The Resurgence of Heroin: Benefiting from the Current Political Climate

Timothy S. Coyne

Follow this and additional works at: http://scholarship.richmond.edu/pilr
Part of the Public Law and Legal Theory Commons

Recommended Citation
Available at: http://scholarship.richmond.edu/pilr/vol20/iss2/7

This Article is brought to you for free and open access by the Law School Journals at UR Scholarship Repository. It has been accepted for inclusion in Richmond Public Interest Law Review by an authorized editor of UR Scholarship Repository. For more information, please contact scholarshiprepository@richmond.edu.
THE RESURGENCE OF HEROIN:
BENEFITTING FROM THE CURRENT POLITICAL CLIMATE

Timothy S. Coyne*

* Timothy Coyne is the Public Defender for the City of Winchester and Counties of Clarke, Frederick, Page, Shenandoah, and Warren. He has worked to help those affected by opioid addiction for many years and served on the 2016 Richmond Public Interest Law Review Symposium panel. He is also Vice-Chairman of the Northern Shenandoah Valley Substance Abuse Coalition.
ABSTRACT

Opioid addiction has been elevated to a public health crisis in the U.S. and the Commonwealth of Virginia in recent years, with overdose deaths growing among all demographics. Federal and state governments have enacted reforms to curb addiction and death, but according to those most closely involved with the epidemic there is still far more that can be done. This Article describes the causes and effects of addiction, outlines government policies enacted to address the epidemic, and provides insights on further policy developments that could reduce opioid addictions and overdose deaths while providing helpful treatment to those already affected.

INTRODUCTION

911: “What’s your emergency?”

Caller: “It’s my roommate. He’s passed out on his bed and I can’t get him up. He’s barely breathing. His lips are blue. I think he’s dead.”

This is a scene that repeats itself with alarming frequency all across the country. By the time emergency personnel arrive on the scene and administer emergency medical services, it is too late. This is not a heart attack victim, or someone suffering from a stroke. The individual has died of yet another heroin overdose. Law enforcement is then left to determine whether any criminal charges should be brought against those individuals on the scene or responsible for providing the drugs that caused the individual’s death. Their response, and the response of the criminal justice system, is critical to properly addressing this epidemic.

Over the past decade, an opioid epidemic has taken hold across the Commonwealth and the nation. This epidemic started with the over-prescribing and misuse of prescription opioid pain medications. From 1999 to 2014, the amount of prescription opioids sold in the United States nearly quadrupled. More and more people became dependent on and addicted to these medications. As authorities tightened up on the over-prescribing of these drugs, those who had become addicted to them turned to heroin as a cheaper and easier to obtain alternative. The effects of opioid and heroin abuse can be deadly.

The response to this epidemic has been markedly different than the historical response of enacting more severe punishments and incarcerating more defendants. Law enforcement officials have openly stated that, “We
cannot arrest our way out of this problem."¹ That attitude, and the response of the legislative and executive branches at the national and state levels, has opened new opportunities for defense attorneys representing clients suffering from the disease of addiction. The objectives of this article are to provide some background and statistics on the current opioid epidemic; discuss the nature of opioid addiction; contrast the current reaction to this epidemic with past epidemics; highlight some of the positive legislative changes that have been made to address this crisis; and discuss how community outreach and collaboration can provide positive alternatives to incarceration for defendants engaged in the criminal justice system. With true community involvement and a full understanding of how to treat the disease of addiction, our criminal justice system may be able to respond more effectively to this current opioid epidemic.

I. BACKGROUND ON THE OPIOID EPIDEMIC

Drug overdose is now the leading cause of accidental death in the United States.² Opioid addiction is driving this epidemic. In 2014, there were 47,055 lethal drug overdoses in the U.S., with 18,893 overdose deaths related to prescription opioids and 10,574 overdose deaths related to heroin.³ In 2015, those numbers climbed higher to a total of 52,404 lethal drug overdoses, with 20,101 of those deaths related to prescription opioids and 12,990 overdose deaths related to heroin.⁴ According to the Centers for Disease Control, ninety-one Americans die every day from an opioid overdose.⁵ Of the 21.5 million Americans twelve years or older with a substance use disorder in 2014, 1.9 million had a substance use disorder involving prescription pain medications and 586,000 had a substance use disorder in-

⁴ Opioid Addiction 2016 Facts & Figures, supra note 2.
volving heroin. In 2015, the sales of opioid painkillers in the United States alone approached $9.6 billion.

