JUDICIALLY MANDATED TREATMENT WITH NALTREXONE
FOR OPIATE-ADDICTED CRIMINAL OFFENDERS

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I. INTRODUCTION

Arrests for drug offenses have nearly tripled since 1980, and more than 1,600,000 people were arrested for drug offenses in 2003.\(^1\) About eighty percent of these arrests were for possession offenses.\(^2\) In any given year, nearly twice as many people are convicted for a drug felony as for a violent felony, and in 2002, drug offenders accounted for about a third of felons convicted in state courts.\(^3\) In 2001, almost 250,000 drug offenders were incarcerated in state prisons, more than twelve times as many as in 1980.\(^4\) The offenses for which offenders were convicted denote only part of a strong relationship between addiction and crime. In 2002, approximately eighty percent of inmates, eighty percent of parolees, and fifty-five percent of probationers were either convicted for a drug (or alcohol)-related offense, were under the influence of drugs or alcohol while committing their offenses, committed their offenses in furtherance of a drug habit, or were regular drug users.\(^5\) More than sixty


percent of adult, male arrestees test positive for illegal drugs at the time of their arrests in United States booking facilities that are part of the National Institute of Justice’s Arrestee Drug Abuse Monitoring Program.6

For two decades, the nation’s policy-makers have seemed indifferent to the high costs of criminal punishment of drug offenders and the apparent failure of repressive policies to reduce heavy drug consumption or to achieve an enduring effect on teenage initiation. In the most thorough assessment of these policies thus far undertaken, Ilyana Kuziemko and Steven Levitt found that the escalation of punishment for drug offenses since 1985 may have increased cocaine prices between five and fifteen percent (and presumably depressed consumption to a small extent) and may have reduced violent and property crime by one to three percent; in light of these modest benefits, they concluded, it is highly unlikely that the dramatic increase in imprisonment was cost effective.7 A recent report by the National Research Council of the National Academy of Sciences issued a strong call for more research on the effects of sanctions against users, characterizing the government’s indifference to the effects of its costly policies as “unconscionable.”8

Increasing frustration with the repressive features of the nation’s drug policy has led to a renewed interest in treatment of addicted offenders and others with drug problems, especially at the state level.9 This renascent therapeutic response is reflected in the creation of specialized drug courts (numbering over 1,800 in existence or in planning stages in 200410), referenda and legislation requiring treatment for non-violent drug-involved offenders,11 and other programs.

7 Kuziemko & Levitt, supra note 4, at 2062-63.
8 NAT’L RESEARCH COUNCIL, INFORMING AMERICA’S POLICY ON ILLEGAL DRUGS 279 (Charles F. Manski et al. eds., 2001).
9 Legal experts and policy analysts are increasingly looking to novel approaches for lowering the social and economic costs of addiction among drug offenders. See, e.g., M. Susan Ridgely & Martin Y. Iguchi, Coercive Use of Vaccines Against Drug Addiction: Is it Permissible and Is It Good Public Policy?, 12 VA. J. SOC. POL’Y & L. 260 (2004).
11 About half the states modified their drug laws in recent years, mainly by diverting drug offenders into treatment and reducing or eliminating mandatory minimum sentences. A leading example is Proposition 36, The Substance Abuse and Crime
Surprisingly, however, this therapeutic movement has not taken full advantage of advances in medical understanding of addiction and associated pharmacological developments. Legislators and judges appear to be deeply skeptical of methadone maintenance for opiate addiction (because it “substitutes one addictive drug for another”)\textsuperscript{12} and have generally overlooked other medications such as buprenorphine (another opiate agonist) and naltrexone (an opiate antagonist). The gap between therapeutic opportunity and actual clinical practice in addiction treatment (not only in criminal justice populations) is about to widen with the introduction of long-acting and depot preparations of existing drugs and the rapid advances now being made in the development of other anti-craving drugs, especially for cocaine addiction.\textsuperscript{13} In short, we are on the threshold of major advances in the pharmacological treatment of addiction.

This paper addresses the potential use of pharmacotherapy for addicted offenders in the criminal justice system. Naltrexone, approved by the FDA in 1985 for treatment of opiate addiction (and in 1995 for treatment of alcoholism), but hardly ever administered to offenders in the criminal justice system, is used as an illustrative case.

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\textsuperscript{12} "Philosophical" objections to so-called "harm reduction" strategies, such as methadone maintenance, were evident even in the ambitious efforts of California’s counties to build a broad treatment capacity – only half of the counties included methadone in the planned treatment continuum, and most of those who did limited it to short-term maintenance. See Klein et al., supra note 11, at 738. Only ten percent of the nation’s 13,500 substance abuse treatment facilities are methadone maintenance facilities. See A. Thomas McLellan et al., \textit{Can the National Addiction Treatment Infrastructure Support the Public’s Demand for Quality Care?}, 25 J. SUBSTANCE ABUSE TREATMENT 117 (2003).

\textsuperscript{13} See Charles P. O’Brien, \textit{Anti-Craving Medications for Relapse Prevention: A Possible New Class of Psychoactive Medications}, 162 AM. J. PSYCHIATRY 1423 (2005) [hereinafter \textit{Anti-Craving Medications}].
II. BACKGROUND ON NALTREXONE

Naltrexone was developed as an offspring of the advances achieved by neuroscience researchers who identified specific receptors for opiate drugs in organ systems throughout the body. These receptors are very similar across species, even lower species, indicating that they have been present since early in evolution. Peptide hormones that act on these receptors were subsequently discovered, and the entire system is now known as the endogenous opioid system. Opioid drugs made from the opium poppy fit very well into these receptors, thus activating them just as well as, or in some cases even better than, natural hormones. Naltrexone was first studied in human subjects in 1973 and was found to attach very strongly to the receptors; however, unlike natural ligands and opiate pain relievers, naltrexone does not activate these receptors.

