief? If we decide to allow them to use these drugs, how should such a system operate? One possibility is to partially decriminalize certain drugs by bringing them under the auspices of physician prescription authority (e.g., California's medical marijuana regime). Another possibility is to provide an excuse defense in the criminal law. Conceptually, this defense would be akin to duress, based upon the notion that a person could be "compelled" by the suffering caused by his or her mental illness to initiate drug abuse. A third option may be to rely on drug courts.

When considering various legal frameworks for allowing limited access to drugs for people suffering from treatment-resistant mental illness, there are a host of questions of which to be cognizant. Will allowing such access hurt society in general? Will this hurt mentally ill people more than

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[147] *Id*. at 53 ("Those experiences didn't stop any of these addicts from continuing their drug use. Their addicted brains had ceased to be tools for survival and had become instruments of pleasure—at any cost.").

[148] CALIFANO, *supra* note 7, at 9. Addiction is "Public Health Enemy Number One" according to Califano. *Id*. at 5.

[149] Melonie Heron et al., *Deaths: Final Data for 2006*, 57 NAT'L VITAL STAT. REP., 1, 11, 93 (April 17, 2009), *available at* http://www.cdc.gov/nchs/products/nvsr.htm#vol57.

it helps them? How could we even distinguish who should be eligible to use these drugs (i.e., identify cases of treatment-resistant illnesses)? Why only focus on suffering from treatment-resistant mental illness—why not make an exception for any treatment-resistant disease?[150] Has not society already faced and answered many of these questions in the context of experimental drugs (not approved by the Food and Drug Administration (FDA)) and terminally ill patients? It is with these concerns in mind that the following proposal is put forward.

A. An Analgesic Exception

Our legal system should carve out an exception to the current drug laws to allow severely ill people access to drugs, without which they would suffer immensely. Structured properly, such an exception would comply with the tenets of palliative medicine and still protect other vital social concerns. As a preliminary matter, before outlining a possible legal scheme, such an analgesic exception must be situated within the confines of medical ethics, particularly those of palliative medicine (which deals with alleviating pain or other problems without dealing with the underlying cause).

Palliative care has been defined as "the active total care of patients whose disease is not responsive to curative treatment."[151] Its goal is the best quality of life for patients and their families, which is achieved by controlling pain and other symptoms, as well as addressing psychological, social, and spiritual problems.[152] Among the paramount principles of palliative care are the affirmation of life, the acknowledgement of death as a normal process, and the directive to "neither hasten nor postpone[] death."[153] It should be noted that even though palliative care originated and is most commonly associated with hospice care, palliative medicine "does not equate with care at the end of life."[154] Moreover, physical pain relief is only one aspect of a holistic approach to pain management, which

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[150] There is no theoretical rationale to make such a distinction, but there may be some practical reasons. For instance, police are not as likely to arrest people with cancer who are using illegal drugs (i.e., society tacitly approves of illicit drug use for 'normal' diseases). Also, co-occurring mental illness and substance abuse is a common feature in drug courts and the criminal justice system in general.

[151] Bill O'Neill & Marie Fallon, *ABC of Palliative Care: Principles of Palliative Care and Pain Control*, 315 BRIT. MED. J. 801, 801 (1997). It has also been defined as "the study and management of patients with active, progressive, far-advanced disease, for whom the prognosis is limited and the focus of care is the quality of life." *Id*.

[152] *Id*.

[153] *Id*. Other tenets include providing "relief from pain and other distressing symptoms," offering "a support system to help patients live as actively as possible until death," and offering "a support system to help patients' families cope." *Id*.

[154] *Id*. at 801–02.

includes "psychological, social, and spiritual aspects of suffering."[155] As for appropriate medication for responding to pain, the general dictum is that the chosen analgesic should be based on the severity of the suffering.[156] Moreover, adjuvant medications—"drug[s] whose primary indication is other than pain but which has an analgesic effect in some painful conditions"—are prescribed regularly to patients.[157] Essentially, the principles of palliative medicine do not forbid the use of illicit drugs *per se*. As long as there is a net positive effect, defined broadly, for the patient, no substantial indirect harms, and a solid empirical basis, medical ethics point toward allowing the use of illicit drugs.

