SHOULD OPIOID USE AND POSSESSION BE SHIFTED FROM THE CRIMINAL JUSTICE SYSTEM TO THE PUBLIC HEALTH SECTOR?

by

David Christopher Gentry

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This thesis for the Master of Criminal Justice and Master of Public Administration degrees by

David Christopher Gentry

has been approved for the

School of Public Affairs

by

Anna E. Kosloski, Chair

Stephanie Bontrager Ryon

Richard Radabaugh

Date
ABSTRACT

Gentry, David Christopher (Master of Criminal Justice and Master of Public Administration)

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Thesis directed by Assistant Professor Anna E. Kosloski

The criminal justice system has historically been the group who is the ‘responsible party’ of those who illegally use and possess opioids. Due to the health implications resulting from using and possessing opioids, this study examines the viewpoint of opioid use and possession from both, the criminal justice and public health perspectives and seeks to establish if the ‘responsible party’ would be better suited to be the public health sector. The examination of these two perspectives was accomplished through interviews conducted by professionals from the criminal justice and public health systems. The goal was to discover what members from these two systems believed to be the most beneficial towards opioid prevention, intervention, and policies. The results indicate that, both, law enforcement officers and drug counselors believe that possession of opioids has been properly labeled as a criminal justice concern. The results further indicate that there are more similarities than disparities between law enforcement officials and drug counselors than previously expected. However, due to the limitations in the amount of data collected in this study, all conclusions reached are strictly exploratory in nature.
DEDICATION

For all those who have supported, motivated, and guided me on this journey called “life,” I cannot thank you enough. To my family, the sacrifices you all have made for me to reach this point in my life are without words. From my professors to my parents, this work is dedicated to you all. Finally, this work is dedicated to those who seek a world in which evidence-based research is the driving force behind U.S. policy decisions.
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CHAPTER I

INTRODUCTION

The opium poppy plant has been grown and harvested for thousands of years for medicinal or recreational use. The opium contained within the poppy plant is the source of well-known natural opiates, such as morphine and heroin. The Drug Policy Alliance (2016) uses the term ‘synthetic opioids’ in reference to non-natural psychoactive substances that provide similar effects as the naturally occurring substance from the opium poppy plant although both, synthetic and natural opiates are used for pain relief and sedation. There are different forms or levels of opiates, with fentanyl being one of the most potent painkillers available and is usually prescribed by a physician when patients have a high tolerance to other prescription opiates, such as oxycodone, hydrocodone, or morphine (“Fact Sheet,” 2016).

In the 19th and early 20th centuries, the federal government was not involved in regulating and enforcing drug use or distribution, and medical and pharmaceutical groups were free to prescribe morphine for pain-management as they felt was necessary (Sacco, 2014). The federal government started to implement the control of drugs in the early 20th century using taxation, which was due to the significant increase in drug abuse across the nation (Sacco, 2014). In 1914, the Harrison Narcotics Act (HNA) was implemented and the Treasury Department perceived patient drug maintenance using cocaine and morphine as outside the scope of the medical field (Sacco, 2014). This resulted in the arrest and prosecution of some physicians and sent these violators to federal prisons (Levinthal, 2012). Physicians began abiding by the HNA and medical prescriptions ceased, which resulted in prior users turning to the illicit drug market (Levinthal, 2012). Ratliff et al.
(2016) can be quoted as stating, “Contrary to popular belief, policies on drug use are not always based on scientific evidence or composed in a rational manner…rather, decisions concerning drug policies reflect the negotiation of actors’ ambitions, values, and facts as they organize in different ways around the perceived problems associated with illicit drug use” (7).

1.1 Scope of Study

In this study, data was collected through interviews from professionals in both, law enforcement and drug treatment centers. The primary goals were to establish what these two groups believe is working, where improvements could be made, whether viable alternatives to the current system are probable, and where the groups differ in prevention, intervention, and public drug policies. The research question explored was, “should opioid use and possession be shifted from the criminal justice system to the public health sector?” The end-goal was to properly assess if the current policies in the United States towards drug use and possession have been properly labeled as a criminal justice concern.

It should be noted that the data available for this current study was limited to one law enforcement agency and one drug treatment center. This study was solely for exploratory purposes and the interpretations within should only be used to illuminate on the topic for future research. The decriminalization of illicit narcotics or a tougher crime control model should not be implied nor insinuated from the analyses.
1.2 Description of the Chapters

This study, primarily concerned with examining if the public health sector would be more beneficial towards drug users and possessors than the criminal justice system, is divided into 5 chapters – with the first chapter being an introduction to the research topic and a description of the chapters to follow. In chapter II, a thorough review of the literature is conducted to address the differences and/or similarities in the current public health and criminal justice systems in reference to drug use and possession. The review of the literature includes subsections in reference to the prevalence and similarities of heroin and prescription opioids, the criminal justice perspective, and the public health perspective on opioids. The goal of the literature review is to provide context towards the understanding of why drug use has been primarily a concern of the criminal justice system and where recent debates have eluded to the idea of the public health system leading the fight against drug use instead.

In chapter III, a description of the methods used to analyze the data are discussed. In chapter IV, the results of the data are presented, which includes the comparisons between the criminal justice and public health personnel. Chapter V concludes this study with a discussion on the results that were discussed in chapter IV, the limitations that were noticed through collection of the data, and considerations for further research.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Due to the broadly stated goals of this study, some historical information will be provided to properly understand where the U.S. drug policies originated. The following review of the literature is organized to look at how prevalent of an issue opioid use is, the similarities between street-level and prescription opioids, the criminal justice perspective towards drug prohibition, and the public health perspective towards combatting the use of opioids. The review of the literature on this subject matter will demonstrate that the controversial views surrounding drug use and abuse is not just emerging for the first time, but rather, has been a topic of debate for more than 100 years in the United States.

In 1930, the Federal Bureau of Narcotics (FBN) was created, which was an independent federal agency to enforce illicit narcotics legislation (The American Disease). The first commissioner of the FBN was Henry Anslinger who expressed to Congress that, “the major criminal in the United States is the drug addict; that of all the offenses committed against the laws of this country; the narcotic addict is the most frequent offender” (U.S. Congress, 1937, 7). The Boggs Act of 1951 implemented mandatory prison sentences for certain drug offenses (P.L. 82-255) and the Narcotic Control Act of 1956 only further increased the penalties for drug charges and implemented the death penalty as a possible punishment for the sale of heroin to juveniles. The FBN continued to assist with local police agencies and relatively stayed the same until 1960 when the American Bar Association (ABA) and other agencies
started to object to the harsh punishments associated with drug policy; resulting in federal support for a public health approach to drug abuse beginning to grow (The American Disease, 230-243).

Even though there was popularity rising in responding and preventing drug abuse through a public health approach, the 1960s simultaneously included a strong emphasis towards preventing drug abuse through law enforcement as well (Sacco, 2014). President Richard Nixon responded in 1969 to the increase in drug abuse (specifically heroin) by making it one of his main priorities once he took office. To increase federal oversight of drug abuse, President Nixon expressed the need for a comprehensive federal drug law, which resulted in the Controlled Substance Act (CSA) (P.L. 91-513). Soon afterwards, Nixon declared a ‘War on Drugs,’ while claiming drug abuse to be ‘public enemy number one’ (Boyum & Reuter, 2005). The ‘War on Drugs’ specified an increased priority towards law enforcement to combat drug use. President Nixon was a key-contributor in the creation of the Drug Enforcement Agency (DEA), which was stated to be a single-mission agency to enforce the CSA (Executive Order 11727). The DEA had an annual budget of $74.9 million in 1973 and increased to $140.9 million in 1975 (U.S. Drug Enforcement 1970-1975). In the fiscal year of 2014, the DEA amounted to a budget of $2 billion (U.S. Department of Justice, FY2015). In 1985, 2% of Americans held the view that drug abuse was the most important problem facing the nation; only four years later, 27% of the public saw drug abuse as the main concern (Sacco, 2014). Similar to Richard Nixon, President Reagan emphasized the use of federal agencies to fight drug abuse (The American, 1982). Even though the majority of federal drug convictions are
for trafficking and distribution, the amount of offenders that were convicted of simple possession went from 302 in 1980 to 1,353 in 1982 (U.S. Department of Justice, 1988).

