

# A BITTER PILL

PRISONS HAVE BECOME THE DEADLY EPICENTER OF ALABAMA'S ADDICTION CRISIS, EVEN AS THE STATE'S RESPONSE BEGINS TO SHOW SIGNS OF SUCCESS ELSEWHERE

*HOW DO WE BRIDGE THE GAP?*



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Alabama Appleseed Center for Law and Justice is a non-profit, non-partisan 501(c)(3) organization founded in 1999 whose mission is to work to achieve justice and equity for all Alabamians. Alabama Appleseed is a member of the national Appleseed Network, which includes 18 Appleseed Centers across the U.S. and in Mexico City. Alabama Appleseed is also a member of the Sargent Shriver National Center on Poverty Law's Legal Impact Network, a collaborative of 36 advocacy organizations from across the country working with communities to end poverty and achieve racial justice at the federal, state, and local levels.

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# Executive Summary

Year after year, across Alabama, more people are convicted and sentenced for drug-related felonies than any other category of crime. The criminalization of addiction means that jails and prisons are expected to absorb what is a complex public health crisis. But they are not equipped to do so — and the results have been catastrophic.

Every year from 2012-2020, Alabama ranked first in the nation for opioid prescriptions per capita.<sup>1</sup> Since 2014, the opioid epidemic has claimed the lives of nearly 7,000<sup>2</sup> Alabama residents who died by overdose. Thousands more lives have been disrupted by substance use disorder and its consequences, often including arrest and long-term involvement with the criminal legal system.

In Alabama prisons, there have been at least 72 suspected drug-related deaths since March 2020, a period during which prisons have been mostly closed to visitors. And deaths are not the only toll illicit substances take on people who are incarcerated.<sup>3</sup> Drug debt drives coercion and violence among prisoners; the potential profit from drug sales tempts and corrupts corrections officers; the behavior driven by drug use endangers incarcerated people who use and those who are around them.

And while opioids and overdose deaths plague much of the country, Alabama combines the nation's highest opioid

prescription rates with the nation's deadliest, most dysfunctional prisons — and has compounded its complicity in the problem by failing to expand Medicaid, which would exponentially increase drug rehabilitation and treatment options in communities.

If the problems created by addiction were easy to solve, someone would have solved them by now. This report seeks to examine addiction in ways not previously done in Alabama, to define and untangle the problems created by addiction, and to offer actionable steps that would improve individual and public health while reducing needless incarceration.

We talked with stakeholders and experts across disciplines, including public and behavioral health professionals, agency heads, retired law enforcement, people in recovery, people who are incarcerated, and families who lost loved ones to addiction. We paid special attention to the difficult questions surrounding criminalization of addiction, including the shockingly long sentences handed down to people convicted of certain drug crimes.

With the plight of a man we met while he served a 26-year sentence for manufacturing methamphetamine for personal use as our north star, we asked tough questions about the wisdom of punishing illness with prison. Did his lengthy sentence in violent prisons where dangerous drugs were readily

available serve any public policy objective? Was it keeping him safer? Was it keeping *us* safer? Was it deterring drug use among other people? Did his punishment fit his crime?

We also conducted an analysis of the economic toll of the opioid pandemic in 2018. We estimate the total costs of opioids (fatal and non-fatal) to the state of Alabama incurred in 2018 alone to be between \$7,485,395,580 and \$9,028,552,090.

There is no single answer to the question of what Alabama can do to quickly and permanently navigate its way out of this crisis. But there are many public policy choices we could make or reinforce that would improve the situation materially, especially for people whose struggle with substance use disorder brings them into contact with the criminal legal system and Alabama Department of Corrections. Among other things, we recommend lawmakers shore up public and behav-

ioral health infrastructure by expanding Medicaid; revisit outdated laws and reclassify simple possession of controlled substances and paraphernalia as misdemeanors; and take steps to ensure that decisions about things like medication assisted treatment are made by medical professionals, not judges, lawyers, or corrections staff.

Blake Puckett, 38, became dependent on opioids when he was 15 and doctors sent him home with a 30-day supply of Percocet to treat pain from an injury. He was sentenced to 26 years in ADOC for nonviolent drug offenses. Though a judge ordered him to participate in treatment as a condition of his confinement, ADOC repeatedly placed him in facilities where programming was unavailable. "Prison is a dangerous place," he told Appleseed. "You come in here with a drug problem — and you might get killed."

PHOTO BY BERNARD TRONCALE



# Introduction

In early 2020, just before the pandemic shut down normal life, a couple showed up on Alabama Appleseed's front porch. Mike and Sabrina Puckett made the three-hour drive from Cullman to Montgomery because they heard that Alabama Appleseed has helped people sentenced under Alabama's Habitual Felony Offender Act challenge their sentences. Their son Blake, they told us, became addicted to opioids after receiving a 30-day prescription of Percocet after he accidentally burned himself at age 15. When they came to our doorstep, he was serving a 26-year sentence for a series of low-level drug crimes. His only victim was himself.

It would be two excruciating years before Blake got out of prison on parole — years during which he languished in a work release facility. For most of that time, visits, work, and nearly all programming were shut down due to the pandemic, and anxiety and restlessness festered. Blake relapsed briefly, using Suboxone that was smuggled into the prison despite a strict lockdown that barred all visitors.

As a pandemic whose side effects included a sharp rise in accidental overdose deaths<sup>4</sup> bore down on America, Blake's situation captured our attention. Why was a 36-year-old man with no history of violent offenses sentenced to decades in minimum custody prison? Was incarceration a sensible response to his addiction? What supports could have been in place to prevent him, and others like him, from getting to this point?

We spent almost two years posing these questions to a host of experts: public health

professionals, addiction specialists, academics, judges, lawyers, social workers, law enforcement, people living with substance use disorder and people in recovery.

We learned that Alabama has begun to reorient its approach to addiction. Agencies and systems that have rarely, if ever, coordinated their approaches — public health, mental health, law enforcement, the courts — have pulled together to try to save lives that are being lost to addiction and overdose at staggering rates. Though the pace of change is slow, there is reason for hope.

But the criminal legal system is lagging in its response and has proved resistant to replacing or even supplementing traditional tools of punishment with evidence-based approaches that are proven to save lives. Alabama's harshest response to substance use disorder — incarceration in a Department of Corrections prison facility — is not keeping Alabama safer. People are dying because prisons have failed at the basic task of preventing dangerous, illicit drugs from falling into the hands of desperate incarcerated people.

If we are serious about saving lives, we must aggressively invest in alternatives to incarceration. We must seriously rethink when, and even whether, it makes sense to involve law enforcement and the criminal legal system in what is fundamentally a medical issue.

Our two-year investigation crossed disciplines, demographics, and political philosophies. It included people with graduate

**If we are serious about saving lives, we must aggressively invest in alternatives to incarceration.**

degrees and fancy titles and people who gained their expertise through personal trauma and experience with addiction, treatment, relapse, and recovery. All of them broadly agree that the current system is broken.

They agree that substance use disorder is a medical condition and that the addiction crisis is a public health problem.

They agree that it is long past time for Alabama to get creative about deploying medical and public health tools to tackle it.

They agree that the criminal legal system is not the best tool to help people whose main problem is addiction, and that criminalizing addiction can make things worse for people with substance use disorder.

They agree that lengthy sentences in prisons where dangerous drugs are readily available keep no one safe, and in fact worsen the problems created by the addiction crisis.

They agree things need to change. There is even broad agreement as to *what* needs to change and how. But for a myriad of structural, financial, political, and cultural reasons, Alabama's progress toward building a system better suited to meet the challenges posed by widespread addiction has been unsteady.

This report is an effort to describe where we are, note where progress is being made, and identify areas where bad policies and practices are costing lives. There is no perfect roadmap out of the present crisis, but there

are things that Alabama is doing well and others it is doing poorly. This report seeks to:

- Describe the ways substance use and addiction intersect with the criminal legal system in Alabama.
- Highlight promising Alabama programs and solutions which could be implemented or scaled up around the state.
- Identify ways in which criminal legal responses to addiction fail to meet people who struggle with addiction where they are.
- Uplift the real-world experiences of people living with substance use disorder, people in recovery, healthcare professionals, law enforcement, and other experts who share a desire to see Alabama take a fresh approach to the age-old problem of addiction.
- Analyze the economic toll of Alabama's opioid crisis.

We can't solve problems we have not described or defined. So let's get started.

# The War on Drugs at 50

In 1971, President Richard Nixon declared that “drug abuse” was “America’s public enemy number one.” Defeating it, he said, would require an “all-out offensive” that would be world-wide, government-wide, and nationwide, tackling supply and demand of illegal drugs. He made it clear that he expected government entities to spend as much as it took to win the War on Drugs, asking Congress for funds that nearly doubled the federal budget for drug enforcement.<sup>5</sup>

Five decades later, the War on Drugs has cost Americans an estimated \$1 trillion.<sup>6</sup> More than a million people are arrested for drug possession every year. One-fifth of America’s incarcerated population is serving time for a drug offense.<sup>7</sup>

Those numbers tell us that this country has spent a lot of money and locked up a lot of people. But have criminalization of addiction and mass incarceration actually won Nixon’s drug war?

The answer is no. According to *The Economist*, “the drug business is resilient and adaptable.” And “[t]he profits from selling illegal drugs are so vast that dreaming up creative ways around the law is just a cost of business. Prohibition has so far proven ineffective at every step in the supply chain.”<sup>8</sup>

Meanwhile in Alabama, overdose deaths have skyrocketed, arrests and convictions for drug offenses are clogging our criminal legal system, and demand for drugs remains high. Prohibition and criminalization have distorted our perception of how to handle the very real public health crisis that is wide-

spread addiction. In the war on drugs, drugs are winning. It’s time to change course.

## LESSONS FROM THE SO-CALLED “CRACK EPIDEMIC”

In 1986, federal lawmakers responded to the rising popularity of smokable cocaine (also called “crack”) by passing a law creating a 100 to 1 sentencing disparity for possession or trafficking crack cocaine as opposed to cocaine powder.<sup>9</sup> Enforcement of this and other excessively punitive drug laws that carried mandatory minimum sentences was a major factor in driving modern mass incarceration.

Black Americans bore the brunt of it. Within four years of its passage, the average federal drug sentence for Black Americans had skyrocketed from an already-unjust 11% higher than white Americans to a shocking 49% higher. By 2000, Black Americans were more likely to be incarcerated than to be in college or other higher education.<sup>10</sup> Over-incarceration broke up families and destabilized neighborhoods.

What it did *not* do was help individuals who were living with addiction. Public health experts at the time were aware that addiction was a medical condition that needed treatment: In a 1991 report produced for the House Select Committee on Narcotics Abuse and Control, researchers sought to understand the health consequences of crack cocaine use and find out what treatment was available to people experiencing addiction.<sup>11</sup> The report blamed “inner-city” “socioeconomic problems” for the epidemic,

# 381

Total number of opioid overdose deaths in Alabama in 2018 according to the CDC

thinly veiled language that was mostly code for “Black.” Successful treatment might require “an entire resocialization process.”<sup>12</sup> Ultimately, researchers threw up their hands, writing, “No state-of-the-art treatment method of crack abusers exists.” Mass incarceration continued apace.

Today, the 1986 law that established the 100 to 1 ratio is widely condemned as a failed policy that did a great deal of harm to Black Americans in particular. In 2010, Congress reduced the ratio to 18 to 1.<sup>13</sup> The Equal Act, which would end the disparity completely, passed through the U.S. House of Representatives in 2021 with 360 votes but stalled in the Senate.<sup>14</sup>

### **A NEW EPIDEMIC PROMPTS DIFFERENT POLICY RESPONSES**

Policymakers have responded differently to the opioid epidemic than they did to the crack epidemic. Instead of demonizing people with addiction as antisocial pleasure-seekers and focusing almost exclusively on increased penalties (as was the case with crack cocaine), the conversation around opioid use has centered treatment and compassion.

This is good news for people who need help with opioid use disorder — and probably for society as a whole. But the racial implications are unmistakable and demand to be acknowledged. Crack addiction and its outcomes were primarily seen as problems for Black people and their communities. By contrast, the opioid epidemic, especially in its early stages, devastated white people and their communities.<sup>15</sup>

Stakeholders Alabama Appleseed spoke with to prepare this report, including retired law enforcement officers who had worked in narcotics enforcement during the height of the war on crack and peer recovery specialists who were incarcerated because of it, voiced dismay and frustration at the disparities and explicitly acknowledged the racism behind

Crack addiction and its outcomes were primarily seen as problems for Black people and their communities. By contrast, the opioid epidemic, especially in its early stages, devastated white people and their communities.

them. At the same time, they expressed relief at the pivot toward looking at addiction through the lens of medicine and public health rather than as a crime problem.

Even Alabama, a proudly tough-on-crime state, has come around to reckoning with the opioid epidemic as a public health issue. The state is investing in things like crisis intervention centers and peer support specialists rather than exclusively in punishment apparatus. This shift in attitude may well be underpinned by the perception that opioids are primarily a problem in white communities. Nonetheless, it is beneficial to individuals with substance use disorder who are now more likely than before to be viewed as ill, rather than purely criminal.

But “more likely than before” is a low bar. The fact remains that all too often, criminalization is Alabama’s first response to addiction. For a problem that is almost universally acknowledged to be a public health crisis, law enforcement and the criminal legal system have far too much to do with determining the trajectory of any situation involving illegal drugs. The consequences of that can be deadly.

## PERSPECTIVES FROM RETIRED LAW ENFORCEMENT

To understand the War on Drugs from the perspective of those who fought in it, Appleseed turned to retired Alabama narcotics officers who were active during its earlier phases. Here is what they told us:

### **CAPTAIN JERRY WILEY** | BIRMINGHAM POLICE DEPARTMENT *retired*

Retired Birmingham Police Captain Jerry Wiley still thinks about the people he arrested and recruited as informants during the height of the crack epidemic. He thinks about his three decades in law enforcement — 14 of them as a narcotics officer, including six on a U.S. Drug Enforcement Agency task force, then 16 more in the patrol bureau as a supervisor.

He thinks about how so much of it made no sense at all.

“We were just perpetually arresting people, charging them ... to get other people that we could arrest. Let them work off their cases. And it was just this perpetual thing. We were just recycling everybody, and just so the narcotics detectives can keep up their arrest numbers,” he said of the drug users he arrested then used as confidential informants.

Eventually, Wiley could take no more of this “numbers game.” He moved to a patrol unit for the remainder of his career, was promoted to captain, and retired in 2016. Today, he wonders if decriminalization of all controlled substances is the most sensible path forward.

“The fallacy of the assumption of criminalization is that it’ll stop people from using. Well, clearly, that didn’t happen. We haven’t stopped anything,” he said.

