

America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis

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ABSTRACT

Nearing the end of its second decade, the overdose crisis in the United States has gone from bad to worse. Despite the advent of a supposed “public health” approach to this epidemic, progress on scaling up evidence-based prevention and response measures remains slow. Meanwhile, criminal law and its enforcement continue to dominate the arsenal of policies invoked to address the crisis. This Article examines the surging popularity of one such approach. Now on the books in the majority of U.S. states and federally, drug-induced homicide laws and their analogues implicate dealers in accidental overdose fatalities. By engaging criminal law theory and empirical legal research, I articulate an interdisciplinary instrumentalist critique of these measures in response to the overdose crisis.

Data systematically extracted from reports on 263 drug-induced homicide prosecutions informs concerns about facial and as-applied defects. Patterns identified suggest rapid, accelerating diffusion in these prosecutions in many hard-hit jurisdictions; pronounced enforcement and sentencing disparities by race; and broad misclassification of drug-using partners, family members, and others as “dealers.” Aside from crowding out evidence-based interventions and investments, these prosecutions run at complete cross-purposes to efforts that encourage witnesses to summon lifesaving help during overdose events. This analysis illustrates an urgent opportunity to critically re-assess the architecture and mechanisms of drug control in the U.S., reframing criminal justice reform as a public health imperative vital to improving the response to the worst drug crisis in America's history.

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INTRODUCTION

On April 14, 2010, Joshua Banka went on a drug-using spree in Nevada, Iowa.¹ After crushing and injecting oxycodone pills he had stolen from a friend, Banka and his wife Tammy Noragon Banka drove to a nearby town to purchase heroin.² Banka, who had a long history of substance use, had only recently initiated heroin and had not used it in six months.³ A dealer named Marcus Burrage sold Banka one gram of heroin in a grocery store parking lot.⁴ The couple cooked and injected some of the drug in the car immediately following the transaction, and then later upon returning home.⁵ After his wife had gone to sleep in the early hours of April 15, 2010, Banka injected another batch.

The next morning, Noragon found her husband's lifeless body on the bathroom floor and called 911. In the process of conducting a death scene investigation, police found drug paraphernalia, about half of the recently-procured heroin, and a cocktail of prescription pills.⁶ Subjected to questioning, the bereaved wife picked Marcus Burrage out of a photo lineup as the dealer who had sold the ill-fated bag the night before.

Noragon was never arrested, but Burrage was soon apprehended and charged with heroin distribution. After taking over this seemingly unremarkable drug case, federal prosecutors charged Burrage with a seldom-used, but powerful enhancement under the federal Controlled Substances Act. This provision—§841(b)(1)(C)—mandates a sentence of 20 years-to-life in cases when “death...result[s] from the use of the substance” unlawfully distributed by the accused.⁷

At trial, two toxicologists testified to the presence of multiple substances in

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¹ *Burrage v. United States*, 134 S. Ct. 881 (2014).

² Brief for the United States at 5, *Burrage v. United States*, 134 S. Ct. 881 (2014) (No. 12-7515).

³ Brief for the United States, *supra* note 2, at 5.

⁴ Brief for the United States, *supra* note 2, at 6.

⁵ Brief for the United States, *supra* note 2, at 6.

⁶ Brief for the United States, *supra* note 2, at 6 (noting that the drugs included opioid analgesics and benzodiazepines).

⁷ 21 U.S.C. §841(b)(1)(C) (“death . . . resulted from the use of the substance”).

Banka's body at the time of death.⁸ In addition to heroin, this included metabolites of prescription opioid analgesics and benzodiazepines. As depressants, all of these drugs act synergistically to slow down the central nervous system, including respiration control. In view of multiple-drug toxicity, the experts opined that heroin was likely an important "contributing" factor, but its causal role in Banka's death could not be determined. Nonetheless, Burrage was convicted on both the distribution and "death results" charges, triggering the 20-year minimum sentence mandated under §841(b)(1)(C).⁹

After losing on appeal at the District and then the Circuit levels, this case was granted *certiorari*. At the United States Supreme Court, Burrage's contention that the language in §841(b)(1)(C)'s "death results" enhancement requires "but-for" causation finally carried the day.¹⁰ Writing for the unanimous Court,¹¹ the late Justice Scalia rebuffed the Government's reading of the enhancement, ultimately rejecting its application in cases where the drug was not an independently-sufficient cause of death.¹²

In reaching this decision, Scalia deliberated about the Government's predictions that the provision's narrow construction would "unduly limi[t] criminal responsibility" and run counter to public policy.¹³ In addition to the customary retribution rationale—that drug dealers deserve severe sanctions based on their high level of blame—the Government advanced a broader narrative of deterrence: Without providing any empirical evidence, it contended that "extremely stiff penalties [are] a way to send a clear message"¹⁴ to drug dealers. Ultimately, the goal articulated by the provision's drafters¹⁵—and implied by the Government in *Burrage*—was to "prevent further drug-related deaths."¹⁶

Scalia was characteristically acerbic in responding to the Government's predictions of a "public policy disaster" if the charge implicating Marcus Burrage in Joshua Banka's accidental overdose were vacated.¹⁷ But the late Justice's

⁸ *Burrage*, *supra* note 1, at 885.

⁹ *Burrage*, *supra* note 1, at 885.

¹⁰ *Burrage*, *supra* note 1, at 892. (A defendant cannot be liable under the penalty enhancement provision of 21 U. S. C. §841(b)(1)(C) unless such use is a but-for cause of the death or injury).

¹¹ Justice Ruth Bader Ginsburg wrote a concurring opinion that Justice Sonia Sotomayor joined.

¹² *Burrage*, *supra* note 1, at 892.

¹³ *Burrage*, *supra* note 1, at 891 (quoting Brief for the United States, *supra* note 2, at 24).

¹⁴ Brief for the United States, *supra* note 2, at 4.

¹⁵ 91 Legis. His. P.L. 513 (1970) (enacted).

¹⁶ Brief for the United States, *supra* note 2, at 4.

¹⁷ *Burrage*, *supra* note 1, at 892-3 (Scalia noting that federal prosecutors had had a track record of successfully applying §841(b)(1)(C) in numerous cases involving multiple-drug toxicity, with the operative difference that the experts were less ambivalent about the role of the substance in the fatal outcome); From a practical perspective, even if the prosecutors could not secure a conviction

opinion never questioned the deployment of such prosecutions—and the underlying statutory provisions—as instruments of overdose prevention.¹⁸ This article endeavors to do just that.

Nearing the end of its second decade, the crisis of fatal opioid-involved overdose in the United States continues unabated.¹⁹ In fact, the crisis has gone from bad to worse,²⁰ but not for the lack of evidence about how it can be brought under control. There is broad agreement that reducing opioid overdose deaths requires wider distribution of the opioid antidote naloxone, rapid scale-up in evidence-based treatment, and reducing stigma associated with substance use and addiction.²¹ Progress on these—and other—vital measures remains abysmally slow, both in terms of translating empirical evidence into policy and implementing programs on the ground.²²

Meanwhile, progress has been far from sluggish in deploying §841(b)(1)(C) and similar state-level prosecutions as a response to fatal drug overdoses. Since Jonathan Banka's death in 2010, such prosecutions have surged at least threefold to now number in the thousands per annum.²³ At the same time, at least three

on the “death results” enhancement, the accused would still typically receive a substantial sentence on the underlying drug trafficking charge, see *Burrage*, *supra* note 1, at 892. Burrage did, in fact, subsequently receive a 20-year sentence on remand. He is still serving this sentence as of 2016.

¹⁸ Perhaps a missed opportunity for public health-minded observers to submit an amicus brief. See Leo Beletsky, Wendy Parmet, and Scott Burris, *Advancing Public Health Through the Law: The Role of Legal Academics*, (Boston: Northeastern University School of Law, 2012).

¹⁹ Holly Hedegaard, Margaret Warner, & Arialdi M. Miniño, *Drug Overdose Deaths in the United States, 1999-2016*, NCHS DATA BRIEF NO. 204 (Dec. 2017) available at <https://www.cdc.gov/nchs/data/databriefs/db294.pdf> (noting that the opioid overdose rate “increased on average by 10% per year from 1999 to 2006, by 3% per year from 2006 to 2014, and by 18% per year from 2014 to 2016.”)

²⁰ *Id.*

²¹ U.S. Department of Health and Human Services, *Facing Addiction in America: Surgeon General's Report on Alcohol, Drugs, and Health* (2016) available at <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>; *President's Commission on Combatting Drug Addiction and the Opioid Crisis*, WHITE HOUSE (2017) available at https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf; Jerome Adams, *Surgeon General's Advisory on Naloxone and Opioid Overdose*, U.S. Department of Health and Human Services (2018) available at <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.htm>; Institute of Medicine, *PAIN MANAGEMENT AND THE OPIOID EPIDEMIC: BALANCING SOCIETAL AND INDIVIDUAL BENEFITS AND RISKS OF PRESCRIPTION OPIOID USE*, (Washington, DC: National Academies Press 2017).

²² *Id.* See also Barrot Lambdin et al., *Identifying gaps in the implementation of naloxone programs for laypersons in the United States*, 52 INT'L J. DRUG POL 52, 52-55 (2018); Noa Krawzyck et al., *Only One In Twenty Justice-Referred Adults In Specialty Treatment For Opioid Use Receive Methadone Or Buprenorphine*, 36 HEALTH AFF. (2017) (noting that only 1 in 20 individuals with opioid use disorder is referred to appropriate treatment from the criminal justice system).

²³ Lindsay LaSalle, *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*, DRUG POLICY ALL. (2017) available at

states have passed—and many more are considering—new provisions to further facilitate such charges.²⁴ At the time of writing, a full 36 states had deployed these prosecutions in response to the opioid crisis.

There are numerous ways to scrutinize drug-induced homicide laws and prosecutions. From a doctrinal standpoint, deployment of harsh criminal penalties in retribution for unintended conduct raises thorny normative and constitutional issues.²⁵ Those questions have been explored elsewhere by scholars expert in history, epistemology, and theory of criminal law.²⁶ The resulting consensus is nearly unanimous in regarding felony murder and other provisions the corollary to drug-induced homicide—to be both bad law and bad criminal justice policy.²⁷ And yet, these laws persist in most jurisdictions.²⁸ Their surging deployment under the banner of overdose prevention adds new urgency to their reexamination, inviting a critical public health lens.²⁹

This article unfolds as follows: Part I provides an overview of the scope of the opioid “epidemic,” tracing its macabre trajectory from a crisis driven primarily by prescription analgesics to the rapid rise of fatalities involving black market drugs like heroin and, more recently, illicitly-manufactured fentanyl.³⁰ As the supposed antidote to problematic substance use, punishment has long been the primary instrument of the U.S. drug control system.³¹ Part II challenges the widely-held

http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf (noting that drug-induced homicide prosecutions are increasing across the country);

²⁴ See also Joseph Walker, WSJ <https://www.wsj.com/articles/prosecutors-treat-opioid-overdoses-as-homicides-snagging-friends-relatives-1513538404>

²⁵ See, e.g. Guyora Binder, *The Culpability of Felony Murder*, 83 *Notre Dame L. Rev.* 965, 965-8 (2008) (providing a comprehensive overview of the empirical and doctrinal scholarship on felony murder)

²⁶ *Id.*

²⁷ *Id.*, at 966 (“Legal scholars are almost unanimous in condemning felony murder as a morally indefensible form of strict liability.”) See also Jason Tashea, *California considering end to felony murder rule*, *American Bar Association Journal*, July 5th, 2018

http://www.abajournal.com/news/article/california_considering_end_to_felony_murder_rule/ (Reforms considered in California would eliminate the legal framework for felony murder, noting that “Forty-five states still have felony murder rules, 24 of which allow for the death penalty in such cases. Hawaii, Kentucky, Massachusetts and Michigan have abolished the rule by either legislation or through the courts”.)

²⁸ Binder, *see supra* note 2525 (providing a comprehensive overview of the empirical and doctrinal scholarship).

²⁹ Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 *U. PA. L. REV.* 1649, 1651-52 (2011); See also James G. Hodge, Jr., Sarah A. Wetter, Sarah A. Noe, *Emerging Legal Responses to Curb the Opioid Epidemic*, 45 *Journal of Law, Medicine & Ethics* 460 (2017).

³⁰ AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: FIFTH EDITION* 483-485 (2013).

³¹ Matthew R. Pemberton, *Containing Addiction: The Federal Bureau of Narcotics and the Origins of America’s Global Drug War*, (University of Massachusetts Press: 2017)

belief that a different, “public health” approach characterizes the response to the current crisis. To illustrate the continued centrality of punitive and carceral policies, Part III focuses on drug-induced homicide laws. After tracing their origins and theoretical underpinnings, I provide an instrumentalist critique of these criminal justice interventions. For the first time, this appraisal draws on an original dataset containing detailed information on 263 drug-induced homicide prosecutions between 2000 and 2016.

My analysis of key legal, logistical and other case elements suggests that, while the number and scope of these laws has grown in the wake of the opioid crisis, prosecutions invoking these laws have proliferated even faster.³² Evaluated for the first time here, emerging trends in the deployment of these provisions raise grave concerns. Mapping onto existing racially disparate patterns of drug law and felony murder enforcement,³³ there is evidence to suggest that prosecutors are applying drug-induced homicide charges selectively (See Figure 3) resulting in gaping sentencing disparities between whites and people of color.

In contrast to the fact pattern in *Burrage*, however, approximately half of the drug-induced homicide charges in the dataset ensnared co-using friends, family, or romantic partners of the deceased (see Figure 2). Had Tammy Noragon Banka handled the purchase and brought the heroin to her husband that fateful night, she could be held liable for his death.³⁴ Such common, but absurd application of these provisions magnify individual and community trauma. They also run at cross-purposes to 911 Good Samaritan laws and other efforts to encourage help-seeking,³⁵ while further fraying trust in law and its enforcement among drug users.³⁶ From a population perspective, a synthesis of existing research with

³² German Lopez, *The new war on drugs*, VOX (2017) available at <https://www.vox.com/policy-and-politics/2017/9/5/16135848/drug-war-opioid-epidemic> (noting that, to specifically address the deadliness of illicit fentanyl, legislative efforts involve making it easier for prosecutors to apply mandatory minimums and prosecute drug-induced homicide cases, and that at least 16 states have increased punishment for dealing and possessing illicit fentanyl); This approach is also garnering support on the federal level *Senators Introduce Legislation to Fight Fentanyl*, US SENATE PRESS RELEASE (2018) available at https://www.cotton.senate.gov/?p=press_release&id=911 (noting that the quantity of fentanyl possession required to trigger mandatory minimums is reduced); *Amendments to the Sentencing Guidelines*, UNITED STATES SENTENCING COMMISSION (2018) available at https://www.ussc.gov/sites/default/files/pdf/amendment-process/reader-friendly-amendments/20180412_prelim_rf_final.pdf?utm_medium=email&utm_source=govdelivery (noting that sentences for possessing illicit fentanyl are becoming more punitive)

³³ Michelle Alexander, *THE NEW JIM CROW*, at 7.

³⁴ *Id.*, (highlighting numerous cases that exemplify this approach).

³⁵ Amanda Latimore & Rachel Bergstein, “*Caught with a body*” yet protected by law? *Calling 911 for opioid overdose in the context of the Good Samaritan Law*, 50 INTL. J. DRUG POL 82, 82-89 (2017)

³⁶ Kathryn Casteel, *A Crackdown On Drug Dealers Is Also A Crackdown On Drug Users*, FIVETHIRTYEIGHT (2018) available at <https://fivethirtyeight.com/features/a-crackdown-on-drug-dealers-is-also-a-crackdown-on-drug->

original data presented here support the finding that drug-induced homicide laws and their deployment likely exacerbate the overdose risk environment for people who use drugs, fueling the very problem they purport to address.