Naltrexone is an opiate antagonist; thus, if it or its short-acting cousin, naloxone, is given to a person receiving opiates, the drug will displace the agonist and produce a withdrawal reaction, regardless of whether that person is dependent on the opiates. If naltrexone is given to a person who is not taking opiate drugs, it will displace any endogenous opioids that are adhering to the opiate receptor and block any additional opioids from attaching. This blockade has been utilized therapeutically to prevent individuals from becoming dependent on an opioid drug, such as heroin.

Naltrexone produces no opiate-like subjective effects. Normal volunteers given naltrexone will sometimes report vague, unpleasant feelings thought to be caused by blockade of normal endogenous opioids (endorphins). This blockade produces therapeutic benefits because injected opiates, such as heroin, are denied access to the receptors and thus have no effect. However, for most heroin addicts, the prospect of taking a medication that does not make them feel good is unappealing.

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14 The material in this section is drawn from Charles P. O'Brien, The Promise and Pharmacology of Naltrexone (January 4, 2005) (paper presented at a Symposium on Opiate Addiction and Other Mental Disorders in the Criminal Justice System) [hereinafter Promise and Pharmacology]. See also CENTER FOR SUBSTANCE ABUSE TREATMENT, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION IN OPIOID TREATMENT PROGRAMS, TREATMENT IMPROVEMENT PROGRAM (TIP) SERIES 43 (2005); James W. Cornish et al., Naltrexone Pharmacotherapy for Opioid Dependent Federal Probationers, 14 J. SUBSTANCE ABUSE TREATMENT 529, 530 (1997); James C. Garbutt et al., Efficacy and Tolerability of Long-Acting Injectable Naltrexone for Alcohol Dependence, 293 JAMA 1617 (2005); Anti-Craving Medications, supra note 13.
In contrast, opiate agonists, such as methadone and buprenorphine, act at the same receptors as heroin and produce feelings of comfort, if not a “high.” Thus, heroin addicts who have the choice of treatment with an antagonist, such as naltrexone, or an agonist, such as methadone or buprenorphine, will almost invariably choose the agonist. White collar addicts, including physicians, nurses, pharmacists, and others, typically do not wish to be on methadone and are often motivated to be treated with an antagonist. Naltrexone has been the treatment of choice for physicians with opiate addiction problems since the 1980s.

Naltrexone also presents therapeutic benefits for alcoholism, an effect that was discovered at the Philadelphia VA Medical Center in the late 1980s. Researchers found that some alcoholics, particularly those with a family history of alcoholism, have endogenous opioid systems that are sensitive to alcohol ingestion. In these drinkers, alcohol releases endorphins, producing euphoric feelings similar to those produced by heroin. If these individuals develop alcoholism, treatment with naltrexone will block the euphoria and aid in the prevention of relapse.

A logical question when naltrexone is considered is whether blocking endogenous opioids has any negative effects, including impairment of the endogenous opioid system. The answer is that the normal physiology of this system is not fully understood. It is known that the endogenous opioid system is involved in the internal blocking of pain perception. This blockade is believed to have developed as part of the “fight or flight” response in order to prevent the perception of pain from impeding an organism during an emergency situation. Endogenous opioids are also involved in the regulation of mood and appetite. Yet, researchers believe that there may be redundant systems for these functions because most patients suffer no perceptible effects on either mood or appetite from long-term blockage of opiate receptors. Addiction specialists report that they have treated addicted patients for fifteen to twenty years using naltrexone to induce continuous opiate receptor blockade without any apparent side effects.

The major challenge posed by naltrexone therapy is adherence to the medication regimen. In this sense, its clinical strength — that it produces no reinforcing pharmacological effects, as do methadone and buprenorphine — is also its weakness. There is no direct reward in the brain for taking naltrexone, nor is there a penalty for stopping; that is, patients experience no withdrawal effects. Addicted physicians are motivated to take the drug because they will lose their licenses if they
relapse. The key question is whether other addicted individuals, including offenders under the supervision of the criminal justice system, could be similarly motivated because they could lose their freedom if they relapse.

A new and important development in the use of naltrexone is the availability of depot preparations. In 2006, the FDA is expected to approve one version that is effective for thirty to forty days after each injection, and a six-month version is under development in Australia. Clinical trials with the depot preparation have been highly promising. Patients may attempt to get high; however, when they inject heroin, they feel little or no effect. This result may produce frustration, but also a sense of liberation for patients who realize that they are now able to move about their neighborhoods with no risk of relapse to heroin use. Some report this as a life-changing experience.

Of course, naltrexone only blocks opiates. The drug has no apparent effect on cocaine use. However, unless a patient has had prior problems with cocaine abuse, few of them take up cocaine de novo as a result of opiate antagonist treatment. Naltrexone also does not alter or block the effects of other categories of drugs, such as benzodiazepines. Finally, it is also important to emphasize that naltrexone treatment is no longer an experimental treatment. It is an FDA-approved medication, is not addicting, has few side effects, and is not considered to be dangerous.\(^\text{15}\) If successful, naltrexone represents a high-gain, low-risk treatment.\(^\text{16}\)

In summary, treatment with the opiate antagonist naltrexone is an under-used approach that is both safe and effective provided that an effective incentive system is available to assure adherence. The criminal

\(^{15}\) Naltrexone does carry a "black box" warning in the Physicians' Desk Reference for potential liver damage; however, this warning represents an error in the approval process. In an experiment to try to treat obesity with naltrexone in the 1970s, when given the drug at seven times the usual dose, patients developed elevated liver enzymes. This result was reversible when the medication was stopped, but the company conducting the research envisioned so little financial success for naltrexone that it failed to perform the subsequent studies that would have lifted the liver warning. In practice, clinicians find naltrexone to actually protect the liver through the reduction of alcohol intake, which is toxic to that organ. Promise and Pharmacology, supra note 14.

\(^{16}\) According to Dr. O'Brien, some researchers have questioned the use of naltrexone in patients who have been in a painful accident or who develop a painful illness. Long experience with naltrexone demonstrates that such situations can be managed pharmacologically by other medications and by stopping treatment with naltrexone. In practice, this hypothetical situation has rarely been an issue. Id.
justice system should consider naltrexone treatment as a means to rehabilitate a greater proportion of offenders with a history of opiate addiction.