“I don’t think there’s a fix for it but putting people in prison and jail definitely hasn’t worked. We’ve been doing that. That’s what I always go back to. We’ve been doing it this way,” he said. “Let’s try it another way.”

“The fallacy of the assumption of criminalization is that it’ll stop people from using. Well, clearly, that didn’t happen. We haven’t stopped anything.”

### **“HENRY”** | JEFFERSON COUNTY SHERIFF’S DEPARTMENT *retired*

When “Henry” joined the Jefferson County Sheriff’s Department in 1968, he was one of the first class of undercover narcotics officers. Training back then was minimal. He was supervised by someone who had been on the job only six months, and his mentor had almost no education about the law.

He rotated off the narcotics beat for a time but returned in 1977 as an undercover officer affiliated with a federally funded multi-county drug unit.

As an undercover officer, much of his job consisted of befriending small-time heroin and cocaine users so he could buy drugs and learn more about the supply chain. Sometimes the people he befriended would do him a favor and sell drugs themselves. As a result, “We put a lot of people in jail that weren’t really drug dealers,” he said. “You’d flip them to get more numbers, more numbers. It was all about headlines.”

Back then, he and his colleagues didn't think much about the human beings whose lives their work interrupted. "We were enforcing the law the way it was written, to the letter of it. If they'd have told me that water was against the law back then, to go arrest anybody that drank water, I would have gone and arrested people that drank water."

Over time, the work wore him down. His voice was strained as he recalled an incident in which a man came into his office and offered to inform on his friends. The man didn't have as much information as Henry needed, so "I chewed him out and told him to hit the road. Well, he gets on his motorcycle and goes across the street about 90 miles an hour right into a brick wall, and killed himself."

Henry took a break from narcotics work after that and began a tour on the SWAT team before taking on homicide, property, and child sexual abuse cases. Eventually, it all became too much. He left after more than two decades on the force.

Henry has seen a lot in the 30 years since then. Substance misuse has twice intruded heartbreakingly on his personal life: when his young niece died over an opioid overdose following an addiction that spiraled out of recreational use, and when a drunk driver killed his brother.

Today, Henry describes himself as personally opposed to alcohol use (though he harbors no hope of it being criminalized) — but thinks that as long as alcohol is legal, marijuana should be too. He remains adamant that people who sell drugs, even small amounts, should be dealt with harshly, but thinks that people with substance use disorder should not be incarcerated for possession. Instead, he supports a drug court model where users are offered treatment, with expungement available for those who succeed.

Reflecting on his law enforcement career 30 years after leaving the sheriff's department, he does not know what to make of the fact that after decades of fighting, the War on Drugs has not substantially eroded drug use or sales.

"I don't know that it can be successful," he said of the Drug War. "People are dying left and right from these opiates. There's a problem in the system there somewhere."

"If they'd have told me that water was against the law back then, to go arrest anybody that drank water, I would have gone and arrested people that drank water."

# Drug Enforcement in Alabama

## *By the numbers*

Data from Alabama’s Sentencing Commission and Department of Corrections illustrates the magnitude of the present-day drug war’s dragnet.

Before presenting these numbers, it bears noting that the majority of people who are convicted of simple possession of a controlled substance or paraphernalia do not find themselves in prison immediately. Many are routed through drug courts or other pretrial diversion programs which aim to connect them with treatment and incentivize recovery. People who graduate from these programs have their cases dropped and are never recorded as guilty.

However, drug court and other diversion programs are mostly user-funded in Alabama, and participation can cost thousands of dollars. This creates a barrier to entry that prevents some of the people who need diversion most from participating. In 2018 and 2019, an Appleseed survey of people who were eligible for or participated in diversion programs found that 20% of survey-takers had been turned down for a diversion program because they could not afford it, and 19% had been kicked out of a diversion program because they could not keep up with payments.<sup>16</sup>

Structural obstacles also abound: 22% of survey-takers who were offered an opportunity to participate in a diversion program were unable to do so because of work, childcare, or school obligations. Another 20% reported they had to drop out of a diversion

program due to these types of responsibilities. Many diversion programs require participants to maintain employment or enrollment in school while also requiring them to appear in court or show up for drug screenings frequently and during regular business hours. These obstacles, together with financial costs, make it extremely difficult for people who lack resources and stability to succeed. Often, drug participants need intense rehabilitation services, which are inaccessible due to money or geography. And people who drop out or fail out of drug court typically face harsher punishment than those who don’t participate at all. Failing out of drug court is one way people whose only charge is simple possession might find themselves in prison.

People who for whatever reason do not participate in diversion after being charged with unauthorized possession of a controlled substance are also unlikely to go straight to prison. Instead, they may be put on probation or placed in a post-adjudication diversion program like Community Corrections (which is administered by the Alabama Department of Corrections) or Court Referral. Probation, Community Corrections, and Court Referral all entail fees and generally require participation check-ins and participation in programming of some type. People who do not comply, including people whose failure to comply is due to financial problems, may have their ability to participate in these programs revoked. That is another way indi-

# 22,931

Alabamians were convicted of Possession of a Controlled Substance between 2014 and 2019

viduals whose only conviction is unauthorized possession find themselves in prison.<sup>17</sup>

While it's rare for people whose only offense is simple possession to land in prison, it is far from unheard of. And it is common for people with substance use disorder to also commit other crimes such as theft or forgery to get the money they need to buy drugs. Convictions for these collateral offenses can be what puts them over the top and sends them to prison for crimes that are driven by addiction, not malice.

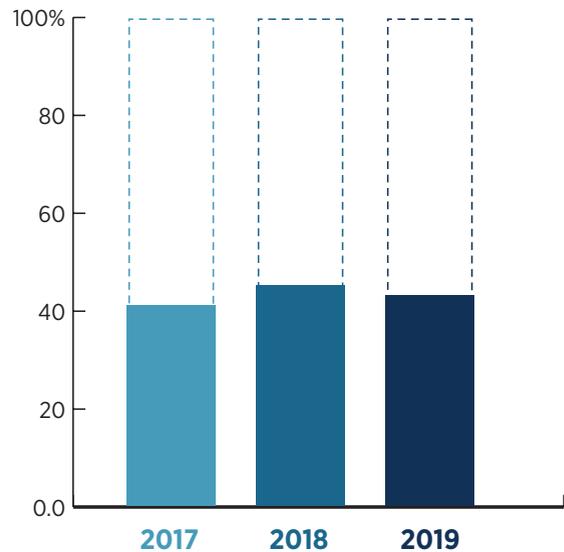
### DRUG ARRESTS | 2014-2019<sup>18</sup>



Between 2014 and 2019, Alabama law enforcement arrested 65,887 people for either drug possession or drug sales. Almost 9 in 10 of these arrests (89%) were for possession.<sup>19</sup>

### DRUG CONVICTIONS

Drug convictions as a percentage of criminal convictions | Oct. 1, 2016-Sept. 30, 2019



Drug offenses are a major driver of criminal convictions in Alabama<sup>20</sup>:

- In Fiscal Year 2017, drug offenses were 41% of all felony offenses at conviction.
- In Fiscal Year 2018, drug offenses were 45% of all felony offenses at conviction.
- In Fiscal Year 2019, drug offenses were 43% of all felony offenses at conviction.

### NUMBER OF ARRESTS BY DRUG TYPE

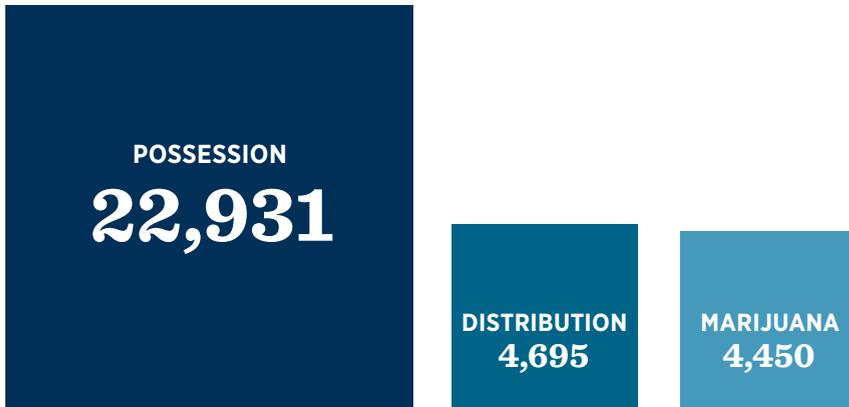
	Heroin	Synthetic Drugs	Other	Marijuana	Total Drug Arrests
<b>2014</b>	2134	1470	2836	3500	9,940
<b>2015</b>	2036	1600	3353	3019	10,008
<b>2016</b>	2181	1725	3986	2546	10,438
<b>2017</b>	2329	1541	4672	4069	12,611
<b>2018</b>	2361	1909	5377	2548	12,195
<b>2019</b>	2599	2180	3826	2090	10,695

**65,887**

## FREQUENCY OF DRUG-RELATED OFFENSES

Among felony offenses at conviction | 2014-2019

Three drug-related offenses made the list of the top 10 most frequent felony offenses at conviction between 2014 and 2019<sup>21</sup>: Possession of a Controlled Substance, Distribution of a Controlled Substance, and First Degree Possession of Marijuana.



### POSSESSION OF A CONTROLLED SUBSTANCE “DOMINATES”

Possession of a controlled substance has for years been the most frequent felony offense at conviction. 22,931 Alabamians were convicted of this offense between 2014 and 2019.<sup>22</sup>

The Alabama Sentencing Commission observes that unlawful possession of controlled substance convictions are a major driver of drug offense convictions overall.<sup>23</sup> Possession of controlled substance offenses also “dominate” among Class D offenses, and these convictions increased by more than 25% between Oct. 1, 2016-Sept. 30, 2019.<sup>24</sup>

■ In Fiscal Year 2017, 81% (3,478 out of 4,304) of Class D convictions were for possession of a controlled substance.

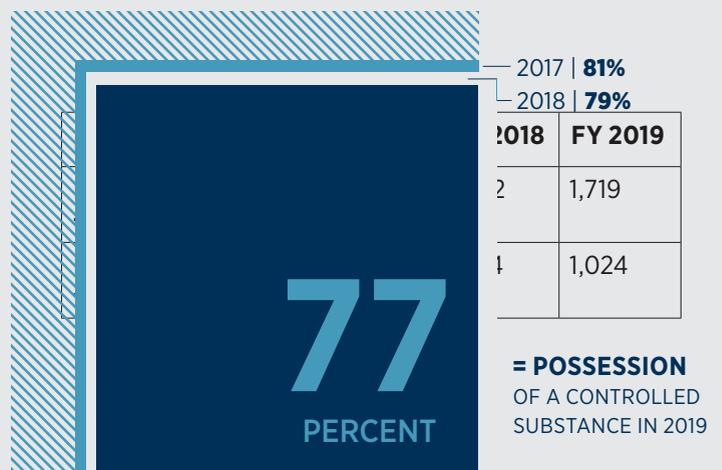
□ In Fiscal Year 2018, 79% (4,810 out of 6,110) of Class D convictions were for possession of a controlled substance.

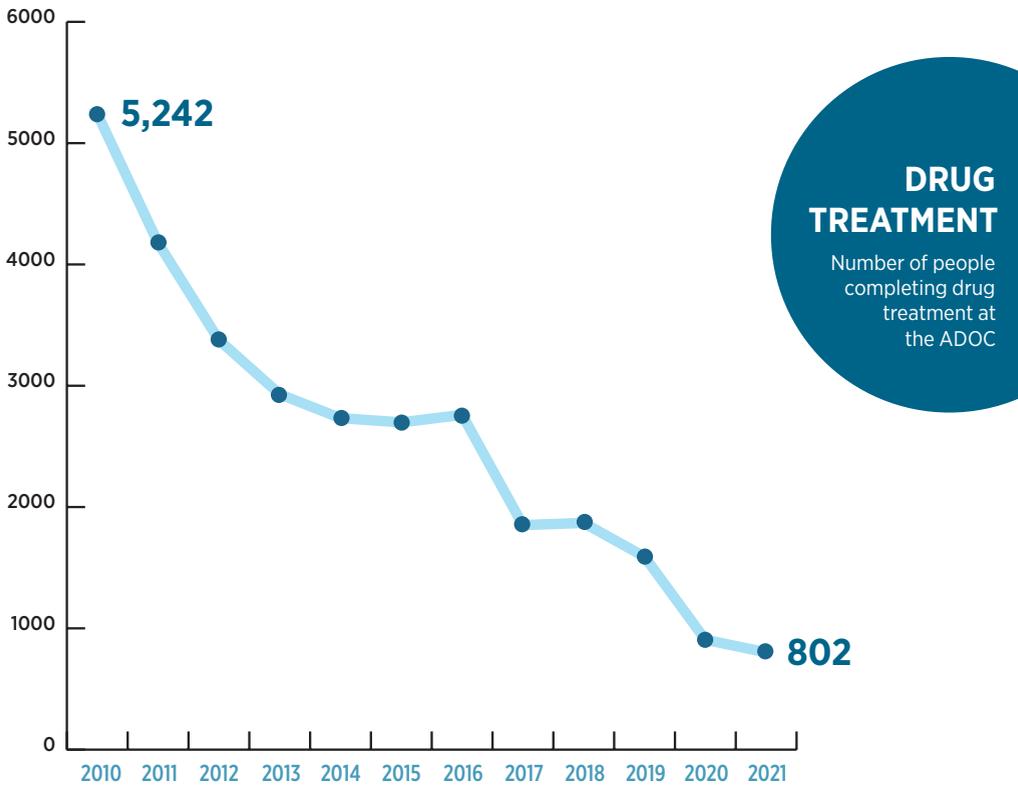
■ In Fiscal Year 2019, 77% (5,209 out of 6,722) of Class D convictions were for possession of a controlled substance.

The Alabama Sentencing Commission observes that unlawful possession of controlled substance convictions are a major driver of drug offense convictions overall.