Federal agencies enforce drug policy under the CSA and can operate anywhere in the nation, but all fifty states include their own framework to enforce drug laws as well (Sacco, 2014). However, the majority of drug offenses are handled on the state or local level, rather than the federal level (Motivans, 2009). In 2012, the DEA took 30,476 suspects into custody for federal drug violations, compared to state and local law enforcement taking 1,328,457 suspects into custody for drug crimes (U.S. Department, 2012). The majority of state and local law enforcement drug arrests are for possession (Federal Bureau), while the majority of federal drug arrests are trafficking or manufacturing offenses. In 2013, roughly 9% of all DEA arrests were for possession, with these arrests not including possession with intent to distribute (DEA, 2014).

2.1 Prevalence & Similarities of Heroin and Prescription Opioids

The 2014 overdose data from the Centers for Disease Control and Prevention concluded that the opioid overdose epidemic is comprised of two separate but interrelated trends: an increase in illicit opioid overdoses from mostly heroin use, and a 15-year increase in prescription pain reliever overdoses (Rudd, Aleshire, Zibbell, & Gladden, 2016). Young adults’ nonmedical and/or medical prescription drug consumption is a growing public health concern, and between 1992 and 2003, the U.S. population grew 14% while the number of individuals abusing controlled prescription narcotics increased by 94% (Mui, 2014). Some studies express there is a correlation between opioid consumption and heroin use, with the National Survey on Drug Use and Health (NSDUH) finding that 80% or 4 out of 5 current heroin users had started their use of
opioids with prescription opioids first (Muhuri, Gfroerer, & Davis, 2013; Pollini et al., 2011). This transition has been hypothesized to be due to heroin being cheaper on the black market, prescription opioids becoming too difficult to inject, or when prescription opioids become hard to obtain (Pollini et al., 2011, Sacco, 2014). The transition was, in part, due to a reformulation of the prescription painkiller OxyContin®, which in 2010 was reformulated and made tougher to crush the medication down to misuse by snorting or injecting. The abuse-deterrent formulation for OxyContin® offers some progress towards safety, but it does not make opioid medication any less addictive (Sacco, 2014). Both, medical and nonmedical use of opioids most often originates through oral means of consumption (USFDA, 2011). The shift from oral consumption techniques to injection poses another serious public health concern; due to the increased risk of HCV, HIV/AIDS, and other blood-borne diseases (Maxwell, 2015).

In the twelve-year period from 1999 to 2011, the legal prescription painkiller hydrocodone doubled in use and oxycodone, another prescription painkiller, saw a 500% increase in legal consumption (Jones, 2013). During the same twelve-year period, the overdose deaths from opioids has almost quadrupled in number (Chen, Hedegaard, & Warner, 2014). In the fourteen-year period from 1997 to 2011, the amount of people who sought opioid treatment has increased by 900% (SAMHSA, 2013). From 2004-2011, the amount of nonmedical use emergencies for prescription drugs has increased by 132% (SAMHSA, 2011). The amount of heroin users has increased by almost 300% from 2004 (166,000 users) to 2013 (681,000) (SAMHSA, 2013). Teenagers and young adults in the age range of 15 to 24 have the highest occurrence of nonmedical opioid use (SAMHSA, 2009), but individuals in the age range of 45 to 54 hold the highest amount of overdose
deaths from opioids (Chen et al., 2014). Overdose deaths occurring from the use of opioids occur more often in individuals who have a medical prescription, rather than those who use the drug non-medically. A study by Johnson et al. (2013) discovered that of the 254 unintentional overdoses sampled due to opioids in Utah, 92% of the individuals had an opioid prescription from a medical physician.

In a research study from Alia Al-Tayyib, Stephen Koester, and Paula Riggs (2017) the goal was to examine the differences in people who reported being addicted to prescription opioids before injecting heroin and those who did not, based on demographics, injection and non-injection characteristics, and overdose. In the sample of 599 participants interviewed, those who had stated they had been hooked on prescription opioids before injecting drugs were, “significantly more likely to be younger, more recent injectors, report a slightly older age at first injection, and report heroin as the first drug injected as well as the drug most frequently injected” (Al-Tayyib et al., 2016, 226).

For those who are seeking treatment, Dr. James Bell (2014) states, “the course of heroin addiction tends to be chronic and relapsing, and longer durations of treatment is associated with better outcomes” (253). Heroin addiction has a correlation with deviant behavior and criminal activity and the key objectives in treating heroin addiction is a combination of humane support, rehabilitation, public health intervention, and crime control. Maxwell (2015) expresses that even though media channels have emphasized the amount of heroin overdoses in recent years, the total amount of fatal overdoses from prescription opioids greatly exceeds those from heroin. The author concludes with the idea that for those who are prescribed prescriptions opioids, naloxone should be an
adjunct as well. Naloxone is an opioid antagonist medication that when administered in a timely manner, can prevent a drug overdose from becoming fatal (Nielsen et al. 2016).

Even though prescription opioids have extreme similarities in the likelihood of abuse as heroin, the perception of prescribed opioids is far less negative than of the taboo associated with heroin (Comer et al., 2008). In a study by Johnston, O’Malley, Bachman, & Schulenberg (2014), 73% of eighth grade students that were surveyed perceived occasional heroin use without using a needle for injection as ‘high risk,’ while 26% of the students perceived occasional use of Vicodin as ‘less risky’ than occasional marijuana use, smoking 1 to 5 cigarettes daily, and moderate use of alcohol. This study implicates that prescription opioids can hold the perception that since it was prescribed by a physician, it will lack the health complications that are perceived to only be associated with illicit street-level narcotics.

2.2 Criminal Justice Perspective on Opioids

Federal law enforcement agencies corroborate with state and local law enforcement to counteract criminal groups that are producing and distributing illicit narcotics, but generally, federal law enforcement will target large drug trafficking groups and leave low-level drug possession and use charges to the state or local law enforcement (Sacco, 2014). The concept of drug prohibition is the strong emphasis on severe penalties for the possession and distribution of illicit drugs, which is the philosophical foundation of deterrence theory and the basic argument used in favor of mandatory minimum sentences (McBride et al. 2009). Friedman et al. (2011) express that the change in hard drug arrest rates were not predictive of the changes in injection drug use, and that the results provide an inconsistency in the use of criminal deterrence theory to combat hard
drug use. Valerie Wright (2010) discusses the problems with deterrence theory and the assumption that humans are rational actors that weigh the consequences of their actions before deciding to commit crime, which is not always the case. This can be seen in the fact that half of all state prisoners were under the influence of a drug at the time they engaged in criminal activity (Murrola, 1999). In essence, “it is unlikely that such persons are deterred by either the certainty or severity of punishment because of their temporarily impaired capacity to consider the pros and cons of their actions” (Wright, 2010, 2).