III. NALTREXONE FOR PREVENTION OF RELAPSE IN CRIMINAL OFFENDERS

Heroin addicts commit many crimes, typically non-violent, to support their habits. Many addicts are detained in the local jail after arrest, and many convicted offenders are incarcerated. The addicted offender becomes abstinent after going through withdrawal in custody, often without the aid of medication. Upon release, there is usually a period of supervised probation or parole, but offenders with a history of heroin addiction will almost always relapse when they are released from incarceration.\textsuperscript{17} Group therapy and counseling in prison have little effect on long-term outcome. Treatment in the community environment is essential. Unfortunately, drug-free treatment of heroin addiction has had minimal success despite decades of effort,\textsuperscript{18} and neither methadone nor buprenorphine have been widely embraced in many parts of the country, largely because of philosophical objections to maintaining the offender’s addiction rather than “curing” it.

Dr. Charles O’Brien argues that naltrexone is well suited to the needs and circumstances of the addicted offender who is under the supervision of the criminal justice system. He suggests that treatment adherence can be significantly improved by making naltrexone ingestion a condition of early release from prison, or of diversion from prosecution, for non-violent, opiate-addicted offenders.\textsuperscript{19} He specifically envisions use of the recently developed depot preparation. Under the

\textsuperscript{17} In some studies, more than ninety-five percent of drug-abusing offenders returned to drug use within three years of their release from prison, and most of them (eighty-five percent) relapsed within the first year. Douglas B. Marlowe et al., A Sober Assessment of Drug Courts, 16 FED. SENTENCING REP. 153, 153 (2003).

\textsuperscript{18} According to Marlowe et al., between fifty and seventy percent of probationers fail to comply with applicable conditions of drug testing and attendance in drug treatment. \textit{Id.} at 154 (citing LAUREN E. GLAZE, PROBATION AND PAROLE IN THE UNITED STATES, 2001 (2002); DOUGLAS YOUNG ET AL., ALCOHOL, DRUGS, AND CRIME: VERA’S FINAL REPORT ON NEW YORK’S INTERAGENCY INITIATIVE (1991); Faye S. Taxman et al., Graduated Sanctions: Stepping Into Accountable Systems and Offenders, 79 PRISON J. 182 (1999)).

\textsuperscript{19} Promise and Pharmacology, \textit{supra} note 14.
O’Brien proposal, the non-violent offender would be offered the choice of incarceration or naltrexone. Counseling would still be required, but this could generally be provided by the probation officer. Cases involving dual diagnoses, – such as depression, schizophrenia or other mental illness in combination with addiction – would require psychotherapy and other medication from a provider in the community. In the only randomized, controlled clinical trial of naltrexone in probationers with a history of opiate addiction, Cornish et al. found that fifty-six percent of the control group were re-incarcerated for parole violations within six months, while the experimental group randomized to naltrexone treatment were re-incarcerated at a rate less than half that (twenty-six percent).\textsuperscript{20}

Despite the fact that naltrexone has been available for treatment for almost twenty years, it has rarely been used in offender populations.\textsuperscript{21} One reason for lack of use is that few physicians have heard of this treatment and fewer still understand it. Thus, judges and probation officials cannot rely on the treatment providers, and this problem will have to be rectified in any jurisdiction wanting to implement the O’Brien proposal. Even if clinical capacity to provide naltrexone treatment is beefed up through physician training, the O’Brien proposal would have to overcome a conventional judicial reluctance to order addicted offenders to take drugs, an attitude that has impeded widespread use of methadone and buprenorphine in criminal settings.

Implementing the O’Brien proposal would require judicial education – judges need to understand the difference between naltrexone (an opiate antagonist with no intoxicating properties) and methadone and buprenorphine (opiate agonists intended to prevent withdrawal) – as well as willingness to innovate. Do courts have the authority to require addicts to take a medication as a condition of their continued freedom? The controversies over hormone treatment of sex offenders and use of anti-psychotic medications in offenders with mental illness come to mind in this connection. It should be emphasized, however, that naltrexone does not produce any lasting change in the patient’s brain or personality – it simply reduces craving for heroin and alcohol.

\textsuperscript{20} Cornish et al., \textit{supra} note 14 at 532.
\textsuperscript{21} Personal Communication with Charles P. O’Brien, MD, PhD. In Alaska, judges are mandating naltrexone for both heroin addicts and alcoholics. See Teresa W. Carns et al., \textit{Therapeutic Justice in Alaska’s Courts}, 19 \textit{Alaska L. Rev.} 1, 30 (2002).
In this paper, I will reflect on the legal principles that would apply to the situations of mandated treatment in the criminal justice system envisioned by Dr. O'Brien. Before doing so, however, I want to consider two different arrangements. First, I want to consider what I will call “no agreement” arrangements under which a probationer or parolee who does not want to receive naltrexone is required to do so under threat of incarceration for non-compliance. Second, I want to consider a purely voluntary arrangement under which the naltrexone treatment is not linked to the criminal sentence at all. Finally, I will consider Dr. O'Brien’s proposals – which I will characterize as “leveraged agreements.”

IV. “NO AGREEMENT” ARRANGEMENTS

First of all, I want to imagine what I will call a “no agreement” arrangement. Assume that probation is the maximum available sanction for the offender’s crime under the state’s applicable sentencing statutes or guidelines, and that the offender is accordingly sentenced to a two-year term of probation. Assume further that the judge orders the offender, as a condition of probation, to take naltrexone for the duration of the two-year period, subject to revocation for non-compliance with this condition or with other conditions, including refraining from use of heroin. Revocation of probation, upon proof of the violation, would result in immediate incarceration.\textsuperscript{22}

Legally speaking, making naltrexone treatment a condition of a probationary sentence is analogous to other orders under which a probationer must comply with mandated pharmacological treatment (e.g., anti-psychotic medication for mentally ill offenders, Depo-Provera for sex offenders) subject to incarceration for non-compliance. Although an offender has the de facto prerogative to “refuse” to follow the judge’s order in such cases (and take the consequences), he is not given any choice and receives no concessions as part of an agreement. In other words, I am envisioning a legal situation in which the treatment has clearly been “coerced” in the sense that the offender was given no choice in the matter, does not want to take naltrexone, has a statutory right to a

\textsuperscript{22} The situation would be legally analogous if a prisoner was entitled to mandatory release on parole under the applicable state law, and was released subject to compliance with a variety of conditions, including the use of naltrexone. I will refer to both probationers and parolees as “offenders.”
non-custodial sentence subject to reasonable conditions, and would prefer to have as few conditions as possible specified in the sentencing order.23

Would mandated use of naltrexone be a permissible probation condition in this situation? What legal principles would be applicable?