### CLASS D CONVICTIONS

■ 2017-2019





**FISCAL YEARS 2017-2019**

**INCARCERATION FOR DRUG OFFENSES**

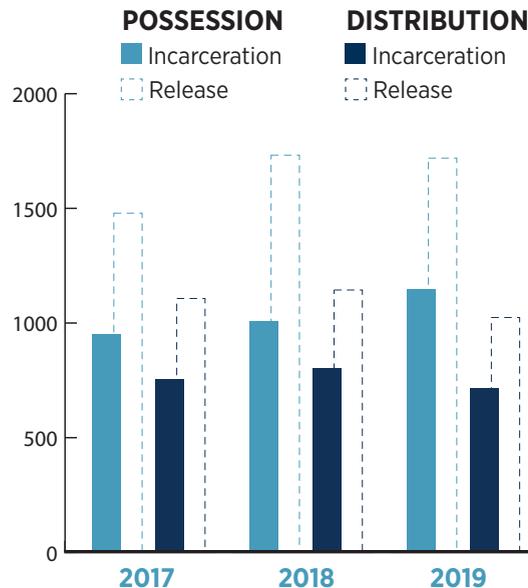
Drug offenses were the leading driver of Department of Corrections admissions every year between Oct. 1, 2016 and Sept. 30, 2019.<sup>25</sup> Possession of a controlled substance and distribution of a controlled substance, respectively, were the top two convictions driving admissions during that time period.<sup>26</sup>

**TREATMENT BEHIND BARS** | The Alabama Department of Corrections (ADOC) estimates that 75-80% of the people in its custody have substance use disorder. Year after year, its annual reports say the Department runs “the largest substance abuse program within the State of Alabama.”<sup>27</sup>

While the number of people admitted to DOC custody for drug offenses has crept up in recent years, the Department’s provision of drug treatment has plummeted.

**RELEASES** | Just as they drove prison admissions, possession of a controlled

substance and distribution of a controlled substance, respectively, were the top two convictions driving prison releases from Oct. 1, 2016-Sept. 30, 2019.<sup>28</sup>



# Understanding the Crisis

Addiction is a medical condition which historically has been “treated” using law enforcement and criminal punishment tools. Here, we define and describe the nature of the illness and why it is so challenging to treat.

## WHAT IS ADDICTION?

A defining characteristic of substance use disorder is that “people keep using the substance even when they know it is causing or will cause problems. The most severe SUDs are sometimes called addictions.”<sup>29</sup>

That definition, from the American Psychiatric Association, is easy to quote. But many people struggle to wrap their heads around why people with substance use disorder continue to engage in a behavior whose possible outcomes include incarceration and death.

In seeking to cultivate some understanding of what compels people with substance use disorder to continue to use drugs even though they understand the potential consequences, Alabama Appleseed spoke with a range of experts, including people in recovery and those who treat them.

Blake Puckett, whose parents’ three-hour drive to Montgomery inspired this paper, likened addiction as a demon awakened by the Percocet doctors prescribed him at age 15. This rendering was common among people living with substance use disorder, who in conversation with Alabama Appleseed often described their early encounters with addictive drugs as turning points in their lives.

In fact, people who struggle with addiction experience neurobiological changes that induce dependence.<sup>30</sup> In the context of opioid use disorder, these changes can transform an act that often begins with a needed prescription into a physical need that

outlasts the condition the prescription was meant to manage.

Scientists describe the “transition to addiction” as follows: “[T]he pleasure derived from opioids’ activation of the brain’s natural reward system promotes continued drug use during the initial stages of opioid addiction. Subsequently, repeated exposure to opioid drugs induces the brain mechanisms of dependence, which leads to daily drug use to avert the unpleasant symptoms of drug withdrawal. Further prolonged use produces more long-lasting changes in the brain that



may underlie the compulsive drug-seeking behavior and related adverse consequences that are the hallmarks of addiction.”<sup>31</sup>

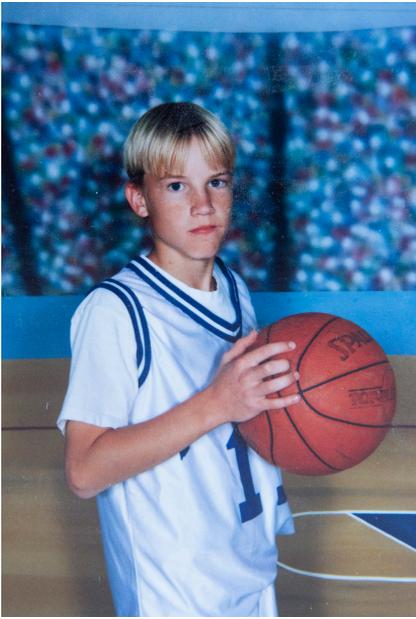
Not everyone who is physically dependent on opioids to manage pain is addicted. For instance, cancer patients may require opioids over long periods of time to manage pain — using them without *misusing them*.<sup>32</sup>

This paper takes no position on medical decisions to prescribe or use medications that can be lifesaving. Those decisions require medical expertise, not ideology or public policy expertise, and should be made by doctors alone.

“What good is it throwing someone in prison and they’re just going to hurt themselves?”

— BLAKE PUCKETT

PHOTO BY BERNARD TRONCALE



Blake Puckett's trouble with substance abuse started with an opioid prescription when he was 15

PHOTOS COURTESY BLAKE PUCKETT

**WHY IS IT SO HARD FOR PEOPLE WHO ARE ADDICTED TO STOP USING OPIOIDS?** “Their brain chemistry has literally changed, and their ability to reason is altered.”

Drs. Leah Leisch and Davis Bradford are Birmingham-based medical doctors who specialize in addiction medicine and have worked with hundreds of individuals who live with opioid use disorder. They work at the University of Alabama at Birmingham's Beacon Recovery, a treatment program that provides counseling, medication assisted treatment (MAT), and other services.<sup>33</sup>

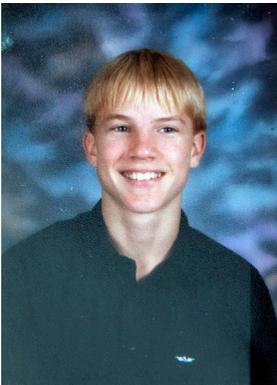
Applesseed asked them for help understanding why it is so difficult for people with opioid use disorder to stop using and remain in recovery. Describing how the neurochemical changes induced by opioid use express themselves in real life, Leisch was blunt: “Someone in their right mind wouldn't choose to lose their children. Someone in their right mind wouldn't inject drugs in their eyeball or their penis. But we see that, because [people with addiction are] not in their right mind,” Leisch said. “Their brain chemistry has literally changed, and their ability to reason is altered.”

The protracted agony of withdrawal is

a major impediment to recovery, Leisch explained. Though some descriptions liken withdrawal to the flu, Leisch and Bradford said the symptoms are far more severe in reality and can even be life-threatening.

“They get horrible pain, horrible nausea, vomiting, diarrhea. We've had several patients actually get admitted because they get such terrible electrolyte abnormalities from all the vomiting and diarrhea. Like not only are they dehydrated, their potassium is low. Their sodium is low. They're really, really, really sick. One patient recently had a tear in his esophagus from all the vomiting. So it gets pretty intense. And [there are] patients where there's been episodes of stress-induced heart failure like Takotsubo's<sup>34</sup> from opioid withdrawal. And people who have coronary risk factors already, who can end up with an MI [myocardial infarction] related to withdrawal, [or] kidney injury from all the dehydration,” Leisch said.

“One patient said, telling someone not to use drugs is sort of like telling someone with chronic diarrhea, if you just wouldn't walk in the bathroom, you wouldn't have diarrhea. That person may try not to go in there. But at some point, your body's going to be like, ‘we have to go in there.’ And she said at that point, you will shove over every chair in your way and every person in your way to get



## ADDICTIVE SUBSTANCES | A PRIMER

Different addictive substances produce different results in the brain. This paper focuses principally on opioid use disorder, but it is worth taking a moment to explore the differences among the substances most commonly misused by the people who shared their stories with us.

### Opioids

Opioids are prescribed to manage pain, for instance after surgery. In general, people who take opioids for short periods of time do not become addicted. It typically takes weeks of regular use for a person to become dependent, though that can vary.<sup>41</sup> Between 5 and 10% of people who receive an opioid prescription for chronic pain develop opioid use disorder.<sup>42</sup> Many of the justice-involved people we spoke with are in recovery from that illness.

Over time, opioids can in essence rewire the brain's pain and pleasure baselines, prompting cravings and intense physical withdrawal. The standard of care for opioid use disorder includes medication assisted treatment (MAT). Methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol) are three common medications which may be prescribed to support recovery from opioid addiction.

### Psychostimulants

Psychostimulants such as cocaine (including crack cocaine, which is a different preparation of the exact same substance<sup>43</sup>) and methamphetamines are the second-most widely used class of drugs worldwide.<sup>44</sup> Several of the people in recovery who shared their experiences with Appleseed used one or both of these substances — sometimes alone, sometimes in conjunction with other substances.

### Cocaine

Cocaine is an addictive stimulant that can be snorted, smoked, or injected. It is possible to overdose on cocaine.<sup>45</sup> Public health officials say that Alabama recently has seen an alarming spike in accidental opioid overdoses among people whose preferred substance was cocaine. This spike has been driven by the recent practice of cutting cocaine with fentanyl, which can easily overwhelm the systems of people who are not used to opioids.<sup>46</sup>

### Methamphetamine

Methamphetamine, commonly found in the form crystal methamphetamine, is an addictive stimulant that can be smoked, swallowed, snorted, or injected. Long-term use is associated with significant changes in brain function. It is possible to overdose on methamphetamine. As with cocaine, methamphetamine is sometimes cut with synthetic opioids, sometimes without the user's knowledge. In 2017, half of U.S. overdose deaths involving methamphetamine also involved an opioid.<sup>47</sup>

### Polysubstance Use

Many of the people who shared their stories with Appleseed — like many people in the overall population of people with substance use disorder — were polysubstance users who use more than one addictive substance. Many people who use psychostimulants are polysubstance users, commonly misusing cannabis, alcohol, or opioids in addition to their psychostimulant of choice.<sup>48</sup>



Mike, Sabrina, and Blake Puckett

PHOTO BY BERNARD TRONCALE

to the bathroom as fast as you can. Because you know that something's wrong. And that's what withdrawal is like."

### WHAT IS MEDICATION-ASSISTED TREATMENT (MAT)?

Medication-assisted treatment, or MAT, refers to a treatment approach that includes the use of medications along with counseling and other tools to treat substance use disorder and maintain recovery. Most physicians consider it the standard of care for opioid use disorder.

The three primary medications used include methadone, buprenorphine (Suboxone), and naltrexone (Vivitrol).

**Buprenorphine** is an opioid partial agonist that "[d]iminishe[s] the effects of physical dependency to opioids, such as withdrawal symptoms and cravings, [i]ncrease[s] safety in cases of overdose, [and] lower[s] the potential for misuse." It can only be prescribed after a person has abstained from opioid use for at least 12-24 hours.<sup>35</sup>

**Methadone** is a long-acting opioid agonist that is taken daily and "reduces opioid craving and withdrawal and blunts or blocks the effects of opioids."<sup>36</sup>

**Naltrexone** for opioid use disorder is administered as an extended-release injection that "blocks the euphoric and sedative effects of opioids such as heroin, morphine, and codeine. Naltrexone binds and blocks opioid receptors, and reduces and suppresses opioid cravings." It can only be administered after people have abstained from opioid use for 7-14 days.<sup>37</sup>

According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), "[t]hese MAT medications are safe to use for months, years, or even a lifetime."<sup>38</sup>

### MAT FOR OTHER SUBSTANCE USE DISORDERS

Throughout this paper, MAT is discussed exclusively as a treatment modality for opioid use disorder (OUD). However, MAT can also be useful in treating alcohol use disorder.<sup>39</sup> Researchers at the University of Alabama at Birmingham and elsewhere are currently exploring options for compounds that could help support treatment and recovery for other substance use disorders such as cocaine use disorder.<sup>40</sup>

# The Opioid Epidemic in Alabama

This report focuses on the opioid epidemic because drug overdose deaths have accelerated alarmingly in Alabama in recent years, and opioids are the type of drug most commonly causing these deaths.<sup>49</sup>

It took decades to get where we are today. The story of Alabama's opioid crisis starts in 1996, when the drug manufacturer, Purdue Pharma, released OxyContin, a potent reformulation of an older opioid, and deployed sales representatives to tell doctors that it was safe, responsible, and compassionate to prescribe their new drug to manage all kinds of pain.<sup>50</sup> At the time, doctors were told that patients who suffered "legitimate pain" were unlikely to become addicted to prescription opioids.<sup>51</sup>

It is now common knowledge that OxyContin and other opioid medications are both addictive and potentially deadly. But the damage is done. According to the Alabama Department of Mental Health, between 2014 and 2021, 21,868 Alabamians who received treatment for opioid use disorder first used opioids at age 15.<sup>52</sup> They were children.

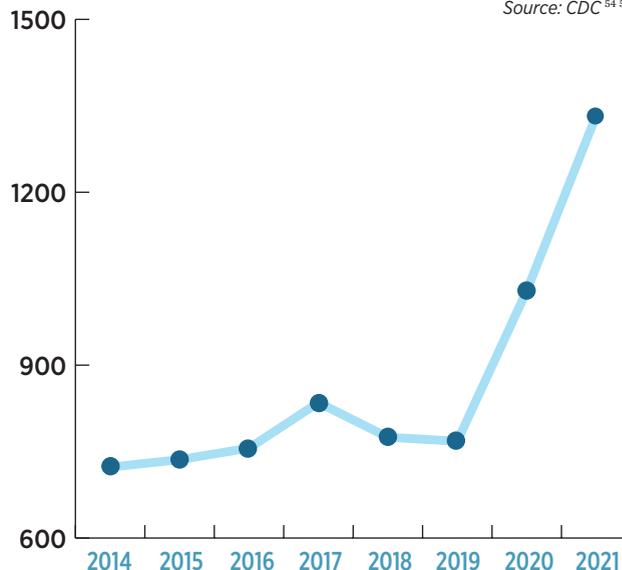
Lax prescribing rules and the false notion that people in real pain could not get addicted meant that pills were readily available and highly sought after on the black market. In 2006, the most distant year for which the Centers for Disease Control maintains data, opioids were dispensed at a rate of 115.6 prescriptions per 100 people in Alabama.<sup>53</sup> Alabama ranked fourth in the nation that year for dispensing rate, behind West Virginia, Tennessee, and Kentucky.

Purdue Pharma corporate records have since shown that the company and its army of sales reps specifically targeted Southern states with high poverty rates and large numbers of individuals injured in dangerous jobs such as coal mining.

In 2012, after years of ranking fourth, Alabama's dispensing rate shot up to first in the country at a staggering 143.8 prescriptions per 100 people. The rate has dropped every year since then and stood at 80.4 prescriptions per 100 in 2020, the most recent year for which CDC data is available. But even with that decline, Alabama still ranked first in the country every year from 2012-2020 (*see chart for details*).