In Virginia, the statistics have been just as alarming. From 2010 through 2015, the number of fatal drug overdoses rose from 690 to 1,020, an increase of 47.8%. The primary drugs involved in those fatal overdoses during that period were: benzodiazepines, cocaine, heroin, prescription opioids and fentanyl. Of those substances, only benzodiazepine deaths decreased. Prescription opioid deaths increased by 31%, and heroin deaths increased by a staggering 616%. In 2014, drug overdose deaths in Virginia exceeded motor vehicle deaths for the first time.

While these numbers are clearly disturbing, addiction and substance abuse are not new phenomena. Understanding what addiction and substance abuse really are is absolutely critical to responding effectively to this public health crisis. The American Society of Addiction Medicine (“ASAM”) defines addiction as:

[A] primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

The Diagnostic and Statistical Manual of Mental Disorders (“DSM”), a publication of the American Psychiatric Association used by clinicians to classify and diagnose mental disorders, recognizes “substance use disorder” as a category of mental disorder. The latest version of this publication, the

---

9 id.
10 Id.
11 The rate of fatal overdose for these substances for the time period 2010 through 2015 was as follows: Benzodiazepines: 183 to 171 (-6.5%); Cocaine: 93 to 167 (+79.5%); Heroin: 48 to 344 (+616.6%); Prescription Opioids: 427 to 560 (+31.1%); Fentanyl: 64 to 123 (+92.2%). Id.
DSM-5, replaced previous categories of substance abuse and substance dependence with the single category of substance use disorder. According to the DSM-5, “[t]he essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant sub-related problems.”¹⁴ The DSM-5 recognizes that “[a]n important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli.”¹⁵

Whether we call it substance abuse or addiction, we are clearly dealing with a disease of the brain. Recognizing this fact, and treating addiction as a disease, is critical to responding to this epidemic and properly treating those suffering from the devastating effects and consequences. Opioid addiction is particularly difficult to treat because of the specific pathology of the disease. Opioids act by attaching to specific proteins called opioid receptors found in the brain, the spinal cord, and other organs in the body.¹⁶ When opioids attach to these receptors, they reduce the perception of pain and increase the sensation of euphoria in the reward center of the brain.¹⁷ Opioids can also produce drowsiness, mental confusion, nausea and constipation, and can depress respiration.¹⁸ When abused and overused, prescription opioids and heroin can lead to death.

II. LEGISLATIVE REACTION TO THE CRISIS

Drug epidemics typically spur a response from the legislative branch. Elected officials, concerned about rampant illegal drug use and deaths, have historically responded by enacting tougher penalties for drug offenses. In the 1980’s, a crack cocaine epidemic gripped the country. The nation was particularly shocked on June 19, 1986, when Len Bias, the number two overall pick in the NBA draft that year, died of severe cocaine intoxica-

¹⁴ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483 (5th ed. 2013)
¹⁵ Id.
¹⁷ Id.
¹⁸ Id.
tion. The Congressional response was swift and punitive. On September 8, 1986, the Anti-Drug Abuse Act of 1986 was introduced. The bill sailed through both houses of Congress and was signed into law by President Ronald Reagan on October 27, 1986. Among its more punitive provisions, the law established severe mandatory minimum sentences for certain drug offenses. The distribution of five grams of cocaine base (crack cocaine) triggered a five-year mandatory minimum sentence, while the distribution of fifty grams of cocaine base triggered a ten-year mandatory minimum sentence. The impact on the federal prison population was staggering. Between 1985 and 1995, the number of offenders incarcerated in federal prisons for drug offenses increased more than five-fold, from approximately 10,000 inmates in 1985 to more than 51,000 in 1995. By 2012, the number of offenders incarcerated in federal prisons whose primary offense was drug-related had grown to 94,678.