Results from a study by Russil Durrant, Stephanie Fisher, & Maria Thun (2011) hold suggestions that, “the amount of punishment deemed appropriate for different drug offenses is most strongly influenced by individuals’ perceptions of the moral wrongfulness of drug offending” (148). The researchers also express the rationale of drug control schemes, which encompasses four overarching factors that influence punishment responses: (1) the perception of the harm done to society; (2) the perceptions of harm that the users of drugs face; (3) perceptions of the basic wrongfulness of drug use; and (4) the perception of drug users as ‘deviant others.’ Albert Kopak & Norman Hoffman (2014) conducted research in order to discover the relationship associated between drug dependence and the probability of being charged with drug possession, comparatively to drug sales or other criminal offenses. The results show that the likelihood of an arrest for drug possession, in comparison to other criminal offenses, rises by 12% for each of the additional drug dependent symptoms that were measured by the researchers. The results indicate that drug dependence is an exceptionally distinguishable factor towards the chances of being arrested for drug possession (Kopak & Hoffman, 2014).
The Uniform Crime Report (UCR) estimated in 2011 that the largest amount of arrests for any criminal offense in the U.S. was for drug abuse violations (Federal Bureau of Investigation, 2011). The Department of Justice (DOJ) classifies drug abuse violations into one of two categories: sale/manufacturing or possession. The classification of possession in 2011 was 82% of all drug abuse offenses and resulted in 1,255,626 arrests made. With the 2.2 million incarcerated offenders in the United States, there is a noticeable correlation between the offender and substance abuse, with an estimated 85% of those incarcerated having a significant substance abuse problem (Norman et al., 2015; Staton-Tindall et al., 2011). There are 1.5 million incarcerated individuals who meet the criteria for substance abuse addiction and almost 500,000 of those incarcerated across the nation were under the influence of a drug at the time the crime was committed or were committing a crime to fund their drug habit (“Behind Bars II,” 2010; James, 2002). The national average cost to incarcerate an individual is $26,000 and in total, the U.S. spent a little more than $51 billion in 2014 on corrections (National Association, 2011). The Federal Drug Control Budget between the fiscal years of 2005 to 2014 have stayed relatively the same as far as the amount of money spent on demand reduction versus supply reduction (ONDCP, 2014). Demand reduction encompasses drug abuse treatment, drug abuse prevention, and total demand reduction; while supply reduction includes domestic law enforcement, interdiction, international enforcement, and total supply reduction. In 2005, the total annual federal drug control budget was $19.88 billion, and in 2014, the budget was $25.21 billion (ONDCP, 2014). Of the federal drug control dollars that are budgeted each year, the majority of all federal drug control spending is focused on supply reduction, which is 60% of the total budget (ONDCP, 2014). Demand
reduction varies between 37% and 41% from 2005 to 2014, while supply reduction varies
between 59% and 63% in the same time period. Caulkins & Sevigny (2005) estimate the
amount of drug-law violators in U.S. prisons that are solely due to drug use/possession
and not drug distribution or crimes in addition to drug use. The numbers found were hard
to pin down due to the large amount of users/possessors who were also involved in
distribution, but the range for only possession charges is between 2% and 15%, roughly
5,000 to 41,000 prisoners nationally (Caulkins & Sevigny, 2005). Of the prisoners in that
range, about 33% of those were new to the court system and the other 66% had already
been on probation or parole at the time of their new drug possession charges. This study
did not state if the 66% were already on probation or parole for previous drug charges or
for other criminal charges.

To address the monetary concerns, specialized drug courts have emerged across
the U.S. as an alternative to the standard incarceration for those who are dependent upon
illicit substances (Norman et al., 2015). The idea of drug courts is the combination of
substance abuse treatment and the authoritative and structural model of the court systems.
The drug court system is the focus of simultaneously treating and punishing drug abusers
that are considered to have a public health issue of addiction that is best managed through
the means of the judicial system (Lyons, 2014). Almost all the approximate 2,500 drug
court programs nationwide require that the individual plead guilty to the crime in order to
participate in drug court (Norman et al., 2015). Some of the issues observed by Lyons
(2013) that arise in drug courts are: “how the courtroom is framed as a therapeutic space
where public appearances by participants are part of the therapeutic process; how judges
have taken on therapeutic practices, effectively compromising their traditional role as
neutral arbitrator; how certain women resisted therapeutic interventions by judges and felt they received harsher punishments than men; and how treatment counselors in drug courts are given powers of enforcement over their clients’” (412). Due to relapses while involved in drug court being expected in the treatment process, most drug courts will not immediately remove the individual from the program, but rather impose punishments such as: more contact with drug court, increased urine testing, and/or a short period of incarceration (Armstrong, 2003). Drug courts are slowly expanding the criteria of those who qualify for drug court treatment programs due to traditional probation and incarceration not efficiently reducing recidivism (Saum et al., 2001). Drug courts initially were for first-time offenders that were charged with possession and are now incorporating more complex offenders who have violent criminal histories. Overall, the research of drug court’s effectiveness and the personal predictors of each participant are both, consistent and contradictory (DeVall & Lanier, 2012).

The outcome of individuals who partake in drug court is subjective, due to one’s personal beliefs on what percentage of recidivism is sufficient enough to claim drug courts as successful, when compared to the traditional judicial process (Miller & Shutt, 2001). For example, the drug court in Columbia, South Carolina admitted 131 individuals over a two-year period that began in 1996, which resulted in an 89% failure rate (Miller & Shutt, 2001). It should be noted though, that of the 89% who failed the program, 45% of the individuals were simply ejected from the program for the failure to appear to their drug court hearings. Jewell et al. (2016) examined the long-term effectiveness of drug treatment courts by gathering data on the recidivism numbers in the 3.5-year period following graduation, withdrawal, or declination into a drug court program. The
outcomes for graduates of the drug treatment court were far superior to the other two
groups of individuals who had withdrawn or declined to enter the treatment court to begin
with (Jewell et al., 2016; Mitchel et al., 2012). The average effect of the participation in
drug treatment court was found to drop recidivism by 38% to 50% in the three-year
period following graduation from the program (Mitchel et al., 2012). Further research on
the comparison of recidivism rates between an individual who only partakes in the
traditional judicial process and one who graduates from drug treatment court will be
beneficial in analyzing objectively the success of drug courts.

2.3 Criminal Justice Perspectives Based on Location

Due to the severity of criminal charges for opioid possession, there is a large
concern in creating a situation of police involvement to an overdose by calling 911
(Banta-Green et al., 2013). When the fear of law enforcement accompanying the medical
services of 911 outweighs the possibility of drug charges, there is an increase in the
chance that an opioid overdose results in death. The state of Washington passed
legislation in 2010 that provided immunity from drug possession charges and allows for
the availability of take-home-naloxone by the general public (Banta-Green et al., 2013).
Of the 251 officers interviewed from the state of Washington, almost 75% of the officers
believed that it was important that they were present at the scene of overdoses to protect
medical personnel and 34% of the officers stated that it was important to be at the scene
to enforce laws. Officer opinions towards the immunity of possession charges and the
provisions of take-home-naloxone were split at 50% (Banta-Green et al., 2013).

All but 3 U.S. states have drug paraphernalia laws that make it illegal for illicit
injection drug users from being in possession of syringes (Bluthenthal et al., 1999). Due
to possibility of an additional criminal charge, injection drug users are sometimes deterred from carrying their own syringes; resulting in the sharing of needles and the increased risk of infectious diseases being spread. In a study by Bluthenthal et al. (1999), 150 of 242 injection drug users that were interviewed reported concerns of being arrested while in possession of drug paraphernalia. The Bluthenthal et al. (1999) study concluded with the thoughts that decriminalizing the possession of syringes and needles would decrease the behaviors that increase the risks of blood borne viruses.

Arizona voters enacted Proposition 200 in 1996 with 65% of the total vote, which required that individuals who were convicted of personal possession and/or use of a controlled substance to be sentenced to probation instead of incarceration, and also, the requirement to be involved in court-ordered drug treatment (Proposition 200, § 10). This proposition does however, exclude defendants with two previous personal possession convictions and stiffens sanctions for those convicted of committing a violent crime while they are under the influence of a controlled substance by requiring they serve 100% of their sentence. Proposition 200, § 10 also allocated specific tax revenues to a Drug Treatment and Education Fund. In 2000, California enacted Proposition 36 with 61% of the total vote that was similar to Arizona’s Proposition 200 (Proposition 36, §5(a)). This proposition does however; allow the state to revoke the probation if the defendant commits one drug-related violation of the probation, leaving them to face incarceration.