1. Goals

The overall structure of drug policy should, for the most part, retain its current form. There should be a general prohibition on most drugs. The criminal justice system should emphasize rehabilitation over retribution and handle most addicts by processing them through drug courts. However, in drug court programs there should be an exception to mandating abstinence for treatment refractory mentally ill addict-offenders. The goal behind this exception is to reduce total harm.[158]

2. Proposed Rule

The exception to mandatory abstinence should only be for severe mental illness. It is difficult to provide bright-line rules for what counts as a severe mental illness and what does not, but it is possible to sketch the contours of a good definition. Severe mental illness should include "psychotic disorders, mood disorders, and certain anxiety disorders—panic disorder, posttraumatic stress disorder, and obsessive-compulsive disorder."[159] The "substantial impairment and chronicity" related to these

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[155] *Id*. at 802.

[156] *Id*. at 802. Powerful medications with high addictive potentials are no strangers to palliative care; in fact, morphine, a Schedule II narcotic, is the mainstay of palliative care. "Morphine is the most commonly used strong opioid analgesic." *Id*. at 803. Morphine is a Schedule II narcotic under the Controlled Substances Act, meaning that (1) "[t]he drug or other substance has a high potential for abuse," (2) "[t]he drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions," and (3) "[a]buse of the drug or other substances may lead to severe psychological or physical dependence." 21 U.S.C. § 812(b)(2) (2006).

[157] O'Neill & Fallon, *supra* note 151, at 802–03.

[158] See generally DRUG ADDICTION AND DRUG POLICY, *supra* note 67 for discussions on harm reduction theory and other ways to critically analyze drug policies. *See also* HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS (G. Alan Marlatt ed., 1998); Alex Wodak, *The Harm Reduction Approach to Prevention and Treatment*, *in* PRINCIPLES OF ADDICTION MEDICINE *supra* note 80, at 423, 423–32; Ernest Drucker et al., *Harm Reduction: Pragmatic Drug Policies for Public Health and Safety*, *in* SUBSTANCE ABUSE, *supra* note 6, at 1229, 1229–45.

[159] Mellman, *supra* note 122, at 620.

diseases ensures that the population eligible for such an exception remains relatively small (as opposed to allowing a more expansive exception for less grave diseases and neuroses).[160] Moreover, given the perils of these drugs, the exception should only be available to those suffering from more grievous psychiatric illnesses. Furthermore, the exception should only be available to the subset of the severely mentally ill population that is treatment-refractory. Stated as succinctly as possible, drug court participants who are suffering from treatment-resistant severe mental illness should not be ordered or forced to stop using illicit drugs with palliative potential.

B. Implementation via Modified Drug Courts

Creating an analgesic exception via changes to drug courts—as opposed to partial decriminalization or an affirmative defense—may be desirable because of its comparative political practicality and the advantages of a judicial-led determination process (in contrast to a physician-led one, like in partial decriminalization schemes). These possible advantages will be discussed in greater detail, below. A more immediate reason for discussing an analgesic exception in the context of drug courts is that drug courts frequently deal with dual diagnosis offenders.[161] And, even if such an exception is not adopted, drug courts should be *aware*, at the very least, of dual diagnosis, treatment-resistant mental illness, and the self-medication hypothesis.[162]

1. Eligibility

For a drug court participant to qualify for the exception, the participant (1) must be severely mentally ill, (2) suffer from treatment-resistant mental illness and (3) the addiction must be connected the mental illness—in the sense that the patient's drug of choice assuages some of their psychiatric suffering. There would, of course, be many practical difficulties in making such a determination. Medical or psychological professionals would need to testify as to all three prongs. Moreover, the second and third prongs may be particularly difficult to determine. First, there is no commonly accepted medical definition for what constitutes a treatment-resistant mental illness. Furthermore, whether a particular drug has palliative

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[160] *See id*.

[161] "[D]rug court clients have been reported to have a high prevalence of histories of physical and sexual abuse, and of suicidal ideation as well as suicide attempts." Belenko, *supra* note 75, at 21.

[162] "The findings from several evaluations that drug court clients have high rates of mental health problems suggest that programs need to consider inclusion of services for co-occurring disorders." *Id*.. at 54. "Despite their popularity among the public, policy makers, and legal practitioners, little is known about how drug courts, especially juvenile drug courts, address the needs of dually diagnosed offenders in actuality." Paik, *supra* note 11, at 570.

effects is not only arguable amongst clinicians, but much of such a determination would likely rest on the specific experience that the drug court participant has had with his or her drug(s) of choice.