In my conclusion, I consider the broader implications of this analysis. I argue that the invocation of drug-induced homicide to address the overdose crisis is symptomatic of U.S.' over-reliance on criminal law and its enforcers to regulate problematic substance use. Under the common law maxim *salus populi suprema lex*,³⁷ it is time for a renewed focus on public health as one of the central goals of law.³⁸ The overdose crisis provides an opportunity to reexamine the flawed architecture of drug regulation in the U.S., with that maxim in mind. A proposal for a substantial redesign of that architecture completes this article.

I. THE U.S. OVERDOSE CRISIS AND ITS CONTEXT

A. The State of the Crisis

The United States is undergoing one of the most alarming public health crises in its modern history. After a near fourfold rise in the rate of drug-related overdose fatalities since the beginning of this century,³⁹ deployment of policies and financial resources to control the crisis have failed to do so.⁴⁰ Indeed, the national situation is getting markedly worse: latest data from the U.S. Centers for Disease Control and Prevention suggest that overdoses involving opioids may have spiked another 30% in the first part of 2017, with a shocking 70% surge in the Midwest.⁴¹ The untold devastation wrought on families, communities, and businesses across the country is adding to the already disproportionate burden on urban communities and people of color, with the heaviest burden falling on Native Americans.⁴²

[users/](#).

³⁷ *Id.*

³⁸ See Wendy E. Parmet, POPULATIONS, PUBLIC HEALTH, AND THE LAW (2009), at 51-54.

³⁹ Holly Hedegaard, Margaret Warner, & Arialdi M. Miniño, *Drug Overdose Deaths in the United States, 1999–2016*, NCHS DATA BRIEF NO. 204 (Dec. 2017) available at <https://www.cdc.gov/nchs/data/databriefs/db294.pdf>

⁴⁰ *Id.*

⁴¹ See *Opioid Overdose Treated in Emergency Departments*, CDC (2018) available at <https://www.cdc.gov/vitalsigns/opioid-overdoses/infographic.html#infographic>; see also Bradley Ray et al., *Examining Fatal Opioid Overdoses in Marion County, Indiana*, 94 J. URB. HEALTH 301 (2017); Svetla Slavova et al., *Drug Overdose Deaths: Let's Get Specific*, 130(4) PUB. HEALTH REP. 339 (2015) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4547584/>

⁴² *The Underestimated Cost of the Opioid Crisis*, The Council of Economic Advisors 1, 3-6 (Nov. 2017) available at <https://www.whitehouse.gov/sites/whitehouse.gov/files/images/The%20Underestimated%20Cost%20of%20the%20Opioid%20Crisis.pdf>; See *Opioid Overdose Treated in Emergency Departments*, *supra* note 41 (illustrating the shocking 54% rise in overdoses involving opioids in urban communities in 2017); German Lopez, *The opioid epidemic has now reached black*

Opioids are a drug class comprised of prescription analgesics and illicitly-manufactured drugs such as heroin and fentanyl.⁴³ When present in excessive quantities—and especially in combination with other sedatives—opioids repress respiration and precipitate a coma-like state that may turn fatal.⁴⁴ Grim as it sounds, the role of opioids in the current crisis of overdose deaths is almost certainly underestimated because of inconsistent surveillance systems, toxicology screening practices, and medical examiner policies.⁴⁵

Joshua Banka’s untimely death reflects the complexity of “opioid overdose” events, for several reasons. His death involved a mixture of opioids, along with additional sedatives and a slew of other substances. Concurrent use of opioids and other depressants, such as benzodiazepines and alcohol, is an especially significant risk factor for life-threatening respiratory depression.⁴⁶ Polydrug

America, VOX (2017) available at <https://www.vox.com/science-and-health/2017/12/22/16808490/opioid-epidemic-black-white> (same); see also Stephanie Schmitz Bechteler & Kathleen Kane-Willis, *Whitewashed: The African American Opioid Epidemic*, CHICAGO URBAN LEAGUE (2017), available at https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed%20AA%20Opioid%20Crisis%2011-15-17_EMBARGOED_%20FINAL.pdf (noting that people of color already experience disproportionate burden of opioid overdose in numerous states in the Midwest and elsewhere); NYC Health, *Unintentional Drug Poisoning (Overdose) Deaths in New York City, 2000 to 2016*, 89 EPI DATA BRIEF (2017) available at <http://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief89.pdf>, at 2, 10 (noting a 112% rise in overdose deaths among African Americans in a one-year period, with the heaviest burden of overdose deaths in New York City to be in the majority-minority borough of Bronx); *How The Opioid Crisis Is Affecting Native Americans*, NPR (2017) available at <https://www.npr.org/2017/11/11/563551077/how-the-opioid-crisis-is-affecting-native-americans> (noting that Native Americans have been the hardest-hit by opioid overdoses of any ethnic group); See also, *Native American overdose deaths surge since opioid epidemic*, ASSO. PRESS (2018) available at <https://www.apnews.com/81eb3ae96c2b4f6ae272ec50f0672d2> (same, and also making light of calls for law enforcement resources to address the issue in Native American communities).

⁴³ Hedegaard, see *supra* note 19.

⁴⁴ *FDA Requires Strong Warnings for Opioid Analgesics, Prescription Opioid Cough Products, and Benzodiazepine Labeling Related to Serious Risks and Death from Combined Use*, FDA (2016) available at <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm>; See also Kyle Pattinson, *Opioids and the Control of Respiration*, 100 BRIT. J. OF ANAESTHESIA 747 (2008).

⁴⁵ See, e.g. Christopher Ruhm, *Geographic Variation in Opioid and Heroin Involved Drug Poisoning Mortality Rates*, 53 AMER. J. PREV MED. 745, 745-753 (2017).; see also Svetla Slavova et al., *Drug Overdose Deaths: Let’s Get Specific*, 130(4) PUB. HEALTH REP. 339 (2015) (describing the variability in policies and practices to determine the causes of drug overdose deaths)

⁴⁶ Christopher M. Jones, Leonard J. Paulozzi, & Karin A. Mack, *Alcohol Involvement in Opioid Pain Reliever and Benzodiazepine Drug Abuse-Related Emergency Department Visits and Drug-Related Deaths - United States, 2010*, 63 MORB. MORTALITY WKLY REP. 881 (2014) (noting that up to a third of opioid pain reliever-involved overdose deaths involve alcohol and/or benzodiazepines, depending on demographic group); See also Maia Szalavitz, *Why These People Took Drug Combinations That Nearly Killed Them*, VICE (Feb. 21, 2018) available at

toxicity may result from poorly-calibrated pharmacotherapy regimens⁴⁷ and poor risk education; it can also occur in cases of deliberate misuse, including non-medical drug consumption (using prescription drugs in unintended ways, or using illicitly-manufactured drugs). Suicidal intent, often undetermined in public health surveillance efforts, may influence the combination of substances and how they are consumed.⁴⁸ Whatever the context, polydrug toxicity currently accounts for the majority of deaths involving opioids, including powerful synthetics like fentanyl and its analogues.⁴⁹

Return to drug use after a period of abstinence, which also likely contributed to Banka's death, is another known risk factor for opioid poisonings.⁵⁰ A loss in tolerance can transform a once-customary dose into a fatal one.⁵¹ Compounded by other stressors, those reentering the community after a period of incarceration,⁵²

https://www.vice.com/en_ca/article/59kwgz/lethal-drug-combinations-with-opioids-heroin

⁴⁷ Lembke et al., *Our Other Prescription Drug Problem*, 378 NEW ENG. J. MED 693-695 (2018) available at <https://www.nejm.org/doi/full/10.1056/NEJMp1715050> (noting that benzodiazepine prescriptions and overdoses have grown precipitously in the last two decades)

⁴⁸ Maria Oquendo and Nora Volkow, *Suicide: A Silent Contributor to Opioid-Overdose Deaths*, 378 NEW ENG. J. MED 1567, 1567-69 (2018)

⁴⁹ Chelsea Carmona, *What opioid hysteria leaves out: most overdoses involve a mix of drugs*, THE GUARDIAN (2016) available at

<https://www.theguardian.com/us-news/commentisfree/2016/jun/08/opioid-epidemic-drug-mix-overdose-death> (noting the under-appreciated and under-documented role of polysubstance use as a driver of "opioid" overdose deaths); the role of polysubstance overdose is reflective in the national picture; they are also echo state and local data, see, e.g. *NYC Health supra* note 42.

⁵⁰ Detoxification or abstinence-based drug treatment, criminal detention, and other episodes of forced interruption in opioid use dramatically lower an individual's tolerance. See Ingrid A. Binswanger et al., *Release From Prison—A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 160-61 (2007) (Among Washington State prisoners, overdose mortality risk was elevated 12-fold compared to similar demographic groups within the general population; See also P.B. Christensen et al., *Mortality Among Danish Drug Users Released From Prison*, 2 INT'L J. PRISONER HEALTH 13, 13-19 (2006); Michael Farrell & John Marsden, *Acute Risk of Drug-Related Death Among Newly Released Prisoners in England and Wales*, 103 ADDICTION 251, 252-54 (2007).; Derek Chang, Jan Klimas, Evan Wood, Nadia Fairbairn, *A Case of Opioid Overdose and Subsequent Death After Medically Supervised Withdrawal: The Problematic Role of Rapid Tapers for Opioid Use Disorder*, 12 J. ADD. MED 80; See also Shane Darke and Michael Farrell, *Would Legalizing Illicit Opioids Reduce Overdose Fatalities? Implications From a Natural Experiment*, 109(8) ADDICTION 1237, 1239 (2014) available at

<https://idhdp.com/media/1111/add12456-1-.pdf>; See also Giftos and Tesema, at 28 (noting that "The criminal justice system confers significant additional health risks to patient with an opioid use disorder. Forced detoxification from opioids while incarcerated lowers a patient's opioid tolerance and is associated with a 129-times the risk of overdose death in the first two weeks after release into the community. And untreated opioid withdrawal—a syndrome characterized by vomiting, diarrhea, intense muscle cramps, and paralyzing anxiety—is a major risk factor for suicide in jails and prisons.)

⁵¹ Darke and Farrell, *supra* note 50, at 1239.

⁵² Binswanger, *supra* note 50, at 160-61; See *An Assessment of Opioid-Related Deaths in Massachusetts (2013-2014)*, MASS. DEP'T OF PUB. HEALTH (2016) available at <http://www.mass.gov/eohhs/docs/dph/stop-addiction/dph-legislative-report-chapter-55-opioid-overdose-study-9-15-2016.pdf>; Grant Rodgers, *U.S. High Court Reverses Iowan's Drug*

detoxification-based treatment, or involuntary commitment⁵³ face a highly-elevated risk of overdose. Since opioid use disorder is characterized by a chronic life course, users in those situations are likely to experience numerous relapses;⁵⁴ simply requiring or imploring them to remain abstinent does not achieve that goal.⁵⁵ There are numerous additional elements that figure into an individual's overdose risk, including respiratory problems, other health conditions, and environmental factors.⁵⁶

B. Strategies to Curb Fatal Overdose are Underutilized

An important element of overdoses due to opioids is that they take more than an hour to turn fatal,⁵⁷ creating an opportunity for life-saving intervention. “Closing the death’s door”⁵⁸ in these situations involves basic first aid measures and timely administration of the opioid antidote naloxone, which reverses the deadly coma,

Conviction, DES MOINES REGISTER (Jan. 27, 2014) available at <https://www.desmoinesregister.com/story/news/crime-and-courts/2014/01/28/us-high-court-reverses-iowans-drug-conviction/4956117/>; There are additional factors that aggravate an individual's risk of overdose, including race and veteran status. See generally Jahi Chikwendiu, *No Time to Waste: Evidence-Based Treatment for Drug Dependence at the United States Veterans Administration Department of Veterans Affairs*, HUMAN RIGHTS WATCH (Nov. 28, 2011) available at <https://www.hrw.org/report/2014/06/30/no-time-waste/evidence-based-treatment-drug-dependence-united-states-veterans>.

⁵³ Leo Beletsky, Elisabeth Ryan and Wendy Parmet, *Involuntary treatment for substance use disorder: A misguided response to the opioid crisis*, HARV. HEALTH BLOG (2018) available at <https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180>; (citing <https://www.mass.gov/files/documents/2016/09/pg/chapter-55-report.pdf>); see also Claudia Rafful et al., *Increased non-fatal overdose risk associated with involuntary drug treatment in a longitudinal study with people who inject drugs*, 113 ADDICTION 1056 (2018).

⁵⁴ *Treatment and Recovery, Drugs, Brains, and Behavior: The Science of Addiction*, NIDA (2014) available at <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>

⁵⁵ *Amicus Curiae Brief Of The American Civil Liberties Union Of Massachusetts, Inc., The Center For Public Representation, And Prisoners' Legal Services In Support Of The Petitioner, COMMONWEALTH VS. Julie Eldred, NO. SJC-12279 (Supr. Jud. 2017)* available at https://aclum.org/wp-content/uploads/2017/09/2017_09_25-ACLUM-PLS-CPR-Eldred-Brief.pdf

⁵⁶ Barbara Zedler et al., *Development of a Risk Index for Serious Prescription Opioid-Induced Respiratory Depression or Overdose in Veterans' Health Administration Patients*, 16 PAIN MEDICATION 1566 (2015).

⁵⁷ Harm Reduction Coalition (2017) available at: <http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/responding-to-opioid-overdose/administer-naloxone/>

⁵⁸ Leo Beletsky, Scott Burris, and Alex Kral, *Closing Death's Door: Action Steps to Facilitate Emergency Opioid Drug Overdose Reversal in the United States*, Center for Health Law, Policy and Practice, Temple University School of Law (2009); see also Scott Burris, Leo Beletsky, Carolyn Castagna, Casey Coyle, Colin Crowe, and Jennie McLaughlin, *Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose*, 1 DREXEL LAW REVIEW 273 (2009).

causing near-immediate overdose reversal.⁵⁹ Naloxone is a safe, effective, and cost-effective drug.⁶⁰ Overdose education and naloxone distribution (OEND) efforts engaging drug users, family members, first responders and others in a position to intervene during an overdose event is more urgent than ever. This is because fentanyl and other powerful synthetic opioids now contaminating the black market opioid supply precipitate fatal overdose much more rapidly,⁶¹ narrowing the vital opportunity for intervention.

The availability of an effective antidote in naloxone provides a critical opportunity to keep overdose events from turning fatal, no matter what led an individual down the path to a poisoning. Community-based and public health organizations have worked for decades to distribute this medication.⁶² These efforts have included equipping first responders, families, service providers and others who are likely to encounter drug overdoses, including people who use illicit drugs. They have also included efforts to persuade providers to prescribe this drug, either on its own or as a companion to opioid analgesics.⁶³ The ultimate idea behind naloxone access is simple: stop overdoses from turning fatal, helping people live to see another day.⁶⁴

But these efforts have long sparked controversy,⁶⁵ raising concerns about sending the “wrong message” and “enabling” immoral behavior.⁶⁶ push drug users towards ever-more risky practices⁶⁷—what economists call “moral hazard.”⁶⁸ Public health researchers evaluating naloxone distribution have looked for behaviors reflecting

⁵⁹ See, e.g. Leo Beletsky, Josiah D. Rich, & Alexander Y. Walley, *Prevention of Fatal Opioid Overdose*, 308(18) JAMA 1863 (2012) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3551246/>; Karl A. Sporer, *Strategies for Preventing Heroin Overdose*, 326(7386) BMJ, 433 (2003) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125320>.

⁶⁰ Id.; See also Phillip O. Coffin and Sean D. Sullivan, *Cost-Effective of Distributing Naloxone to Heroin Users for Lay Overdose Reversal Variation in the Delivery of Health Care: The Stakes are High*, 158 ANN. OF INTERN MEDICINE 866 (2013) (showing law naloxone distribution to be very cost-effective).