A. Does the Order Restrict a Constitutionally Protected Liberty?

The sentencing order would implicate the offender’s constitutional liberty interest in refusing unwanted medical treatment grounded in the due process clause. A competent person’s right to refuse unwanted medical treatment24 has been vindicated repeatedly over the past two decades in the context of end-of-life care, where it is virtually absolute, and no state interest is strong enough to override it.25 The right to refuse unwanted anti-psychotic medication is also well developed, mainly in the context of refusal by persons who have been involuntarily committed to psychiatric hospitals (or to prison medical facilities).26 The right is naturally more limited in this context since the patients have already been involuntarily hospitalized for treatment, but even here it may be overridden only if the patient poses a danger to himself or others and the treatment is medically necessary and appropriate. It is well established, then, that every competent individual has a right to refuse unwanted medical treatment and that this right may be overridden only if necessary to serve important governmental interests. This principle applies, prima facie, to a criminal offender who objects to taking naltrexone.

23 The subject of this paper is “coercion” based on a threat of imprisonment, not “compulsion,” by which I mean the use of physical force to administer medication over the offender’s objection. I will assume throughout the paper that, in a non-emergency situation, the state does not have the authority to administer addiction medication by force. Such “compulsion” would “shock the conscience” and is therefore impermissible under the due process clause. See Rochin v. California, 342 U.S. 165, 172 (1952).

24 I am assuming throughout this paper that the offender is competent to make medical decisions, and specifically that the offender has the capacity to give informed consent for naltrexone treatment.

25 Bouvia v. County of Los Angeles, 241 Cal. Rptr. 239, 244 (Cal. Ct. App. 1987); McKay v. Bergstedt, 801 P.2d 617, 624 (Nev. 1990). Under the Supreme Court’s dictum in Cruzan v. Director, Missouri Department of Health, it is also clear that the person’s right to refuse treatment is constitutionally protected even after loss of decisional capacity if he or she has executed an advance directive. 497 U.S. 261, 279 (1990).

B. In This Context, May the Offender's Liberty Interest Be Overridden?

The United States Supreme Court's most recent decision on the right to refuse medical treatment concerned a defendant who had been found incompetent to stand trial and had been committed to a forensic hospital for restoration of trial competence. The prisoner, Dr. Charles Sell, a dentist with a delusional disorder, refused anti-psychotic medication. Because of the way the case was presented to the Supreme Court, the Court assumed that Dr. Sell was competent to make medical decisions and was not dangerous, and that the question was therefore whether the government's interest in bringing him to trial was strong enough to override his "significant" liberty interest in refusing unwanted anti-psychotic drugs. The Court held that:

[T]he Constitution permits the Government involuntarily to administer anti-psychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.

The Sell decision pertained to a defendant properly committed to a psychiatric hospital for treatment, and is not directly applicable to the mandatory administration of drugs as a condition of probation or parole. However, a variation of the Sell test will probably be held to apply to a situation where a state conditions a person's continued freedom on probation or parole on compliance with mandated pharmacological treatment. Indeed, in the only federal case directly on point, Felce v. Fiedler, the Seventh Circuit Court of Appeals applied pre-Sell precedents dealing with the curtailment of prisoners' constitutional rights to Felce, the parolee in that case. Felce was required to have monthly injections of Prollixin decanoate as a condition of parole from the Wisconsin prison system after serving six and a half years of a ten-year sentence for aggravated assault of his ex-wife. He objected to the

28 Id. at 177-78, 183-85.
29 Id. at 179.
30 974 F.2d 1484 (7th Cir. 1992).
mediation requirement, signing his parole release agreement under protest. The Seventh Circuit concluded that Felce had a conditional liberty interest in being free from the involuntary use of antipsychotic drugs during his period of mandatory parole. "Before the use of such drugs may be made a condition of his continued parole, the state must demonstrate that such administration is medically indicated to accomplish the goals of the parole program of reintegrating Mr. Felce into the community."\textsuperscript{31}

In sum, when the prisoner is otherwise entitled to a mandatory release on parole, involuntary administration of anti-psychotic drugs is not a permissible condition of parole unless the government can show that it is necessary to prevent criminal conduct during the period of parole or to promote successful rehabilitation. Note that the Circuit Court assumed that Felce had been subjected to involuntary medication because he was entitled to release, as a matter of law, after serving six and a half years.\textsuperscript{32} He was required to take unwanted medication as the price for release on parole to which he was legally entitled. That was a coerced choice even though, as the Court acknowledged, he could have turned down parole and stayed in prison for another three and a half years.\textsuperscript{33}

What are the implications of \textit{Sell} and \textit{Felce} for the administration of naltrexone to a probationer or parolee? Obviously these cases pertain to anti-psychotic medication, and there are many clinical differences between the two contexts. The Court's reasoning in \textit{Sell}, however, does tell us, at the very least, that if naltrexone is ordered over objection it must be medically appropriate, must serve important governmental interests, must significantly further those interests (i.e., must be effective), and must be necessary to further those interests (i.e., there are no less restrictive alternatives that could also be effective).\textsuperscript{34} Assuming that the \textit{Sell} criteria apply in this context, the most critical showing a state would need to make is that the imposition of medication would be substantially likely to prevent criminal conduct in the short run and to promote rehabilitation in the long run.