Another difficulty in making such a determination is that all three prongs of the test depend upon an examination of the subjective experiences of the drug court participant. This requires investigating (1) the amount of pain from which the defendant suffers, (2) the defendant's lack of relief from conventional treatments, and (3) the amount of relief provided by the drug of choice. While these three issues are all extremely subjective, the law is no stranger to making inquiries as to the inner workings of the human mind (a prime example being *mens rea*).

An additional problem that an eligibility determination for an analgesic exception poses is the issue of malingerers: i.e., participants faking or exaggerating illness or treatment-resistance in order to continue using their drug of choice.[163] A careful examination by the judge and medical experts should enable the court to differentiate between malingerers and participants that truly need the exception. For example, it is possible for psychiatrists to distinguish true cases of self-medication from mere rationalization through periods of abstinence and the development of a more trusting and solid treatment relationship.[164]

2. Disposition

What should the outcome be if the drug court participant is eligible for the analgesic exception? In other words, what should happen to participants who are not ordered to abstain from their drug use? Ideally, the underlying charges should be dismissed upon completion of a probation-type program that monitors and attempts to prevent antisocial behavior.[165] In effect, this type of disposition would "allow" palliative use of drugs by not punishing/incarcerating individuals with treatment resistant mental illness.

Of course, without further drug policy changes, drug use will remain illegal. But, conceptually, even if an individual with a treatment-resistant mental illness was prosecuted on drug charges again, he or she would end up in the same drug court program with the same probation-type disposition. So, in the end, this rule would be a *de facto* allowance of drug

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[163] One study "of a program for dually diagnosed clients [found that] clients attributed their 'bad' behaviors to their schizophrenia to absolve themselves of a responsibility that their 'drug addicted' selves should have been able to assume." Paik, *supra* note 11, at 572. "It is not unlikely that patients try to make sense out of their addiction by claiming to self-medicate their unhappiness or affect dysregulation when in fact they use such explanations to explain, resist, or rationalize their addiction." Khantzian, *supra* note 1, at 233.

[164] *See* Khantzian, *supra* note 1, at 233.

[165] For these purposes, the definition of "antisocial behavior" does not include drug use.

use for a very particular reason (relief for sufferers of treatment-refractory psychiatric illness). Additionally, this approach—i.e., a court-ordered and monitored probation-type program—would address public-safety concerns (e.g., violence, theft, or other criminal behaviors). If the individual were to violate the terms of their probation, he or she would be subject to penalties and/or prosecution.

3. Collateral Issues

One clear downside to trying to implement an analgesic exception solely through drug courts is that many other problems would not be addressed. Foremost among these problems is that the only way to procure these drugs would be through the black market, which carries with it a host of dangers, including purity issues and gang violence. Another concern is how these severely mentally ill individuals would be able to afford the drugs this exception would allow them to access. After all, it is likely that many of these individuals would have become involved in the criminal justice system in the first place because of theft-type crimes committed to obtain money for drugs. An analgesic exception set up strictly through and by drug courts would not be able to consider any sort of government subsidization or provision, e.g., similar to methadone programs.[166] In sum, while it might be possible for drug courts to implement an analgesic exception, it would be optimal to do so with legislative involvement.

IV. DISCUSSION AND CRITICISM

Given the immense complexity of mental illness, drug addiction, and the criminal justice system, it is impossible to address even a majority of the potential problems and concerns an analgesic exception would pose. There is no shortage of hard questions: Is this proposal basically giving up on the profoundly mentally ill? Is this proposal tantamount to assisting suicide? What about contraindications and drug interactions with regular psychiatric drugs? For the purposes of beginning a discussion of the plethora of issues surrounding an analgesic exception, however, this Article will attempt to explore some of the more pressing and obvious problems and concerns. The two key questions that will be addressed in this section are: (1) whether illicit drugs can have a net beneficial effect when considering not only the individual suffering from treatment-resistant mental illness but society as a whole, and (2) whether implementing an analgesic exception via drug courts can offer any benefits compared to more intuitive options such as an excuse defense or partial decriminalization.

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[166] *See generally* Joycelyn Woods et al., *A New Era for Methadone Advocacy*, *in* SUBSTANCE ABUSE, *supra* note 6, at 1325, 1325–30.

A. Efficacy of Illicit Drugs?

How much do illicit drugs help?[167] This is an inherently empirical question, but the fact that individuals do self-medicate and the preliminary results of research outlined above suggest that illicit drugs can generate some relief. How much do the drugs hurt the patients? How much do the drugs hurt society? How much of this harm is a collateral consequence of our current drug policy? Again, these are largely empirical questions but some answers can still be put forward.