⁶¹ *Fentanyl*, NIDA (2018) available at <https://www.drugabuse.gov/publications/drugfacts/fentanyl>.

⁶² *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014*, 64 MMWR 631 (2015) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm>

⁶³ Leo Beletsky et. al., *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities*, 84 J. Urb.Hea. 126, 126-36(2007).

⁶⁴ See *Prevention of Fatal Overdose supra* note X.

⁶⁵ Carrie Arnold, *The Fight For the Overdose Drug*, THE ATLANTIC (2014) available at <https://www.theatlantic.com/health/archive/2014/12/the-fight-for-the-overdose-drug/383467/>

⁶⁶ As with other harm reduction efforts like syringe exchange and vaccination against HPV,

⁶⁷ Richard Knox, *Overdose Rescue Kit Saves Lives*, NPR (2008) available at <https://www.npr.org/templates/story/story.php?storyId=17578955>

⁶⁸ Jennifer Doleac and Anita Mukherjee, *The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime* (2018) available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3135264

moral hazard, finding none. Half-dozen analyses on this topic⁶⁹ reflect other research that, with very few exceptions, has refuted concerns about this kind of “disinhibition” in HPV vaccination,⁷⁰ HIV treatment-as-prevention,⁷¹ and other harm reduction measures.⁷²

Thanks in no small part to evidence demonstrating naloxone distribution to reduce overdose without precipitating more risk,⁷³ all U.S. states eventually adopted laws to facilitate it.⁷⁴ Varied in scope and design, these laws include some mixture of liability protections. This is because, as discussed in more detail below, concerns about criminal and civil liability can impede naloxone rescue and help-seeking practices.⁷⁵ Other provisions of these laws seek to minimize red tape surrounding distribution.⁷⁶ Recently, scarce funding has finally given way to more resources, spurring scale-up in access in some areas. Nationally, however, coverage remains low,⁷⁷ translating into lost opportunities to save lives.⁷⁸

To be clear, naloxone is an emergency antidote, not a silver bullet to avert future overdoses, addiction, or other issues. It simply enables life, paving the way for prevention and other measures. Principal among such measures is maintenance treatment with opioid agonist medications: There is solid evidence that methadone and buprenorphine slash risk of future overdose risk by 50-80%.⁷⁹ Overall rates of

⁶⁹ Jermaine Jones et al., *No evidence of compensatory drug use risk behavior among heroin users after receiving take-home naloxone*, 71 ADD. BEH. 104, 104-106 (2017) available at <https://www.sciencedirect.com/science/article/abs/pii/S0306460317301119>

⁷⁰ Monica Kasting et al., *Tempest in a teapot: A systematic review of HPV vaccination and risk compensation research*, 12 HUM. VAC. & IMM 1435 (2016).

⁷¹ Kelly Freeborn and Carmen Portillo, *Does Pre-exposure prophylaxis (PrEP) for HIV prevention in men who have sex with men (MSM) change risk behavior? A systematic review*, J. CLIN. NUR.(2017) available at <https://www.ncbi.nlm.nih.gov/pubmed/28771856>

⁷² Sanjeev Sharma et al., *Male circumcision for the prevention of human immunodeficiency virus (HIV) acquisition: a meta-analysis*, 121 BJU INT’L 515 (2017).

⁷³ See Jones et al., *supra* note 46.

⁷⁴ *Naloxone Overdose Prevention Laws*, PRESC. DRUG ABUSE POL’Y SYS. (2017) available at <http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139>,

⁷⁵ See Latimore and Bergstein *supra* note 35; Robert Sykes, *Bucks County drug dealer who left friend to die of an overdose in a Bensalem hotel room sentenced to prison*, BUCKS LOCAL NEWS (2018) available at http://www.buckslocalnews.com/news/bucks-county-drug-dealer-who-left-friend-to-die-of/article_864d14cf-dc41-5b8f-8d30-159f19c0ab53.html;

⁷⁶ Leo Beletsky, *A Drug That Should Be Easier to Get*, NYT (2014) available at <https://www.nytimes.com/roomfordebate/2014/03/17/lowering-the-deadly-cost-of-drug-abuse/a-drug-that-should-be-easier-to-get>

⁷⁷ Barrot H. Lambdin et al., *Identifying gaps in the implementation of naloxone programs for laypersons in the United States*, 52 INT’L J OF DRUG POL 52, 52-55 (2018) (estimating that only 8% of US counties have a naloxone distribution program).

⁷⁸ See Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise Impact and Missed Opportunities*, AMER. J. LAW & MED. (2018) (forthcoming)

⁷⁹ Maia Szalavitz, *The Wrong Way to Treat Opioid Addiction*, NYT (2018) available at <https://www.nytimes.com/2018/01/17/opinion/treating-opioid-addiction.html>

people with OUD who are on these medications remain low.⁸⁰ It is especially shocking that far less than 10% of people who experience opioid overdose receive these life-saving medications.⁸¹ This is despite the reality that, in absence of support, many will experience future overdoses that are likely to be fatal. Among OUD-affected individuals in custodial settings, access to such treatment is almost non-existent.⁸²

Other strategies that are known to reduce overdose risk include safe consumption facilities (SCFs), which allow non-medical drug use under the supervision of clinical staff and provide linkages to treatment and other services.⁸³ Although surrounded by considerable controversy and subject to legal challenge, syringe exchange programs (SEPs) have demonstrated unequivocal benefits without causing theorized collateral effects.⁸⁴ The bottom line is that, when it comes to policies that hold the most empirical promise for addressing the overdose crisis, we know what to do; we just are not doing it.⁸⁵

⁸⁰ Christine Vestal, *Still Not Enough Treatment in the Heart of the Opioid Crisis*, THE PEW CHARITABLE TRUSTS (2016) available at <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/09/26/still-not-enough-treatment-in-the-heart-of-the-opioid-crisis> (noting that “West Virginia is one of the 17 states where Medicaid does not pay for methadone, and it has had an adversarial relationship with methadone clinics for decades. Methadone clinics weren’t allowed in the state until 2001, and after nine for-profit clinics set up shop in West Virginia, the Legislature in 2007 placed a moratorium on opening any more”).

⁸¹ Massachusetts Department of Public Health, *An Assessment of Opioid-Related Deaths in Massachusetts (2013 - 2014)*, MA DPT. OF P.H. (2016) available at <https://t.co/pB5iZCGEgW>

⁸² *Id.* See also, Giftos and Tesima, at 28.; See also, Noa Krawczyk et al., *Only One in Twenty Justice- Referred Adults in Specialty Treatment For Opioid Use Receive Methadone or Buprenorphine*, HEALTH AFFAIRS (2018)

⁸³ Therese C. Fitzgerald et al., *Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts*, MMS. 1, 1-61 (2017); See also (These facilities have solid documented benefits in slashing community overdose rates, addressing infectious disease associated with drug injection, and addressing community problems related to open-air drug use); See also Zachary Siegel, *It’s Time to Bring Supervised Injection Sites Above Ground*, UNDARK (2018) available at <https://undark.org/article/supervised-injection-sites-study/> (Over 100 SCFs operate worldwide, with numerous facilities now emerging in Canada in response to that country’s overdose crisis. Despite the mounting burden of overdose and its negative health and societal impact, no authorized SCF currently exists in the U.S.).

⁸⁴ See also Leo Beletsky, Alexander Walley & Josiah Rich, *Prevention of Fatal Opioid Overdose*, 308 JAMA 1863, 1863-1864 (2013) (In addition to addressing infectious disease risk, SEPs have served as a critical platform for OEND programs); See also Traci Green, Leo Beletsky et al., *Life After the Ban: An Assessment of US Syringe Exchange Programs’ Attitudes About and Early Experiences With Federal Funding*, 102 AMER. J. PUB. HEA e9, e9-e16 (2012) (Nevertheless, syringe exchange—a vital public health tool—is only authorized in 20 U.S. states. Even when authorized by state or local law, SEPs remain substantially under-resourced: Until recently, SEPs could not be supported by federal funds, and funds still prohibit the purchase of actual syringes); See also Danae Bixler, et al., *Access to Syringe Services Programs — Kentucky, North Carolina, and West Virginia, 2013–2017*, 67 Morbidity and Mortality Weekly Report MMWR 529 (2018) (The U.S. CDC estimates that US is in need of substantial additional syringe exchange capacity to bring this proven intervention up to scale).

⁸⁵ Carl Hart, *People are Dying Because of Ignorance, Not Opioids*, SCIENTIFIC AMERICAN (2017), available at <https://www.scientificamerican.com/article/people-are-dying-because-of-ignorance->

C. Framing the “Opioid Epidemic”

United States is a nation in pain,⁸⁶ with 126 million adults complaining of pain in the last 3 months.⁸⁷ Puzzlingly, Americans report being in pain more frequently and at higher severity than “citizens of other advanced, and even not-so-advanced, countries.”⁸⁸ It should come as no surprise that America’s consumption of opioid painkillers—along with numerous other psychoactive medications⁸⁹—tops world rankings.⁹⁰ Of course, humans’ complex relationship with opioids has deep historical roots;⁹¹ Americans’ love affair with this class of drugs has experienced at least three previous cycles of booms and panics, followed by periods of recoil.⁹² Addiction and other collateral negative consequences of opioid use are not novel public policy concerns,⁹³ but opioid-related overdose has become an issue of broad and sustained public attention only in the context of the current crisis.⁹⁴

It bears noting that what is deemed a drug “crisis” or “epidemic” worthy of

[not-because-of-opioids/](#)

⁸⁶ Institute of Medicine, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, (Washington, DC: The National Academies Press, 2011).

⁸⁷ See *Relieving Pain in America supra* note 89; RL Nahin, *Estimates of pain prevalence and severity in adults: United States, 2012*, 16 J PAIN. 769-780 (2015), (noting that 25.3 million (11.2%) complaining of daily (chronic) pain and another 23.4 million (10.3%) a lot of pain)

⁸⁸ David G. Blanchflower & Andrew Oswald, *Unhappiness and Pain in Modern America: A Review Essay, and Further Evidence, on Carol Graham’s Happiness for All?*, NBER 2, 2-32 (2017).

⁸⁹ Maia Szalavitz, *The Mystery of the Terrifying Xanax Resurgence in America*, VICE NEWS (2018) available at https://www.vice.com/en_us/article/paxg39/the-mystery-of-the-terrifying-xanaxresurgence-in-america.

⁹⁰ See, e.g., Winfried Hauser et al., *The Opioid Epidemic and the Long-Term Opioid Therapy for Chronic Noncancer Pain Revisited: A Transatlantic Perspective*, 6 PAIN MGMT. 249 (2016); See also Dina Gusovsky, *Americans Consume Vast Majority of the World’s Opioids*, CNBC (Apr. 27, 2016) available at <https://www.cnbc.com/2016/04/27/americans-consume-almost-all-of-the-global-opioid-supply.html>; See also Jennifer Warner, *U.S. Leads the World in Illegal Drug Use*, CBS NEWS (Jul. 1, 2008) available at <https://www.cbsnews.com/news/us-leads-the-world-in-illegal-drug-use/>

⁹¹ Mojtaba Heydari, Mohammad Hashem Hashempur, & Arman Zargarani, *Medicinal Aspects of Opium as Described in Avicenna’s Canon of Medicine*, 11.1 ACTA MEDICO-HISTORICA ADRIATICA 101, 101-3 (2013) available at https://hrcak.srce.hr/index.php?show=clanak&id_clanak_jezik=156368

⁹² See Pembleton at 4-6 (noting the cyclical popularity of opioid medications and panics throughout American history, and that opioid use for both medicinal and recreational purposes dates back centuries); see also DAVID MUSTO ET AL., *ONE HUNDRED YEARS OF HEROIN* (2002).

⁹³ *Id.*

⁹⁴ Scott Burris, Leo Beletsky, Carolyn Castagna, Casey Coyle, Colin Crowe, and Jennie McLaughlin, *Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone to Prevent Opioid Overdose*, 1 DREXEL LAW REVIEW 273, 274-6 (2009) (noting the number of high-profile deaths from heroin or prescription drug overdose over the course of the last several decades of the 20th Century, and the corresponding lack of action to address this issue).

concerted public policy focus appears somewhat arbitrary.⁹⁵ Even at its current—and projected—shocking levels,⁹⁶ opioid-involved overdoses kill far fewer Americans per year than other drugs. Yearly, alcohol-related overdose and disease is linked to approximately 88,000 US fatalities, while tobacco is responsible for a shocking 450,000 American deaths. Even in the domain of health care practice, medical errors (e.g. prescription or administration of incorrect medications, erroneous dosage, or drugs in dangerous interactions with other drugs) are estimated to be responsible for at least 250,000 fatalities per annum.⁹⁷ Though certainly noteworthy in human and financial terms, these critical public health issues receive far less legislative or media attention.⁹⁸

For decades, drug overdose had received the same treatment. Although long endemic in certain urban and rural communities,⁹⁹ public inattention to drug overdose was only punctuated only by occasional tragic events.¹⁰⁰ Meanwhile, by framing heroin and non-medical opioid use as a moral failing,¹⁰¹ criminal law codified societal stigma and stunted concerted public health and other effective response to this endemic problem.¹⁰²

⁹⁵ TALEED EL – SABAWI, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition* _Univ Memphis Law Review_ (2018)

⁹⁶Max Blau, *STAT forecast: Opioids could kill nearly 500,000 Americans in the next decade*, STAT (2017) available at <https://www.statnews.com/2017/06/27/opioid-deaths-forecast/>

⁹⁷ Martin Makary and Michael Daniel, *Medical error—the third leading cause of death in the US*, 353 *BMJ* i2139 (2016).

⁹⁸ German Lopez, *The deadlier drug crises that we don't consider public health emergencies*, Vox, <https://www.vox.com/policy-and-politics/2017/10/27/16557550/alcohol-tobacco-opioids-epidemic-emergency> (2017)

⁹⁹ Jose A. Del Real, *The Bronx's Quiet, Brutal War With Opioids*, NYT (2018) available at <https://www.nytimes.com/2017/10/12/nyregion/bronx-heroin-fentanyl-opioid-overdoses.html>; see also Theodore J. Cicero et al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past Fifty Years*, 71 *JAMA PSYCHIATRY* 821 (2014).

¹⁰⁰ See Burris and Beletsky, *Invisible Epidemic*, *supra* note 58; See also *Ledger's Death Caused by Accidental Overdose*, CNN (Feb. 6, 2008) available at <http://www.cnn.com/2008/SHOWBIZ/Movies/02/06/heath.ledger/index.html> (Heath Ledger, a well-known Hollywood actor, famously died of an accidental overdose after consuming a combination of opioid analgesics and benzodiazepines); see also Scott Burris et al., *Stopping An Invisible Epidemic: Legal Issues In The Provision of Naloxone to Prevent Opioid Overdose*, 1 *DREXEL L. REV.* 273 (2009) available at <http://heinonline.org/HOL/P?h=hein.journals/drexell&i=279>. See also Ctrs. for Disease Control and Prevention, *Nonpharmaceutical Fentanyl-Related Deaths – Multiple States, April 2005-March 2007*, 57(29) *MORB. AND MORTALITY WKLY REP.* 793 (2008) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm> (Documenting prior outbreak of fentanyl-related deaths in what would be the precursor to the current fentanyl crisis); See also Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality* 15 *INDIANA HEALTH LAW REVIEW* 139, 155-8 (2018).

¹⁰¹ Jules Netherland J & Hanna Hansen, *White opioids: Pharmaceutical race and the war on drugs that wasn't*, 12 *BIOsocieties* 217, 217-238 (2017).