By stark contrast, the legislative reaction to the current opioid epidemic has generally been far more treatment-oriented, with some exceptions. At the federal level, the Comprehensive Addiction and Recovery Act ("CARA") was passed by both houses of Congress and signed into law by President Barack Obama on July 22, 2016. CARA was the first major federal addiction legislation in forty years and the most comprehensive effort undertaken to address the opioid epidemic, encompassing prevention, treatment, recovery, law enforcement, criminal justice reform and overdose reversal. While CARA authorized over $181 million each year in new funding to fight the opioid epidemic, monies must be appropriated every year.

21 Id.
through the regular appropriations process, in order for it to be distributed in accordance with the law.  

In Virginia, Governor Terry McAuliffe created the Task Force on Prescription Drug and Heroin Abuse, a 32-member group of multi-disciplinary, bi-partisan leaders from across Virginia. Five distinct workgroups were defined in the Executive Order: Education, Treatment, Data and Monitoring, Storage and Disposal, and Enforcement. The Task Force ultimately approved fifty one recommendations, including improved access to and availability of treatment services; fostering best practices and adherence to standards for treatment of individuals addicted to opioids; identifying and promoting evidence-based practices and strategies across the criminal justice system to address public safety risks and treatment needs of individuals with opioid addiction; training in the use of life saving interventions; expanded alternatives to incarceration, including drug courts; and cross-system collaboration to improve access and the availability of treatment. While these were but a few of the recommendations, the Task Force clearly recognized the need for accessible treatment services across the Commonwealth to address this epidemic.

The Virginia General Assembly responded to a number of the Task Force recommendations and enacted them into law. The General Assembly started by tightening several provisions in the Virginia Prescription Monitoring Program (“PMP”) to control the prescription and dispensing of prescription opioids:

- Virginia Code Section 54.1-2521 – Beginning January 1, 2017, all dispensers of prescription medications must report to the PMP database within 24 hours, or the next business day, after the prescription is dispensed. Prior to the amendment, dispensers had 7 days after dispensing to report to the PMP. Also, the amendment granted access to PMP information by dispensers who are providing clinical consultation on the care and treatment to the recipient. Finally, the

amendment permitted a copy of the PMP report to be included in the patient’s record. Under prior law, a copy of the PMP could not be included in the patient’s record.30

- Virginia Code Section 54.1-2522.1 – Beginning July 1, 2016, all prescribers of opioids are required to query the PMP database if treatment is anticipated to last more than fourteen (14) consecutive days. Under prior law, a prescriber was required to query the database if treatment was expected to last more than 90 days.31

- Virginia Code Section 54.1-2523.1 – This amendment requires the Director of the PMP to develop, in consultation with the Boards of Medicine and Pharmacy, criteria to detect unusual patterns of prescribing or dispensing covered substances by prescribers or dispensers and authorizes such information to be provided to the prescribers or dispensers as well as to the Enforcement Division of the Department of Health Professions, in addition to the Virginia State Police Drug Diversion Program or chief law enforcement officer in a county, city, town, or campus police department for the purposes of an investigation into issues surrounding drug diversion.32

The General Assembly also enacted a “Safe Reporting” law to encourage individuals to call 911 if they were present when someone experienced a drug overdose. Virginia Code Section 18.2-251.03 creates an affirmative defense for an individual charged with unlawful possession of alcohol, possession of a controlled substance, possession of marijuana, DIP, or possession of paraphernalia. In order to assert the defense, an individual must meet the following specific requirements:

1. The individual must, in good faith, seek medical attention for himself or someone experiencing an overdose;

2. The individual must remain on the scene of the overdose until law enforcement responds;

3. The individual must identify himself to law enforcement;

4. If requested, the individual must substantially cooperate in any investigation; and

31 VA. CODE ANN. § 54.1-2522.1(b) (Amended 2016).
5. The evidence was obtained as a result of the individual seeking medical attention.\textsuperscript{33}