\textsuperscript{31} \textit{Id}. at 1495-96.
\textsuperscript{32} \textit{Id}. at 1492.
\textsuperscript{33} \textit{Id}. at 1494. \textit{See also} United States v. Williams, 356 F.3d 1045, 1055 (9th Cir. 2004).
\textsuperscript{34} \textit{Sell}, 539 U.S. at 179.
In the present context, the government’s interest is in preventing continued opiate use during the period of probation and in reducing the risk of relapse thereafter. Assuming medical appropriateness in the individual case, and taking into account the favorable risk-benefit profile of naltrexone, the pivotal issue will be effectiveness. It is difficult to determine exactly how much proof of naltrexone’s effectiveness would be needed. Given the paucity of literature on the comparative effectiveness of the treatment in a “coerced” population of offenders, it is likely that the courts would demand more data than is now available. Additional studies with criminal offenders are urgently needed.

C. What Procedures Are Required?

The Constitution requires an individualized determination of the necessary facts by a judge or other impartial fact-finder after a proceeding that satisfies the requirements of due process. The Seventh Circuit ruled in *Felce* that the prison and parole agency had not complied with due process requirements because they failed to have an independent decision-maker determine whether the prisoner’s parole in that case should be conditioned upon anti-psychotic drug treatment.\(^{35}\) Review by doctors who had treated Mr. Felce was not adequate from the court’s perspective because it differed from the procedure approved by the Supreme Court in *Washington v. Harper*\(^{36}\) – review by a three-person panel, none of whom could be involved in the patient’s treatment at the time of the review.

D. Is Mandated Naltrexone Use a Reasonable Condition of Probation or Parole?

The legal principles thus far discussed emerge from the so-called “right to refuse treatment” cases. The related body of law pertaining to the conditions that may permissibly be prescribed in a probation or parole order leads to the same conclusion. Under this line of cases, the question is when, if ever, compliance with pharmacological treatment is a “reasonable” condition of probation. Generally, courts decide whether a probation condition is reasonable by weighing the likely effectiveness of the challenged condition in serving the purposes of probation or parole (crime prevention and rehabilitation) against the nature and extent of the infringement of an otherwise constitutionally protected liberty

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\(^{35}\) *Felce*, 974 F.2d at 1498.

interest, while factoring in the general needs of law enforcement.\textsuperscript{37} To put it another way, being convicted of a crime and sentenced to probation does not abrogate all of the offender's constitutional rights; some rights may virtually never be curtailed, and even if a right may be limited, the need for the condition must be specifically justified in the individual case.

Cases involving two particular probation conditions provide illustrative applications of this "balancing" test. On the one hand, two federal courts have ruled that a sex offender may be subjected to a penile plethysmograph as a valid condition of his parole.\textsuperscript{38} The tests were conducted as part of a general psychological treatment program that was mandated as a condition of parole, and the courts were persuaded that the plethysmograph was not exceptionally more intrusive than other physical or mental examinations or counseling that are typically required as a condition of parole or probation.\textsuperscript{39} On the other hand, courts have uniformly invalidated bars to procreation as conditions of probation or parole,\textsuperscript{40} and it is generally assumed that requiring a female offender to take Norplant, a long-acting contraceptive implanted under the skin, as a condition of probation would be impermissible.\textsuperscript{41} Along with obvious

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\item[37] See, e.g., Closs v. Weber, 238 F.3d 1018, 1022 (8th Cir. 2001); Felske, 974 F.2d at 1496.
\item[38] See United States v. Dotson, 324 F.3d 256, 261 (4th Cir. 2003); Walrath v. United States, 830 F. Supp. 444, 447 (N.D. Ill. 1993).
\item[39] Walrath, 830 F. Supp. at 447. See, e.g., United States v. Cooper, 171 F.3d 582, 587 (8th Cir. 1999) (abstaining from consumption of alcohol, participating in testing for drug and alcohol abuse, and mental health counseling); United States v. Wilson, 154 F.3d 658, 667 (7th Cir. 1998) (mental health treatment program); United States v. Stine, 675 F.2d 69, 72 (3d Cir. 1982) (same).
\item[41] A search of the reported decisions reveals only two cases on point, but they both were moot by the time they got to the state appellate courts. See People v. Johnson, No. F015316, 1992 WL 685375 (Cal. Ct. App. Apr. 13, 1992); People v. Walsh, 593 N.W.2d 558 (Mich. 1999). A concurring judge in Walsh specifically states that the sentencing court's order of the implantation of Norplant was an unlawful condition of probation, reasoning that the order is directly analogous to ordering sex offenders to submit to Depo-Provera treatment, which the Michigan Supreme Court found to be "unlawful and invalid" in People v. Gauntlett, 352 N.W.2d 310, 317 (Mich. Ct. App. 1984). Gauntlett relies solely on non-constitutional limitations, instead finding that the order to use Depo-Provera was unlawful under the state probation statute and that there was no informed consent in this case. 352 N.W.2d at 316-17.

There is also some scholarly commentary on the implantation of Norplant as a condition of probation. See Scott J. Jebson, Conditioning a Woman's Probation on Her
policing problems, the courts in these cases have been hesitant to allow such conditions on the basis of the fundamental nature of the right to procreate. The question is where the line is drawn along this continuum of probation conditions. Involuntary use of a naltrexone depot preparation probably lies somewhere between the plethysmograph and a ban against procreation or required use of Norplant, and would therefore be permissible only if based on a strong showing of necessity and effectiveness, together with minimal risks, as indicated above.

V. VOLUNTARY ARRANGEMENTS

Thus far, I have assumed that the naltrexone treatment has been prescribed as a condition of probation or parole over the offender’s objection. Now, I want to assume that the treatment is sought by the offender on an unequivocally voluntary basis, and that the use of naltrexone is not in any way linked to the criminal justice system. Let us assume, for example, that the offender has been sentenced for a drug-related crime to a two-year term of probation during which he is required to undergo periodic urine screens, and that his probation may be revoked, *inter alia*, for a dirty urine. Wanting to reduce the likelihood that he will relapse, the offender goes to the community’s public substance abuse treatment provider (where he has previously received treatment) and asks for naltrexone. Assume further that the offender is denied naltrexone treatment on the basis of an agency policy precluding clients under criminal justice supervision from receiving naltrexone.