¹⁰² Katharine A. Neill, *Tough on Drugs: Law and Order Dominance and the Neglect of Public Health in U.S. Drug Policy*, 6(4) *WORLD MEDICAL & HEALTH POL'Y* 375 (2014) available at <http://onlinelibrary.wiley.com/doi/10.1002/wmh3.123/full>

In the late 2000's this erasure would give way to increasing visibility and alarm, as overdose deaths grew in number and shifted beyond their prior confinement to geographical and demographic realms of concentrated disadvantage.¹⁰³ The rapid and unexpected pace of this diffusion explains the popularity of the moniker "epidemic" being used to describe the phenomenon. As explored in detail elsewhere,¹⁰⁴ this oft-invoked figurative use of the word conjures up a literal contagion. By invoking this framing, thought leaders, members of the media, and the public at large embraced a discursive vision of the overdose crisis as being fueled by prescription medications as vectors of death and health care providers as death's merchants.¹⁰⁵

Language matters,¹⁰⁶ and the vector model inevitably shapes the "problem definition"¹⁰⁷ used by decision-makers to inform remedial policy and programmatic interventions.¹⁰⁸ As discussed in more detail elsewhere,¹⁰⁹ the vector narrative foregrounds opioid supply, with a root cause analysis invoking over-prescription of opioid painkillers as the original source of harm.¹¹⁰ This narrative points to well-intentioned efforts by the health care sector to address untreated and under-treated pain, which were hijacked by pharmaceutical industry malfeasance (including false, deceptive, and aggressive marketing),¹¹¹ regulatory

¹⁰³ See Cicero, *supra* note 103; Julie Netherland and Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 CULTURE, MED., & PSYCHIATRY 664 (2016) available at <http://link.springer.com/article/10.1007/s11013-016-9496-5>

¹⁰⁴ Nabarun Dasgupta, Leo Beletsky, & Daniel Ciccarone, *overdose crisis : No Easy Fix to Its Social and Economic Determinants*, 108(2) AM. J. PUB. HEALTH 182 (2018).

¹⁰⁵ *Id.*

¹⁰⁶ Taleed El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*, UNI. MEMPHIS. LAW REV. (2018).

¹⁰⁷ David A. Rochefort & Roger W. Cobb, THE POLITICS OF PROBLEM DEFINITION: SHAPING THE POLICY AGENDA (1994)

¹⁰⁸ Deborah A. Stone, POLICY, PARADOX AND POLITICAL REASON (1988)

¹⁰⁹ See No Easy Fix *supra* note 108.; Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality* 15 INDIANA HEALTH LAW REVIEW 139, 155-8 (2018).

¹¹⁰ Rose A. Rudd et al., *Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014*, 64 MORB. MORTALITY WKLY REP. 1378 (2016) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mmm6450a3.htm>; See also Jane C. Ballantyne and Mark D. Sullivan, *Intensity of Chronic Pain — The Wrong Metric?* 373 N. ENGL. J. MED. 2098 (2015); See also Ed Silverman, *Opioid Makers Gave Millions to Patient Advocacy Groups to Sway Prescribing*, STAT (Feb. 12, 2018) available at <https://www.statnews.com/pharmalot/2018/02/12/opioids-patient-groups-funding/> (Describing astroturf groups and their role in promoting opioid prescribing)

¹¹¹ Opioid litigation; see also Kolodny and Frieden *supra* note X.

capture,¹¹² gaps in provider education,¹¹³ and perverse incentives.¹¹⁴ These efforts did in fact broaden access to opioid analgesics,¹¹⁵ reframing them as the go-to tool for addressing all types of pain under legitimate¹¹⁶ and not-so-legitimate circumstances.¹¹⁷ However, accidental opioid poisonings also grew in tandem, giving rise to the so-called “prescription drug epidemic.”

By the year of Joshua Banka shifted his drug use at issue in *Burrage* to include heroin, the crisis entered its second phase. Driven by a variety of pull and push factors, users of opioid prescription drugs began transitioning to street opioids like heroin and counterfeit pills in unprecedented numbers.¹¹⁸ In context of shifting policy and logistical environment of prescription drug access, individuals dependent on—or addicted to opioids—found alternatives on the black market. It is important to highlight that, despite decades of investment in drug control measures at home and abroad, black market alternatives to prescription opioids were widely available at lower cost in many US communities.

Shifting to these alternatives represented a rational choice, in view of the shifting market and other forces. Once exposed to illicit supply chains,¹¹⁹ their risk of overdose, infectious disease transmission, and other drug-related harms skyrocketed.¹²⁰ Around 2014, the crisis entered its third, most deadly phase. This is when illicitly—and relatively-easily—manufactured fentanyl began to dominate the black-market supply. Deaths linked to fentanyl began their stratospheric rise—nearly tripling within a short time. This deadly climb continues,

¹¹² Scott Higham and Lenny Bernstein, *The Drug Industry's Triumph Over the DEA*, WASH. POST (Oct. 15, 2017), available at https://www.washingtonpost.com/graphics/2017/investigations/dea-drug-industry-congress/?utm_term=.8af982716f8f

¹¹³ Ingrid A. Binswanger, *Overdose Education and Naloxone for Patients Prescribed Opioids in Primary Care: A Qualitative Study of Primary Care Staff*, 30(12) J. GEN. INT. MED. 1837, 1839 (2015) available at <https://link.springer.com/article/10.1007/s11606-015-3394-3>

¹¹⁴ Ballantyne and Sullivan, *supra* note 63.

¹¹⁵ Gery Guy Jr. et al., *Vital Signs: Changes in Opioid Prescribing in the United States, 2006–2015*, MMWR (2017) available at https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s_cid=mm6626a4_w

¹¹⁶ Gabe Gutierrez, Adam Reiss, & Corky Siemaszko, *Welcome to Williamson, W.Va., Where There are 6,500 Opioid Pills Per Person*, NBC NEWS (Feb. 1, 2018) available at <https://www.nbcnews.com/news/us-news/welcome-williamson-w-va-where-there-are-6-500-opioid-n843821> (“Other recovering addicts, like Deira Warrix and Mindy Leffe, said that Williamson feels awash with opioids”).

¹¹⁷ Kristine Phillips, *The Pill Mill Doctor Who Prescribed Thousands of Opioids and Billed Dead Patients*, WASH. POST (Sept. 22, 2016) available at https://www.washingtonpost.com/news/to-your-health/wp/2016/09/22/deceitful-pill-mill-doctor-who-prescribed-thousands-of-opioids-and-billed-dead-patients-settles-civil-lawsuit/?utm_term=.6fbfa7b87b36

¹¹⁸ See *No Easy Fix supra* note 108; See also Beletsky, *Ideology Meets Reality supra* note 109.

¹¹⁹ Nicholas Kristof, ‘*Drug Dealers in Lab Coats*’, NY TIMES (2017) available at <https://www.nytimes.com/2017/10/18/opinion/opioid-pharmaceutical-addiction-pain.html>

¹²⁰ Dita Broz et al., *Multiple injections per Injection Episode: High-risk injection practice among people who injected pills during the 2015 HIV outbreak in Indiana*, 52 INT’L. J. OF DRUG POL. 97, 97-101 (2018).

uncontained, to this day.¹²¹

Under the vector model, a contagion can be controlled by targeting the source of the disease agent and its vehicles (or vectors).¹²² Though certainly reflective of both public health and criminal justice discourse on drug-related problems, this one-dimensional view of a complex socio-structural problem ultimately reinforces erroneous public policy approaches. Unfortunately, this view has shaped the policy responses to date, causing the overdose crisis to morph into something far more deadly.

In understanding why, nearly two decades into a crisis, the U.S. continues to grossly under-utilize proven prevention and response tools, it is useful to consider the competing narratives that can be used to define the “opioid epidemic.”

The term “policy narrative” refers to the “way of structuring and communicating our understanding of the world” in policy discourse and advocacy.¹²³ Just as with other narratives, policy narratives feature a plot, heroes and villains, and other key elements.¹²⁴ By casting the “opioid epidemic” as a plot involving dangerous drugs peddled by villainous doctors, the modal policy narrative helped pave the way for the suite of solutions deployed to date.

In the realm of population health analysis health and disease must be considered in the context of their social, economic, and other structural determinants.¹²⁵ Situating the overdose crisis in this discourse can help reshape the narrative, whereby the “opioid epidemic” is recast as a symptom of complex problems besetting American society.¹²⁶

¹²¹ *Id.* (though some of this increase may have been caused by broader awareness and better surveillance of the problem).

¹²² Robert Lowes, *CDC Issues Opioid Guidelines for 'Doctor-Driven' Epidemic*, MEDSCAPE (2016) available at <https://www.medscape.com/viewarticle/860452>; See also (Characteristically, the former Director of the Centers for Disease Control and Prevention, Dr. Thomas Frieden declared the overdose crisis as “doctor driven,” and could therefore be reversed by prescribing fewer opioids. As the leader of America’s premier public health agency, Frieden echoed the broadly-adopted diagnosis of this challenge as parallel to the way public health science conceptualizes crises involving contaminated food products or an infectious disease.)

¹²³ Elizabeth A. Shanahan, Michael D. Jones & Mark K. McBeth, *Policy Narratives and Policy Processes*, 39 POL ’ Y STUD . J. 535, 539 (2011).

¹²⁴ See Stone *supra* note X, at 158.

¹²⁵ Wendy E. Parmet, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* 13 (2009); This framework recognizes the existence of health disparities that are not explained by biological factors alone, at 53-4; see also Katherine Unger Davis, *Racial Disparities in Childhood Obesity: Causes, Consequences, and Solutions*, 14 U. PA. J. L. & SOC. CHANGE 313, 333 (2011);

¹²⁶ See *Ideology Meets Reality*, *supra* note 109 at 158-60; See also *No Easy Fix* *supra* note 108; See also *Id.*; Majid Ezzati et al., *The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States*, 5 (2008) (Drug overdose fatalities have risen in concert with other causes of deaths, including alcohol-related diseases and suicides. The rise of so-called “deaths of despair” and their impact on the overall declining life expectancy across the US signal a “reversal of fortunes”); See also Anne Case and Angus Deaton, *Conference Report, Brookings Panel on Economic Activity, Mortality and Morbidity in the 21st Century* (March 23-

Reconceptualizing “pain” to integrate both physical and emotional distress refocuses the policy problem statement on demand, rather than supply.¹²⁷ Financial stress, changing nature of work, lack of community cohesion, and other broad societal patterns demand exploration as key determinants of such demand. Other health trends, such as rising rates of obesity and occupational injuries (both acute and chronic) drive people’s demand for pain relief, further complicating the equation.¹²⁸ Further problematizing the simplistic “opioid epidemic” policy narrative of the overdose crisis is the structure and function of the healthcare system. Access, cost, quality, and cultural competence in provision of physical, mental, and behavioral health services¹²⁹ all shape an individuals’ demand for opioid analgesia;¹³⁰ all are well-understood to be areas of American health care system’s profound inadequacy.¹³¹

24, 2017), available at https://www.brookings.edu/wp-content/uploads/2017/03/6_casedeaton.pdf (in direct demographic) ; See also Kenneth D. Kochanek et al., *Mortality in the United States, 2016*, NCHS DATA BRIEF No. 293 (2017) at available

<https://www.cdc.gov/nchs/data/databriefs/db293.pdf> (but also broader societal terms. The rapid diffusion); See also Case and Deaton, *supra* note 133. (“The epidemic spread from the southwest, where it was centered in 2000, first to Appalachia, Florida and the west coast by the mid - 2000s, and is now country – wide”); These patterns have been both spurred by—and have paradoxically accelerated—government austerity and deregulatory policies; See also Arne Ruckert and Ronald Labonté, *Health Inequalities in the Age of Austerity: The Need for Social Protections Policies*, SOC. SCI. & MED. (2017) (of declining life expectancy patterns from their origins in highly-disadvantaged groups and geographic locales has traced the expansion of economic and social fissures in the fabric of American society.).

¹²⁷See El-Sabawi, *supra* note 110 at 2; see also Tamyko Ysa et al., GOVERNANCE OF ADDICTIONS: EUROPEAN PUBLIC POLICIES 3 (2014) (providing a taxonomy of various approaches to drug policy).

¹²⁸ Institute of Medicine, *Accelerating Progress in Obesity Prevention*, at 1; David E. Wennberg, *Variation in the Delivery of Health Care: The Stakes are High*, 128 ANN. OF INTERN MED. 866 (1998); Kevin Fiscella et al., *Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA PSYCHIATRY 2579 (2000); see also *Census of Fatal Occupational Injuries Summary, 2016*, U.S. BUREAU OF LABOR STAT. (2017) available at <https://www.bls.gov/news.release/cfoi.nr0.htm>. (as American workers have taken on more dangerous jobs and work conditions have deteriorated); see also Ling Li, Shawn Rohlin, & Perry Singleton, *Labor Unions and Occupational Safety: Event-Study Analysis Using Union Elections*, 205 MAXWELL SCHOOL CTR. FOR POLICY RES. (2017) available at https://www.maxwell.syr.edu/uploadedFiles/cpr/publications/working_papers2/wp205.pdf (attributing deteriorating conditions, in part to the decline in the power of trade unions); see also Megan Dunn and James Walker, *Union Membership In The United States*, U.S. BUREAU OF LABOR STAT. (2016) available at <https://www.bls.gov/spotlight/2016/union-membership-in-the-united-states/pdf/union-membership-in-the-united-states.pdf>.

¹²⁹ Ling Ding et al., *Predictors and Consequences of Negative Physician Attitudes Toward HIV-Infected Injection Drug Users*, 165 ARCH. INTERN. MED. 618-23 (2005) (In general, there is assumption among physicians that substance users prove burdensome patients that do not respond to typical medical interventions.)

¹³⁰ Columbia University, National Center on Addiction and Substance Abuse, *Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse* (2000) available at <http://files.eric.ed.gov/fulltext/ED452442.pdf>

¹³¹ Sarah Bowman et al., *Reducing the Health Consequences of Opioid Addiction in Primary Care*. 126 AM. J. MED. (2013) available at <https://www.ncbi.nlm.nih.gov/pubmed/23664112>

Instead of a renewed focus on these systems-level factors, policy response to the crisis has been principally operationalized through an suite of supply-side interventions of unknown promise, including the deployment of prescription limits, prescription drug monitoring systems, and prosecutions of providers and patients.¹³² These policy interventions to restrict opioid supply in the healthcare arena have caused the pendulum of access to swing rapidly in the opposite direction.¹³³ Similarly, well-worn tropes¹³⁴ applied to (deservedly unsympathetic) pharmaceutical companies have generated enormous momentum for litigation.¹³⁵ Resonant, but inaccurate, policy narratives result in poorly designed legal interventions. The resulting “riptide” has engendered problems in providing adequate care for pain patients and maintaining patient engagement, risking transition to the black market.¹³⁶

In the context of the overdose crisis, a rhetorical shift towards a “public health” approach began to take shape. However, as the next section will show, this framing has been co-opted by the false promises of supply reduction measures. This has created the space for criminal justice measures such as drug-induced homicide, along with involuntary commitment statutes and others, to be recast in a role of public health-oriented approaches.

II. THE DRUG CONTROL REGIME AND ITS ROLE IN THE OVERDOSE CRISIS

A. The Origins of the U.S. Drug Control

The first hundred years in the Republic’s history were characterized by a relatively permissive regime for the use of drugs for medicinal and recreational purposes.¹³⁷ Around the turn of the 20th Century, social, cultural, and economic

¹³² See Beletsky X

¹³³ Kurt Kroenke & Andrea Cheville, *Management of Chronic Pain in the Aftermath of the Opioid Backlash*, 317 JAMA 2365, 2365–2366 (2017).

¹³⁴ Derek Carr, Corey S. Davis, & Lainie Rutkow, *Reducing Harm Through Litigation Against Opioid Manufacturers? Lessons from the Tobacco Wars*, 133(2) PHR 207, 207-213 (2018).