While the goal of the “Safe Reporting” law is certainly commendable, its impact in practice has been limited. In order to take advantage of the affirmative defense, an individual must be charged with one of the enumerated criminal offenses. The defendant must then convince a prosecutor, judge or a jury that the defense applies before the charge can be dismissed. Prosecutors are sometimes reluctant to simply dismiss a felony charge, and a defendant is thereby subjected to the risk of conviction. As the law becomes more widely used, and prosecutors become more comfortable with its life-saving goals, more overdoses will hopefully be reported and lives saved.

Drug treatment courts have been operating in Virginia since 1995. The goals of these judicial programs are to:

1. Reduce drug addiction and drug dependency among offenders;
2. Reduce recidivism;
3. Reduce drug-related court workloads;
4. Increase personal, familial and societal accountability among offenders; and
5. Promote effective planning and use of resources among the criminal justice system and community agencies.\textsuperscript{34}

In 2015, there were thirty-six drug treatment court dockets approved to operate in Virginia. Eleven of those dockets were approved between 2012 and 2015.\textsuperscript{35} Three more dockets were approved by the Virginia Supreme Court’s Drug Treatment Court Advisory Committee on April 28, 2016.\textsuperscript{36} The two year budget approved by the Virginia General Assembly in 2016 included $1.2 million in new funding for drug treatment courts that have not previously received state funding and have significant drug-related caseloads.\textsuperscript{37} This was a significant step toward addressing the opioid epi-

\textsuperscript{33} VA. CODE ANN. § 18.2-251.03 (2016).
\textsuperscript{34} Department of Judicial Services Office of the Executive Secretary, Supreme Court of Virginia, Virginia Drug Treatment Court: 2015 Annual Report, at 1-2 (2016), http://leg2.state.va.us/dls/hsdocs.nsf/By+Year/RD602016/$file/RD60.pdf.
\textsuperscript{35} Id. at v (discussing that approved programs include: twenty-four (24) adult, eight (8) juvenile, two (2) family and two (2) regional DUI Drug Treatment Court Dockets.).
\textsuperscript{36} Department of Judicial Services Office of the Executive Secretary, Supreme Court of Virginia, Virginia Drug Treatment Court: 2016 Annual Report, at v (2016), http://leg2.state.va.us/dls/hsdocs.nsf/By+Year/RD5622016/$file/RD562.pdf.
demic as no new funding for drug treatment courts had been approved by the Virginia General Assembly since 2009.

III. PROSECUTORIAL RESPONSE TO THE CRISIS

Prosecutors across the nation and the Commonwealth have struggled with how to appropriately respond to the opioid epidemic and the devastation it is causing in communities and families. In Virginia, the distribution of heroin, a Schedule I controlled substance, is an unclassed felony punishable by a maximum of forty years in the penitentiary for a first offense.\(^{38}\) While prosecutors are aware that many addicts sell heroin to support their own habits, there is still pressure to enforce the law and prosecute drug offenders. In some cases, the distribution of heroin resulting in an overdose death has led to charges of felony murder. Since 2011, in the Northern Shenandoah communities of Winchester and Frederick County, at least six felony murder prosecutions have been commenced in cases involving heroin or opioid overdose deaths.\(^{39}\)

Felony murder prosecutions for overdose deaths are not new. In the case of *Heacock v. Commonwealth*, the Virginia Supreme Court clearly reiterated the legal principles required to sustain a felony murder conviction where death results from a drug overdose.\(^{40}\) In *Heacock*, the defendant was convicted of felony murder, distribution of cocaine, and conspiracy to distribute cocaine.\(^{41}\) Heacock supplied "very high quality cocaine" at a "drug party" held at the home of two other individuals.\(^{42}\) Heacock and another individual prepared a mixture of the cocaine in a spoon for injection. An individual at the party injected the cocaine mixture, experienced paralyzing convulsions, but revived.\(^{43}\) A short time later, another individual injected cocaine that Heacock supplied. The evidence did not show who actually administered that injection. After injecting the cocaine, the individual suf-

---

\(^{38}\) The maximum punishment for a second or subsequent conviction is life in prison, and mandatory minimum punishments are also triggered by second or subsequent offenses. VA. CODE ANN. § 18.2-248(C) (2014).