ALABAMA DRUG OVERDOSE DEATHS 2014-2021

Source: CDC <sup>54-55</sup>



## ALABAMA'S RANK ON CDC STATE OPIOID DISPENSING RATE TABLES | 2006-2020

Rx Rank and Rate per 100				
Year	1st	2nd	3rd	4th
2006	WV 129.9	TN 124.8	KY 122.6	<b>AL 115.6</b>
2007	WV 135.1	KY 130.8	TN 128.8	<b>AL 120.3</b>
2008	WV 145.5	KY 136.6	TN 132.9	<b>AL 126.1</b>
2009	WV 146.9	TN 138.4	KY 135.2	<b>AL 131.6</b>
2010	WV 143.1	TN 140.0	KY 136.5	<b>AL 134.3</b>
2011	WV 139.6	TN 138.5	KY 137.0	<b>AL 136.6</b>
2012	<b>AL 143.8</b>			
2013	<b>AL 142.4</b>			
2014	<b>AL 135.2</b>			
2015	<b>AL 125.0</b>			
2016	<b>AL 121.0</b>			
2017	<b>AL 108.8</b>			
2018	AL 97.5			
2019	AL 85.8			
2020	AL 80.4			

Drug overdose deaths, many of which are linked to opioids, began to climb even as prescription rates tapered. One reason for this is that many people who are addicted to opioids continue to seek them out even after prescriptions dry up. The contents of illicit opioids are less predictable than those of prescription pills, and higher potency leads to greater likelihood of overdose.

Overdose deaths first peaked in 2017, the same year Alabama established its Opioid Overdose and Addiction Council. The number of deaths decreased in 2018 and 2019, only to get higher than ever in 2020 and 2021, years during which the pandemic drastically disrupted lives and created horrific stress even as it complicated efforts to provide treatment and recovery services to Alabamians who needed them more than ever.

# 21,868

Alabamians who received treatment for opioid use disorder between 2014 and 2021 **FIRST USED OPIOIDS AS CHILDREN AT AGE 15.**

# Alabama’s Opioid Overdose and Addiction Council

This report focuses on areas where Alabama’s drug policy is making things worse for people with substance use disorder. The main arena in which that is occurring is the criminal legal and punishment systems, particularly the Alabama Department of Corrections, which is failing at the extremely basic task of keeping the people in its custody from dying of preventable causes, including drug overdose.

But there are bright spots as well. Chief among them is Alabama’s Opioid Overdose and Addiction Council, a multi-stakeholder entity established in 2017 and co-led by the Commissioner of the Alabama Department of Mental Health, the Attorney General of Alabama, and the State Health Officer and tasked with developing an evidence-based approach to reducing addictions and opioid-related deaths.<sup>56</sup>

The council’s first report, issued Dec. 31, 2017, set out a four-pronged action plan focused on “*prevention* of opioid misuse, *intervention* within the law enforcement and justice systems, treatment of those with opioid use disorders (OUD), and *community response* that engages ordinary Alabamians to become involved with finding solutions at a local level.”<sup>57</sup>

Elaborating, the council wrote, “*Intervention* strategies address drug trafficking laws and working with drug courts in Alabama to encourage the use of medication assisted treatment (MAT) for those with OUD. *Treatment* strategies include increasing access to care for those with OUD in Alabama and

encouraging the use of evidence-based practices to improve the identification and treatment of those with OUD.”<sup>58</sup>

The council made many sound recommendations, stressing the need to educate the public about the nature of OUD, reduce stigma, encourage people to seek help, and increase the availability of naloxone, a life-saving treatment that can stop overdose deaths from occurring.<sup>59</sup>

Regarding Alabamians who are justice-involved and live with OUD, it noted that “[o]verdoses in Alabama are associated with release from incarceration. Statistics have shown opioid overdoses are more than 50 times higher for those leaving incarceration or enforced abstinence. The tolerance of these persons to opioids is lower and, as such, they are more likely to overdose when resuming their previous patterns of use.”<sup>60</sup>

The council also noted that “Alabama’s rate of incarceration is one of the highest in the country, with co-occurring substance use and mental disorders being more common among people in jails, prison, and other criminal justice settings than among persons in the general populations, which often results in the criminal justice system serving as de facto mental health system. Unfortunately, there are insufficient data to inform policy makers who can develop a system-wide response.”<sup>61</sup>

Over the next several years, the council monitored progress toward its original goals and refined them. In early 2018, trafficking fentanyl was made a felony, which accord-

## 802

The number of people who completed drug treatment in ADOC in 2021, down from 5,242 in 2010

ing to the Council “provided law enforcement the tools needed to prosecute Fentanyl related crimes more effectively.”<sup>62</sup>

Regarding other goals directly intended to impact justice-involved people, the council reported, “Law Enforcement (LE) Officers and the Judiciary come into contact frequently with individuals and families struggling with substance misuse issues related to opioids and heroin. This use may not be in the forefront for them and as a result LE officers and the Judiciary need training and education on addiction, how it affects the brain, and best practices for dealing with these individuals.”<sup>63</sup> The strategy for dealing with this deficit, the Council wrote, would be to have the Alabama Department of Mental Health “provide training on addiction to LE agencies and the Judiciary.”<sup>64</sup>

The Council made a great deal of progress implementing its goals around safer prescribing, data collection, community education, stigma reduction, and increasing the availability of life-saving naloxone. By the end of 2020, the Department of Mental

Health had trained several hundred law enforcement officers in behavioral health issues, including addiction, and dissemination of naloxone to officers had begun.<sup>65</sup>

<sup>66</sup> In 2022, based on the Council’s recommendation, the Alabama legislature passed a groundbreaking law<sup>67</sup> that decriminalized possession of fentanyl testing strips, which is expected to reduce overdoses and save lives by enabling people who use drugs, and those who interact with them, to test drugs for the presence of fentanyl.<sup>68</sup>

Statistics have shown opioid overdoses are more than 50 times higher for those leaving incarceration or enforced abstinence. The tolerance of these persons to opioids is lower and, as such, they are more likely to overdose when resuming their previous patterns of use.

# Dollars and Cents

## *Estimating the cost of this crisis*

This report is primarily an effort to understand the impact on Alabama of criminalizing addiction, bringing into focus the experiences of justice-involved people and those who serve and work with them, identifying places where Alabama is making smart investments and pointing out gaps that are costing our neighbors their lives.

But even as we center human experiences and lives, there are other costs to consider, including the explicit monetary costs associated with opioid use disorder in Alabama. (We chose opioid use disorder, rather than substance use disorder more broadly, because of the high-quality data that exists regarding opioid use and its outcomes in Alabama.) We do this not to portray people living with opioid use disorder as a burden to the state — we would no more do that than we would seek to describe people who have any other life-threatening illness as a burden. But the simple reality is that losing Alabamians to addiction costs money.

This section of the report is an effort to estimate just how much. To do this, we relied on a methodology performed in “The Staggering Cost of Long Island’s Opioid Crisis” written by Jonas J.N. Shaende and Shamier Settle.<sup>69</sup> Below, we break the costs associated with opioid addiction into two main categories:

► **Fatal cost:** This number looks at what a person who died from an opioid overdose would have contributed to Alabama the

rest of their life if they had lived.

► **Non-fatal cost:** This number encompasses criminal justice costs, productivity costs, health care costs, and substance abuse treatment costs associated with addiction that does not result in fatality.

Combining these two numbers provides an estimate of the financial costs created by Alabama’s opioid in 2018.

### **FATAL COST**

To estimate fatal cost, we used a reported total of opioid overdose deaths in Alabama from the CDC WONDER database.<sup>70</sup> In 2018, this total was 381 deaths. To estimate cost per death, we used a common metric called value of a statistical life (VSL). As stated in *The Value of a Statistical Life* by Thomas Kniesner and Kip Viscusi,<sup>71</sup> VSL is “the local tradeoff rate between fatality risk and money” and it is used by governments and researchers alike to measure the cost of a life lost. We used the accepted figure of around \$10 million (\$2017) per life put forth by Thomas Kniesner and Kip Viscusi. After adjusting for inflation, these two figures give a cost estimate of \$3.89 billion dollars incurred in 2018 due to opioid-related overdose deaths in Alabama.

### **NON-FATAL COST**

Calculating non-fatal cost is more complex and depends on several considerations. For the most conservative estimate, we combined the number of individuals who

**\$3.89  
BILLION**

Total cost incurred in 2018 due to opioid-related deaths in Alabama

are documented as receiving public opioid dependency treatment and an annual cost estimate of \$30,000 established in *Florence et al.* (2016),<sup>72</sup> represents the cost of an opioid dependent individual to the state in a year. This figure includes criminal justice costs, productivity costs, health care costs, and substance abuse treatment costs.

The Alabama Department of Mental Health reported that in 2018, 9,716 individuals received opioid dependency disorder treatment.<sup>73</sup> This serves a partial estimate of the number of dependent persons in Alabama in 2018. These render a highly conservative estimated non-fatal cost of \$309,140,384 in 2018. This is conservative because it only includes publicly treated patients and assumes that all opioid dependent Alabamians are reported as having received treatment.

These assumptions almost certainly undercount the number of Alabamians who are dependent on opioids. A Johns Hopkins School of Public Health Study estimates that only 20% of opioid dependent persons receive treatment at a given time.<sup>74</sup> Assuming Alabama's publicly treated patients (9,716) only account for 20% of our total publicly insured dependent population, we can estimate that around 48,500 publicly insured Alabamians were dependent on opioids in 2018. Using this, we can generate a more accurate estimate of non-fatal cost of around \$1.5 billion in 2018.

Even this amount is likely an underestimate, as it still only factors in publicly treated patients. To account for those uninsured or privately insured, we will assume the proportions of publicly, privately, and uninsured opioid dependent people resembles that of Alabamians with public, private, or no health care insurance. We believe this to be a reasonable assumption because many opioid dependencies are the result of prescriptions and there is no reason to believe these two populations would receive

opioid prescriptions at different rates. Additionally, although within the \$30,000 (\$2,015) non-fatal figure there are some costs only incurred to the state for persons receiving public treatment, we agree with Florence et al (2016) and believe this is made negligible by differences in other categories like consumer spending, thus allowing us to apply our non-fatal estimate to privately insured persons.

Using US Census Bureau ACS data from 2018,<sup>75</sup> we can approximate the proportions of the private, public, and uninsured populations in Alabama. This results in an approximation of 60% privately insured, 30% publicly insured, and 10% uninsured Alabamians. Using these proportions and the adjusted number of publicly treated patients (48,500), we estimate the privately insured dependent population to be 97,000, the publicly insured to be 48,500, and the uninsured to be 16,000. This makes a total of 161,500 dependent Alabamians. If there is some failed assumption or abnormality considering the privately insured population, we can assume they are dependent at half the rate of publicly treated patients. This results in a lower estimate of 113,000 dependent Alabamians and an upper bound of 161,500.

Our estimates of our dependent individuals and the annual cost estimate of \$30,000 (\$2015) provide a non-fatal cost of between \$3,595,395,580 and \$5,138,552,090 for 2018.

#### **TOTAL COST**

In sum, we estimate the total costs of opioids (fatal and non-fatal) to the state of Alabama incurred in 2018 alone to be between \$7,485,395,580 and \$9,028,552,090.

This is conservative because it only includes publicly treated patients and assumes that all opioid dependent Alabamians are reported as having received treatment.

## DISCUSSION

No person's worth can be calculated in dollars and cents. Each individual represented in the fatal and non-fatal costs is someone whose value to the people who love them — their family, their friends — is incalculable.

### **So why engage in this ghastly exercise? What does this dollar amount represent?**

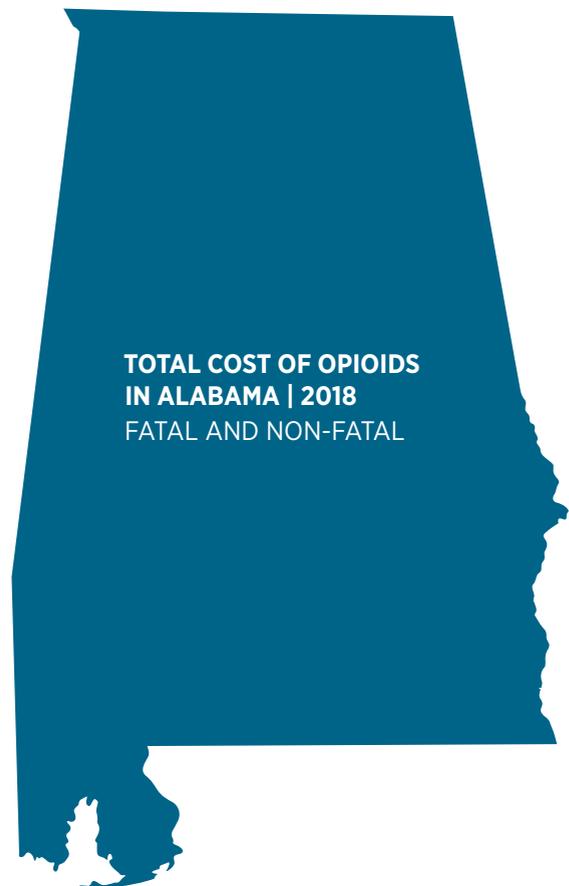
In plain language, it represents our best estimate of the costs Alabama incurred due to opioid use disorder in 2018. Seven and a half billion dollars — the low estimate — is a staggering amount of money. We do not contend that criminalization of addiction is wholly responsible for this loss: As discussed throughout this report, addiction is complicated, and if there were a simple and obvious solution, we would have implemented it already.

But since at least the 1970s, the criminal justice system has been the primary toolkit with which Alabama has sought to tackle

drug use and addiction. Even as state officials pivot to viewing this crisis through a public health lens, the attorney general — who is the state's top law enforcement officer — remains the leading voice on the crisis.

It is not the criminal legal system's failings alone that cost Alabama so many lives and so many dollars in 2018. But the criminal justice-led War on Drugs is not working. It is long past time for a different system to take the reins as Alabama seeks more effective ways of tackling this crisis and saving lives.

**BETWEEN**  
**\$7,485,395,580**  
**AND**  
**\$9,028,552,090**



# Criminalizing Addiction

Addiction is a medical condition. Why are police, judges, and jails so heavily involved in “treating” it? In this section, we will talk about what happens when law enforcement becomes involved in the lives of people with substance use disorder.

## FIRST RESPONDERS AND OVERDOSE PREVENTION

In many jurisdictions, police have begun to carry naloxone (Narcan), a life-saving treatment that can instantly reverse the effects of an opioid overdose. Steve Marshall, Alabama’s attorney general, has strongly encouraged law enforcement officials to carry Naloxone.

“I remember one time during my tenure as district attorney I was meeting with a local physician, who was trying to tell me about the need to be able to increase naloxone in our community, explained to me how it’s increased availability and use it save lives,” Marshall recalled at a Sept. 2020 event sponsored by The Healing Network of Walker County. “And when he shared this with me my first statement to him was my concern that having Naloxone readily available would make it easier for someone to decide to use a controlled substance that potentially could result in overdose. I thought it might encourage or enable an active use of controlled substances, as opposed to helping us get someone clean. The physician patiently listened to my concerns. And then he completely changed my perspective when he had this simple reply: ‘I can’t save a dead person.’”