Countries, such as the Netherlands, Portugal, Mexico, and Argentina have all claimed to have been effective in decriminalizing the possession of certain drugs that are strictly attributed to personal use (Jelsma, 2009). In 2012, Denmark saw a drastic shift in the drug policing strategies, previously being a zero-tolerance policy to a non-
enforcement strategy in the drug scene (Houborg, Frank, & Bjerge, 2014). The zero-tolerance approach was used from the late 1980s until 2012 and sought to exclude drug users by simply removing them from the drug scene; the non-enforcement strategy was implemented in 2012 and seeks to include drug users through the regulation of their movements and conduct in the drug scene (Houborg, Frank, & Bjerge, 2014). Illicit drugs have been a criminal offense in Denmark since 1955, but from 1969-2004, the personal use and possession of drugs was decriminalized for first or second time offenses. In 2004, Russia passed new legislation that made jail no longer an option for the possession of small, but illegal amounts of drugs (“No More Jail,” 2004). The amount of opium an individual can possess without being detained is set at 5 grams. Even though Russians may no longer be detained for small amounts of illicit drugs, they are required to pay administrative fines or engage in community service.

In 2001, Portugal decriminalized the possession, acquisition, and use of small quantities of all psychoactive drugs, including cocaine and heroin (Laqueur, 2015). Contrary to the media attention given to the new legislation, decriminalization did not create significant changes in the drug-related behaviors. It should be noted that Portugal did not legalize drugs, which would have included allowing for the production, distribution, regulation, and sale of drugs (Laqueur, 2015). In the context of European and international laws, Portugal was not the first to create such legislation. Spain and Italy both stopped the imposition of criminal sanctions for possession of small quantities of all psychoactive substances several decades prior (MacCoun & Reuter, 2001). However, Portugal was unique in their creation of a separate institution that is not a part of the criminal justice system, which is solely dedicated to reviewing drug use citations.
and properly providing additional support for users that are in need of drug treatment (Laqueur, 2015). Mexico in 2009 also had enacted legislation that eliminated the criminal sanctions for individuals possessing small amount of marijuana, cocaine, heroin, and methamphetamine (Luhnow & Córdoba, 2009). When discussing drug policy in the United States though, the perspective differs.

Laqueur (2015) is quoted as stating, “the United States remains unmatched among Western nations in the scale and punitive nature of its drug policies” (774). Reformers looking to change drug policies in the U.S. call for an end to the aggressive use of the criminal justice system for controlling drug use due to its ineffectiveness, the unmistakable inequalities based on race, and the countless costs to financial resources, human lives, and civil liberties (Laqueur, 2015). If the U.S. was to adopt decriminalization legislation similar to that of Portugal, the outcome may be considerable due to the approximate 1.2 million, or 80% of all drug arrests being from possession in any given year (Snyder, 1990-2010). From the roughly 1.2 million Americans convicted of drug possession, approximately one-third were sentenced to prison, and approximately one-third are in jail (BJS, 2007). Laqueur (2015) concludes with the statement that, “removing criminal penalties for possession would not eliminate many of the serious problems stemming from the current drug prohibition polices,” (776) but some of the public health concerns would be addressed.

2.4 Public Health Perspective on Opioids

The concept of harm reduction is the use of the public health approach to decrease the risk and harms that result from drug use (McBride et al. 2009). The public health approach encompasses drug prevention through education, an increase in drug use safety
for those who continue to use, and the idea of drug treatment rather than incarceration (Inciardi & Harrison, 2000). Some view this approach to drug use as a masking attempt in favor of legalizing drugs, which ultimately prevents open discussions on harm reduction as a policy implementation. One of the most noticeable trend changes has been the demographics of opioid users. Heroin users are no longer inner-city minorities as trends used to express, but now hold a higher likelihood to be young Caucasians that do not reside within the large urban environment (Maxwell, 2015). When it comes to gender, males are more likely to die from prescription pain killers, but the gap between genders is closing quickly (Jones & Paulozzi, 2013).

Drug use disorders hold substantial neuropsychiatric conditions that result in significant economic, health, and societal costs (Johnson & Lovinger, 2016). The life-course for many individuals with substance abuse issues is full of cycles of recovery, relapses, and repeated treatments that take place before the individual can reach a stable recovery period (Dennis & Scott, 2007). Key features associated with substance abuse include an escalation of intake amounts, drug relapses even after long periods of abstinence, an increase in tolerance to the drug, and continued consumption while disregarding the adverse consequences of health, finances, and social relationships (American Psychiatric Association, 2013; Hasin et al., 2013; Koob & Volkow, 2016). Jane Maxell (2015) identified the changes in the opioid epidemic and looks to establish the gap that exists between the availability of drug treatment and the demand for it. The findings further emphasize the shift from prescription narcotics to heroin and the lack of supply of medication-assisted therapies. The amount of new drug users and those already dependent on prescription narcotics and heroin are more than three times larger than the
public health’s current capacity to administer treatment (Maxwell, 2015). Kolodny et al. (2015) express that, “The need for opioid addiction treatment is great and largely unmet” (568). The NSDUH estimates that there are 2.1 million Americans who are addicted to prescription opioids and 500,000 who are addicted to heroin (SAMHSA, 2013). The estimated number of individuals in 2005 who were prescribed daily long-term opioid prescriptions was at 10 million, but the continued increase in opioid use from 2005 to 2011 has speculated that this number may be much higher (Boudreau et al., 2009). An estimate from the United Nations Office on Drugs and Crime state that between 15.2 and 21.1 million individuals abuse and/or are dependent on opioids worldwide (UNODC, 2007).

The American Journal of Public Health that was published in 2011 included excerpts from 1914, which demonstrates that the issues surrounding opioid abuse have been evident for more than 100 years (“Drug Addiction”, 2011). In 1912, ordinances began to be implemented to regulate the sale of drugs such as morphine, which also included the requirement that a written prescription from a physician to be given morphine. One of the sections of this ordinance allowed for habitual drug users to obtain, free of charge, prescriptions for the drug they were to be addicted to. Charles Terry (1914) can be quoted as stating, “It might seem, at first sight, anomalous that a bill aimed to curtail the sale of certain drugs should provide for the furnishing of gratuitous prescriptions by the health department” (28). This section, however, was intended to be the focal point of the ordinance in order to remove any justification for the illegal sale of narcotics, and to bring the habitual drug user into personal contact with public health officers (Drug, 2011). Terry (1914) recorded the drug users that he would meet with as
his patients and was able to create a frequency table for the most common causes of drug-habit formation. The largest group was 54.8% of the sample and Terry (1914) is quoted as stating, “It may seem a strong statement to make that over 50% of drug users owe their habit to the medical profession, and yet I am convinced that my figures are not far wrong” (Drug, 2011, 449).

Terry (1914) concludes with the statement,

“It seems to me that the whole subject is one which, may best be handled by health authorities, municipal, state and Federal. For the most part, its control has been left to the police departments and violators of existing drug laws are spasmodically prosecuted, whenever chance or some too flagrant act brings the matter to their attention. In most communities, the time of the police department is fully occupied with other matters nor should they be expected to possess such a realization of the profound importance of this subject as much precede and accompany any successful effort at control” (“Drug Addiction”, 2011, 450).

Research involving drug dependence will often include the drug of abuse to be administered to habitual drug users while under controlled laboratory conditions. The objective of Roux et al. (2012) was to assess if being a drug-using participant in this type of research changes the frequency of heroin use after the study has ended. Of the 69 participants that successfully completed the study, there was a significant decrease in the amount of heroin used one month after the study. Not only was there a decrease, 42% of the sample were completely abstinent from heroin one month after completion, which lead to Roux et al. (2012) concluding that being a habitual drug user in opioid administered research does not increase the amount of heroin used. Drug dependence is
generally a chronic disorder that includes relapses from the alterations of the brain structure and functions (Hser et al., 2015, Vogel et al., 2017). Other chronic medical conditions, such as asthma or diabetes, will almost always include long-term treatment, routine physician monitoring, and access to medication that has the proper dosage. When it comes to drug dependence though, these options are not always provided (McLellan et al., 2000; Vogel et al., 2015). Kari Johnson & David Lovinger (2016) focus on recent evidence from laboratory animal models (with some evidence in humans) that implicate the receptors of three neurotransmitters in the brain can possibly control drug seeking and drug taking tendencies. Even though this research is in the early stages, the researchers express that the, “ability of drugs targeting these receptors to modify drug seeking behavior has raised the possibility of using compounds targeting these receptors for addiction pharmacotherapy” (1).