The first reaction many people might have to an analgesic exception is to reject the idea, claiming that illicit drugs do not have therapeutic value. After all, they might argue, the Controlled Substances Act defines Schedule I narcotics as having no medical benefit.[168] However, this is not necessarily true. For instance, consider two common answers to criticism of the self-medication hypothesis based on the notion that becoming addicted to drugs "causes as much or more distress than it relieves."[169] First, it is argued that patients who self-medicate "are willing to accept such distress in exchange for whatever momentary relief they experience with their drug of choice."[170] Second, it is theorized that patients self-medicate in order to *control* their feelings—or experience suppressed feelings—rather than alleviate pain in a more strict sense.[171] Moreover, in the case of treatment resistant mental illness, it may not even be true that the addiction is causing more distress. The patient may be suffering so greatly that any harms that accompany addiction simply do not register in comparison to their preexisting psychic pain.

In addition, drugs like marijuana and opium have been shown to alleviate physical and mental pain—even though they also cause harm.[172] Alcohol and other drugs do have some mitigating effects on anxiety,

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[167] *See* Clark, *supra* note 137, at 40 ("The major criticism of these alternative therapies is that they have not been scientifically tested; therefore, their safety and efficacy has been called into question.").

[168] *See* 21 U.S.C. § 812(b)(1)(B) (classifying Schedule I substances as having "no currently accepted medical use in treatment in the United States").

[169] Khantzian, *supra* note 1, at 233.

[170] *Id*. at 235.

[171] *See id*.

[172] Peter J. Cohen, *Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology*. *Part One of Two*, 23 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 4, 5 (2009).

> Opioids have significant addiction liability, and even a small dose causes measurable respiratory depression, whereas larger doses are capable of producing respiratory arrest and death. Even so, their undisputed capability to relieve pain is thought to far outweigh these risks. Consequently, opium and its derivatives are a legal mainstay in today's medical practice.

Id. (footnotes omitted).

although the evidence of these effects is mixed.[173] More importantly, however, there have been several studies that suggest some patients perceive self-medication of anxiety by alcohol and other drugs to be somewhat effective.[174] In addition, many drugs of abuse, such as morphine and tranquilizers like diazepam, "play a significant role in legitimate medical practice."[175] It is simplistic, but it bears repeating that just because a drug/medication has a high addictive potential or other deleterious side effects does not mean it is without therapeutic value. After all, "physicians are often confronted with the problem of making not the *best* choice but the *least worst* choice."[176]

Even though there is evidence of certain drugs having some therapeutic value or properties, there is a great deal of evidence that these drugs exacerbate mental illness. For self-medication of anxiety with alcohol or other drugs, "many patients are probably not sufficiently aware of the negative consequences [of their actions]."[177] Specifically, a patient's overall condition "usually deteriorates rather than improves (e.g. associated depression)."[178] In the case of schizophrenia, many reports of symptom improvement attributed to drug use "are contradictory to concurrent objective clinical observations that clearly show symptom exacerbation."[179] In general, self-medication "greatly increases the likelihood of rehospitalization, length of hospitalization, [and] need for greater neuroleptic dosage . . . in schizophrenic patients."[180] While all of this evidence may be generally true, it should be reemphasized that the analgesic exception would only apply to individuals with treatment refractory mental illness. It is certain that drug use is a terrible idea for patients who respond to conventional medications, but if nothing else is working, any relief is better than no relief.

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[173] *See* Brian J. Cox et al., *Substance Abuse and Panic-Related Anxiety: A Critical Review*, 28 BEHAV. RES. & THERAPY 385, 389–90 (1990). ("CNS depressants such as alcohol effect adrenergic functioning and so are likely to reduce anxiety to some extent (if only temporarily).").

[174] *Id*. at 389.

[175] Cohen, *supra* note 172, at 17.

[176] *Id*. at 14.

[177] Cox, *supra* note 173, at 389.

[178] *Id*.

[179] Chambers, *supra* note 83, at 72 (citation omitted). "Heavy substance abusers believe their use to be self-medicating, whereas psychiatric staff note symptomatic exacerbation with use, together likely to contribute to poorer compliance and thus poorer outcome." DeQuardo, *supra* note 80, at 268 (citation omitted).

[180] Chambers, *supra* note 83, at 72.