\(^{41}\) Id. at 93.

\(^{42}\) Id. at 92.

\(^{43}\) Id. at 93.
ferred convulsions and died three days later of “acute intravenous coca

ingism.”44 There was also evidence that Heacock left the premises before the
rescue squad arrived, took and hid the cocaine from the party, and tried to
get witnesses to change their stories about who was present when the co-
caine was injected.45

The Virginia Supreme Court interpreted the felony murder statute,
Va. Code Section 18.2-33, to apply to an accidental killing that occurs dur-
ing the commission of any felonious act, including distribution of a con-
trolled substance. The Court reiterated the holding of Haskell v. Common-
wealth, 218 Va. 1033 (1978), where the Court held:

[W]hen the homicide is within the res gestae of the initial felony and is an
emanation thereof, it is committed in the perpetration of that felony. Thus, the
felony-murder statute applies where the initial felony and the homicide were
parts of one continuous transaction, and were closely related in point of time,
place and causal connection.46

The court did not specifically rule on the question of whether felony
murder requires a showing of “causal connection” or whether a showing of
“mere nexus” will suffice because the evidence in Heacock’s case was
“conclusive” in showing that “cause and effect were proximately interre-
lated.”47 The Court had little trouble sustaining the felony murder convi-
cption in Heacock’s case.

In 2012, the Virginia Court of Appeals dealt with a felony murder con-
viction for a death resulting from a drug overdose in Hylton v. Commo-
wealth.48 This case did not involve a death resulting from the distribution of
a controlled substance, but rather a death resulting from the possession of a
controlled substance. In Hylton, the defendant illegally purchased metha-
done without a prescription, poured it into a cup which her son used to take
his cold medicine, and left the cup unattended in the kitchen. Hylton’s son
drank the methadone and subsequently died from an overdose.49 Hylton
was convicted of felony murder in the commission of possession of a con-
trolled substance.50

The Court of Appeals affirmed the conviction, holding that the son’s
drinking of the methadone was closely related in time, place and causal

44 Id.
45 Heacock, 323 S.E.2d at 93, 94.
46 Id. at 93.
47 Id. at 94, 95 (quoting Haskell v. Commonwealth, 243 S.E.2d 477, 482 (1978)).
49 Id. at 630.
50 Id. at 629.
connection to the mother’s possession of the drug. The Court of Appeals specifically held that the possession of the methadone continued up until the point that the son drank it and therefore the killing occurred within the res gestae of the felonious possession. Hylton’s conviction was upheld.  

A more recent case, Woodard v. Commonwealth, has sparked some concern among prosecutors in the Commonwealth. In Woodard, the defendant sold ecstasy to an individual in a store parking lot in Danville. Once the transaction was completed, the defendant and the individual parted ways. The individual went to dinner, stopped at a gas station for cigarettes, and went to a friend’s apartment. She did not inject the ecstasy until over two hours after the transaction with Woodard. She died two days later. Woodard admitted that he sold the ecstasy to the decedent, and admitted that he knew that ecstasy can kill a person. The trial court convicted Woodard of felony murder under 18.2-33.

The Virginia Court of Appeals reversed the conviction finding that the killing did not occur during the prosecution of the sale of the ecstasy. The transaction was completed more than two hours before the substance was actually ingested. The Court held that “the killing must be ‘so closely related to the felony in time, place, and causal connection as to make it part of the same criminal enterprise.’” The Court specifically held that the killing did not occur during the prosecution of the sale of ecstasy because two of the elements were missing: time and place. The distribution was not a continuing transaction. The Court distinguished Heacock by stating that the facts in Heacock established the time, place and causal connection elements of the felony murder rule. The Court also distinguished Hylton finding that the distribution was completed in the store parking lot and was not a continuing crime.