I would be prepared to argue that such an agency policy would violate the constitutional guarantee of equal protection of the laws because it arbitrarily denies probationers access to a medically appropriate ameliorative treatment for addiction without any rational justification. It might be argued in response that the agency’s policy is based on a judgment that people under the supervision of the criminal justice system are under duress and therefore lack the capacity to provide voluntary, informed consent. I doubt that this argument would survive what the courts call the “rational basis” test, much less the heightened

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constitutional scrutiny that might be required for policies that deny people access to accepted medical treatments.\textsuperscript{42}

I do not know whether any addiction treatment agency has promulgated a policy of the kind that I just imagined, but even if the example is fanciful, it helps me make a very important point. Preoccupation with impediments to obtaining valid consent, and particularly with the problem of voluntariness, can lead to policies that unfairly deny access to treatment. Again, the best illustration of this problem has come up in the context of psychiatric treatment, specifically electroconvulsive treatment (ECT).

During the past three decades, states have been concerned about the adequacy of consent for ECT, and have prescribed various forms of external review of the appropriateness of the treatment and the adequacy of consent\textsuperscript{43} – a review process analogous to the procedures that are sometimes required before people are permitted to enroll in certain types of medical research.\textsuperscript{44} Typically, these external review procedures for ECT are required only for patients in public hospitals, reflecting the historical evidence of abuse in that context. However, when California enacted its special review procedures in 1974, it made them applicable to all ECT, whether provided in public or private settings.\textsuperscript{45} The statute permitted ECT only if heightened criteria were met ("all other appropriate treatment modalities have been exhausted and that this mode of treatment is critically needed"), family members were notified, and the need for the treatment and the patient’s capacity to consent was affirmed by a three-physician panel.\textsuperscript{46} The California Supreme Court invalidated these procedures,\textsuperscript{47} viewing them as an impermissible interference with medical decision-making autonomy:

\begin{itemize}
\item \textsuperscript{42} I want to emphasize that this argument is an anti-discrimination argument and that it does not obligate the government to provide naltrexone in the first instance. The government is not constitutionally obligated to provide addiction treatment services at all. However, ethicists might argue that the addicted offender has a "right" to addiction treatment, including the naltrexone, and that the state is morally obligated to offer it to offenders whose offenses are addiction-related. I can imagine an Eighth Amendment argument to this effect, but I doubt that it would prevail.
\item \textsuperscript{43} \textit{See, e.g.,} VA. CODE ANN. §§ 37.1-10, 37.2-1102(3) (2005).
\item \textsuperscript{44} \textit{See, e.g.,} Richard J. Bonnie, \textit{Research with Cognitively Impaired Subjects}, 54 ARCHIVES GEN. PSYCHIATRY 105, 107-08 (1997).
\item \textsuperscript{45} CAL. WELF. & INST. CODE § 5326.4 (1974).
\item \textsuperscript{46} \textit{Id.}
\end{itemize}
Once the competency of a voluntary patient has been confirmed, and the truly voluntary nature of his consent is determined, the state has little excuse to invoke the substitute decision-making process . . . . ECT is not an experimental procedure, nor are its hazards as serious as those of psychosurgery . . . . Where informed consent is adequately insured, there is no justification for infringing upon the patient’s right to privacy in selecting and consenting to the treatment. The state has varied interests which are served by the regulation of ECT, but these interests are not served where the patient and his physician are the best judges of the patient’s health, safety and welfare.48

The same can be said of policies or practices that impede access to naltrexone by patients whose physicians prescribe it for them and who seek the treatment, even if they are under the supervision of the criminal justice system.

VI. “LEVERAGED AGREEMENTS”

Now we come to Dr. O’Brien’s proposal.49 Under the arrangements he envisions, offenders would be offered an opportunity to receive naltrexone as a part of a favorable disposition of their cases or as a condition of early release on discretionary parole. These arrangements entail what I will call “leveraged agreements.” In order to explore the legal principles applicable to a “leveraged agreement” in the criminal justice system, I will address two specific variations of such arrangements – plea-bargaining for conditional probation, and early release on conditional parole.

A. Plea Agreements for Conditional Probation

Consider probation first. Assume that the defendant faces a high likelihood of conviction and a possible sentence of two years in jail for his drug-related offense. However, as part of a plea agreement,50 the defendant agrees to take naltrexone in return for the prosecution’s

48 Id. at 549.
49 Promise and Pharmacology, supra note 14.
50 A pre-adjudication diversion, as envisioned in Dr. O’Brien’s proposal, is functionally equivalent to post-conviction conditional probation for my purposes.
recommendation of a non-custodial disposition. He understands that non-compliance with the prescribed requirements can result in revocation.

The central question in these cases is whether individual's consent is valid or has been coerced. Another way of putting the same question is whether the defendant has validly "waived" his right to refuse unwanted medical treatment. If the consent is valid, there is no basis for judicial scrutiny of the medical and behavioral justification for prescribing naltrexone, and the offender’s probation may properly be revoked for non-compliance. However, if the consent is said to be invalid, then the permissibility of the condition will be evaluated according to the criteria applicable to a "No Agreement" arrangement, as discussed above.

There is no doubt that the defendant may "feel coerced" in a psychological sense – his choices are obviously limited. But, the subjective experience of "coercion" – of being faced with a "hard choice" – is not the same as being "coerced" in a legal or moral sense. Whether a leveraged arrangement is "coercive" (or voluntary) is a normative question, not an empirical one. In the present context, whether the offender's agreement to take naltrexone should be regarded as "voluntary" or "coerced" ultimately depends on whether the plea agreement itself should be regarded as "voluntary" or "coerced."