B. Alternative Legal Responses

As stated above, there are two other legal schemes that could be used to allow treatment resistant mentally ill individuals to use certain drugs. First, there could be an excuse defense that would allow treatment resistant mentally ill defendants to avoid conviction of certain drug-related offenses. Second, there could be a system of partial decriminalization, where the FDA and Drug Enforcement Agency (DEA) could reschedule many of the Schedule I narcotics so that physicians could prescribe the drugs where appropriate. After a pithy description of each option, this Article will discuss whether any of these other alternative drug policies might be better at implementing an analgesic exception than modified drug courts.

1. Defenses—Addiction as an Excuse

In general, very few jurisdictions have accepted medical necessity defenses for drug possession, but academics largely agree that duress is the best legal paradigm with which to construct an addiction defense.[181] Excuse defenses exculpate based on the normative "judgment that the actor could not reasonably have been expected to have done otherwise."[182] Here, the actor would be a treatment resistant mentally ill individual self-medicating with illegal drugs. The defense would excuse a crime like simple possession because of the judgment that the person could not reasonably be expected to forego the drugs because they are the defendant's only source of relief from extreme pain. It is important to note that the excuse defense is not based on the fact that there is a biological cause for addiction (e.g., mental illness); rather, the defense excuse is based on the fact that the situation is one of internal duress (the actor is confronted with a very hard choice, and society will excuse the actor for

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[181] *See, e.g.*, Gary Watson, *Excusing Addiction*, 18 L. & PHIL. 589, 590 (1999); Husak, *supra* note 15, at 663.

> Duress obtains if the agent is coerced to commit a criminal offense by the threat or use of unlawful force of death or grievous bodily harm against the defendant or another and a person of reasonable firmness would have been "unable to resist." In other words, an agent faced with a particularly "hard choice" – commit a crime or be killed or grievously injured – is excused if the choice is too hard to expect the agent to buck up and obey the law.

Morse, *supra* note 3, at 32 (footnote omitted).

Medical necessity is normally viewed as a choice of evils defense, but this distinction is mostly irrelevant. The difference between choice of evils (justification defense) and duress (excuse defense) is that in choice of evils the actor does some harm, but it is the lesser harm so society will not blame him; in duress, the actor does a greater harm, but the pressures on him are such that society finds him blameless. *See* Watson, *supra*, at 604–05.

[182] PAUL H. ROBINSON, CRIMINAL LAW: CASE STUDIES AND CONTROVERSIES 632 (2d ed. 2008).

making the "wrong choice").[183] Moreover, a duress defense for addiction that results from treatment-resistant mental illness satisfies the defense's requirement "that the defendant is not responsible for his coercive predicament."[184]

There are several reasons why drug courts are a better system than an excuse defense for implementing an analgesic exception. First, it is important to monitor these individuals for safety and rehabilitative reasons. If a defendant were successful with an excuse defense, he or she would be completely free. It is critical that the court be able to maintain some control over these individuals so they do not engage in any more antisocial behavior, which would threaten the community as well as the individual's freedom. Second, the less adversarial nature of drug courts lends itself to the quasi-medical eligibility determination of whether a drug court participant falls under the analgesic exception. And third, the expertise of the drug court judge would promote more accurate determinations compared to lay juries or bench-trials, where the decision makers would likely have far less training and experience with addiction and mental health issues.

2. Partial Decriminalization and Regulation

Another way to implement an analgesic exception is to partially decriminalize and highly regulate drugs. There are two main ways this could be accomplished, both requiring substantial legislative involvement. The first method would be to mimic California's medical marijuana policy.[185] An alternative would be to acquire FDA approval for certain drugs (but that might require restructuring of the Controlled Substances Act (CSA) and less politicization of the approval process).[186] Either way, the basic idea would be to put the dispensation power in the hands of doctors; and as long as a treatment-resistant mentally ill individual has a legal prescription, he or she cannot be held criminally liable for possessing prescribed drugs.

Drug courts may be a more practical way to begin implementing an analgesic exception. Partial decriminalization would require heavy legislative involvement. Moreover, FDA approval would be difficult to receive, even for the extremely limited use of these drugs to treat palliatively medication-resistant mental illness. In general, it has been

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[183] "Determinism cannot be guiding our practices. If one wants to excuse addicts because they are genetically determined or determined for any other reason to be addicts, one is committed to negating the possibility of responsibility for anything." Morse, *supra* note 12, at 174.