¹³⁵ *Id.* (Such litigation, though promising in terms of litigators’ access to corporate deep pockets, will likely have limited impact on the crisis of overdose deaths, in both immediate and longer-term.); See also Leo Beletsky, *The Benefits and Potential Drawbacks in the Approval of EVZIO for Reversal of Opioid Overdose*, 48 AMER. J. PREV. MED. 357, 357-9 (2015).

(Aside from crowding out attention to meaningful solutions to the overdose crisis, this framing also obscures broader, systemic problems with how the pharmaceutical industry is regulated, as illustrated in the pricing of the opioid antidote naloxone); See also Aaron Kesselheim, Jerry Avorn, and Ameet Sarpatwari, *The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform*, 316 JAMA. 858, 858-871 (2016) (Problems with pharmaceutical malfeasance and deregulation go far beyond the narrow set of concerns at issue in the opioid lawsuits.)

¹³⁶ Alison Knopf, *Patients with chronic pain forced into opioid tapers by their prescribers*, 30 ALCOHOL & DRUG ABUSE WKLY. 1 (2018); see also Stefan G. Kertesz et al., *Opioid Prescription Control: When The Corrective Goes Too Far*, HEALTH AFF. BLOG (2018).

¹³⁷ David F. Musto, *The American Disease: Origins of Narcotic Control* (New Haven: Yale

concerns spurred increasing efforts to regulate psychoactive substances; in large part, these efforts were animated by disciplinarian and moralistic impulses operationalized through commodity control instruments.¹³⁸ In concert with the evolution of policy and enforcement regimes in the alcohol realm during Prohibition, criminal law and law enforcement came to dominate efforts to reduce drug-related harms.¹³⁹ Incidentally, public health regulation during that era was almost exclusively limited to the biggest public health threat— infectious disease— through vector control measures.¹⁴⁰

The legal framework for this regime evolved on local, state, and federal levels. The use of opioids saw several periods of growth, including in response to massive trauma of the Civil War and the upheaval wrought by the Industrial Revolution.¹⁴¹ The first major federal statute to construct a punitive framework to control opioid consumption was the Harrison act of 1914, which established a system for Pigouvian taxation and supply controls.¹⁴² The same law and subsequent jurisprudence¹⁴³ also misguidedly placed severe restrictions on prescription of heroin for opioid maintenance—a measure that had been effectively employed by US physicians to reduce the negative consequences of addiction.¹⁴⁴

During the Vietnam Era, public concern about the use of psychoactive substances and their wide availability through illicit supply chains led to the passage of the Controlled Substances Act (CSA), which marked a substantial shift in drug regulation.¹⁴⁵ The Act established a distinct architecture for the regulation of certain drugs, based on their “accepted medical use” and “potential for abuse.”¹⁴⁶

University Press, 1973); David Musto, *Opium, Cocaine and Marijuana in American History*, 265 SCIENTIFIC AMER. 40 (1991); David T. Courtwright, *Dark Paradise: A History of Opiate Addiction in America* (Cambridge, MA: Harvard University Press, 2001); Richard Davenport-Hines, *The Pursuit of Oblivion: A Global History of Narcotics, 1500-2000* (London: Weidenfeld & Nicolson, 2001).

¹³⁸ *Id.*; The same Temperance Movement that ushered in the national alcohol prohibition took on the banners of drug control using arguments that had clear racist, xenophobic and classist elements; See also Robert B. Matchette et al., *Records of the Drug Enforcement Agency*, NAT. ARCHIVES (1995) available at <https://www.archives.gov/research/guide-fed-records/groups/170.html#170.3>

¹³⁹ See Musto, *supra* note 147.

¹⁴⁰ George Rosen, *A History of Public Health* (2015).

¹⁴¹ Jessica Glenza, *America's Opioid Epidemic Began More than a Century Ago – With the Civil War*, THE GUARDIAN (Dec. 30, 2017) available at <https://www.theguardian.com/science/2017/dec/30/americas-opioid-epidemic-began-more-than-a-century-ago-with-the-civil-war>; The Editorial Board, *An Opioid Crisis Foretold*, THE NEW YORK TIMES (Apr. 21, 2018) available at <https://www.nytimes.com/2018/04/21/opinion/an-opioid-crisis-foretold.html>

¹⁴² P.L. 63-223, 38 Stat. 785.

¹⁴³ *Jin Fuey Moy v. United States*, 241 U.S. 394 (1916); *Webb v. United States*, 249 U.S. 96 (1919); and *United States v. Behrman*, 258 U.S. 280 (1922).

¹⁴⁴ See *Webb*, *supra* note 158.

¹⁴⁵ *Thirty Years of America's Drug War: A Chronology*, FRONTLINE (2000) available at <https://www.pbs.org/wgbh/pages/frontline/shows/drugs/cron/>

¹⁴⁶ 21 U.S.C. § 812.

Thanks in large part by concerted efforts by the US Department of Justice, all states would eventually adopt a close analogue of the federal CSA.¹⁴⁷

Long before President Nixon's famous proclamation of drugs as "public enemy number one," the Federal Narcotics Bureau had done considerable work to reframe social challenges as panics over drug exposure.¹⁴⁸ These deep roots set the stage for 1973 when, as part of this major overhaul, the Food and Drug Administration (FDA), FNB and other agencies ceded legal and functional authority over many enforcement activities to the much more powerful newly-created Drug Enforcement Administration (DEA).¹⁴⁹ Using its consolidated power, the DEA would be charged with using criminal justice tools to suppress the illicit production and trafficking of drugs in the United States.¹⁵⁰ The Agency would also curate a risk schedule and a "closed system" for pharmaceutical products deemed to have substantial addictive potential in order to prevent their abuse and diversion.¹⁵¹

In contrast to the FDA, this new entity was given purview over health care and pharmacy practice as it relates to the prescription of enumerated controlled substances.¹⁵² Given the historical roots, these agencies and other government units including law enforcement conceptualized their role as focusing on specific substances of concern, rather than systems-level issues that may drive problematic drug use.¹⁵³

With this commodity problem focus, U.S. drug control came to be organized around two categories of policy and enforcement interventions: supply reduction and demand reduction.¹⁵⁴ Mirroring Law and Economics discourse, this model

¹⁴⁷ *Controlled Substance Analogues - Statutory Comparison and Compilation*, NAT. ALL. MODEL STATE DRUG LAWS (2015) available at <http://www.namsdl.org/library/04E9074D-F157-1E58-F70445C2F1FA98B4/>

¹⁴⁸ See Pemberton *supra* note 31 at 6.

¹⁴⁹ *Organization, Mission and Functions Manual: Drug Enforcement Administration*, U.S. DEP'T. OF JUS. (2014) available at <https://www.justice.gov/jmd/organization-mission-and-functions-manual-drug-enforcement-administration>

¹⁵⁰ *Id.*

¹⁵¹ *Drug Schedules*, DRUG ENF. ADMIN. (Accessed on Mar. 1, 2018) available at <https://www.dea.gov/druginfo/ds.shtml>.

¹⁵² See *Organization, Mission And Functions*, *supra* note 164. Nonetheless, the DEA as well as its state analogues lacks the scientific expertise available to the FDA. See e.g. *Memorandum of Understanding Between the U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research, and the U.S. Department of Justice Drug Enforcement Administration*, MOU 225-15-011, FDA (2017) available at <https://www.fda.gov/AboutFDA/PartnershipsCollaborations/MemorandaofUnderstandingMOUs/DomesticMOUs/ucm440091.htm>; see also David Downs, *The Science Behind the DEA's Long War on Marijuana*, SCIENTIFIC AMER. (Apr. 19, 2016) available at <https://www.scientificamerican.com/article/the-science-behind-the-dea-s-long-war-on-marijuana/>

¹⁵³ *DEA Mission Statement*, DRUG ENF. ADMIN. (Accessed on Mar. 1, 2018) available at <https://www.dea.gov/about/mission.shtml>

¹⁵⁴ *Program Overview*, DRUG ENF. ADMIN. (Accessed on Mar. 1, 2018) available at

focuses on microeconomic levers to calibrate the relationship between supply, demand, price, and quantity.¹⁵⁵ It employs administrative and criminal law tools to maintain the supply chains¹⁵⁶ for controlled substances, with extensive controls on their availability in health care settings to prevent misuse and diversion.¹⁵⁷

There is little evidence that DEA efforts to monitor and regulate prescription and pharmacy practices as they relate to controlled substances have helped achieve a balance between adequate access and diversion control.¹⁵⁸ The DEA closely tracks and exerts active authority over manufacturer, distributor, prescriber, and pharmacist practices.¹⁵⁹ Yet, starting in the late 1990's, it failed to effectively respond to skyrocketing production, distribution, and clinical over-reliance on opioid analgesics that contributed to the current crisis in opioid overdoses.¹⁶⁰

Though regulatory capture is a pervasive problem in the space of pharmaceutical industry as well as elsewhere,¹⁶¹ this was but a minor contributor to the DEA's dismal performance in preventing and responding to the mounting overdose crisis. In the years since the establishment of this drug control framework, the availability and purity of illicit substances on the American black market has only increased, while their prices have fallen.¹⁶² Ultimately, supply reduction

<https://www.dea.gov/prevention/overview.shtml>

¹⁵⁵ Hubert Henderson, *Supply and Demand* (1922).

¹⁵⁶ *Pharmacist's Manual An Informational Outline of the Controlled Substances Act*, DRUG ENF. ADMIN. (2010) available at https://www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_manual.pdf

¹⁵⁷ Jane C. Ballantyne, *Regulation of Opioid Prescribing*, 33 *BMJ* 811 (2007) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1853184/>

¹⁵⁸ See Single Convention; See also M. Mofizul Islam and Ian S. McRae, *An Inevitable Wave of Prescription Drug Monitoring Programs in the Context of Prescription Opioids: Pros, Cons and Tensions*, 15(46) *BMC PHARM. & TOXICOLOGY* 1, 4-5 (2014) available at <https://bmcpharmacolotoxicol.biomedcentral.com/articles/10.1186/2050-6511-15-46>.

¹⁵⁹ Ronald Friedman, *DEA Audits: "Coming to a Theatre Near You"*, 8 *AMER. BAR ASSOC. EHEALTH* (2011); See also Michael Gabay, *Federal Controlled Substances Act: Dispensing Requirements, Electronic Prescriptions, and Fraudulent Prescriptions*, 49 *HOSP. PHARM.* 244-246 (2014).

¹⁶⁰ Ronald T. Libby, *Treating Doctors as Drug Dealers: The Drug Enforcement Agency's War on Prescription Painkillers*, 10(4) *IND. REV.* 511, 516-17 (2006). Aside from the demonstrable miscalibration of opioid analgesic supply, the Agency's heavy-handed, overly-restrictive regulation of opioid agonist treatment contributed to this sector's dismal quality and coverage, whereby only one out of ten people affected by opioid use disorder is able to access medication-assisted modalities. See e.g. Facing Addiction SG Report, at 2-3.

¹⁶¹ Lenny Bernstein and Scott Higham, *'We feel like our system was hijacked': DEA agents say a huge opioid case ended in a whimper*, *WASH> POST* (2017) available at https://www.washingtonpost.com/investigations/mckesson-dea-opioids-fine/2017/12/14/ab50ad0e-db5b-11e7-b1a8-62589434a581_story.html?utm_term=.3ff4d0130326.

¹⁶² Leo Beletsky and Corey S. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 *INT. J. OF DRUG POL'Y* 156-159 (2017) available at [http://www.ijdp.org/article/S0955-3959\(17\)30154-8/abstract](http://www.ijdp.org/article/S0955-3959(17)30154-8/abstract); See also Dan Werb et al., *The Temporal Relationship Between Drug Supply Indicators: An Audit of International Government Surveillance Systems*, 3(9) *BMJ OPEN* 1 (2013) available at <http://bmjopen.bmj.com/content/bmjopen/3/9/e003077.full.pdf>; See also *The*

interventions employed (and supported) by the U.S. have resulted in major collateral detriment in spheres of overdose, injection-related bloodborne infection, drug-related violence, and mass incarceration,¹⁶³ often violating “the very same belief system[s they were purported] to uphold.”¹⁶⁴

The impact of drug control policy on the explosion of the U.S. penal system cannot be understated. Since the 1980s, the number of Americans behind bars has risen by 500%.¹⁶⁵ At the peak of the national incarceration boom in 2009, there were approximately seven million Americans under the supervision of the correctional system, with more than twelve million cycling in and out of jails.¹⁶⁶ Although this has seen recent decline, almost seven million people currently remain under the control of criminal justice system, with 70% on probation and parole.¹⁶⁷ A substantial proportion of this surge is attributed to the “War on Drugs,”¹⁶⁸ as well as to the sharp defunding and dismantling of publicly-financed mental health, substance use treatment, and other social safety net resources.¹⁶⁹

Federal Drug Control Budget, DRUG POL’Y. ALL. (2015) available at https://www.drugpolicy.org/sites/default/files/DPA_Fact_sheet_Drug_War_Budget_Feb2015.pdf (Enormous investment in domestic and international supply reduction operations.); *See also* Steven West and Keri O’Neal, *Project D.A.R.E. Outcome Effectiveness Revisited*, AMER. J. PUB. HEALTH (2004). Policies and activities such as school drug education and exclusion of people with substance use from various government benefit schemes long advanced by U.S. drug control efforts have been conclusively shown to be counterproductive. Others, including Youth Dance Program, have never been properly evaluated using appropriate metrics and research methodology. *See e.g.* Kristen Eskow, *DEA Brings Youth Dance Program to East Dayton School*, WDTN (Feb. 2, 2018) available at <http://wdtn.com/2018/02/02/dea-brings-youth-dance-program-to-east-dayton-school/>

¹⁶³ Joanne Csete et al., *Public Health and International Drug Policy*, 387 THE LANCET 1427-80 (2016) available at [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)00619-X.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00619-X.pdf); *See also* Pembelton, *supra* note 31, at 3-4.

¹⁶⁴ *See* Pembelton, *supra* note 31 at 5 (describing the US drug control regime as involving a “cognitive and behavioral trade-off...as the United States tested drugs on unwitting citizens, initiated a drug war at home and abroad, supported dictators, fought wars of choice, and readily intruded upon the sovereignty of foreign nations—all while citing the imperatives of life, liberty and the pursuit of happiness”).

¹⁶⁵ Lauren-Brooke Eisen and James Cullen, *Update: Changes in State Imprisonment* (2016) available at <https://www.brennancenter.org/sites/default/files/analysis/UpdateChangesinStateImprisonment.pdf>

¹⁶⁶ Lauren E Glaze and Erika Park, *Correctional Populations in the United States*, U.S. DEP’T. OF JUS. (2012) available at <http://www.bjs.gov/content/pub/pdf/cpus11.pdf>; Amy L. Solomon et al., *Life after Lockup: Improving Reentry From Jail to Prison*, THE URBAN INSTITUTE xv (2008) available at http://www.urban.org/uploadedpdf/411660_life_after_lockup.pdf.

¹⁶⁷ Daniele Kaebler, *Probation and Parole In The United States*, BJS. 1, 1-24 (2018).

¹⁶⁸ *See* Alexander *supra* note 33.; Although drug - related charges account for a relatively minor proportion of the overall carceral burden, weapon, property, parole violation and other charges ancillary to drug crimes make up a substantial portion of the carceral burden. In addition, untreated substance use and mental health issues are a principally driver of criminal justice involvement, regardless of charge. *See* John Pfaff, *Locked In: The True Causes of Mass Incarceration—and How to Achieve Real Reform* (Basic Books: 2017).