“And that was an epiphany moment for me. It made me recognize that my overly simplis-

tic view of addiction was wrong, and that there was much that I could do to help others, especially those in law enforcement, see the value in the use of this life saving drug.”<sup>76</sup>

In conversation with Alabama Appleseed, officials who helped train law enforcement in the use of naloxone said that many law enforcement officers shared Marshall’s initial attitude. Some law enforcement officers have been traumatized by seeing the same individuals overdose repeatedly, sometimes within very short periods of time.

Aware of these attitudes, the Opioid Council took action to reinforce the benefits of naloxone and prepare law enforcement officers to deploy it appropriately, attending law enforcement conferences and creating specialized resources and training materials. In 2021, 7,069 naloxone kits were distributed to law enforcement in Alabama, a 374% increase compared to 2020.<sup>77</sup> Having Marshall’s stamp of approval has increased distribution and likely saved lives.

## ARREST & JAIL

*Alabama takes a maximalist approach to prohibition. Here, unauthorized possession of even small amounts of controlled substances is typically a felony. Between 2014 and 2019, Alabama law enforcement arrested 65,857 people for either drug possession or drug sales. Almost 9 in 10 of these arrests (89%) were for possession.*<sup>78</sup>

When law enforcement officers encounter a person who is in possession of suspected illegal drugs, the process typically goes as follows: The person is arrested, booked into jail, and

charged with Unauthorized Possession of a Controlled Substance, a Class D felony. A judge determines the bail amount.

If the person can put up the required amount of money, they are released from jail to await additional proceedings, potentially including diversion into drug court (*see next section*).

If they are unable to access the required amount, they may sit in jail for weeks or months awaiting trial. Judges may revisit their bail amount and lower it to make it possible for them to leave, but some people sit in jail for lengthy periods because they do not have access to people who can bail them out and because a judge, for any number of reasons, does not believe it is safe to release them on their own recognizance.

For people with addiction who are jailed for lengthy periods, the situation is often bleak. Suddenly stopping the use of most addictive substances typically triggers physical withdrawal, which range from extremely unpleasant to potentially deadly. Though some jails in Alabama permit the people in their custody to continue using medication assisted treatment (MAT) such as methadone or Suboxone, others do not. In many instances, people whose recovery depends partially on access to MAT may find themselves suddenly without the medication they require.

Information about deaths and medical emergencies in Alabama jails is not collected in a central public repository, making it extremely difficult to track what happens to people who detox in jail. Some insight is afforded by a lawsuit filed against Madison County by a woman named Whitney Foster. According to court records,<sup>79</sup> Foster alleged that jail officials knew she was taking methadone when she was booked into jail in April 2014. She was abruptly denied access to her medication after being admitted and began to experience withdrawal symptoms including elevated blood pressure, slurred speech, incontinence, and difficulty controlling her body. Jail staff accused her of faking and gave

her ibuprofen, but about two weeks after she was admitted, Foster began having strokes and seizures. It took two days and the intervention of multiple people with whom she was incarcerated before Foster was sent to the emergency room. She sustained permanent neurological damage as a result of this series of events.

In addition to triggering serious medical outcomes, disruptions to MAT caused by jails' refusal to allow people access to their medications can lead to deadly consequences later. A 2018 study out of North Carolina found that during their first two weeks after release, formerly incarcerated people were more than 40 times as likely to die of an opioid overdose than people in that state's overall population.<sup>80</sup> Other studies show that overdose is the leading cause of death for recently incarcerated people.<sup>81</sup>

Public health professionals attributed these staggering numbers to a range of causes, including the unpredictable potency of many street drugs, which can lead to accidental overdose, and the scarcity of MAT, which medical and public health professionals almost universally describe as the standard of care for opioid use disorder. People leaving jail or prison are at especially high risk of overdose after detoxing and/or losing access to MAT because their systems are unready to process the doses they may have gotten accustomed to prior to being detained in jail.<sup>82</sup>

Without access to MAT or other evidence-based treatments in jail, there is little evidence to suggest that pre-adjudication jail time is effective at addressing addiction, yet there is plenty of evidence that it can be deadly.

### **CRISIS CENTERS: AN ALTERNATIVE TO ARREST AND JAIL**

Drug use can set off behavioral crises that

“I have detoxed many people in jail. That is not appropriate, that is not humane, but it is what we have.”

ALABAMA DRUG COURT JUDGE

## DETOXING IN JAIL | PARKER'S STORY

“Parker” is a 38-year-old mother who lives in Marshall County and relies on Suboxone to manage opioid use disorder. In summer 2021, she detoxed in Tuscaloosa County jail.

Parker told the jail’s medical provider that she relied on prescribed Suboxone and two other medications for depression and anxiety. They permitted her to keep taking one of those medications but denied her access to the Suboxone that helps her stay off illicit drugs. Instead, “he started me on detox protocol for Suboxone, which was a blood pressure pill, a little packet of NyQuil type stuff [or] some kind of syrup, cough syrup, and a Benadryl. Clonidine for blood pressure. And I’m thinking that’s about it,” Parker recalled.

Crowded in with as many as 42 women in a cell built for 18, she traded some honey buns from the jail’s commissary so she could rest as comfortably as possible in a “boat,” or makeshift plastic bed commonly used in jails that lack bunk space for all the people they are holding. She detoxed in jail for 10 days. After her release, Parker reconnected with her free world doctor and got back on the Suboxone that helps her stay healthy and on track to parent her young son and make her way in this world.

Parker’s experience in the Tuscaloosa County Jail was not unusual. A local defense lawyer who has had countless clients incarcerated there over his career said that jail does not allow people who rely on methadone or Suboxone to access their medication while they are incarcerated there.<sup>132</sup> Other jails in Alabama choose differently, however. According to Parker, the Boaz City Jail allowed her to continue using Suboxone when she was held there.

result in calls to 911. But mental health and behavioral treatment options are thin on the ground in Alabama. When police encounter a person who is having a mental health or behavioral crisis, at present, a common response is to arrest the person for something like disorderly conduct and take them to jail.

In researching this report, Alabama Appleseed spoke with stakeholders in law enforcement, mental health, and public health. No one was happy with the status quo. Law enforcement officers, including people who staff jails, know they lack the training and expertise to meet the needs of people who are in crisis, including crisis that is prompted by drug use. Stakeholders from all disciplines expressed distress and frustration at the fact that jails are often seen as the safest or only place for people in crisis to be.

Recently, Alabama has begun to invest in alternatives. Specifically, the state has begun to construct crisis centers which are administered by the Alabama Department of Mental Health. The state has three such centers so far in Mobile, Montgomery, and Huntsville.<sup>83</sup> Jefferson County announced last year that it would be next to open a center as more are being planned.<sup>84</sup> One explicit purpose of the centers is to reduce arrests by giving “police officers and deputies another option of where to take individuals who are dealing with a mental crisis,”<sup>85</sup> including substance use disorder.

### DRUG COURT

Drug courts are intended to be opportunities for people who have engaged in unlawful behavior driven by addiction to get into treatment and be held accountable in a more supportive, rehabilitative environment than traditional courts permit. Though there is variation among drug courts in Alabama, in general, individuals accused of offenses like possession of a controlled substance

are offered the opportunity to participate in drug court as an alternative to the conventional criminal process. The decision to offer drug court as an option is generally made by a judge and a district attorney.

To participate, a person must plead guilty to whatever offense they have been charged with. In drug court, the judge does not pronounce them guilty, and if the person completes the drug court program to the judge's satisfaction, they will not be pronounced guilty. But if they drop out or circumstances arise that make it impossible for them to finish (for instance, if they are charged with another offense), they will be pronounced guilty and sentenced.

Between 2018 and 2021, Alabama Appleseed observed drug courts all over the state. We also surveyed hundreds of people who had participated in drug court and other diversion programs, conducted in-depth interviews with dozens of them, and talked with drug court judges and professionals about their experiences. Our purpose was to develop an understanding of both the user experience of these programs as well as the practices and experiences of the system actors who run them, to the end of identifying what is working well and what could be improved.

Our findings were mixed. On the positive side, people who successfully complete drug court avoid felony convictions. Some successful participants told us that the treatment and programming they were able to access through drug court helped them get into recovery.

But we also discovered that drug court professionals' ability to provide high-quality services is hindered by a threadbare system where treatment beds are scarce and detox facilities are nearly nonexistent, undermining participants' ability to get the care and support they need in a timely fashion (or at all). Many drug courts impose onerous conditions, including financial costs

and time commitments that put successful completion beyond the reach of people who might otherwise benefit from them or who are simply trying to maintain employment and cannot spend a day in court every week.

The inconsistent access and services can result in felony convictions, probation violations, and ultimately prison sentences in certain circumstances, thereby ensuring that people with documented substance use problems land in violent prisons where dangerous drugs are readily available.

#### **LACK OF RESOURCES HOBBLER SUCCESS**

In 2019, Alabama Appleseed was granted access to the deliberative process of several drug court teams. Overall, we were struck by the teams' detailed understanding of their participants' situations, and the seriousness and compassion with which they discussed each case. It is clear these teams are dedicated to supporting drug court participants' success.

But structural obstacles and scarce resources prove a hindrance to even the most well-meaning teams' efforts and create serious impediments to recovery for the vulnerable people in their care. One immediate problem is the lack of safe places for people to undergo the agonizing and potentially deadly rigors of detoxing.

Jails are also de facto housing for people who require inpatient treatment but face delays in getting a treatment bed. Most treatment facilities in Alabama require people to detox before they arrive: Having illegal drugs in your system disqualifies you for treatment.

When drug court teams believe people who qualify for treatment are at high risk of relapsing before they are able to get to a treatment facility, they may hold those people in jail while they wait for a bed to become avail-

“I keep them [in jail] until I can get some tools to them by way of getting them to an inpatient facility somewhere.”

able. Appleseed witnessed teams make this determination in several instances. No judge or team was comfortable or happy with the notion of incarcerating drug court participants who needed treatment, but all felt that it was the better choice than letting people who had no other place to stay relapse when they were on the verge of getting help.

“These people have burned every bridge that they have so they don’t have a place to go,” one judge explained. “I keep them [in jail] until I can get some tools to them by way of getting them to an inpatient facility somewhere.”<sup>86</sup>

### **SANCTIONS AND CONSEQUENCES**

While drug courts aim to provide treatment, it is important to remember that the criminal legal system is the only social service provider with the power to incarcerate people who do not comply with the prescribed course of treatment. Participation in drug court, therefore, comes with a variety of possible sanctions including increased surveillance in the form of drug testing, long periods of community service, and jail time. Some of these sanctions, including drug testing and extensions on the length of time the person must spend in drug court, can be financially onerous.

In general, Appleseed found that Alabama drug court professionals understand that addiction is a medical condition that requires treatment, not just punishment. Based on that understanding, some drug courts were pivoting away from the most harshly punitive measures in favor of systems they believe to be more effective.

For instance, the Shelby County drug court used to punish drug court participants who relapsed with automatic jail time, but around 2019, they began to reevaluate that approach in light of evidence that relapse is common even among people who are committed to recovery. Research cited by the National Institutes of Health, for instance, says that 40-60% of people with substance use disorders relapse at some point in their treatment.<sup>87</sup>

Today, people who relapse while partic-

ipating in Shelby County’s drug court program may be required to participate in community service instead of serving jail time. While still punitive, this pivot away from the harshest punishment is a step in the right direction by a drug court which is widely considered by professionals and other stakeholders to be one of Alabama’s strictest.

Elsewhere in Alabama, other drug court judges were still jailing participants who failed drug tests. One judge Appleseed spoke with shared that he sanctions people who relapse to four nights in jail if they admit relapsing before they are drug tested; seven nights if they admit relapsing after their drug test results indicate drug use, and 10 nights if they deny relapsing even after their urinalysis indicates drug use.

“Some literature will tell you that’s the stupidest form of sanction on earth,” he said, “but that’s what we do.”<sup>88</sup>

### **REVOCATION AND SENTENCING**

As a rule, Alabama drug court judges sentence people who attempt but do not complete drug court more harshly than people who plead guilty to the same offenses but never attempted drug court. Multiple drug court judges told Appleseed they send people who are unable to complete drug court to prison even if those same people would not have been incarcerated had they not pled in.

They characterized this threat of harsher punishment as a threat to ensure drug court participants remained compliant with program conditions, which typically include frequent court appearances, cooperation with a case manager, and participation in a recovery program matching the participant’s needs as assessed by a behavioral health professional, as well as community service and the maintenance of a job or school course load.

The utility of threatening people who do not successfully complete drug court

“Some literature will tell you that’s the stupidest form of sanction on earth, but that’s what we do.”

programming with harsher punishment is questionable at best. In 2019, Alabama Appleseed surveyed 122 Alabamians who had participated in a diversion program, asking detailed questions about their experience with structural obstacles. One-fifth of our survey sample reported having dropped out of a diversion program because other responsibilities including work, childcare, and school prevented them from fulfilling their obligations.<sup>89</sup>

Judges we spoke with discussed terminating people from drug court because they had been charged with an additional crime or were otherwise noncompliant. Several expressed regret at the idea that they would now sentence those individuals to prison time, but few seemed to contemplate the idea of declining to do so.

The evidence is scarce, at best, that the threat of harsher punishment incentivizes success in drug courts. Indeed, experts in the field have found that punitive sanctions like jail time or other “scared straight” initiatives do not work in this context and can even lead to worse outcomes.<sup>90</sup>

### **MAT IN DRUG COURT: “DO YOU SWAP THE DEVIL FOR A WITCH?”**

In its 2020 year-end report, Alabama’s Opioid Overdose and Addiction Council noted that drug courts’ ability to effectively serve participants with opioid use disorder were still hindered because the courts were still largely “not being receptive to participants participating in allowing [sic] Medication-Assisted Treatment (MAT) or requiring participants stop participating in MAT if they are on drug court.”<sup>91</sup> Eleven months later, the Council again restated its intention to “increase the number of drug courts who allow the use of MAT” by providing education and training to drug court staff.<sup>92</sup>

Here, the council has its work cut out for

it. Drug courts in Alabama do not maintain records showing which drugs are driving their participants’ population. But in a state that placed first in the nation for per-capita opioid prescriptions every year from 2012-2020<sup>93</sup>, it is reasonable to assume that many drug court participants are opioid users, many of whom could benefit from MAT if it were offered.