[184] Watson, *supra* note 181, at 614.

[185] Cohen, *supra* note 172, at 4.

[186] *Id*.

argued that the FDA approval process and the process for rescheduling drugs under the Controlled Substances Act are too politicized.[187] For example, psychiatric research on hallucinogens has been "difficult to get…off the ground."[188]

Another benefit of using drug courts to implement an analgesic exception is that judges would be making eligibility determinations (with reliance on physician and other professional testimony) instead of doctors making the decisions alone. A transparent judicial-run process would be less prone to abuse. For instance, it would prevent doctor shopping, which occurs when an individual goes from doctor to doctor until he or she finds one who will prescribe the desired medication.[189] Moreover, utilizing drug courts instead of partial decriminalization would help address the oft-cited concern about sending a message that drug use is ok (i.e., "save the children").[190] Involvement with the criminal justice system via drug courts would send a very different message than that communicated by a system that only requires a doctor's note or prescription.

However, as noted above, the optimal solution would likely be some form of drug court system combined with partial decriminalization. Regardless of the form an analgesic exception might take, there remains the stark reality that drug policy reform moves at a geological pace. Because of this political truth, it is less important to discuss the possible legal regimes by which an analgesic exception could be made, and far more important to begin discussing the possible need for an analgesic exception in the first place. There are people with severe mental illness who cannot obtain relief from traditional therapies, and this is a matter of which the legal community needs to be aware.

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[187] Marijuana "remains a Schedule I controlled substance 'without currently accepted medical use in treatment in the United States.' This decision was not made by scientific experts but by Congressional legislative fiat." Peter Cohen, *Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology*. *Part Two of Two*, 23 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 120, 127 (2009) (citation omitted).

[188] Marsa, *supra* note 124, at 54.

[189] *See, e.g.*, Susan Okie, *Medical Marijuana and the Supreme Court*, 353 NEW ENG. J. MED. 648, 649 (2005) ("In San Francisco, some journalists or investigators who posed as patients have reported that they had little difficulty obtaining a recommendation for medical marijuana, which allows the holder to purchase the drug from a dispensary.").

[190] *See* Burns, *supra* note 3, at 209, 212 (describing the effect of drugs on the young, and asserting that "drug courts work"); Annas, *supra* note 94, at 436 (contrasting the belief that marijuana is not harmful with the research findings that it is "dangerous to our health"). *Cf.* Marsa, *supra* note 124, at 54 ("Critics worry that this research will legitimize reckless recreational use, especially among impressionable young adults.").

CONCLUSION

Mental suffering can be horrific. In 2006, there were 34,598 suicide deaths, making suicide the eleventh leading cause of death in the United States.[191] Moreover, there are approximately 380,578 attempted suicides annually.[192] When severe mental illness fails to respond to conventional therapies, the law should be humane and allow some of these people relief. If self-medication with illicit drugs is the only way for treatment resistant mentally ill individuals to achieve some peace, then the law should strive to create an exception to current drug policy that allows this without sacrificing other important goals of drug prohibition.

Drug courts and partial decriminalization may be one way to implement such an exception to our current drug laws. Certainly, more discussion, research, and evidence-building must be done.[193] At a minimum, however, drug policy experts and policymakers need to be aware of concepts such as the self-medication hypothesis and treatment-resistant mental illness. Sadly, society tends to follow a general pattern of only treating mentally ill patients so they are "manageable," even if they are still suffering immensely.[194] A humanitarian society should try its hardest to find a drug policy that will be merciful to people with intense and otherwise untreatable suffering.

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[191] *Suicide in the U.S.: Statistics and Prevention*, NAT'L INST. OF MENTAL HEALTH, (Sept. 9, 2010), http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml.

[192] *See id*.

[193] Some critics of the medical marijuana movement have accused proponents of "hiding behind a screen of misplaced (or deliberately misleading) compassion for the ill[.]" Cohen, *supra* note 172, at 4. Obviously, compassion for the ill is the driving force behind this Article's arguments, but a strong empirical foundation is necessary for any sound policy changes. Many of the points made in this Article are speculative and certainly would be affected by new findings from the medical and social sciences.

[194] "In many public sector settings, patients who are considered stable by the treatment team continue to experience disabling symptoms. Because switching medications involves some risk of behavioral deterioration, treatment teams may forgo attempts to treat remaining symptoms in order to maintain the status quo." Mellman, *supra* note 122, at 623.