¹⁶⁹ Michelle McKenzie et al., *Overcoming Obstacles to Implementing Methadone Maintenance for*

Many of those imprisoned meet the clinical definition of substance use disorders, and exhibit mental health comorbidities.¹⁷⁰ Rehabilitative services in correctional settings are severely lacking. Despite modest recent advances, access to evidence-based treatment for those with opioid use disorder is virtually non-existent.¹⁷¹

Racial and economic disparities characterize this paradigm. In 2010, individuals sentenced to state prisons for drug-related crimes were disproportionately poor people of color.¹⁷² Evidence that economically disadvantaged individuals and minority individuals are not any more likely to misuse drugs or engage in drug-related crimes underscores the gross and systemic injustice of these disparities.¹⁷³

B. Criminalizing Addiction: from “Diseased Soul” to “Brain Disease”

The use of substances to alter the human condition is as old as civilization itself.¹⁷⁴ Alcohol and other intoxicating substances were a core part of the American colonial experience, as medicinal, recreational, and performance-enhancing agents.¹⁷⁵ With the advent of the Industrial Revolution, however, the focus on productivity and discipline began to bolster existing moralistic attitudes towards excessive substance use.¹⁷⁶ Enmeshed in increasing concerns about poverty, crime, and truancy in quickly-urbanizing society, the “diseased soul”¹⁷⁷ view of addiction invoked criminal law responses.¹⁷⁸ Racialized and xenophobic sentiments further bolstered the framing of addiction as deviant, and anti-social;¹⁷⁹ the impulse for increased control paved the way for the Temperance Movement and the evolution

Prisoners: Implications for Policy and Practice, 5 J. OPIOID MGMT 219 (2009).

¹⁷⁰ Leo Beletsky et al., *Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration*, 7 NE. U. L. REV. 155 (2015); see also Jonathan Giftos and Lello Tesema, *Reforming the Criminal Justice Response to the Opioid Epidemic*. The Judges' Journal, Volume 57, Number 1, Winter 2018. American Bar Association

¹⁷¹ *Id.*

¹⁷² E. Ann Carson and William J. Sabol, *Prisoners in 2011*, BUREAU OF JUS. STATISTICS: U.S. DEP'T OF JUS., (2012) available at <https://www.bjs.gov/content/pub/pdf/p11.pdf>.

¹⁷³ See generally, Li-Tzy Wu et al., *Racial/Ethnic Variations in Substance-Related Disorders Among Adolescents in the United States*, 68 ARCH. GEN. PSYCHIATRY 1176, 1181–84 (2011).

¹⁷⁴ Sean M. Robinson and Bryon Adinoff, *The Classification of Substance Use Disorders: Historical, Contextual, and Conceptual Considerations*. Behav Sci 2016; 6(3): 18, 18-19 (see Figure 1 outlining the role of drugs and alcohol in ancient civilizations).

¹⁷⁵ *Id.*, at, 19-21 (describing the use of opium and cocaine in patent medicines, the complex relationship between religion and alcohol use, as well as the provision of cocaine to slaves to boost cotton production).

¹⁷⁶ *Id.*

¹⁷⁷ R Davenport-Hines. *The Pursuit of Oblivion: A Global History of Narcotics*. WW Norton & Company; New York, NY, USA: 2003, at 63

¹⁷⁸ Robinson and Adinoff, *supra* note 194 at 20-22.

¹⁷⁹ Robinson and Adinoff, *supra* note 194 at 21-23 (noting for instance, the trope of the “negro dope fiend” popular in the 19th century).

of laws criminalizing various aspects of drug and alcohol at the local, state, and federal levels.¹⁸⁰

It took decades for the scientific consensus to evolve from the conception of problematic substance use as a moral and character defect. But advances in Psychology and other scientific disciplines gradually shifted this understanding towards a medicalized view, framing addiction as an actual, rather than moral “disease.” One codification of this evolution was the formal classification of addiction as a psychological disorder by the American Psychological Association with the publication of its first Diagnostic and Statistical Manual (DSM) in 1952.¹⁸¹

This evolving understanding soon found its way into American jurisprudence. For instance, the 1962 US Supreme Court decision in *Robinson v. California* struck down a law criminalizing addiction on Eighth Amendment grounds.¹⁸² In a fragmented opinion, the Court held that it is cruel and unusual to criminalize addiction because it is a “disease.”¹⁸³ In his opinion, Justice Stewart focused on the fact that the law at issue—§1721 of the California Health and Safety Code—targeted an individual’s “status;”¹⁸⁴ this view was echoed Justice Harlan’s concurrence expressing skepticism about criminal penalties for constructs devoid of an *actus rea*.¹⁸⁵

Since *Robinson*, scientific advances in the empirical understanding of problematic substance use have accelerated. Breakthroughs in neuroimaging have elucidated the role of brain function and chemistry in the etiology and severity of addiction. Research has also identified adverse childhood experiences, various forms of trauma, and stress among the principal risk factors for problematic substance use. The contribution of various genetic and environmental factors has also been documented.¹⁸⁶

It is part and parcel of the human condition to experience lapses in willpower—indeed, the consumer economy owes much of its vibrancy to impulsivity.

¹⁸⁰ *Id.*

¹⁸¹ Robinson and Adinoff, *supra* note 194 (see Figure 1, depicting the evolution of the definition of substance use disorder/addiction).

¹⁸² 370 US 660 (1962)

¹⁸³ *Robinson v. California*, at 667 (reasoning that “It is unlikely that any State at this moment in history would attempt to make it a criminal offence for a personal to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the general health and welfare require that the victims of these ... afflictions be dealt with compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an inclination of cruel and unusual punishment.”)

¹⁸⁴ *Robinson v. California*, at 666.

¹⁸⁵ *Robinson v. California*, at 666.

¹⁸⁶ Ming D. Li & Margit Burmeister, *New Insights into the Genetics of Addiction*, 10 NATURE REV. GENETICS 225 (2009).

Nevertheless, we also possess some ability to moderate our compulsions with rational thinking based on socio-cultural norms, economic calculations, and other cues. Depending on the severity of their condition, however, people with SUD experience a diminished ability to moderate their impulses, at times resulting in self-destructive and antisocial behavior.¹⁸⁷

There are still differences in schools of thought about physiological or external factors that determine impulse control. In the realm of SUD, the dominant view is the “brain disease model of addiction” (BDMA), which faults impairments in the structure and function of the brain for poor impulse control.¹⁸⁸ In particular, the ventromedial prefrontal cortex and the amygdala—areas that regulate behavior based on risk-benefit calculus—can be impaired in individuals suffering from severe SUD.¹⁸⁹ Many critics of the BDMA point to the importance of situational, environmental, and other factors, sometimes decrying the over-reliance on “reductionist” brain pathology to explain a complex socio-physiological phenomenon.¹⁹⁰ An evolving framework integrates these views as complementary, rather than oppositional by considering how a variety of environmental and situational stressors may neurologically impact impulsivity control and related brain function.¹⁹¹

Although this debate continues to evolve, there is broad agreement that severe SUD is a chronic disease, characterized by relapse and the rejection of a curative frame.¹⁹² The modern definition of addiction has evolved to reflect this consensus.¹⁹³ This evolution is traceable through a number of changes in language and framing of DSM and other treatises, including its articulation of the distinction between addiction and physical dependence—two previously conflated terms.¹⁹⁴

¹⁸⁷ *Americans report willpower and stress as key obstacles to meeting health-related resolutions*, APA (2010) available at <http://www.apa.org/news/press/releases/2010/03/lifestylechanges.aspx>.

¹⁸⁸ See also Nora D. Volkow, George F. Kobb & Thomas McLellan, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363, 365 (2016); see also Nick Heather, *Q: Is Addiction a Brain Disease or a Moral Failing? A: Neither*, 10 NEUROETHICS 115, 115-124 (2017) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5486515/#CR9>.

¹⁸⁹ Antoine Bechara, *Decision Making, Impulse Control and Loss of Willpower to Resist Drugs: A Neurocognitive Perspective*, 8 NATURE NEUROSCIENCE 1458 (2005).

¹⁹⁰ See Heather *supra* note 208. See also Emile Durkheim medicalization of problems in other areas. For example, ADHD is overdiagnosed when in reality children may have a variety of other issues.

¹⁹¹ See Heather *supra* note 208.

¹⁹² Richard Saitz, et al., *The Case for Chronic Disease Management for Addiction*, J. ADD. MED. (2008) (“Like other chronic diseases (e.g., diabetes, congestive heart failure), substance dependence has no cure and is characterized by relapses requiring longitudinal care.”); See also McLellan AT, O’Brien CP, Lewis D et al. (2000). Drug addiction as a chronic medical illness: Implications for treatment, insurance and evaluation. 284 *Journal of the American Medical Association* 1689 (2000)

¹⁹³ Robinson and Adinoff, *supra* note 194; DSM V was published in 2013 and the DSM-IV, in 1994; AM. PSYCHIATRIC ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2015).

¹⁹⁴ Dependence is simply the need for a substance based on physical symptoms. Addiction is

But what is critical to this discussion is that addiction (now defined as severe SUD) is characterized by continued, compulsive drug use *despite negative consequences*. Such consequences include employment, family, or other problems resulting from drug consumption.¹⁹⁵ In other words, the established scientific consensus predicts that individuals affected by addiction will substantially discount—or totally disregard—legal risks and threats of punishment as a matter of course. Without needing to engage complex philosophical and epistemological questions about conceptions of free will and decisional capacity,¹⁹⁶ a system that relies on the instrument of punishment to regulate the behavior of people affected by severe SUD fundamentally misconstrues the nature of addiction.¹⁹⁷

This scientific construct has yet to be translated into U.S. jurisprudence, however. Although *Robinson* introduced a minor crack in the conception that criminal law is a constitutionally-appropriate instrument to address problematic substance use, the U.S. criminal law and its judicial stewards have proved unreceptive to further efforts to disrupt the status quo. Despite a number of attempts, *Robinson* has been distinguished away in subsequent jurisprudence that has attempted to challenge the constitutionality of criminal laws that punish conduct emanating from SUD.¹⁹⁸

The most prominent of such cases in U.S. Supreme Court jurisprudence, *Powell v. Texas*, is broadly understood to have held that that an *actus reus* resulting from addiction could be criminalized whereas a simple propensity could not. It bears noting, however, that was decided by a 5-4 vote.¹⁹⁹ In their dissent, the four justices persuasively articulated the view that criminal laws punishing addicted

characterized by compulsive, spiraling use. One can be dependent on insulin, for instance, without being addicted.

¹⁹⁵ *Id.*

¹⁹⁶ See, e.g. Dilip V. Jeste & Elyn Saks, *Decisional Capacity in Mental Illness and Substance Use Disorders: Empirical Database and Policy Implications*, 24 *Behav. Sci. & L.* 607, 621-623 (2006).

¹⁹⁷ The evidence base on the impact of negative incentives and punishment on behavioral modification of people with addiction is substantially based on studies of limited generalizability. See, e.g. Robert L. DuPont et al., *Setting the Standard for Recovery: Physicians' Health Programs*, 36 *J. SUBSTANCE ABUSE* 159 (2009) (research finding success in physician substance use treatment programs that use the threat of losing one's medical license as an incentive). Considering what it takes to become a physician in the United States, individuals in this profession are systematically selected for those who are the best equipped for impulse control and delayed gratification. Physicians are also supported by social, economic, and other systems that are a far cry from what is available to the average American.

¹⁹⁸ See, e.g. *Powell v. Texas*, 392 U.S. 514 (1968) (declining to invalidate a Texas law criminalizing public intoxication). Attempts to use this decision to invalidate substance use-related laws on the state have also proven futile. See e.g. *State v. Margo*, 40 N.J. 188, 191 A.2d 43 (1963) (declining to invalidate a state statute that criminalized "being under the influence"), *Salas v. State*, 365 S.W.2d 174 (Tex. Crim. App. 1963) (same, and the case was denied cert.), and *State v. Brown*, 103 Ariz. 289, 440 P.2d 909 (1968) (en banc) (declining to invalidate a statute that criminalized "use," rather than "addiction").

¹⁹⁹ *Powell v. Texas*,

individuals for conduct resulting from the “pattern of [their] disease” violates the Eighth Amendment.²⁰⁰ As Alex Kreit points out,²⁰¹ it is remarkable just how narrowly that view missed becoming the guiding principle of US criminal law in 1968.²⁰² By reviving this line of constitutional argument, litigation emerging out of the overdose crisis has the potential to bring some long-overdue change to this doctrinal realm.

C. Legal and Policy Responses to the Overdose Crisis

As a reflection of this historical and doctrinal context, the U.S. response to the overdose crisis has been primarily focused on suppression of opioid supply, with distinct emphasis on criminal law tools.²⁰³ Reflecting the “vector model,” this response has drawn on multi-pronged policy and programmatic efforts to roll back patient access to opioids.²⁰⁴ The structural determinant framework makes clear, however, that the opioid overdose crisis did not rise solely (or even principally) as a consequence of lax, unscrupulous prescribing and pharmaceutical marketing.²⁰⁵ Framing health care providers and pharmaceutical companies as “pushers” calls up a familiar, but misleading War on Drugs trope that glosses over critical structural issues that helped spark and continue to fuel overdose morbidity and mortality.²⁰⁶

Providers experienced both internal and external pressure to sharply reduce opioid prescribing.²⁰⁷ Mechanisms like patient contracts and random drug tests, when

²⁰⁰ Id. (noting that “The statute [prohibiting public drunkenness] covers more than a mere status [at issue in *Robinson*]. But the essential constitutional defect here is the same as in *Robinson*, for in both cases the particular defendant was accused of being in a condition which he had no capacity to change or avoid.”)

²⁰¹ Alex Kreit, *Controlled Substances: Crime, Regulation, and Policy*. Carolina Academic Press (2013), at 331.

²⁰² *Powell v. Texas*,

²⁰³ Abby Alpert, David Powell, & Rosalie Liccardo Pacula, *Supply-Side Drug Policy in the Presence of Substitutes: Evidence from the Introduction of Abuse-Deterrent Opioids*, 23031 RAND 1, 2-3 (2017) available at <http://www.nber.org/papers/w23031>

²⁰⁴ *FDA’s Efforts to Address the Misuse and Abuse of Opioids*, FDA (Feb. 6, 2013) available at <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm337852.htm>; *Guideline for Prescribing Opioids for Chronic Pain*, CDC (Accessed on Mar. 20, 2018) available at https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf; *Risk Evaluation and Mitigation Strategy (REMS) for Opioid Analgesics*, FDA (Feb. 27, 2018) available at <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163647.htm>; Jan L. Losby et al., *Safer and More Appropriate Opioid Prescribing: A Large Healthcare System’s Comprehensive Approach*, 23(6) J. EVAL. CLIN. PRACT. 1173 (2017) available at <https://onlinelibrary.wiley.com/doi/full/10.1111/jep.12756>

²⁰⁵ Nabarun Dasgupta, Leo Beletsky, & Daniel Ciccarone, *Opioid Crisis: No Easy Fix to its Social and Economic Determinants*, AM. J. PUB. HEALTH 108, 182-86 (2018).