51 Id. at 633.
52 See Woodard v. Commonwealth, 739 S.E.2d 220 (2013); See also Allison M. Roberts, Murder Conviction Overturned for Danville Man, THE NEWS & ADVANCE, March 27, 2013, http://www.newsadvance.com/go_dan_river/news/danville/murder-conviction-overturned-for-danville-man/article_3c6cdb4c-9709-11e2-a6c0-001a4bcf6878.html (showing that the Woodard decision may make it more difficult for prosecutors to prove the elements of felony murder for cases involving narcotics sales and subsequent overdose).
54 Id. at 222.
55 Id. at 224. The Woodard decision prompted a legislative response in the 2015 legislative session of the Virginia General Assembly. House Bill 102 would have clearly established felony murder if the underlying felonious act that resulted in the killing of another involved the manufacture, sale, gift, or distribution of a Schedule I or II controlled substance. That bill passed the House of Delegates on a 94-5 vote, but was carried over the 2017 session by the Senate Finance Committee. The bill was left in the Senate Finance Committee for the 2017 Session. HB 102 Felony Homicide; Certain Drug Offenses,
Felony murder prosecutions certainly raise the risk of punishment for defendants who distribute heroin resulting in an overdose death. Many of these defendants, however, are addicts themselves who shared their heroin with other addicts, never intending for anyone to die. Unfortunately, overdose deaths are occurring with alarming frequency. Simply bringing tough prosecutions alone will not solve this epidemic. To their credit, prosecutors in the Northern Shenandoah Valley have been willing to amend a number of felony murder charges to lesser felonies of involuntary manslaughter, resulting in less prison time for those defendants.  

IV. TREATMENT OPTIONS

The good news is that there are effective treatment options available to treat the disease of addiction. Treatment can include detoxification, psychotherapy, and the use of addiction medications. Treatment is not quick or easy. Successful treatment requires a long-term commitment from the addicted individual, who will experience relapses along the way. Medical detoxification, or “detox,” is a process used to manage the acute physical symptoms of withdrawal associated with stopping drug use. Detox is typically a first step in a longer-term process to treat individuals suffering from severe substance abuse. Psychotherapy utilizes group and individual treatment sessions to teach addicted individuals strategies to function without drugs, avoid situations that might lead to drug use, deal with cravings and handle relapses.

Medication Assisted Treatment (“MAT”) is a somewhat controversial form of treatment that is gaining more acceptance and wider use. MAT has been shown to be an effective treatment option for opioid addiction when


Id.

coupled with proper psychotherapy. Different types of MAT include methadone, buprenorphine, naltrexone and naloxone. Methadone is a synthetic opioid agonist that works by reducing or extinguishing cravings for opioids, and allowing the patient to function without the major physiological components of opioid disorder. When used as an addiction medication, methadone can only be dispensed in an opioid treatment program. It is typically dispensed in liquid form as a daily dose under observation.60

Buprenorphine is a partial opioid agonist which functions similarly to methadone but has a lower maximal effect than a full agonist like methadone. Maintenance on buprenorphine produces no euphoria, intoxication, or withdrawal symptoms. Buprenorphine is almost always combined with Naloxone to deter abuse. Buprenorphine can be dispensed in an opioid treatment program, or can be provided by a physician who meets established qualifications to provide office-based treatment for opioid addiction.61

Naltrexone is an opioid antagonist which operates by blocking the effects of opioids so patients will not experience a high from using opioids. Individuals who are dependent on opioids must stop their drug use at least seven days prior to starting naltrexone. Individuals can receive naltrexone in many settings, including doctors’ offices, opioid treatment programs, and other drug treatment settings. Naltrexone is most effective when dispensed in the form of a monthly injection by a physician.62