In 2014, a Shelby County drug court participant named Alex Leith died from a heroin overdose after he stopped using the methadone that helped him stay sober in order to comply with a judge’s requirement that participants taper and quit using MAT before they could graduate.<sup>94</sup> Shelby County no longer requires participants to wean themselves off of MAT.<sup>95</sup>

This practice is in keeping with 2018 guidance issued by the National Association of Drug Court Professionals: “If adequate treatment is available, candidates are not disqualified from participation in the Drug Court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication.”<sup>96</sup> It notes further that “numerous controlled studies have reported significantly better outcomes when addicted offenders received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid agonist medications such as methadone, and partial agonist medications such as buprenorphine.”<sup>97</sup>

Yet despite this guidance, the best efforts of the Opioid Council, and the tragic lesson of Mr. Leith’s 2014 death in Shelby County, some Alabama drug court professionals remain skeptical of MAT.

Even as he acknowledged it is the standard of care, one Alabama judge derided it as simply another addiction and said he generally does not allow participants to remain on

# 40x

Formerly incarcerated people were more than 40 times as likely to die of an opioid overdose than people in a state’s overall population.

MAT for long periods of time. Describing his thinking on trading an addiction to heroin for a reliance on Suboxone, he asked rhetorically, “Do you swap the devil for a witch?”<sup>98</sup>

### **DRUG USERS VS DRUG DEALERS: A DISTINCTION WITHOUT A DIFFERENCE?**

The National Association of Drug Court Professionals provides the following guidance on inclusion of people charged with selling drugs: “Barring legal prohibitions, offenders charged with drug dealing or those with violence histories are not excluded automatically from participation in the Drug Court.”<sup>99</sup>

It continues, “[T]here also appears to be no justification for routinely excluding individuals charged with drug dealing from participation in Drug Courts, providing they are drug addicted. Evidence suggests such individuals can perform as well (Marlowe et al., 2008) or better (Cissner et al., 2013) than other participants in Drug Court programs. An important factor to consider in this regard is whether the offender was dealing drugs to support an addiction or solely for purposes of financial gain. **If drug dealing serves to support an addiction, the participant might be a good candidate for a Drug Court (emphasis added).**”<sup>100</sup>

In Alabama drug courts, district attorneys act as gatekeepers whose consent is necessary before any individual may participate in drug court.<sup>101</sup> In many, individuals accused of offenses deemed by the drug court team to be driven by addiction — for instance, theft or passing bad checks to get money to purchase drugs — were generally allowed to participate in drug court as long as they also agreed to pay restitution to anyone who had experienced loss or harm as a result of their offense. People accused of distribution were excluded from every drug court we observed or spoke with.

According to Alabama’s central data repository on drug use, 89% of drug-related arrests in Alabama are for drug possession, while the

## **I GAVE IT MY ALL AND MY ALL WASN’T GOOD ENOUGH | MICHELLE**

“Michelle” was 16 when her mother, who also struggled with addiction and had a history of incarceration, shared alcohol with her. She was 33 when she was sent to Alabama’s Julia Tutwiler Prison for Women months after being convicted of unlawful distribution of a controlled substance. It was her first felony conviction, after more than half a lifetime of involvement with illegal drugs.

The 17-year road between her first illegal drug use and her first felony conviction was a bumpy one. Michelle, now 41, said she used drugs recreationally for years without becoming addicted. Then she became involved with a man who introduced her to methamphetamines. They cared for each other deeply, and he was a loving father figure for her two children. But in using methamphetamines with him, she also became addicted.

Criminal involvement followed, including a spate of petty misdemeanors for passing bad checks at local businesses. She stayed out of serious trouble until her boyfriend died suddenly from a heart attack.

Alone, grieving, and still addicted, Michelle turned to selling drugs to get the money she needed to support her habit and her children. Growing up, “I had to do without a lot. And I said that my kids would never want or need for anything. And I stuck by that,” Michelle told Appleseed. As a small-time drug dealer, in addition to supporting her habit, “I was feeding my kids, I was clothing them, I was putting them through school, paying all those fees, paying bills at home, car payments, you know just different little things.”

Michelle’s first felony conviction, the distribution charge, was precipitated by a betrayal. Law enforcement had recruited her best friend to serve as a confidential informant, and “in exchange for him getting some sort of immunity or a deal or whatever, he had to turn somebody in, and that somebody just happened to be me.”

She pled guilty and went to Alabama’s Julia Tutwiler Prison for Women. She spent a year there, and also did time at a work release facility and the Alabama Therapeutic Education Facility. Though she would have liked to participate in a rehabilitation or recovery program, none was offered to her during this time. She told Appleseed she was also

ineligible for certain incentive and reward opportunities at the Therapeutic Education Facility because they were only available to men.

About two years after her conviction, Michelle was released from prison into unforgiving pressure. Her top priority was rebuilding a relationship with her children, who she felt she had abandoned. Alabama's top priority was collecting money from her, testing her for drug use, and ensuring she stayed busy.

As a participant in ADOC's Supervised Release Program, Michelle was required to keep a job or do 40 hours a week of community service and make payments toward fines, fees and court costs. She was ineligible for food stamps and other forms of government assistance because of her criminal history. And her felony conviction meant a good-paying job was hard to find.

While she was looking for work, she did community service. "My [Supervised Release Program] officer was just like, 'Okay, well we're still going to need you to pay these fines,'" Michelle said. "And I was like, 'Well you know I just got out of prison, you know, how am I gonna do that after being locked up for a year?' Well, 'any means necessary' is what I got told. And I'm just like, okay, now if I hadn't changed my way of thinking, I would think that you were telling me to go back out and sling dope or do whatever I had to do to get the fine money."

Eventually, she found a job at a deli in Auburn, where she opened every morning and took on extra hours closing when no one else was available.

"It felt good to actually be able to have a legitimate paycheck," Michelle said. "I was in there a hundred percent. But then they had cutbacks, and because I was the last man in, I was the first man out. You know, so it just kind of—it left me

with the feeling of, okay, I gave it my all and my all wasn't good enough so I'm just going to resort back to what I know."

And so she did. "It was only a matter of time before they got me again," Michelle said. "I got arrested June the second of 2019 for possession of a controlled substance times two, possession of drug paraphernalia. I got two tickets and a big heartbreak when I heard [my two children] say, 'Mom, you're there again.'"

When she went back to Tutwiler, Michelle participated in a drug treatment course led by a counselor who had served time for manufacturing drugs, then on release had gotten a bachelor's degree, obtained a pardon, and returned to prison to teach. In contrast with other programs she had encountered, this one moved her.

"One of the things that made it so helpful this time, I believe, is it was taught by someone that had actually been in my shoes," she said. "There are people that go to school for this and they've never experienced it. But once you get with somebody that has gone through what you went through, they do understand what you've been through, because they've been in your shoes. That right there is incentive enough in itself because you're seeing somebody that used to be in the shoes that you're in that has made it and been successful, and is still successful, and so that tells you that you're able to do that."

**"I had to do without a lot. And I said that my kids would never want or need for anything. And I stuck by that."**

remaining 11% are for drug sales.<sup>102</sup> At first glance, those two numbers seem to suggest that the overwhelming majority of people who commit drug offenses possess drugs, but do not sell them.

But conversations with both people in recovery and law enforcement officials who pursue them indicate that this is not necessarily the case. Jerry Wiley, a retired Birmingham police captain who spent 14 years as a narcotics officer (including six on a DEA task force), said that in his experience, many drug users turn to small-time dealing to get the money they need to support their drug use.

Wiley's observation tracks that of people in recovery who explained that they sometimes sold drugs in small quantities because that was the most economical way to ensure they had the money they needed to buy drugs to use themselves. This suggests that the fact that almost 9 in 10 drug-related arrests are for drug possession is more an artifact of how policing is conducted, rather than the habits and behaviors of people who experience addiction.

As the public's collective understanding of addiction evolves, it has become acceptable even within law enforcement and criminal legal circles to acknowledge that lengthy incarceration is not the ideal response to drug use. With varying degrees of success and fidelity to science, crisis intervention centers, decriminalization of simple possession, pre-arrest diversion, and drug courts are all attempts to respond more sensibly to the fact that drug use — and therefore drug possession — is best understood primarily as an illness, not a crime.

Despite all this, in Alabama, the criminal legal system draws a bright line between drug possession and drug distribution. Officials who are inclined to be sympathetic to people who use drugs are often deeply unsympathetic to people who sell them. In a law enforcement setting, this distinction can mean the difference between being offered an opportunity to be supported in recovery, in the instance

of drug possession, and being arrested and convicted of a felony, in the instance of drug distribution.

As things stand, Alabamians charged with simple possession currently have access to pretrial diversion and drug court. Though they are often costly and onerous to complete, successful completion of either of these forms of pre-adjudication diversion can result in a clean criminal record. But in Alabama, the diversion programs available to people facing distribution charges generally cannot result in charges being dropped.

In part because of this policy, thousands of people whose drug-related offenses, including distribution and manufacturing, are driven by addiction wind up sentenced to time in the Department of Corrections, where it's almost impossible to avoid access to illegal drugs.

# The Deadly Consequences of ADOC’s Indifference to Evidence-Based Approaches

Even as other parts of the system have begun to function in an evidence-based way, the experience of incarcerated Alabamians with substance use issues remains grim. Watchdogs estimate at least 72 people have died of overdoses in Alabama prisons since 2018.<sup>104</sup> Donaldson Correctional Facility alone, which is considered a maximum-security prison, has had at least 11 overdose deaths in the last three years.<sup>105</sup>

In conversations with Alabama Appleseed, incarcerated and formerly incarcerated Alabamians spoke consistently of a dangerous, chaotic environment where illicit drugs were freely available and used without consequence in front of terrified, corrupt corrections officers who lacked the will or ability to keep the people in their custody safe. Drugs are readily available, even in prison dorms that are designated locations for drug treatment programs, multiple program providers have told us.

ADOC says that 75 to 80% of incarcerated Alabamians have histories of substance use, making the prison system the “largest substance abuse program within the state of Alabama.”<sup>106</sup> According to ADOC, 802 incarcerated individuals completed some form of substance use treatment in 2021.<sup>107</sup>

ADOC is compensated well for providing this service. In Fiscal Year 2021, the agency took in \$2,838,378 in County Drug

Conviction Fees.<sup>108</sup> On top of that, \$674,069 in state and federal grant funds went toward Residential Substance Abuse Treatment (RSAT).<sup>109</sup>

But despite all that money — more than \$3.5 million in 2021, or \$4,364 per each of the 802 people completing programming that year — addiction treatment in ADOC is patchy and inadequate. For example, Blake Puckett, the man whose experience with ADOC inspired this report, was assigned to a prison that did not even offer the treatment program he was ordered to take.

That’s not uncommon, according to Hayden Sizemore, a former ADOC classification specialist who is now an attorney.

Sizemore explained to Appleseed that classification specialists are alerted when a person’s incarceration is supposed to include conditions like participation in SAP or Crime Bill. She said those conditions are noted in the summaries they prepare for the central review board. But other factors, including the person’s risk level and how many beds are available at any given facility, may take priority over conditions set out in a judge’s order. And even if the person is placed at a facility that offers the program-

“Punishment alone is a futile and ineffective response to drug abuse, failing as a public safety intervention for offenders whose criminal behavior is directly related to drug use.”<sup>103</sup>

ming they are required to participate in, Sizemore said, it often falls to that person to alert corrections staff that they have been ordered to engage with certain programs and insist that they be offered access.

The system, Sizemore said, is driven by “logistics,” not court orders.

“Judges think they’re doing the person a favor, ‘I’m going to sentence you to this treatment to make sure you get it,’” Sizemore said. But “[w]hen it comes down to it, you have to have somewhere to put them,” even if that means a facility that doesn’t offer them what they need.

Nor does ADOC offer MAT, an evidence-based treatment proven to save lives. In its very first report, Alabama’s Opioid Overdose and Addiction Council stated that the Alabama Department of Corrections would “begin a pilot program using Vivitrol (naltrexone),” a form of long-acting medication assisted treatment, to “help recently released inmates remain drug free after release.”<sup>110</sup>

The notion of offering MAT to incarcerated people is not new. In a paper published over a decade ago in *JAMA* (the Journal of the American Medical Association), researchers wrote ...

*The benefits of medications for drug treatment were shown in a recent randomized trial in which heroin-dependent inmates began methadone treatment in prison prior to release and continued in the community postrelease. At 1-, 3-, and 6-month follow-up, patients who received methadone plus counseling were significantly less likely to use heroin or engage in criminal activity than those who received only counseling. The potential exists for immediate adoption of methadone maintenance for incarcerated persons with opioid addictions, but most prison systems have not been receptive to this approach.*

*Economic analyses highlight the cost-effectiveness of treating drug-involved offenders. On average, incarceration in the United States costs approximately \$22 000 per month,*

*and there is little evidence that this strategy reduces drug use or drug-related re-incarceration rates for nonviolent drug offenders. By contrast, the average cost of methadone is \$4000 per month, and treatment with methadone has demonstrated effectiveness in reducing drug use and criminal activity following release. Alternatives to incarceration can also defray job productivity losses and the separation from family and social support systems.*<sup>111</sup>

As of 2021, prisons in at least 20 states — including Southern neighbors like Arkansas, Georgia, Kentucky, Louisiana, South Carolina, Tennessee, Virginia, West Virginia — offered some form of MAT to the people they incarcerate.<sup>112</sup>

Even as our sister states adopt evidence-based practices to keep incarcerated people safe, Alabama’s Department of Corrections has dragged its feet. Put simply, the apparent inability or unwillingness of prisons in Alabama to adopt the standard of care about the public health crisis that is addiction is a catastrophic failure that is costing Alabamians their lives.

The ADOC MAT pilot program contemplated by the Opioid Overdose and Addiction Council remained in the “planning” phase year-on-year, even as the council reported progress on other elements of its agenda. In its 2020 annual report, a brief note said that the project had been moved to Day Reporting Centers, which are run by the Department of Pardons and Paroles and do not serve people who are incarcerated in ADOC. Just weeks before that annual report was issued, the U.S. Department of Justice alleged in a complaint that “in 2019 and the first eight months of 2020, at least six prisoners died of drug overdoses” while in ADOC custody.<sup>113</sup>

And the council’s 2021 annual report omits the “Justice Involved Population” section entirely, with no mention made of progress toward interventions intended to save the lives of incarcerated Alabamians, even as overdose

# 39

The number of incarcerated people who died suspected drug-related deaths Jan.-Aug. 2022

deaths in custody continued to stack up.

Alabama Appleseed asked ADOC for a meeting to discuss its plan to reduce overdose deaths in custody and ensure that incarcerated people with Opioid Use Disorder have access to evidence-based forms of recovery support, including medication assisted treatment.<sup>114</sup> Via email, an ADOC spokesperson declined a meeting and wrote, “ADOC’s Office of Health Services (OHS) is in the process of developing a Medication Assisted Treatment (MAT) program with Wexford Health Sources, the agency’s contracted medical and mental health partner.