However, there are some drugs that are already being used in combatting opioid addiction, such as naltrexone and methadone (Kolodny, 2015). Methadone is used in controlling drug user’s cravings for the drug, while naltrexone is used to block opioid-addicted individuals from receiving the sought-after effects of opioids. The acceptance of methadone as a common alleviation for heroin addiction was introduced in the 1960s and is now the most commonly used treatment for heroin addiction on an international level (Bell, 2014). Many studies have provided strong support for the use of methadone maintenance as a safe and effective means for treating opioid addiction (Fudala et al., 2003; Johnson et al., 2000; Kakko et al., 2003; Ling et al., 1998; Sees et al., 2000; Strain et al., 1999). The study conducted by Karen et al. (2002) emphasizes the importance retaining clients in methadone treatment, due to the increased likelihood of positive
outcomes for the individuals who remain throughout. Karen et al. (2003) expressed significant improvements in the areas of drug use, productivity, criminality, and HIV risk behaviors for opioid users who entered methadone maintenance treatment and remained in the treatment center for the appropriate length of time. In the attempt to suppress use of street-level heroin, pharmacological maintenance treatment methods are significantly more effective than the use of short-term treatment models or no treatment at all (Mattick et al. 2009). Methadone treatment practices are much more attractive and have a higher likelihood of retaining opioid users than treatment approaches that are drug-free in nature (Mattick et al. 2009 & Teesson et al. 2007). Research from Kenny et al. (2006) emphasizes that dependent drug use is driven largely by the avoidance of withdrawal symptoms. De Maeyer et al. (2011) discusses the popularity of methadone treatment as a means for ending drug addiction as appealing to the drug user who can take a daily-dose of medication that is long-acting and abolishes the feelings of withdrawal; which ultimately can allow for the individual to be freed from the compulsive behaviors of drug use and resume their normal activities and interests.

In recent years in Norway, there has been an increasing emphasis on viewing drug abuse as a health-related issue instead of one of solely control (Skretting, 2014). Norway’s perception recently is now viewed as dependency and/or a disease, with harm reduction being the pivotal aspect of drug policy. Currently, Norwegian drug users are termed “drug dependents” rather than drug abusers (Skretting, 2014). The Norwegian government continues to apply a dual approach to illicit drugs by applying harsh control measures towards the prevention of drug trafficking, while providing individuals with drug abuse concerns with the relevant help and treatment. Although Norway
acknowledges the need for drug abuse treatment, the government disagrees with the arguments in favor of liberalizing or legalizing narcotic drug use. In 2004, Norwegian Parliament passed a temporary law that gave certain municipalities the ability to create drug injecting room facilities (Ot. prp. nr. 8, 2004–2005). Because of the exemption from prosecution for the use of drugs inside these facilities, the clear need for harm reduction was seen as much more important than pure prohibition of narcotic drug use and/or possession (Skretting, 2014). Harm reduction is the focal point of Norwegian drug policy today.

2.5 Summary

There is a lack of studies looking to intertwine the criminal justice and public health perspectives when discussing drug abuse. The central idea that can be used to summarize the review of the literature is the steady increase in funding to combat drug abuse and the steady increase in the number of drug abusers for at least the past 100 years. With such a noticeable divide between the approach of viewing drug use through the public health or criminal justice lens, there is an expectation that the feedback from law enforcement officers and drug treatment counselors will be noticeably divided as well. The next section will outline the methods used to collect interview data and the ways in which the data was analyzed.
CHAPTER III

METHODOLOGY

This chapter is used to describe the data and research methods that were used to analyze the impact of opioid use and possession being handled primarily by the public health sector, rather than the criminal justice system. As previously stated, due the limitations in the amount of data that was collected, this thesis is solely an exploratory study that should be used only for guiding future research on the topic. Finally, a quick summary of the data collected will conclude this chapter.

3.1 Data

Three individuals from law enforcement and three individuals from drug treatment centers responded to the recruitment flier, yielding a total of six participants (n=6). Table 3.1 illustrates the breakdown of respondents from law enforcement and from drug treatment centers. The average age of the sample was 41.5 years old. Among the sample the law enforcement participants averaged 37 years old, while the average age of the drug counselors was 46 years. Of those interviewed, the average amount of time in their current position was 9 years. The average length of career among the law enforcement participants was 12 years and among drug treatment counselors was 27 years.
Table 3.1 Basic Demographic and Career Information

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Age</th>
<th>Career Length</th>
<th>Current Position Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law Enforcement Interview #1</td>
<td>37 years</td>
<td>14 years</td>
<td>6 years</td>
</tr>
<tr>
<td>Law Enforcement Interview #2</td>
<td>Mid-30s</td>
<td>6 years</td>
<td>2 years</td>
</tr>
<tr>
<td>Law Enforcement Interview #3</td>
<td>39 years</td>
<td>16 years</td>
<td>7 years</td>
</tr>
<tr>
<td>Drug Counselor Interview #1</td>
<td>50 years</td>
<td>29 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Drug Counselor Interview #2</td>
<td>Unanswered</td>
<td>Unanswered</td>
<td>Unanswered</td>
</tr>
<tr>
<td>Drug Counselor Interview #3</td>
<td>58 years</td>
<td>32 years</td>
<td>24 years</td>
</tr>
</tbody>
</table>

Table 3.2 Logbook of Interview Dates

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Data Conducted</th>
<th>Date Transcribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Law Enforcement Interview #1</td>
<td>May 17&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>May 17&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
<tr>
<td>Law Enforcement Interview #2</td>
<td>May 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>May 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
<tr>
<td>Law Enforcement Interview #3</td>
<td>May 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>May 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
<tr>
<td>Drug Counselor Interview #1</td>
<td>June 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>June 29&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
<tr>
<td>Drug Counselor Interview #2</td>
<td>June 18&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>June 29&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
<tr>
<td>Drug Counselor Interview #3</td>
<td>June 29&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
<td>June 29&lt;sup&gt;th&lt;/sup&gt;, 2017</td>
</tr>
</tbody>
</table>
3.2 Data Collection Procedure

Data for this study were collected through interviews with professionals in law enforcement and drug treatment centers in Colorado. With permission from local law enforcement and drug treatment centers, an invitation to participate in the research study was shared with staff through the use of recruitment flyers. The participant population drawn from the recruitment flyer were chosen based on their willingness to participate and the minimum of 1 year of experience in their current positions as patrol officers and drug counselors. The minimum year of experience allowed for the participants to have had enough contact with those who use and possess opioids to produce relevant data to the study. The participants were further informed that the researcher was not seeking information on specific individuals they have been in contact with, but rather ‘big picture’ questions focusing on drug users, those who possess narcotics, and their experiences when interacting with them.