Finally, naloxone has become a staple for first responders due to its life-saving qualities. Commonly manufactured as “Narcan,” naloxone is an opioid blocker and immediately reverses effects of opioids. It is dispensed in nasal spray or injectable form and can bring overdose victims back to life.63

CONCLUSION

One of the biggest opportunities for criminal defense attorneys defending clients suffering from the disease of addiction is to build coalitions within your community to provide treatment and support. Coalitions can be built around law enforcement officials who realize that we cannot arrest our way of this problem. These officials can become supporters, if not advocates, for the idea of changing the way we treat criminal defendants suffering with the disease of addiction. Law enforcement officers who deal with addicts every day know that treatment is a far better alternative than incarceration in many cases. Partners can be found in the public health sector among professionals who know this epidemic must be addressed as the public health crisis it is. They deal with the realities of the disease every day in emergency rooms and clinics. Treatment providers are absolutely critical to helping clients. They can offer psychotherapy and medication-assisted treatment to help clients on the long road to recovery. Treatment, however, must be accessible and affordable to clients.

Local community service boards and some local treatment providers will typically accept and treat patients on a sliding scale based on income. Finally, the recovery community is an absolutely critical partner in this effort. Individuals in recovery have struggled with the disease of addiction themselves and have lived to come out on the other side. They know what our clients are experiencing and can speak to them with the voice of someone who has lived through the nightmare and survived. All of these players are crucial parts of building an effective coalition to address this epidemic on a community level.

While the task of building a community coalition may seem daunting, one such example has been created in the Northern Shenandoah Valley of Virginia. In 2012, one person died from an opioid/heroin overdose in the Northern Shenandoah Valley catchment area served by the Northwest Virginia Regional Drug Task Force (City of Winchester and Counties of Clarke, Frederick, Page, Shenandoah and Warren). In 2013, that number had risen to twenty-one persons who died as a result of an opioid/heroin overdose. By the end of 2014, thirty-three persons had died as a result of an opioid/heroin overdose. In 2015, the number of opioid/heroin overdose deaths was thirty. Another thirty individuals died as the result of an

---

65 Id.
66 Id.
opioid/heroin overdose in 2016, bringing the total loss of life to 115 overdose victims in that five-year span.  

Concerned by this unprecedented and tragic rise in the loss of life, a committed and diverse group of community stakeholders began meeting and formed a task force, later named the Northern Shenandoah Valley Substance Abuse Coalition (“NSVSAC”). This group was created for the purpose of eliminating deaths resulting from heroin and opioid abuse, preventing addiction in the community through comprehensive education efforts, treating those suffering from addiction as a disease, and supporting the responsible enforcement of the laws of the Commonwealth to ensure public safety. A unique feature of the NSVSAC is its representation from law enforcement, the local hospital system, the judicial system, local community service board, private substance abuse and mental health providers, non-profit organizations and concerned citizens.

The NSVSAC has engaged the community through a number of events aimed at educating the public about the current opioid epidemic and fostering a discussion of viable solutions. The NSVSAC was very fortunate to receive an initial amount of funding from Clarke County, Frederick County, the City of Winchester, and Valley Health Systems. Using those funds, the NSVSAC hired an Executive Director whose primary initial duties were to plan and implement a drug treatment court that would serve the City of Winchester and counties of Frederick and Clarke. One of the biggest successes of the effort to date was the creation of the Northwest Regional Adult Drug Treatment Court which began operation in August 2016. As of February 2017, the Court is serving ten defendants, giving them an alternative to incarceration and the hope of treatment and recovery.

The criminal justice system is not particularly adept at treating the disease of addiction. The recent epidemic caused by opioid and heroin overdoses has placed even more pressure on an already overburdened court system. Defense attorneys must be creative and find resources in their communities that will serve as an alternative to incarceration. Drug treatment courts are certainly one alternative, but not every criminal defendant is able to get the opportunity to participate. Other community treatment options must be explored and presented to courts as alternatives for defendants suffering from addiction. Only by treating this epidemic as a public health

---

crisis can we hope to make progress, save lives, protect the public and build safe and sober communities.