The United States Supreme Court has addressed this question directly and has concluded that such plea agreements are valid and should be enforced. In Brady v. United States,\(^5^1\) decided in 1970, Brady sought to set aside his guilty plea on the ground that he had agreed to plead guilty only to avoid the death penalty and that his plea had accordingly been "coerced." The Supreme Court rejected that argument and explained why as follows:

Of course, the agents of the State may not produce a plea by actual or threatened physical harm or by mental coercion overbearing the will of the defendant. But nothing of the sort is claimed in this case; nor is there evidence that Brady was so gripped by fear of the death penalty or hope of leniency that he did not or could not, with the help of counsel, rationally weigh the advantages of going to trial against the advantages of pleading

guilty. Brady’s claim is of a different sort: that it violates the Fifth Amendment to influence or encourage a guilty plea by opportunity or promise of leniency and that a guilty plea is coerced and invalid if influenced by the fear of a possibly higher penalty for the crime charged if a conviction is obtained after the State is put to its proof.

Insofar as the voluntariness of his plea is concerned, there is little to differentiate Brady from (1) the defendant, in a jurisdiction where the judge and jury have the same range of sentencing power, who pleads guilty because his lawyer advises him that the judge will very probably be more lenient than the jury; (2) the defendant, in a jurisdiction where the judge alone has sentencing power, who is advised by counsel that the judge is normally more lenient with defendants who plead guilty than with those who go to trial; (3) the defendant who is permitted by prosecutor and judge to plead guilty to a lesser offense included in the offense charged; and (4) the defendant who pleads guilty to certain counts with the understanding that other charges will be dropped. In each of these situations, as in Brady’s case, the defendant might never plead guilty absent the possibility or certainty that the plea will result in a lesser penalty than the sentence that could be imposed after a trial and a verdict of guilty. We decline to hold, however, that a guilty plea is compelled and invalid under the Fifth Amendment whenever motivated by the defendant’s desire to accept the certainty or probability of a lesser penalty rather than face a wider range of possibilities extending from acquittal to

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52 At this point, the Court stated in an important footnote: “We here make no reference to the situation where the prosecutor or judge, or both, deliberately employ their charging and sentencing powers to induce a particular defendant to tender a plea of guilty. In Brady’s case there is no claim that the prosecutor threatened prosecution on a charge not justified by the evidence or that the trial judge threatened Brady with a harsher sentence if convicted after trial in order to induce him to plead guilty.” Id. at 751, n.8.
conviction and a higher penalty authorized by law for the crime charged.\textsuperscript{53}

The Court's conclusion rests on the premise that plea agreements expand the defendant's available options rather than constricting them. Without the prosecution's offer of a life sentence in return for a guilty plea, Brady had two choices: he could go to trial, putting the state to its proof, hoping that he would be acquitted or convicted of a non-capital offense, or he could plead guilty to the capital offense, gambling that the judge would sentence him to life. The plea agreement expanded his choices by precluding the death penalty in return for surrendering his right to go to trial.

This way of looking at plea agreements implicates the normative basis of enforcing all contracts. According to Robert Scott and William Stuntz, "[t]he normative claim that supports enforcing bargains is that voluntary exchange offers people more choices than they would otherwise enjoy and, other things being equal, more choice is better than less."\textsuperscript{54} This is especially true for individuals whose choices are limited to begin with:

\textit{[T]he norm of expanded choice is solely concerned with the marginal effects of the contract on an individual's choices. A person with few and unpalatable choices may live in a coercive environment. An offer that exploits those circumstances is nevertheless value enhancing, and enforcement is appropriate. More choices are better, even - perhaps especially - if one has few to begin with.} \textsuperscript{55}

Using a plea agreement to illustrate the idea of expanded "choice" may strike some people as counter-intuitive - after all, the defendant has very little bargaining power when he succumbs to the prosecution's "offer" of a more lenient punishment than otherwise would have been sought and imposed. It seems like the prosecution has all the cards. How can we use the language of contract in such an overwhelmingly coercive environment? The answer is that the defendant does have a choice - he has the option of going to trial (putting the state to the time,

\textsuperscript{53} Id. at 750-51.
\textsuperscript{55} Id. at 1920.
trouble and cost of trying to proving his guilt) and refusing to assist the state in investigating and prosecuting other people. These prerogatives are of genuine value in the criminal justice system as it is now designed, and provide meaningful consideration for the state’s concessions on charges and sentence. As long as we assume that the defendant has been fairly charged (and that the risks of going to trial have not been unfairly magnified in order to induce guilty pleas), then the plea agreement is voluntary (and has not been “coerced”).

Philosopher Alan Wertheimer has stated “the ability to obligate oneself by creating a binding contract is an important aspect of our freedom.”56 “Voluntariness – and, in particular, the absence of coercion,” he stated, is “a necessary condition of obligations grounded in agreement.”57 How is one to determine which contractual decisions are voluntary and which are the product of coercion? The standard view of coercive proposals is that threats coerce, but offers do not. And the crux of the distinction between threats and offers is that A makes a threat when B will be worse off than in some relevant baseline position where B does not accept A’s proposal, but that A makes an offer when B will be no worse off than in some relevant baseline position where B does not accept A’s proposal. On this view, the key to understanding what counts as a coercive proposal is to properly fix B’s baseline.58

Assuming that the defendant has been fairly charged by the prosecutor, a tendered plea agreement is an offer (which expands the defendant’s choices), not a threat. In the context of a prosecutorial offer of probation conditioned on taking naltrexone (in lieu of recommending a more severe sentence authorized by law for the defendant’s offense), the defendant who accepts the offer has made a voluntary choice and has not been coerced. To be sure, the choice has been “leveraged” by the possibility of imprisonment – and the defendant is more likely to comply with the order every month rather than invite revocation – but all of these choices are “voluntary” in a legal and moral sense.