²⁰⁶ *Id.*

²⁰⁷ George Comerchi, Joanna Katzman, & Daniel Duhigg, *Controlling the Swing of the Opioid Pendulum*, 378 NEW ENG. J. MED. 691 (2018) available at

considered in combination with prescription monitoring efforts, aggravated stigmatization of substance users in health care settings, injecting suspicion and distrust within the provider-patient relationship.²⁰⁸ Patients suspected of drug-seeking behavior, misuse, and/or diversion faced the risk of being “fired” by their providers; in some cases, such patients are turned over to law enforcement.²⁰⁹ Faced with the risk of judgement and criminalization, patients with unmet physical or mental health needs would be deterred from seeking care altogether.²¹⁰

For the many opioid users whose dependence had been already established, efforts to rapidly restrict access proved catastrophic.²¹¹ Inadvertently, but predictably, this strategy led many patients to transition from legitimate opioid supplies to black market supplies.²¹² This had major implications for overdose morbidity and mortality, as well as for initiation of injection and its sequelae.²¹³

Whether such remedies can be considered beneficial depends on the beholder’s metrics of “success.” Measured in terms of surrogate endpoints like the number, duration, and dosage of opioid prescriptions,²¹⁴ prescription monitoring and supply reduction efforts have had a measurable impact.²¹⁵ Some of these interventions have been associated with reductions in opioid overdose mortality linked to

<http://www.nejm.org/doi/full/10.1056/NEJMp1713159>

²⁰⁸ Joanna L. Starrels et al., *Systematic Review: Treatment Agreements and Urine Drug Testing to Reduce Opioid Misuse in Patients with Chronic Pain*, 152(11) ANN. INTERN. MED. 712 (2010) available at <http://annals.org/aim/article-abstract/745804/systematic-review-treatment-agreements-urine-drug-testing-reduce-opioid-misuse>

²⁰⁹ Peter Grinspoon, *Free Refills* (2016); *See also* Markian Hawryluk, *Opioid Crisis: Pain Patients Pushed to the Brink*, THE BULLETIN (JUN. 2, 2017), available at <http://www.bendbulletin.com/topics/5342867-151/opioid-crisis-pain-patients-pushed-to-the-brink>

²¹⁰ Jay Baruch, *Did I Just Feed an Addiction? Or Ease a Man’s Pain? Welcome to Modern Medicine’s Moral Cage Fight*, STAT NEWS (Oct. 23 2017) available at <https://www.statnews.com/2017/10/23/addiction-opioids-prescribing-doctors/>; *see also* Sarah Frostenson, *The Crackdown on Opioid Prescription is Leaving Chronic Pain Patients in Limbo*, VOX (Apr. 7, 2017) available at <https://www.vox.com/science-and-health/2017/4/7/14738292/crackdown-opioid-prescriptions-chronic-pain>.

²¹¹ *Patients with Chronic Pain Forced into Opioid Tapers by their Prescribers*, 30 ALCOHOL & DRUG ABUSE WKLY 1 (2018); *see also* Stefan G. Kertesz, Adam J. Gordon & Sally L. Satel, *Opioid Prescription Control: When The Corrective Goes Too Far*, HEALTH AFFAIRS BLOG (2018).

²¹² Sarah G. Mars et al., “Every ‘Never’ I Ever Said Came True”: *Transitions from Opioid Pills to Heroin Injecting*, 25(2) INT. J. DRUG POL’Y 257 (2014) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/>

²¹³ Steffanie A. Strathdee and Chris Beyner, *Threading the Needle—How to Stop the HIV Outbreak in Rural Indiana*, 373 NEW ENG. J. MED. 397 (2015).

²¹⁴ Recent clinical literature on failure of surrogate endpoints to translate into clinical benefit is a good corollary to this. *See, e.g.* Behnood Bickdeli et al., *Two Decades of Cardiovascular Trials with Primary Surrogate Endpoints: 1990-2016*, 6 J. AMER. HEART ASSOC. 1 (2017).

²¹⁵ U.S. Department of Health and Human Services, *Facing Addiction in America: Surgeon General’s Report on Alcohol, Drugs, and Health* (2016) available at <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>.

prescription medications.²¹⁶ But with the exception of six studies with deeply divergent outcomes,²¹⁷ the ability of supply-side approaches to curb overall opioid overdose rates has been scarcely evaluated, let alone established.²¹⁸

Even more tragically, supply control interventions were not balanced with the imperative to engage and retain opioid users in a comprehensive spectrum of opioid maintenance and other care, just as their access to prescription analgesics may be declining.²¹⁹ But opioid dependence and addiction did not simply recede with the contraction in the availability of opioid pills. Instead, affected individuals turned to cheaper, more accessible, and more potent black market opioid alternatives in unprecedented numbers.²²⁰ Unintended, but foreseeable (and sometimes directly foreseen²²¹), this transition exposed users to much higher risk of overdose because of the lack of regulation over the quality and dosage in black market opioid products.²²² Many also became shut out from the health care system and the risk-reduction intervention that it potentiated.²²³

As heroin began to devastate largely white, non-urban communities,²²⁴ its advent spurred renewed emphasis on—and investment in—interdiction.²²⁵ This included major scale-up in the staffing and funding of border control along the US-Mexico Border, where the amount of heroin seized quintupled between 2008 and 2015.²²⁶

²¹⁶ Deborah Dowell et al., *Mandatory Provider Review and Pain Clinic Laws Reduce the Amounts of Opioids Prescribed and Overdose Death Rates*, 35(10) HEALTH AFFAIRS 1876 (2016) available at <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.0448>

²¹⁷ Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 IND. HEALTH L. REV. 139 (See table 1).

²¹⁸ Leo Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 IND. HEALTH L. REV. 139; Kinnard L, Philbin M, Beletsky, L. Government actions to curb the opioid epidemic: Comments on ‘Ten steps the federal government should take now to reverse the opioid addiction epidemic.’ 319 JAMA 1619 (2017).;

²¹⁹ See Guy Jr., *supra* note 119.

²²⁰ Cicero, *supra* note 103; Christopher M. Jones, *Heroin Use and Heroin Use Risk Behaviors Among Nonmedical Users of Prescription Opioid Pain Relievers – United States, 2002–2004 and 2008–2010*, DRUG ALCOHOL DEP. 95 (2013).

²²¹ Joshua Vaughn, *2016 Crime Review: Heroin Deaths Rise as Prescription Policies Go into Effect*, THE SENTINEL (Feb. 12, 2017) available at http://cumberland.com/news/local/closer_look/digital_data/crime-review-heroin-deaths-rise-as-prescription-policies-go-into/article_fcde5d45-676a-54d4-873e-aac9a79b2cb0.html (One of the most shocking articulations of these sentiments is attributed to Pennsylvania’s former Chief Physician, who recently remarked “We knew that [drug user transition to the black market] was going to be an issue, that we were going to push addicts in a direction that was going to be more deadly... But...you have to start somewhere.”)

²²² Cicero, *supra* note 103.

²²³ Rudd, *supra* note 114; Cicero, *supra* note 103.

²²⁴ Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, N.Y. TIMES (Oct. 30, 2015) available at <https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html>

²²⁵ *Id.*

²²⁶ Drug Enforcement Administration, *National Drug Threat Assessment Summary*, U.S. DEP’T. OF

On the domestic front, law enforcement leaned on its toolkit of harsh criminal penalties to disrupt the black market for opioids.²²⁷ The escalation in supply-reduction efforts also included high-profile drug-induced homicide prosecutions like Murray Burrage's.²²⁸ Such prosecutions, as well as the advent of new legal provisions that facilitate them—have grown especially common in areas hardest-hit by the crisis.²²⁹ With heroin consumption rising quickly and supply-reduction measures mounting, the rise of fentanyl—the more potent, more easily manufactured, and more deadly—as a heroin alternative was just a matter of time.²³⁰

I have already discussed how interventions informed by a singular focus on the supply of opioid drugs failed to accomplish their goals, in some ways inadvertently fueling the very problem they sought to control. But it would be incorrect to suggest that supply-reduction interventions have been the sole response advanced to prevent opioid fatalities. Before turning to an in-depth analysis of drug-induced homicide, it is useful to first examine innovative public health-driven innovations that have evolved.

D. Emergence of a “Public Health” Approach

Public Health focuses on data-driven solutions and the imperative to prevent harm before it happens.²³¹ So what defines the “public health response” to the overdose

JUS. (2016) available at <https://www.dea.gov/resource-center/2016%20NDTA%20Summary.pdf>; See also Pew Charitable Trusts Immigration and the States Project, *Immigration Enforcement Along U.S. Borders and at Ports of Entry: Federal, State, and Local Efforts* (2016) available at http://www.pewtrusts.org/~media/assets/2015/02/borderenforcement_brief_web.pdf

²²⁷ Jim Parsons, *Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis*, VERA (2017) available at https://storage.googleapis.com/vera-web-assets/downloads/Publications/for-the-record-public-health-justice-system-responses-opioid-crisis/legacy_downloads/Minimizing-Harm-Evidence-Brief.pdf

²²⁸ See *Burrage v. United States*, *supra* note 1.

²²⁹ Bryan Polcyn and Stephen Davis, *The Legacy of Len Bias: Police Treating Overdoses as Homicides*, FOX (Oct. 31, 2013) available at <http://fox6now.com/2013/10/31/the-legacy-of-len-bias-police-treating-drug-ods-as-homicides/>

²³⁰ See Clark Warburton, *The Economic Results of Prohibition XX* (1932) (describing that the “Iron Law of Prohibition” predicts that in a context of interdiction enforcement, more bulky products become more expensive relative to less bulky ones, incentivizing increases in potency. During US’ national alcohol Prohibition, relative to products with lower alcohol content like beer (Prohibition-era cost increase: over 700 percent), the price of spirits rose much more slowly (Prohibition-era cost increase: 270 percent). At the same time, the ability of black market traffickers to get the “biggest bang for their buck” is catalyzed by reduced consumer ability to exercise preferences; See also Johann Hari, *Yes, Pot is Stronger Today, but Not for the Reasons You Think*, L.A. TIMES (Jan. 14, 2016) available at <http://www.latimes.com/opinion/op-ed/la-oe-0114-hari-iron-law-drug-prohibition-20160114-story.html>

²³¹ *The Precautionary Principle: Protecting Public Health, the Environment and the Future of our Children*, WHO (2004) available at http://www.euro.who.int/_data/assets/pdf_file/0003/91173/E83079.pdf; See also Richard

crisis? In the realm of demand reduction, this has included increasing public and provider education.²³² A number of such informational campaigns focused on about opioid misuse and overdose prevention.²³³ The federal and state governments also took on a project to reduce stigma of problematic drug use to encourage those affected and their families to seek help.²³⁴ Medical schools and other health care institutions have been recruited to build provider capacity to offer competent care for people affected by substance use disorder.²³⁵

Demand reduction efforts also focused in increasing access to evidence-based maintenance therapy.²³⁶ One of the definitive paradoxes of the overdose crisis that it is currently much easier to access pharmaceutical and black-market products that cause addiction and increase overdose risk than it is to access medications designed to reduce one's overdose risk.²³⁷ As a result of these and other measures, the uptake of maintenance therapy grew substantially between 2008 and 2015.²³⁸

Riegelman and Brenda Kirkwood, *Public Health 101: Healthy People - Healthy Populations* (1st ed., 2015).

²³² Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANN. REV. PUB. HEALTH 559, 566 (2015) available at <https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-031914-122957>

²³³ *Id.*, at 567.

²³⁴ See Massachusetts's State without Stigma Campaign, available at <https://www.mass.gov/state-without-stigma>

²³⁵ Lynn Arditi, *Brown Medical School to Pioneer Addiction-Treatment Program*, PROV. J. (2017) available at <http://www.providencejournal.com/news/20170710/brown-medical-school-to-pioneer-addiction-treatment-program>; Melissa Hanson, *UMass Medical School Partnering with Prisons to Improve Addiction Treatment Behind Bars*, MASSLIVE (Feb. 7, 2017) available at http://www.masslive.com/news/worcester/index.ssf/2017/02/umass_medical_school_partnerin.html

²³⁶ Kirsten Beronio, Sherry Glied, & Richard Frank, *How the Affordable Care Act and Mental Health Parity and Addiction Equity Act Greatly Expand Coverage of Behavioral Health Care*, 41(4) J. BEHAVIORAL HEALTH SERV. & RES. 410, 410-11 (2014) available at <https://link.springer.com/article/10.1007/s11414-014-9412-0>

²³⁷ Elizabeth Olivia et al., *Barriers to Use of Pharmacotherapy for Addiction Disorders and How to Overcome Them*, 13 CURR. PSYCH. REP. (2011); See also Beronio et al., *supra* note 257 (To address this, the Affordable Care Act strengthened parity provisions and included substance use treatment as an essential health benefit.); See also German Lopez, *We really do have a solution to the opioid epidemic — and one state is showing it works*, VOX (2018) available at <https://www.vox.com/policy-and-politics/2018/5/10/17256572/opioid-epidemic-virginia-medicaid-expansion-arts> (Medicaid expansion made such services accessible to many more low-income and disabled Americans.); See also *Proposed Patient Limit Raised to 275*. ASAM *Applauds Important Action to Help Close Addiction Treatment Gap*, AMER. SOC. ADDICTION MED. (Jul. 6, 2016) available at <https://www.asam.org/resources/publications/magazine/read/article/2016/07/06/asam-applauds-important-action-to-help-close-addiction-treatment-gap.-proposed-patient-limit-raised-to-275> (The previously imposed 100-patient cap for prescribers of the maintenance drug buprenorphine was also recently lifted to 275 patients.)

²³⁸ Rachel M. Burns et al., *Policies Related to Opioid Agonist Therapy for Opioid Use Disorders: The Evolution of State Policies from 2004 to 2013*, 37(1) SUBST. ABUSE 63 (2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4801690/>; Andrew W. Dick et al., *Increasing Potential Access to Opioid Agonist Treatment in U.S. Treatment Shortage Areas*, 34(6) HEALTH

Nevertheless, the sheer prevalence and incidence of opioid mortality created urgency for decisive death prevention measures. The nature of opioid overdose leaves ample scope for life-saving interventions even after all forms of prevention have failed.²³⁹ Opioids kill by depressing respiration, a process that can take up to 90 minutes or longer.²⁴⁰ Concerted action to improve survival after overdose occurs has taken three forms of responsive innovation: programs that provide access to overdose response training and emergency naloxone, informational outreach on how to reduce the risk of fatal overdose among drug users, and interventions aimed at reducing the fear of bystanders to call for emergency help²⁴¹

Opioid-related respiratory depression can be effectively reversed outside of a medical setting by rescue breathing and the administration of naloxone—an opioid antidote.²⁴² This drug has no psychoactive properties or abuse potential.²⁴³ The basic OEND model is to combine naloxone distribution efforts with a brief training for non-medical lay responders. Standard curriculum includes coverage of the signs and symptoms of overdose, distinguishing between different types of overdose, rescue breathing and the rescue position, and the importance of calling 911.²⁴⁴

These initiatives have been well-received by drug users and other participants, including family members, partners, and friends of both medical and non-medical

AFFAIRS 1028 (2015) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4743254/>

²³⁹ Leonard Paulozzi et al., *Increasing Deaths from Opioid Analgesics in the United States*, 15 PHARMACO. & DRUG SAFETY 625 (2006).

²⁴⁰ *Overdose Basics*, INT. OVERDOSE AWARENESS DAY (Accessed on Mar. 9, 2018) available at <https://www.overdoseday.com/resources/overdose-basics/>

²⁴¹ Karl A. Sporer, *Strategies for Preventing Heroin Overdose*, 326(7386) BMJ 442 (2003) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1125320/>; *Now What? The Role of Prevention Following a Nonfatal Opioid Overdose*, SUBST. ABUSE & MENTAL HEALTH SERV. ADMIN. (2018) available at https://www.samhsa.gov/capt/sites/default/files/resources/role_of_prevention_following_and_overdose-v02.pdf

²⁴² Todd Kerensky and Alex Walley, *Opioid Overdose Prevention and Naloxone Rescue Kits: What We Know and What We Don't Know*, ADD. SCI. & CLIN. PRAC. 12 (2017).

²⁴³ Alexander Bazazi et al., *Preventing Opiate Overdose Deaths: Examining Objections to Take-Home Naloxone*, 21 J. HEALTH POOR & UNDER. 1108 (2010).