“According to Deputy Commissioner of OHS Deborah Crook, ‘Prior to 2019, MAT was limited to individuals that could be separated from general population. However, the science has changed considerably and there are more medication options that are safer to prescribe — even in general population.’”

Responding to a follow-up email requesting details about the scope of the “limited” MAT program as it existed prior to 2019, ADOC clarified that “the program is in development only at this stage.”<sup>115</sup> In response to a request asking for records related to the program in development, ADOC stated no such records exist.<sup>116</sup>

In July of this year, ADOC announced it was switching medical providers to a company called YesCare Corp., based in Tennessee.<sup>117</sup> It rescinded that decision in August for reasons that were not made public.<sup>118</sup> It’s unclear whether the program supposedly being developed with Wexford would move forward.

## DRUG-RELATED DEATHS IN PRISON

The Alabama Department of Corrections does not maintain accurate or timely records regarding deaths of the people in its custody.<sup>119</sup> Additionally, autopsy reports can take months to produce and are sometimes difficult to obtain, worsening the lag between deaths and confirmation of their causes. For these reasons, it is necessary to turn to unofficial sources to monitor the number of incarcerated people who die from overdoses or other drug-related causes. The numbers in this section are based on evidence collected by investigative reporter Beth Shelburne.

Shelburne’s database of deaths in custody is based on ongoing communication with sources including people who are incarcerated, corrections staff, medical examiners, and public records when they are available. She classifies a death as “drug-related” if it was caused by overdose or from disease or action with prolonged or acute drug use as a major contributing factor.

To classify a death as a “suspected drug-related death,” Shelburne requires confirmation of the death itself and at least one prison source citing likely overdose or other drug-related cause. Her major findings from recent years are as follows:

As of August 31, 39 incarcerated people had died suspected drug-related deaths in 2022.

In 2021, 23 incarcerated people died suspected drug-related deaths. Of those, 12 are confirmed through autopsy results. Not all the 12 confirmed drug-related deaths involved overdoses. For example, one suicide (Jerry Purnell at St. Clair on May 7, 2021) the cause of death was hanging but acute meth intoxication was a factor. His toxicology was positive for meth. Another example was a hematoma from an accidental fall (Johnnie James at Donaldson on August 11, 2021) but his toxicology came back positive for Fentanyl.

In 2020, 10 incarcerated people died confirmed drug-related deaths. Three were overdoses, three died from health complications due to drug use, three were homicide victims who tested positive for drugs, and one was a suicide victim who tested positive for meth.

There have been 72 suspected drug-related deaths since March of 2020, when ADOC closed prisons to outside visitors.

## ROBERT HARRIS

*“I wanted them to help me understand what I was going through. And what could I do if I’ve made up in my mind to get better? What can I do to get better?”*

Robert Harris, 49, of Walker County, started using drugs and alcohol as a child to cope with the unwanted feelings related to trauma in his home. As he grew older and life grew more complicated, he used whatever he could get his hands on: alcohol, marijuana, heroin, cocaine, methamphetamines. “Everything that went wrong, I didn’t want to feel it.”

He started to get in trouble, and eventually found himself incarcerated, first in Georgia and then Alabama. Each time he was released, he fell back into his old habits and got locked up again.

In 2020, Harris violated the terms of his probation and was taken to Walker County Jail. Because transfers from jail to prison slowed to a crawl during the pandemic, he spent the better part of two years there. It was awful. Jails are designed for short-term stays and have little programming and few services even in the best of times. The pandemic made everything worse.

When Harris finally came face to face with an ADOC classification specialist at Kilby Correctional Facility, where incoming prisoners are sent for evaluation and classification, he took a leap of faith. ADOC already knew he struggled with substance abuse, but in prior interaction with classification specialists, he had successfully masked his mental health issues.

This time was different. “I was honest with them. I’m having a hard time dealing with myself. I’m having a hard time dealing with my anger, I’m having a hard time grasping reality, I get anxiety when I think about dealing with the things that people have to deal with in life every day,” he said. “I wanted them to help me understand what I was going through. And what could I do if I’ve made up in my mind to get better? What can I do to get better?”

ADOC placed him at Fountain Correctional Facility, a medium security prison in Atmore, Ala. Harris described it in stark terms.

“From pulling up at the back gate at Fountain State Prison, me and the other guys in the van were told to get a knife. That this was a dangerous place. And we were told that by the intake guard,” he said.

Though there were corrections officers in the dorms, Fountain, like many ADOC facilities, was run by incarcerated men who told newcomers where to sleep and how to act. Harris said some incarcerated men had access to cell phones and outside money, which they used to bribe corrections officers to bring drugs into the facility.

Harris’s description of conditions at Fountain conjures a scene of Hobbesian chaos, where corrections officers looked the other way as strong preyed upon the weak and addiction was the most dangerous weakness of all. Incarcerated men who came in with substance use problems found a smorgasbord of substances available to them — for a price. Those who could not pay their drug debts were forced to engage in coerced sex with their dealers.

Harris felt himself being dragged down by it all. Drugs were “dirt cheap,” the corrections officers didn’t care, and the pandemic shut down most other activities, so for a while, he used whatever was available: synthetic drugs like flakka, ice, “paper wrap,” which is strips of paper sprayed with chemicals that is cut into strips and smoked.

“The funny thing about addiction is that a part of you can want to be clean. But it’s engraved

itself in your soul — in your bones — in your heart. And it won't let you go," Harris said.

At some point during his stay, Harris decided to listen to the part of himself that wanted to stop using drugs. With great difficulty, he succeeded — and after seven months in ADOC custody, he was released from prison with \$10 and a bus pass and ordered to report to a treatment program at Walker County's Day Reporting Center.

At first, he resented the mandatory treatment program. He had a job waiting and he wanted to move on with his life. But soon he came to see the program, which included therapy, counseling, drug testing, and other forms of support and accountability, as a blessing.

"It was something that I needed because I had no idea how to be clean. I had no idea how to deal with anything," Harris said. "I've come to understand that if you don't do what it takes to fix it, if you don't surround yourself with people that will equip you with the tools to fix it, the problems don't get fixed — and they certainly don't get fixed inside the institution."

When Appleseed spoke with him, Harris was three days shy of the end of his sentence, after which he would no longer be required to participate in programming at the Day Reporting Center. He planned to continue coming to group sessions and to stay in touch with Stacey Fuller, his peer support specialist. He hopes to become a peer support specialist himself, someday.

He has a hard road ahead of him. Harris is on the sex offender registry, which drastically limits his housing and employment options. When Appleseed spoke with him, he was working at a chicken plant and living at a motel he described as "surrounded by drugs." The state considers him homeless, meaning he must check in with law enforcement once a week and pay \$10 each time he does. The rest of his income goes toward rent, gas money, food, and fines.

Nonetheless, Harris is determined to maintain his sobriety and continue the excruciating, rewarding work of reconciling who he has been with who he wants to be. His five

months in treatment, he said, "barely graze the surface" of correcting 40 years of addiction, untreated mental illness, and trauma. But "I know in my heart the right things are going to open up for me and I know in my heart, I want to continue to do what's right, and continue to go down the pathway that I've been going down," he said.

"Today I don't have any fears about that. I know I may not see right now those doors that are open, but I know they're going to be opened at the right time for me to continue on."

## BRENT HESTER

*"The guards can get you anything you want."*

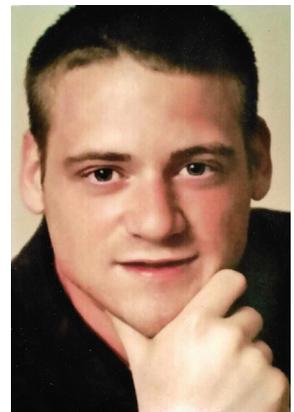
Every night, as Glenda Hester Adams drove home from her shift at Waffle House, her son Brent kept her company. "He would call me — talking to me on the phone till I got home, making sure I didn't break down or nothing like that. 'Like, what can you do, Brent? You ain't here if I get broke down.'"

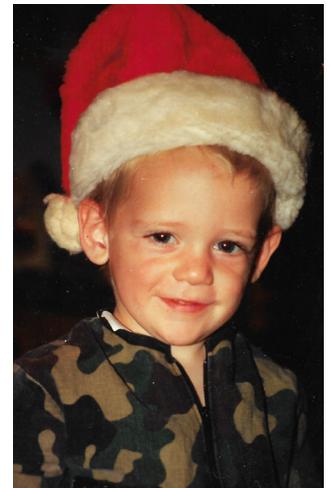
Reflecting on the agonizing three days when the calls stopped and she realized she might never speak to him again, she said "I was crying because — waiting for his phone call, you know?"

The reason that Brent couldn't get to Glenda if her car broke down was because he was incarcerated in Alabama's Ventress Correctional Facility.

The reason she'll never speak to him again is because he died there.

The last time Glenda spoke with Brent was Feb. 18, 2021, a Thursday. By Sunday, Feb. 21, he was dead. He was 30 years old.





Brent Hester his family through the years

PHOTOS COURTESY OF GLENDA HESTER ADAMS AND DANIELLE SOMERVILLE

Brent's struggle with addiction began when he was a teenager. Glenda says a cousin gave him Xanax, and he started using it and getting into trouble, committing crimes to get money to pay for the drugs.

He spent some time in Department of Youth Services custody. When he got out, he fell back into drug use. He told his mother he wanted help. At his request, she took him to a doctor, who prescribed him more Xanax and offered no suggestions about how to stop abusing it or other drugs.

Soon after that, Glenda said, Brent got involved with an older woman and committed a robbery. He was tried as an adult and at 17, he was sentenced to five years in prison.

His first stint was at Staton Correctional Facility. Glenda visited him there once a month and felt he was safe enough. He soon moved on to work release, where he had very little supervision. But he failed a drug test after using a form of synthetic cannabis that was sold over the counter at a gas station, and went back to prison — this time, to Atmore Correctional Facility in Escambia County.

“Atmore is where he learned to do the shooting up and the meth,” Glenda said. “That’s where he got on the drugs really really bad.”

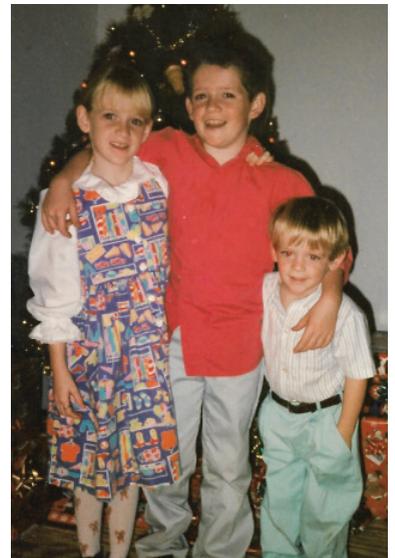
Brent did receive drug treatment in

prison. In a letter from November 2017, he told Glenda he was going to start Crime Bill, a 6-month treatment program, in January 2018.

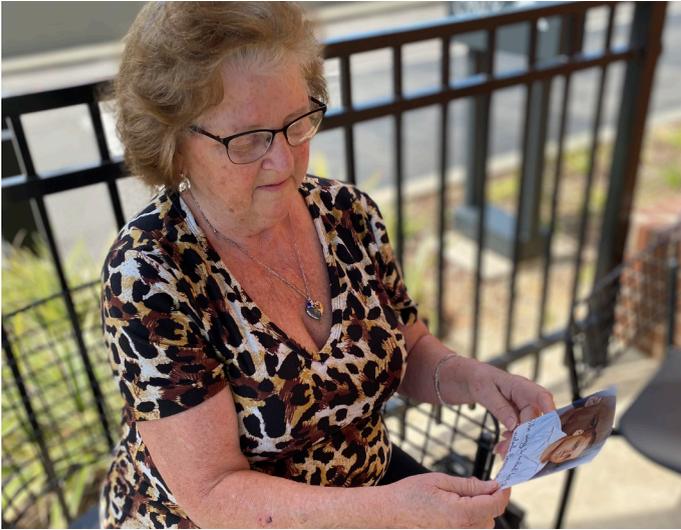
But Department of Corrections treatment programs are notoriously uneven. While some people have told Applesseed they found the programs helpful, others have described chaos. One incarcerated man said the people he shared a classroom with were literally injecting themselves with drugs under the table during class.

None of this is any surprise given the state of things within the Alabama Department of Corrections, where watchdogs estimate that close to 50 people have died of drug overdoses since 2018.<sup>120</sup> The U.S. Department of Justice cited overdose deaths and the widespread availability of illicit drugs as a driver of the violence, death, and chaos that underpin its Eighth Amendment lawsuit against the Alabama Department of Corrections.<sup>121</sup>

The Alabama Department of Corrections’ own report shows that corrections staff confiscated more than 56 pounds of contraband drugs from incarcerated people between January and March 2022.<sup>122</sup> During that same period, the department closed eight death investigations from 2021 where illicit drugs including methamphetamine,



“Atmore is where he learned to do the shooting up and the meth. That’s where he got on the drugs really really bad.”



“They said ‘We can bury him, but you cannot come and see him.’”



fueled by addiction clog Alabama’s prisons. Incarcerating them is expensive, but it rarely improves their condition, and there is no public safety benefit to a system that churns out people as traumatized and addicted as when they entered — let alone on that allows them to die in large numbers in state custody.

Aside from the robbery charges that prompted his initial sentence (including a lengthy term on probation), Brent’s other convictions were for things like third degree burglary, breaking into a vehicle, and unauthorized possession of a controlled substance. Each of these convictions led his probation to be revoked, sending him back into prisons where illicit drugs were readily available and his substance abuse problems got worse.

His mother recalled a call he made from Ventress Correctional Facility, where she says he had seemingly unfettered access to illicit drugs.

“He’d call me and he’d be so messed up. And I’d say, ‘Where’d you get the drugs from, Brent?’ Well — ‘The guards give ‘em to you, momma. The guards can get you anything you want.’”

The last time Glenda saw Brent was on a Skype call. He had a parole hearing coming up, and she’d hired a lawyer. They felt confident he would be coming home. During the call, she showed him the bedroom suite she’d fixed up at her house.

About two weeks after that Skype visit, Brent stopped calling. After three days of

fentanyl were cited as the cause of death.<sup>123</sup>

When Brent got out of Atmore, Glenda sent him to rehab — several times, each for 90 days. Sometimes she paid out of pocket; other times the programs were covered or partly covered by Medicaid. “It makes me so mad when people say, you know, ‘You can’t do nothing with a drughead, they ain’t no good.’ It’s a sickness, you know?”

Brent Hester’s story is heartbreaking, but not unusual. Individuals whose offenses are

silence, Hester told her daughter Danielle Sommerville she was going to call the prison and find out what was going on with her son.