B. Early Release on Parole

Now consider an offender who is eligible for parole in a system in which the parole board has the discretion to grant or deny parole based

57 Id. at 21.
58 Id. at 204.
on its judgment about the likelihood of recidivism and the prospects for successful rehabilitation. Assume that the parole board concludes that the prisoner's offenses have all been addiction-related and that the best plan for successful rehabilitation is to prevent relapse when the prisoner returns to the community. It offers the prisoner a parole agreement involving administration of naltrexone and participation in counseling. This situation is analogous to the plea bargaining situation. We are assuming that, under the applicable parole statutes, the prisoner has no right to release, with or without conditions. However, the parole agency has the discretionary authority to grant early release, and offers that option to the prisoner, conditioned on his agreement to take the naltrexone. Judged by the legal baseline (being in prison with no right to release), the parole agency has made an offer which he is free to accept or reject. By contrast, in the situation imagined in the discussion of "No Agreement" arrangement earlier in this article, the prisoner was entitled to release under the applicable statutes, and the parole agency was essentially saying that the prisoner has to give up his right to refuse treatment in order to obtain the liberty to which he is otherwise entitled.

Bruce Winick argues that the promise of release for agreeing to pharmacotherapy should not "necessarily render voluntariness legally impossible." 59 Relying on Brady v. United States, Winick observes that "[i]f avoidance of the possibility of a death sentence is not so inherently coercive as to invalidate a guilty plea, then it is difficult to see how the possibility or promise of early release could be considered so inherently coercive as to invalidate a patient's or offender's choice of therapy." 60

This distinction is nicely reflected in two federal circuit court decisions concerning parolees who had been required to take antipsychotic medication. In Felce, reviewed earlier, Mr. Felce was entitled to release, having served his sentence minus good time, and the court held that his "agreement" to take the prolixin had therefore been "coerced" by the agency. 61 In Closs v. Weber (2001), 62 by contrast,
Randy Closs was granted a conditional parole after serving fourteen years of his sentence.

The parole agreement, which he signed, stated that “[i]n consideration” of being granted parole he would comply with instructions regarding his parole supervision and with other “special limitations and conditions.” Mr. Closs had a long-term diagnosis of schizophrenia, and as part of the “special limitations and conditions” of his parole, he agreed to “[b]egin and maintain psychological or psychiatric treatment at a facility or with a psychologist or psychiatrist approved by the [Board of Pardons and Parole].”

In compliance with the parole agreement, Mr. Closs voluntarily entered a board-approved mental health facility for psychiatric treatment. At the facility, his attending psychiatrist prescribed a psychotropic drug for him . . . . Mr. Closs initially refused to take the prescribed medication. After his parole agent reportedly explained to him that “cooperation with his treatment was imperative and that any future refusal to do so would . . . result in a [parole] violation,” he took the drug for about two days. On the next day, Mr. Closs refused a scheduled increase in his medication, and for the next two days he refused to take the medication at all. The facility then discharged him to his parole agent.

At his parole violation hearing, Mr. Closs testified that the parole agreement did not require him to take medication, and that he quit taking the medicine because it caused him side effects, including a dry mouth, stiff muscles, and drowsiness. The board concluded that he had violated his parole conditions by failing to comply with “all instructions affecting [his] supervision.” As a result, the board revoked Mr. Closs’s parole . . . .

The South Dakota state courts rejected Closs’s claim that conditioning his parole on taking unwanted medication violated due

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62 238 F.3d 1018 (8th Cir. 2001).
63 Id. at 1019.
process. The Eighth Circuit upheld the state court ruling, reasoning that Closs, "rather than being forcibly medicated, [had] agreed to treatment that included prescribed medication," and that "there was no evidence that Mr. Closs was forced to agree to the parole terms or that he objected to the treatment condition when it was imposed." Moreover, Closs had no protected liberty interest in receiving parole under South Dakota law because the parole decision is entirely discretionary, and he was "not required to accept a conditional parole." "Thus, in return for receiving the discretionary benefit of parole, Mr. Closs agreed, inter alia, to maintain board-approved treatment for his mental illness." The Eighth Circuit distinguished Felce on the ground that Felce had been entitled to mandatory parole.

In my opinion, then, a "leveraged agreement" with the parole condition envisioned by Dr. O'Brien would be a voluntary one, constitutionally speaking, and would not implicate the due process clause. The state, therefore, does not have to prove that any criteria other than medical appropriateness have been met or that the agreement has been reviewed or approved by any third party.

VI. CONCLUSION

In closing, I think that the legal prospects for mandated treatment of probationers and parolees with naltrexone are excellent. It is clear that everyone, including a criminal offender, has a strong constitutionally protected interest in refusing unwanted medical treatment, including naltrexone. However, this right can be waived as part of a plea agreement for conditional probation or for early release on parole as long as the treatment is medically appropriate in the offender's case and the offender has been fully informed about what is expected of him. I see no reason why the courts would regard the offenders as categorically unable to enter into such agreements or would otherwise decline to uphold them. Indeed, I think that organizations advocating on behalf of prisoners should argue that the failure to make naltrexone available to offenders with histories of opiate addiction who seek such treatment amounts to a form of discrimination against them.

64 Id. at 1020.
65 Id. at 1021-22.
66 Id. at 1022.
67 Id.
The harder question is whether the courts or parole agencies have the constitutional authority to order offenders with histories of addition and addiction-related offenses to take naltrexone as a condition of probation or parole even if they have not agreed to do so. Although the answer is not altogether clear, I believe that mandated naltrexone treatment would be upheld by the courts if the trial judge or some other impartial decision-maker found, after a suitable hearing, that the use of naltrexone is medically appropriate, without significant risk, and likely to prevent relapse and thereby prevent crime and promote rehabilitation, and that no less intrusive, reasonably effective alternative is available.\textsuperscript{68}

\textsuperscript{68} Cf. United States v. Williams, 356 F.3d 1045, 1057 (9th Cir. 2004) ("[B]efore a mandatory medication condition can be imposed at sentencing, the district court must make on-the-record, medically-grounded findings that court-ordered medication is necessary . . . and [make] an explicit finding on the record that the condition ‘involves no greater deprivation of liberty than is reasonably necessary.’") (citation omitted).