The participants were asked a pre-determined set of semi-structured interview questions to better understand the potential disparities in approaches used by law enforcement and drug counselors when associating with drug users. A semi-structured approach was used in order to not limit the respondents to a pre-determined set of answers and to allow for further exploration of a particular theme if the opportunity presented itself. The interview participants were given the choice between face-to-face, phone calls interviews, or by filling out the interview questions and emailing them back once completed. It was known that the interviews would take approximately 60 minutes to conduct.
3.3 Analytical Strategy

Notes taken and data collected were then transcribed and analyzed using a grounded theory approach to research. Simple descriptive statistics were recorded and a qualitative analysis technique looking at the themes found was used. The data were organized into two sections: data collected from law enforcement professionals, and data collected from public health professionals. Due to this study looking to compare the differences in perspectives between the two, organizing by topic was the most beneficial way to analyze the data. The next goal was to focus on the possible meanings of the data collected from each of these two sections. Amanda Coffey and Paul Atkinson (1996) mention three basic procedures for qualitative coding: “(a) noticing relevant phenomena, (b) collecting examples of those phenomena, and (c) analyzing those phenomena in order to find commonalities, differences, patterns, and structures” (p. 29). When looking for relevant phenomena from the responses of law enforcement professionals, there were clear commonalities and structures between the majority of their responses, which would also entail the lack of differences in between their responses. Esterberg (2002) states, “the same kinds of events might occur over and over,” (168) which was the case for law enforcement officers. When looking for relevant phenomena from the responses of drug counselors, there were clear commonalities and differences between their responses. These themes will be discussed in further detail in chapter 4.
CHAPTER IV

RESULTS

The results of the data are broken into two sections. The first section focuses on the differences in the interview responses between law enforcement officers and drug counselors. The second is focused on the similarities between the responses of the two groups.

4.1 Disparities

One of the first questions asked in the interview was the question about if there was a noticeable disparity between heroin and prescription opioids. Two of the drug counselors answered, “yes,” with one being quoted as stating, “heroin users seem more physically ill.” Two of the officers answered, “no,” with one being quoted as stating, “there is a large illicit market of pills right now.” One of the officers and one of the drug counselors had very similar responses with the officer being quoted as stating, “prescription and heroin users are all the same crowd,” while the drug counselor expressed, “abuse is abuse, illicit or prescription opioids.”

A question included in the interview states, “many states in the U.S. spend on average, $26,000 a year to incarcerate one inmate, do you think that these funds would serve a better end-result for society if redistributed from the criminal justice system and allocated into the public health realm?” As stated above, this totals the U.S. spending slightly more than $51 billion on corrections in 2014 (National Association, 2011). One counselor and all three officers answered this question as, “no.” One officer can be quoted as stating, “I don’t want to see that money going into a system that doesn’t have
the strongest record… I don’t think the money that goes into the public health realm is doing a strong effect,” while another officer expressed, “it needs to be balanced between the criminal justice and public health systems.” One counselor mentions the need for ‘lock up’ drug treatment centers, while another counselor expressed, “incarceration without the means to educate does very little good for the money we spend.”

4.2 Similarities

Both, law enforcement and drug counselors expressed that they have been required to partake in some form of substance abuse training. All law enforcement officers stated that the police department requires them to participate in ‘Narcan’ (Naloxone) training and are each issued Narcan to use in case an individual has an opioid overdose. Two of the officers mentioned that there are required drug recognition classes and one officer mentioned yearly-narcotic investigation meetings. All of the drug counselors interviewed expressed a significant amount of required substance abuse training, including the educational requirements needed to be a drug counselor. One counselor in particular mentioned the state required classes that they must participate in as well.

A question was asked in reference to their experiences with individuals having a tendency to be violent while under the influence of opioids when compared to other illicit narcotics, such as cocaine, methamphetamine, or PCP. All three drug counselors and 2 officers expressed that they have not experienced these individuals to be more violent than other illicit substances. One of the officers discussed that opioids are a depressant and usually will make people sleepy and can be quoted stating, “I’ve interviewed dozens of people on opioids who can’t stay awake during the whole interview…. stimulants is
where you see most of the violent individuals.” The one officer whose opinion differed expressed that he has done some side-studying about the nature of drugs, while also being quoted as stating, “No, they [drugs] are all the same, being under the influence is being under the influence.”

Among drug counselors and law enforcement officers, it was generally well-established that the individuals sent to drug treatment and the individuals who have been in contact with law enforcement were not exclusively due to a drug possession offense, but rather, a drug possession offense in addition to other criminal charge(s). A similar question was asked to both groups that was in reference to how often they are in contact with an individual who engages in criminal activity in order to simply fuel their drug addiction. The responses all indicated that the majority of offenders who are drug users are involved in criminal activity to fuel their drug addiction. All three of the officers expressed property crimes as the main activity used by drug users to fuel their drug addiction, such as shoplifting or breaking into vehicles. One officer is quoted as stating the, “clear majority of offenders who engage in criminal activity is to fuel their drug addiction,” while one of the drug counselors is quoted as stating, “most clients commit crimes to fuel their addiction and not just for crime sake.”

Another question that held similar answers between officers and counselors was a hypothetical question that stated, “if a drug was to be created and prescribed that could eliminate the addiction to illicit narcotics, would this eliminate the need for criminal sanctions attached to drug possession?” This question is in reference to the study by Johnson & Lovinger (2016) that implicated that the receptors of three neurotransmitters in the brain can possibly control drug seeking and drug taking tendencies. The majority
of officers and counselors each mentioned that addicts do not want to stop using illicit narcotics, with one counselor quoted saying, “addicts don’t have self-strength to even try stopping,” and one officer quoted as saying, “they are addicted and they want the ‘high’ and even if you can change their brain function, people will still be seeking the ‘high’……you are only addressing the chemical side and not the emotional side.”

The question was asked, “based on your experience, which one of these two categories holds more optimism at eliminating or significantly decreasing in our society; illicit drug use or illicit drug trafficking?” The overwhelming answer from all the participants was ‘illicit drug trafficking.’ One counselor expressed, “illicit drug use can be reduced, but there will always be someone in the drug trafficking business.” One officer stated, “we need to be harder on traffickers…. if you hold traffickers more accountable, there would be a big change, you are getting rid of the source of the opioids.”

One of the final questions that was asked is similar to the title of this research study, which stated, “do you believe that possession of opioids (without a valid prescription) has been properly labeled as a criminal justice concern?” All six participants answered this question as “yes,” while their justifications differed. One counselor expressed, “opioid use can start in middle school and without consequences in the justice system, nothing will stop the spread.” One officer can be quoted as stating, “I think it is a crime and it was made a crime for a reason…. addiction drives a lot of crime and that’s why it is a scheduled I narcotic… them being in jail may be good for them to help them get clean.”
4.3 Summary

Surprisingly, the questions asked during the interview held more similarities than differences between the responses from drug counselors and law enforcement officers. The area of importance was the final paragraph, which demonstrates that both, law enforcement and drug counselors hold the belief that that possession of opioids has been properly labeled as criminal justice concern. It should be noted though, that due to the limitations in the amount of data collected, the conclusions of this research should be held to be strictly exploratory in nature.
In this exploratory study, both, law enforcement and drug counselors hold the view that the possession of opioids has been properly labeled as a criminal justice concern. As stated earlier, the U.S. spent a little more than $51 billion on corrections in 2014 (National Association, 2011). If the law enforcement and drug counselor data could be generalized to the general population, this would entail not decreasing the corrections budget and relocating it to the public health realm, but rather, possibly increasing their budget in the coming years. One officer can be quoted as stating, “It is considered a criminal justice concern…the bigger part is the accountability with physicians…they are too eager to prescribe opioids…. we got to be more diligent with how we address the pain needs of people.”

As much as the literature review can elude to the idea that the U.S. is continually increasing the criminal justice budget while the issue of drug abuse is getting worse, there is a lack of research on who the responsible party for this increase in drug abuse is.

When reading the literature, one is left with the idea that there is a significant problem that is in need of being addressed; while the responses from law enforcement and drug counselors could leave an individual to believe that the issue is being properly handled within their respective fields. The literature review discusses several articles that mention that there is a significantly larger demand for drug treatment than drug treatment centers can supply, but this was not a concern that was expressed by law enforcement nor drug counselors. No law enforcement officers and only one drug counselor mentioned drug court programs as a needed part of reducing drug abuse. None of the respondents
mentioned the drug policies of other countries and if they viewed them as successful or not, there was no mention of America’s War on Drugs, how long of a time-period the U.S. has been battling drug use, nor the idea of if the U.S. was even facing an opioid crisis.