Danielle stopped her. She showed her mother a text she had just received from an unknown number that turned out to belong to a friend of Brent's who also knew his cellmate.

"I've been trying to reach yall all day," it read. "Has the prison contacted yall ... hopefully by now they have. I was asked to come to yall this morning but I wasn't sure if yall still lived off [street name redacted] & under the circumstances I thought it would be rude to just pop up. Please know I will do whatever it takes to help yall through this time. Brent's been my friend since I was 14 years old and although he's been in prison a lot of our friendship that never changed anything. I love him ya know, my heart is so broken."

"Im not sure what your talking about," Danielle wrote back.

Panicked, Glenda called the prison. The warden told her her son was dead. She said he told her that Brent and a corrections officer "had words," and the corrections officer took him to a private room and put a sheet up for privacy. Then, according to Glenda's recollection of the warden's telling, "the guard left for 20 minutes. Came back to Brent dead."

Brent's autopsy report shows that he had methamphetamine, fentanyl, and morphine in his system when he died. His cause of death is listed as methamphetamine toxicity. His manner of death is listed as "accident."

She wanted to see her son one last time. The Department of Correction "said they'd do the funeral but I'm not allowed to go," she said. "They said 'We can bury him, but you cannot come and see him.'"

Glenda couldn't afford the cost of bringing Brent's body home. "So I told Danielle,

'Well, we'll just remember him like we seen him,'" over Skype, she said. "But we'd have loved to have had an open casket."

Glenda paid to have Brent cremated in Montgomery, and Danielle's husband drove up to retrieve his cremains.

Reflecting on her own efforts to save Brent, Glenda said, "I did everything I could. If it had took every bit of money I had I'd have done whatever.

"But only God could have got him off — that or long-term rehabilitation."

FEB 21, 2021 AT 3:48 PM

I've been trying to reach yall all day. Has the prison contacted yall...hopefully by now they have. I was asked to come to yall this morning but I wasn't sure if yall still lived off & under circumstances I thought it would be rude to just pop up. Please know I will do whatever it takes to help yall through this time. Brent's been my friend since I was 14 years old and although he's been in prison a lot of our friendship ❤️ that never changed anything. I love him ya know, my heart is so broken ❤️



Im not sure what your talking about

Brent's sister learned he had died in prison via text message from his cellmate's friend.

## Brighter Spots

There is much to lament about Alabama's response to substance use disorder. But there are also innovations to admire and learn from. As Alabama Appleseed surveyed the landscape, focusing particularly on areas where the criminal legal system interfaced with substance use issues, we found cause for optimism as we examined the work the Department of Mental Health has fostered and supported.

In 2021, Alabama Appleseed sat down with Kimberly Boswell, Commissioner of the Alabama Department of Mental Health (DMH), to talk about the work they are doing to pivot toward treating substance use disorder within the justice-involved population.

“What I am really excited about is just this attitude lately that we're all in this together and we're all trying to figure it out. That's not always the way state government works, but I've seen folks saying “This is ridiculous, jail is not the place for people with mental health problems or substance use disorder,”” she said.

Boswell stressed the need to provide evidence-based treatment and support to people with mental health and substance use issues as early as possible in their involvement with the criminal legal system. She observed that police are not the best response to behavioral health crises, including those precipitated by substance use, and talked about plans to create an alternative to 911 that people could call to get appropriate responders onsite in response to crises.

Crisis centers are also part of this alternative model. “We had a system where you could get detox but there wasn't a treatment bed, or if there was you couldn't get to it,” she said. Finding ways to bridge that gap is “part of the model for crisis care.” One advantage of this model, she noted, is that it affords people whose only unlawful activity is possession of illicit drugs or paraphernalia to avoid police contact and potential criminal charges. If a person is brought to a crisis center and found to have illicit drugs or paraphernalia, staff are expected to confiscate, securely dispose of the contraband and move

forward with an evaluation and referral, not pressing charges. Though not a perfect model, this is a significant and positive development for Alabama, where government officials typically prioritize criminal enforcement over other forms of intervention.

In addition to crisis centers, DMH is also working to increase the availability of detox and treatment facilities, as well as recovery homes, which are meant to offer supportive environments for people who need them. This will depend on funding and culture change, including work to increase legal system actors' comfort with the notion of dropping charges when unlawful behavior is best addressed through behavioral health rather than legal means.

Ultimately, successful long-term recovery also requires people to have networks of support, Boswell said.

"We can do treatment, we can get folks on medication, and we can do therapy. That's all great. But at the end of the day the way people really heal is in community. If they're going to stay in recovery, if they're going to be successful, they're going to have to do that in community," she said. "It's when people are isolated and they don't have that support that's where they're not successful."

## PEER SPECIALISTS

One way ADMH is working to develop and foster community for people in recovery is by employing people in long-term recovery as peer support specialists. Since 2018, the state has certified at least 456 peer specialists, with programs in more of half of Alabama's counties.<sup>124</sup>

Many peers work through the Recovery Organizations of Support Specialists (ROSS) a federally funded<sup>125</sup> statewide network affiliated with ADMH<sup>126</sup> that connects people in recovery with training, resources, and certification, and pays them to support people who wish to address their addiction issues. ROSS specialists are available to any Alabamian seeking to get into recovery, including people in jail and day reporting centers.

## TUNJA TOLBERT

*"That person now sees me just like them, but clean. So that gives them hope."*

Tunja Tolbert, a former ROSS specialist in Montgomery, got many of her referrals from the public defender's office and judges. Once she received a referral, she typically went to the jail to meet with the potential client.

"When I sit down and I talk to them, before there's any paperwork, I say, 'I want you to know, I'm just like you. I'm no different from you. I'm a woman in recovery. And I'm just on the other side, you know. Whatever me and you talk about, this between me and you. I'm



PHOTO BY LEAH NELSON

here to support you. I say I don't have a degree, I'm not a therapist, I'm not a doctor," Tolbert says. "So that breaks the barrier, right? And so now that person now sees me just like them, but clean. So that gives them hope."

ROSS employs licensed social workers to conduct needs assessments, but its peer specialists are the foundation of the support and programming it offers. Tolbert built relationships with judges and advocated for her clients in court, asking judges to sign off on treatment instead of longer terms of incarceration. In addition to connecting people with treatment, peer specialists can be helpful in mitigating sentences. For instance, Tolbert told Appleseed she has seen clients who violated the terms of their probation avoid revocation if they enter a treatment program through a ROSS referral.

Individual advocacy and personal relationships with credible peer specialists like herself "changed the dynamic in the system," Tolbert said. Where judges might once have been skeptical about offering alternatives to people who violated the terms of their supervision, many are now more open to allowing people to go into treatment instead of back into prison. Given the dire state of Alabama's prisons, this is a win for everyone.

Peer specialist networks, and the treatment and recovery ecosystem generally, still need work. In its 2020 report, the Opioid Overdose and Addiction Council identified deficits in funding, retention, interagency cooperation, and accessing services as "critical challenges within Alabama's system of care for opioid use disorders."<sup>127</sup> Tolbert said things like transportation to treatment and clothing for people who are leaving incarceration to get help are not adequately covered, creating obstacles that hinder success. She sought donations for things like personal hygiene items so her clients would have what they needed on the way to treatment, Tolbert said. "I used a lot of my personal money to do those things."

## CHARISSE PARKER

*"I told her, I said, I'm not trying to get anything besides help. I'm afraid of what's going to happen to me and my children if I don't get some help. Something's wrong. I need help. And I did not get that help."*

Peer specialist Charisse Parker's description of her experience with addiction is evocative. "I could think back and remember how normal life was. But it seemed so far away," she said. "It's like being on one of those roller coasters, you know, and you're up at the top. How do I get back down? How do I get off of this thing?"

Like many people, Parker experienced both addiction and mental health issues, which can exacerbate each other. Today, she is a peer specialist with JBS Mental Health Authority, a regional provider affiliated with the Alabama Department of Mental Health that offers services to residents of Jefferson, Blount, and St. Clair Counties.

Things were very different for her 15 years ago. In early 2007 while in the throes of a mental health crisis, Parker sought help at a public mental health center in rural Washington County, Ala. She walked into the appointment with her young child on her hip, and the clinician who met her accused her of malingering so she could get put on disability.

"I told her, I said, I'm not trying to get anything besides help. I'm afraid of what's going to happen to me and my children if I

don't get some help. Something's wrong. I need help. And I did not get that help," she said. "After that, that's when everything went downhill," Parker said. She started smoking crack, became homeless, and temporarily lost her children to the foster care system.

Parker wrote a check on an account that did not belong to her. In 2009, she was convicted of possession of a forged instrument and put on probation for five years.<sup>128</sup>

Over the next 10 years, she worked at various facilities serving people with mental health and substance use disorders. Her recovery was not perfectly smooth. Some years ago, she relapsed for a period and had to go through treatment again. In 2021, she applied to the Certified Recovery Support Specialist (CRSS) program at the University of Alabama, which trains people in recovery to be peer support specialists.

Parker was honest about her criminal history in her application. But her acknowledgment led to questions from the program that confused Parker. They wanted more information about her criminal history.

"The program I am seeking admission for ... is focused on CRSS (certified recovery support specialist) certification meaning a person with personal lived experience with substance abuse," she wrote in an email to the admission committee. "The crime for which I was convicted of in 2009 occurred at the onset of my substance abuse struggles, which in turn is the very thing that qualifies me to be a CRSS through the Alabama Department of Mental Health."

Parker was able to satisfy the University of Alabama's concerns and enter the CRSS



program. Though baffled by the fact that her application was hindered by the very credential that qualifies her for the program, she is determined to make the most of the opportunity.

"I want to not just be an advocate, but an activist as well, dealing with these specific issues. Because I know for a fact there are so many people who don't know they have a voice, who lost their voice, who are treated as if they shouldn't have a voice. And unfortunately, I know people in my life who have lost their lives because of substance use disorder," she said. "Peer services, it's an amazing thing, and it's an awesome thing. And it's growing now in the state."

Charisse Parker  
PHOTO BY LEAH NELSON

## Recommendations

If the addiction crisis was an easy problem to solve, someone would have solved it already. In this report, we seek to be clear-eyed about the complexity of addiction and its externalities, lift up innovative steps Alabama has taken to save and improve lives impacted by addiction, while also being blunt about how much remains to be done.

As discussed at length throughout this report, the weakest link in Alabama's response to drug addiction is the criminal punishment system. In conversations with Appleseed, experts from many disciplines raised the idea of reclassifying simple possession of controlled substances as a civil violation, which would decrease the likelihood that people with substance use disorder would find themselves detoxing in jail or obtaining drug treatment through the criminal legal system.

Alabama does not yet have the infrastructure to support reclassification. Putting it in place would require investment in solutions outside of jail and prison walls. The state has scores of county and city jails and dozens of prisons, but only three crisis centers. Lawmakers plan to use federal funds to build prisons but have not yet expanded Medicaid, which has provided a lifeline to treatment in states that have opted for expansion. People with substance use disorder must have opportunities to access the treatment and support they need with or without the legal system's involvement. In a better system, it would be easier to access free or affordable treatment on demand than by court order and under penalty of criminal conviction. Alabama has a long way to go.

We recommend the following measures to reduce the harm done to people with addiction who find themselves involved with the courts and criminal punishment system:

### **LAWMAKERS AND REGULATORS SHOULD ...**

- Expand Medicaid and otherwise generously fund public and behavioral health infrastructure to reduce the likelihood that people with substance use disorder will come into contact with the criminal legal system at all and create opportunities to authentically divert them when they do.

■ Reclassify simple possession of a controlled substance, and possession of paraphernalia, as misdemeanors instead of felonies.

■ Clarify that medical decisions should be made by medical professionals, not judges, lawyers, or corrections staff, and support medication assisted treatment by:

- ▶ Requiring drug court judges to defer to medical professionals' decisions about the use of interventions like medication assisted treatment. Incentivizing and funding opportunities for medical professionals to participate in drug court teams.
- ▶ Requiring jails and all Alabama Department of Corrections facilities and programs to make medication assisted treatment available to people in their custody and provide funding to support hiring of medical professionals to facilitate this process.
- ▶ Requiring jails and all Alabama Department of Corrections facilities and programs to ensure that people leaving their custody who rely on medication assisted treatment are referred to medical professionals who can continue to provide treatment upon release.

■ Amend laws regulating diversion programs to ensure that people who are unsuccessful in their attempts to seek treatment through programs like drug court do not face harsher punishment than people who do not participate in programs at all.

■ Fully fund diversion programs and take other steps to make them more accessible to the people who need them.

**LAW ENFORCEMENT AGENCIES SHOULD** continue to train officers in the use of life-saving interventions like Narcan. Officers should be empowered and encouraged to divert people whose behavioral crises are driven by substance use disorder to crisis centers *without* arresting them, to minimize potentially harmful contact with jails and the criminal legal system.

**JAILS AND PRISONS SHOULD** ensure that all corrections staff have access to and are trained in the use of Narcan and other life-saving interventions, and should consider making Narcan and fentanyl test strips available for use by people who are incarcerated.

## Endnotes

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This report is dedicated to Blake Puckett and his family.

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BRENT HESTER | 1991 – 2021

Unless Alabama brings evidence-based practices to end the drug crisis in its prisons and starts viewing people who are incarcerated as human beings with lives that matter, people will keep dying like this. How many is too many?

## CHANGE IS NEEDED

# Every year from 2012-2020, Alabama ranked first in the nation for opioid prescriptions per capita.

Since 2014, the opioid addiction has claimed the lives of nearly 7,000 Alabama residents who died by overdose, and disrupted the lives of countless more.

Since 2017, many state agencies have collaborated successfully via the Alabama Opioid Overdose and Addiction Council to chart a better path. The state has invested in treatment and peer specialists and reframed addiction as a public health issue, not a moral failing. For people who manage to steer clear of jails and prisons, things are starting to look up.

But the combination of harsh criminal laws, the nation's highest opioid prescription rate, and Alabama's under-resourced jails and violent and dysfunctional prisons mean that many of the people who need treatment most are not getting it. Instead, they are dying preventable deaths in record numbers. **Something must change.**

**75-80%**

THE PERCENTAGE OF PEOPLE IN ALABAMA DEPARTMENT OF CORRECTIONS CUSTODY WHO HAVE **SUBSTANCE USE DISORDER**

**72**

SUSPECTED **DRUG-RELATED DEATHS** IN ALABAMA PRISONS SINCE MARCH 2020

**\$7.49-\$9 BILLION**

ESTIMATED **TOTAL COST** OF OPIOID FATALITIES AND NON-FATAL LOSSES TO THE STATE OF ALABAMA IN 2018 ALONE



**ALABAMA APPLESEED**  
CENTER for LAW & JUSTICE