Stated in the literature review is the idea that 85% of the 2.2 million individuals incarcerated in the U.S. have a significant substance abuse problem (Norman et al., 2015; Staton-Tindall., 2011). The issue in need of being addressed is how to gain access to this population before their drug addiction leads them to the point that they have engaged in criminal activity that is severe enough to send them to prison, rather than a drug court program. The literature review mentions that roughly 500,000 of those incarcerated were under the influence of an illicit narcotic at the time their crime was committed or were committing a crime to fuel their drug addiction (“Behind Bar II, 2010; James, 2002). The majority of the responses from law enforcement officers and drug counselors elude to the idea that the individuals they are in contact with are, more times than not, engaging in criminal activity to fuel their addiction. Based on the responses from the interviews and the available research, figuring out how to get into contact with those with drug addictions before they begin engaging in criminal activity to fuel their addiction seems to be the answer to reducing the U.S. prison population.

5.1 Research Limitations

One of the largest limitations to this study was the scarce amount of data that was obtained. In total, only three law enforcement officers and three drug counselors were interviewed. The norm in research methods generally includes the idea that, the larger the sample size, the more accurate and replicable the data collected becomes. The issue that
arose in this study was the lack of participants from law enforcement and drug counseling agencies that were willing to speak on behalf of an issue that can be controversial. The law enforcement agency only provided three officers to participate, while several of the drug treatment facilities declined to participate or did not respond to requests.

The second limitation was due to the type of law enforcement officials that were provided. When looking for police departments that would be willing to participate, it was clearly articulated that this study was seeking patrol officers that were in routine contact with the general public. The researcher was provided three drug detectives, whose positions took them out of the day-to-day patrols and focused on decreasing drug trafficking in the community. This study was looking for patrol officers whose job descriptions would place them in positions where individuals possessing small amounts of illicit drugs would be in contact with law enforcement. Due to this limitation, much of what the law enforcement participants expressed was in relation to large-scale drug distribution rather than the low-level drug possessors.

5.2 Suggestions for Future Research

When discussing some of the suggested ideas for future research on this topic, a couple of concepts come to mind. First, the final question that was asked in the interview was, “is there anything else that I have forgot to mention that you believe would be beneficial to include in my research?” There was one counselor and one officer that both mentioned that speaking with drug addicts and asking them what they need would be beneficial. Future studies could use this idea with the method of focus groups that bring the participants together in the same room to talk about what is needed and where improvements can be made. There is, however, research available from the perspectives
of the drug user. This study was interested in possibly decreasing drug users in the future, rather than figuring out what to do once an individual has begun the use of opioids.

Secondly, the idea of interviewing patrol officers and drug counselors may be inferior to the idea of interviewing the criminal attorneys and the prescribing physicians who are in contact with individuals seeking these prescription narcotic medications. Interviewing the criminal attorneys who are either, prosecuting or defending these individuals who have been charged with simple possession may help demonstrate how much of a burden, or lack thereof, that these cases are actually having on the criminal justice system. Interviewing the physicians who are prescribing these painkiller medications may help demonstrate the lack of time that the physicians are able to dedicate to each patient, the addictive behavior that their patients use in order to receive more opioid medication, and the physician’s views on if this issue would be better handled within their offices. As was stated above, 80% or 4 out of 5 current heroin users started their use of opioids with prescription opioids (Muhuri et al., 2013; Pollini et al., 2011). If this is the case, an argument could be made to address the problem from the providers of prescription opioids.

5.3 Conclusion

The topic of drug abuse is far from a new concept that has just emerged in the last few years. In 1914, when the Harrison Narcotics Act was implemented, morphine was viewed as falling outside the scope of the medical field and sent many drug addicts to the illicit market to fuel their addiction. In 2017, addictions to prescription medications, such as hydrocodone, oxycodone, and OxyContin® are currently considered to fall within the
scope of the medical field. The issue is, in part, that there is still a steady-flow of addicts turning to the illicit market to fuel their addiction.

There is a clear disparity between the responses from the individuals interviewed and the research that was included in the literature review. The reason for this gap in available research and what currently employed professionals in their respective fields expressed is unknown. The literature could be stated to be over-dramatizing the issue, while the responses from professionals seems to under-dramatize the problem. The answer to significantly reducing drug abuse seem to lay somewhere in-between the two.


Ot. prp. nr. 8 (2004–2005). Om lov om endringer i midlertidig lov 2. juli 2004 nr. 64 om prøveordning med injeksjon av narkotika (sprøyteromsordning) m.m. [On the act on changes in the provisional act relating to a trial scheme of premises for drug injection (the drug injection rooms act) etc.].

(P.L. 82-255)

(P.L. 84- 728)


Proposition 36, § 5(a)
Proposition 200, § 10


APPENDIX A

LAW ENFORCEMENT INTERVIEW QUESTIONS

During the interview the term “opioids” will be used to include the entire family of opiates (i.e. natural, synthetic, semi-synthetic). If possible, the most beneficial data collected will be responses that reflect your experience as a patrol officer, if your current position has changed.

1. Basic demographic information
   a. Age?
   b. Career length?
   c. Length in current position.?

2. How often are you involved with individuals who use opioids?
   a. More males or females?
   b. Race?
   c. Age?
   d. Users or traffickers?
   e. Prior criminal records?

3. Have you been required or volunteered to partake in some form of substance abuse training? If so, what?
   a. Has the specific topic of opioid abuse been discussed?
   b. Have you received any training on how to interact with an individual under the influence of opioids?
      i. Naloxone?
4. Do you engage with opioid users more frequently as solely a drug possession offense, or is it often a criminal act in addition to the possession of narcotics?
   a. Have you found sole drug possession offenses to be a burden on your ability to pursue violent crimes?
   b. How often is a crime discovered, later to find narcotics to be involved?

5. When interacting with opioid users, have you noticed an increase or lack of violent tendencies when compared to users of other illicit narcotics (cocaine, methamphetamine, PCP, etc.)?

6. Have you noticed a disparity in arrests in heroin vs. prescription opioids? If so, what?
   a. Location?
   b. Race?
   c. Age?
   d. Socioeconomic standing?

7. How often do you interact with offenders who engage in criminal activity to simply fuel their drug addiction, rather than for economic or personal gains?
   a. Robberies? Break-ins? Credit card or check fraud?

8. If drug offenders who claim they are physically addicted were to be properly treated and abstain from drug use, would you expect their criminal activity to cease?
   a. What if they have been properly treated but are not clean and sober?
9. *Hypothetical* If a drug was to be created and prescribed that could eliminate the addiction to illicit narcotics, would this eliminate the need for criminal sanctions attached to drug possession?
   a. Would probable cause of an individual only possessing an illicit narcotic result in a visit to the hospital rather than being booked into CJC?

10. What would be your view on the idea of possession of opioids without a prescription not being considered a criminal act, while the distribution of such substances would remain a crime?

11. Do you believe that possession and use of opioids without a prescription has been properly labeled as a criminal justice concern?
   a. Please explain

12. Based on your experience, which one of these two categories holds more optimism at eliminating or significantly decreasing in our community; illicit drug abuse or illicit drug trafficking?

13. Is it possible to reduce criminal activity (not including drug possession) without addressing drug use?
   a. “The chicken or the egg ideology” Which one comes first?
   b. Have you observed drug use to be begin, followed by further criminal activity or vise-versa?

14. Many states in the U.S. spend on average $50,000 a year to incarcerate an inmate, do you believe that these funds would serve a better end-result for society and the offender if it were redistributed from the criminal justice system and allocated into the public health realm (Stevenson, 2011)?
a. Please explain

15. Is there anything else that I have not mentioned that you think would be beneficial to include in my research?

16. After completion of the study, would you like to receive a copy of the final research?
   
   a. Best delivery option that doesn’t jeopardize anonymity or confidentiality of your responses?
APPENDIX B

DRUG COUNSELOR INTERVIEW QUESTIONS

During the course of the interview the term “opioids” will be used to include the entire family of opiates (i.e. natural, synthetic, semi-synthetic)

1. Basic demographic information
   a. Age.
   b. Career length.
   c. Length in current position.

2. How often are you involved with individuals who use/used prescription opioids?
   a. More males or females?
   b. Race?
   c. Age?
   d. Drug users or traffickers?
   e. Prior criminal records?

3. Have you been required or volunteered to partake in any form of substance abuse training? If so, what?
   a. Has the topic of heroin and/or prescription opioid abuse been discussed?
   b. Have you received any form of training on how to interact with an individual under the influence of opioids?

4. Have you ever experienced heroin or prescription opioid users to be more ‘violent’ individuals when compared to other patients/clients seeking treatment for other illicit substances (cocaine, methamphetamine, PCP, etc.)?
5. How many of your patients/clients have been sent here solely due to a non-violent drug offense?
   a. How many have another criminal charge in addition to the drug possession charge?

6. Have you noticed a disparity in patients/clients who are in treatment for heroin vs. prescription opioids?
   a. If so, what? Location? Race? Age? Socioeconomic standing?

7. Are there noticeable differences in willingness by clients/patients to participate in drug treatment based on family, self-will, or those who have been court-ordered?

8. How many patients/clients have you interacted with who engage in criminal activity in order to fuel their drug addiction, rather than the sole purpose of engaging in crime?

9. What would be your view on the idea of opioid possession not being considered a criminal act, while the distribution of such substances would remain a crime?

10. Could you see any possible benefits that could come from conducting drug-counseling sessions while the patient/client is under the influence of opioids at the time of treatment (Bjarke & Esben, 2015)?

11. Do you believe that possession of opioids (without a valid prescription) has been properly labeled as a criminal justice concern?

12. Based on your experience, which one of these two categories holds more optimism at eliminating or significantly decreasing in our society; illicit drug use or illicit drug trafficking?
13. *Hypothetical* If a drug was to be created and prescribed that could eliminate the addiction to illicit narcotics, would this eliminate the need for criminal sanctions attached to drug possession?
   
   a. Would evidence of an individual possessing an illicit narcotic result in a trip to the hospital rather than being booked into CJC?

14. Is it possible to reduce criminal activity (besides drug possession) without addressing drug use?
   
   a. “The chicken or the egg ideology” Which one comes first?

   b. Does drug use come first, followed by further criminal activity or vise-versa?

15. Many states in the U.S. spend on average, $50,000 a year to incarcerate one inmate, do you think that these funds would serve a better end-result for society if redistributed from the criminal justice system and allocated into the public health realm (Stevenson, 2011)?

16. Do you believe there are specific drug counselors that you think would benefit my research?

17. Is there anything else that I have forgot to mention that you believe would be beneficial to include in my research?
APPENDIX C

U.S. DRUG HISTORY TIMELINE

- **19th & Early 20th Century:** The U.S. federal government is not involved in regulating and/or enforcing drug use or distribution.

- **1912:** Ordinances begin to be implemented to regulate the sale of drugs, such as morphine, and required a written prescription from a physician to be given morphine. One ordinance allows for habitual drug users to obtain, free of charge, prescriptions for the drug they are addicted to.

- **1914:** The Harrison Narcotics Act (HNA) was implemented, which ceased the medical prescriptions from physicians. The Treasury Department perceived patient drug maintenance using cocaine and morphine as outside the scope of the medical field.

- **1930:** The Federal Bureau of Narcotics (FBN) was created and was stated to be an independent federal agency to enforce illicit narcotics legislation.

- **1951:** The Boggs Act was implemented and required mandatory prison sentences for certain drug offenses.

- **1956:** The Narcotic Control Act was implemented and further increased the penalties for drug charges and implemented the death penalty as a potential punishment for the sale of heroin to juveniles.

- **1960:** The American Bar Association (ABA) and other agencies began to object to the harsh punishments associated with drug policy, and federal support for a public health approach to drug abuse began to grow.
• **1960s:** Methadone becomes accepted as a common alleviation for heroin addiction.

• **1969:** President Richard Nixon responds to the increase in drug abuse by making it one of his main priorities as president.

• **1971:** President Nixon signs the Controlled Substance Act into law. Soon after, he claims drug abuse to be ‘public enemy number one’ and declares a ‘War on Drugs.’

• **1973:** President Nixon authorizes the implementation of a single-mission federal agency to enforce the CSA, which is titled the Drug Administration Agency (DEA). The DEA’s annual budget is set at $74.9 million.

• **1975:** The annual budget of the DEA is $140.9 million.

• **1980:** Most federal drug convictions are for trafficking or distribution of narcotics, only 302 were convicted for simple possession.

• **1982:** President Ronald Reagan announces federal initiatives against drug trafficking and organized crime, which includes the establishment of 12 additional task forces in key areas around the United States.

• **1982:** The amount of federal drug convictions for simple possession rises to 1,353.

• **1985:** 2% of Americans view drug abuse to be the most important problem facing the nation.

• **1986:** The Anti-Drug Abuse Act, in part, establishes criminal penalties for simple possession of a controlled substance.
• **1989:** 27% of Americans view drug abuse to be the most important problem facing the nation.

• **1989:** The first American drug court is established in Florida to address the perceived connection between drug addiction and crime.

• **1996:** Arizona enacts Proposition 200, which requires that individuals convicted of personal possession and use of a controlled substance to be involved in court-ordered drug treatment and sentenced to probation rather than incarceration.

• **1997-2011:** The number of individuals seeking opioid treatment increases by 900%.

• **1999-2011:** In this time period, hydrocodone use doubled, oxycodone use saw a 500% increase in consumption, and overdose deaths from opioids quadruples in number.

• **2000:** California enacts Proposition 36, which is very similar to Proposition 200 passed by Arizona in 1996.

• **2004:** There are approximately 166,000 heroin users in the United States.

• **2004:** Russia passes legislation that makes jail no longer an option for possessing small, but illegal, amounts of drugs.

• **2004:** Norwegian Parliament passes a temporary law giving certain municipalities the ability to create ‘drug injecting room’ facilities, which exempts drug users from prosecution for drugs consumed inside these facilities.

• **2004-2011:** The number of nonmedical use emergencies of prescription opioids increases 132% in this time period.

• **2004-2013:** The number of heroin users increases 300% in this time period.
2005: The annual federal drug control budget is $19.88 billion, which encompasses drug demand reduction and drug supply reduction.

2005: The estimated number of Americans prescribed long-term opioid prescriptions is at 10 million.

2010: Due to prescription drug abuse, the prescription painkiller OxyContin® is reformulated to make it tougher to crush down to be misused through snorting or injecting the drug.

2010: Due to the fear of being charged with drug possession when seeking emergency services for someone who has overdosed, the state of Washington passes legislation that provides immunity from drug possession charges when seeking emergency services. The same legislation allows for take-home naloxone by the general public.

2011: The Department of Justice (DOJ) classifies drug violations into one of two categories: sale/manufacturing or possession. The classification of drug possession was 82% of all drug abuse violations, resulting in 1,255,626 arrests made.

2012: The DEA takes 30,476 suspects into custody for federal drug violations, while the state and local law enforcement take 1,328,457 suspects into custody.

2012: Denmark shifts their drug policy from a ‘zero-tolerance’ approach to a non-enforcement strategy for drug users, but not drug traffickers.

2013: There are approximately 681,000 heroin users in the United States.

2013: Roughly 9% of all DEA arrests are for drug possession, not including possession with intent to distribute.
• **2014:** The annual federal drug control budget is at $25.21 billion, which encompasses drug demand reduction and drug supply reduction. The annual budget of only the DEA is $2 billion.

• **2014:** The national average cost to incarcerate an offender is at $26,000 and the annual budget for corrections was slightly over $51 billion.

• **2014:** Overdose data from the Centers for Disease Control and Prevention (CDC) conclude that the opioid overdose epidemic is comprised of two interrelated trends: (1) an increase in illicit opioid overdoses from mainly heroin; and (2) a 15-year increase in prescription pain reliever overdoses.