²⁴⁴ See Kerensky & Walley, *supra* note 266; See also *Naloxone*, SAMHSA (Accessed on Mar. 13, 2018) available at <https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone> (Since naloxone is a prescription drug, training on the appropriate use and dispensing of naloxone is provided by, or under the supervision of a licensed prescriber.); See also Eliza Wheeler, *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons — United States, 2014*, 64 MMWR 631 (2015) (Participants are usually given naloxone at the training to carry with them; programs have provided both injectable and intranasal formulations.); See also Leo Beletsky et al., *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities*, 84 J. URB. HEALTH 126 (2007) (Naloxone co-prescription with opioid medications and pharmacy dispensation represents another route of access, such efforts have been slow to catch on.)

opioid users.²⁴⁵ They have shown to reduce opioid overdose rates and be cost-effective—even despite recent major spikes in the cost of naloxone.²⁴⁶

In the U.S., naloxone was first distributed to drug users in 1999 through underground programs in Chicago and San Francisco.²⁴⁷ As of 2014, there were over 200 community-based programs operating in 47 U.S. states.²⁴⁸ Originally focused on primarily urban heroin users, these efforts have expanded to include other settings serving at-risk populations, including methadone clinics, detox centers, homeless shelters, correctional settings, and government agencies.²⁴⁹ At the time of writing, all states had passed laws to facilitate naloxone access among bystanders, including providing civil immunity to lay first responders and/or naloxone prescribers.²⁵⁰ Numerous police departments have also taken on this function. But it is best prioritized to drug users.²⁵¹

²⁴⁵ This pattern counters moral hazard-based concerns that naloxone users will engage in riskier drug use, suggesting instead that the information and sense of empowerment acquired by trainees actually helps them attain the kind of self-efficacy that can help individuals dealing with substance use problems. See, e.g. Karla Wagner et al., *Evaluation of an Overdose Prevention and Response Training Programme for Injection Drug Users in the Skid Row Area of Los Angeles, CA*, 21 INT’L J. OF DRUG POL’Y 186 (2010); Traci Green et al., *Social and Structural Aspects of the Overdose Risk Environment in St. Petersburg, Russia*, 20 INT’L J. OF DRUG POL’Y 270 (2009).

²⁴⁶ Coffin and Sullivan, *supra* note 60; see also Leo Beletsky, Josiah Rich and Alex Walley, *Prevention of Fatal Opioid Overdose*, 308 JAMA 1863, 1863-1864 (2012) (providing an overview of the evidence behind the community benefits of naloxone access).

²⁴⁷ Ctrs. for Disease Control and Prevention, *Community-Based Opioid Overdose Prevention Programs Providing Naloxone—United States, 2010*, 61(06) MORB. & MORTALITY WKLY REP’T 101 (2012) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm>

²⁴⁸ Eliza Wheeler et al., *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014*, MORB. & MORTALITY WKLY REP’T (2015) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm>.

²⁴⁹ Alexander Walley et al., *Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis*, 346 BRI. MED. J. f174 (2013); Alexander Walley et al., *Opioid overdose prevention with intranasal naloxone among people who take methadone*, 44 J. SUB. ABU. TRE., 241, 241-247(2013); SM Bagley et al., *Expanding access to naloxone for family members: The Massachusetts experience*, DRUG & ALC. REV. (2017); See also *Chicago Recovery Alliance*, HARM RED. COAL. (Accessed on Mar. 13, 2018) available at <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/naloxone-program-case-studies/chicago-recovery-alliance/>; See also *Clean Works*, HARM RED. COAL. (Accessed on Mar. 13, 2018) available at <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/naloxone-program-case-studies/clean-works/>

²⁵⁰ See *Naloxone Overdose Prevention Laws* *supra* note 73 (shows that at the time of writing, 41 states have passed legislation providing civil immunity to prescribers for prescribing, dispensing or distributing naloxone to a layperson. 46 states have also passed legislation protecting a lay person administering naloxone with immunity from civil liability).

²⁵¹ Tarlise Townsend, Freida Blostein, Tran Doan, Sammie Madson-Olson, Paige Galecki, and David Hutton, *Improving Naloxone Distribution in the Opioid Epidemic A cost-effectiveness analysis of naloxone distribution to first responders and laypeople*, Academy Health Annual Meeting, 2017 (noting that naloxone distribution is much more effective when directed at users, rather than police).

Black market drugs obtained from illegal sources vary in purity, composition, and are more likely to be administered non-medically, vastly accelerated the onset of overdose symptoms.²⁵² Fentanyl strength and that of its even more potent analogues vastly accelerates the onset of overdose symptoms, as evidenced by the fact that many of the victims are discovered with needles still in their arm.²⁵³ This substantially constricts the time available for lifesaving interventions, adding weight to the rationale of empowering partners, relatives, and others who are likely to encounter overdose victims.²⁵⁴

Education is also essential to attune members of the public—especially users, caregivers and others who are likely to come in contact with users—to the risk factors for and proper responses to overdose.²⁵⁵ This includes encouraging users not to use drugs alone, not to mix drugs, testing new batches for potency, buying drugs from a trusted source, and knowing exactly what to do in the event that overdose does occur.²⁵⁶ Although we will never know for sure, the multiple-drug toxicity death of Joshua Banka may have been averted if some of these measures were in place in Nevada, Iowa at the time of his tragic passing.

Though lay administration of naloxone is a vital step, the optimal response to an overdose is timely medical intervention.²⁵⁷ But emergency medical assistance is too often not summoned when an overdose occurs. This could be because there is no one to make the call; even when there are bystanders who could call for help, however, they often fail to do so.²⁵⁸ Companions of overdose victims delay or

²⁵² S Darke et al., *Fluctuations in Heroin Purity and the Incidence of Fatal Heroin Overdose*, 54 DRUG & ALC. DEPEND. 155 (1999); See also Thomas Kerr et al., *Predictors of Non-Fatal Overdose Among a Cohort of Polysubstance-Using Injection Drug Users*, 87 DRUG & ALC. DEPEND. 39 (2006); See also Leonard Palouzzi, *Increasing Deaths from Opioid Analgesics in the United States*, 15 PHARMACO. & DRUG SAFETY 618 (2006).

²⁵³ Ctrs. for Disease Control and Prevention. *Nonpharmaceutical Fentanyl-Related Deaths—Multiple States, April 2005–March 2007*, MORB. & MORTALITY WKLY REP'T (2008) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm>.

²⁵⁴ Nicholas Somerville et al., *Characteristics of Fentanyl Overdose — Massachusetts, 2014–2016*, 66 MMWR 382–386 (2017) available at <http://europepmc.org/articles/pmc5657806> (shows that only 6% of fentanyl overdoses in MA had evidence of bystander intervention, in many cases due to lack of knowledge of overdose symptoms, and of naloxone and naloxone training).

²⁵⁵ *Id.* (describes cases where bystanders did not recognize overdose symptoms, or believed the deceased to be sleeping); See also Alex Walley et al., *Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis*, 346 BMJ 174 (2013).

²⁵⁶ Tracy Green, Robert Heimer & Lauretta Grau, *Distinguishing Signs of Opioid Overdose and Indication for Naloxone: an Evaluation of Six Overdose Training and Naloxone Distribution Programs in the United States*, 103 ADDICTION 979-989 (2008); *Drug Overdose Prevention & Education (DOPE) Project: San Francisco*, HARM RED. COAL. (Accessed on March 13, 2018) available at <http://harmreduction.org/issues/overdose-prevention/dope-sf/>

²⁵⁷ Leo Beletsky, Josiah Rich and Alex Walley, *Prevention of Fatal Opioid Overdose*, 308 JAMA 1863, 1863-1864 (2012).

²⁵⁸ Melissa Tracy et al., *Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention*, 79 DRUG & ALC. DEPEND. 181 (2005) available at

resist contacting 911 because of concerns about police contact and a cascade of legal consequences.²⁵⁹

Of key relevance to this article, this fear of legal consequences to overdose victims or bystanders warrants special attention. By default, dispatcher systems in most U.S. jurisdictions distribute emergency calls regarding suspected overdoses to law enforcement.²⁶⁰ Depending on the jurisdiction's emergency response design and geographical setting, police may be the first to arrive on the scene. Their role has traditionally included providing security to emergency medical personnel, but also frequently includes various forms of intelligence-gathering.²⁶¹ Police involvement at overdose scenes may result in arrests on drug, parole violation, weapons, and other charges.²⁶² It may also lead to loss of child custody, violation of community supervision conditions, and other legal consequences rooted in pervasive stigmatization of substance use, but not directly linked to criminal law.²⁶³

Research suggests that fear of police contact and legal detriment is actually *the single most important* reason why people who witnessed overdoses do not seek timely emergency medical help.²⁶⁴ This is particularly true of events that involve heroin: out of all such overdoses, witnesses report calling 9-1-1 less than half the time.²⁶⁵ In other words, the fear of legal repercussions likely costs thousands of Americans' their lives each year. What fuels these deadly fears? High-profile prosecutions tied to overdose events.

E. Redefining the Role of Criminal Law and Policing Practice

Public health-focused innovation in response to the overdose crisis has even

https://deepblue.lib.umich.edu/bitstream/handle/2027.42/40301/Tracy_Circumstances%20of%20Witnessed%20Drug%20Overdose%20in_2005.pdf?sequence=2&isAllowed=y

²⁵⁹ *Id.*, at 183; TR at 2, 60, 61

²⁶⁰ Caleb Banta-Green, Leo Beletsky, et al., *Police Officers' and Paramedics' Experiences with Overdose and Their Knowledge and Opinions of Washington State's Drug Overdose-Naloxone-Good Samaritan Law*, 90 J. URB. HEALTH (2013) 1102; Tobin KE, Davey MA, & Latkin CA, *Calling Emergency Medical Services During Drug Overdose: An Examination Of Individual, Social And Setting Correlates*, 100(3) *Addiction* 397–404 (2005) *see also*

²⁶¹ *The Unprecedented Opioid Epidemic: As Overdose Become a leading Cause of Death, Police, Sheriffs, and Health Agencies Must Step Up Their Response*, Police Executive Research Forum (Sept. 2017) available at <http://www.policeforum.org/assets/opioids2017.pdf>

²⁶² *See* Latimore & Bergstein *supra* note 35.

²⁶³ Wendy Height et al., "In these bleak days": Parent methamphetamine abuse and child welfare in the rural Midwest, 27 *CHILD. AND YOUTH SER. REV.* 949, 949-971 (2005) available at <https://experts.umn.edu/en/publications/in-these-bleak-days-parent-methamphetamine-abuse-and-child-welfare>

²⁶⁴ *See* Latimore & Bergstein *supra* note 35; *See also* Amy S.B. Bohnert et al., *Characteristics of Drug Users Who Witness Many Overdoses: Implications for Overdose Prevention*, 120 *DRUG & ALC. DEPEND.* 168 (2012);

²⁶⁵ Bohnert et al., *supra* note 207.

impacted the stalwart focus on supply reduction laws and enforcement interventions.²⁶⁶ This shift resulted from both internal and external pressures. Criminal justice professionals, including police and prosecutors, have in recent years spoken out about their frustration with the traditional drug control regime that emphasizes punishment and retribution.²⁶⁷ In times of relative austerity, policymakers and institutions have had to rethink their approaches because of runaway costs and plain failure of punitive drug control measures as applied to the overdose crisis.²⁶⁸

Public health innovation in the U.S. has always come from the local level. This is the level where frontline personnel engage in experimentation that defies traditional silos and, at times, contravenes formal and informal norms in search of pragmatic solutions. As a result, the discourse around the overdose crisis had begun to reflect an intention to respond to the overdose crisis as a “public health problem, and not just a criminal problem.”²⁶⁹ Despite some indications of a shift in the opposite direction on the federal level,²⁷⁰ the adage that “we can’t arrest our way out” of raging opioid overdose and addiction crisis now figures prominently in policy discussions at all levels of government.²⁷¹

To remove barriers to help seeking, almost all U.S. states have now passed “911 Good Samaritan” laws that carve out immunity from a limited set of criminal provisions to reduce the legal consequences of calling 911.²⁷² As part of a comprehensive overdose package, New Mexico enacted one of the first such laws

²⁶⁶ *The Unprecedented Opioid Epidemic: As Overdoses Become A Leading Cause Of Death, Police, Sheriffs, And Health Agencies Must Step Up Their Response*, THE POLICE EXECUTIVE RESEARCH FORUM (2017) available at <http://www.policeforum.org/assets/opioids2017.pdf>

²⁶⁷ Leo Beletsky et al., *Attitudes of Police Officers Towards Syringe Access, Occupational Needlesticks, and Drug Use: A Qualitative Study of One City Police Department in the United States*, 16 INT’L J. DRUG POL’Y 267 (2005).

²⁶⁸ Lev Facher, *White House panel urges Trump to declare state of emergency over opioid crisis*, STAT (2017) available at <https://www.statnews.com/2017/07/31/opioid-emergency-declaration/>.

²⁶⁹ For instance, President Barack Obama reaffirmed his Administration’s in a speech to the National Rx and Heroin Summit available at <http://www.c-span.org/video/?407358-1/president-obama-remarks-prescription-drug-abuse>; The Police Executive Research Forum committed to teaming up with health agencies to address opioid overdoses available at <http://www.policeforum.org/assets/opioids2017.pdf>

²⁷⁰ Sari Horwitz and Scott Hingham, *DEA Launches New Crackdown on Pharmacies and Opioid Over-Prescribers*, WASH. POST (Jan. 30, 2018) available at https://www.washingtonpost.com/world/national-security/dea-launches-new-crackdown-on-pharmacies-and-opioid-over-prescribers/2018/01/30/14cc20be-0600-11e8-94e8-e8b8600ade23_story.html?utm_term=.064a40f5196f.

²⁷¹ Joe Davidson, *Obama Anti-Heroin Strategy Shifts Focus to Treatment from Arrests*, WASH. POST (Mar. 29, 2016) available at https://www.washingtonpost.com/news/powerpost/wp/2016/03/29/obama-unveils-anti-heroin-strategy/?utm_term=.5f63bbdc15f9.

²⁷² *Good Samaritan Overdose Prevention Laws*, PRESC. DRUG ABUSE POL’Y SYS (2016) available at <http://pdaps.org/datasets/good-samaritan-overdose-laws-1501695153>.

exempting both the caller and the victim from drug possession charges.²⁷³ However, this law and all others are limited to drug possession charges, and do not extend to drug trafficking charges.²⁷⁴ Some of the more progressive provisions also cover parole violations and actual arrest, not just amnesty from prosecution.²⁷⁵

There are other models. For instance, Alaska has a sentence-mitigation provision for a person convicted of a drug offense who “sought medical assistance for another person who was experiencing a drug overdose contemporaneously with the commission of the offense”.²⁷⁶ These laws depend on public knowledge and confidence in that police will at least follow the letter, if not also the spirit—of the law to have its desired impact.²⁷⁷

The role of risk perception is critical in this area. Research demonstrates that drug users (as well as, to a considerable extent, police officers) lack an accurate understanding of Good Samaritan policies.²⁷⁸ When weighing the risk of arrest an overdose event, users’ assessment is magnitudes higher than that of police.²⁷⁹ Some officers report using their enforcement discretion to not arrest or charge individuals for various violations in the spirit of the law, even if these are not covered by the scope of the Good Samaritan amnesty.²⁸⁰ The extent to which such elective law enforcement decisions are articulated and communicated to the broader public is unclear. Ultimately, it is the perception of bystanders about legal risks to self or the victim that drives help seeking behavior.²⁸¹

On the level of street-level enforcement, the primary “public health” innovation in the criminal justice realm has been police training and access to naloxone.²⁸² Popularized as the “Quincy Model” after its successful adoption in 2010²⁸³, it has

²⁷³ *Id.*

²⁷⁴ *911 Good Samaritan Fatal Overdose Prevention Law*, DRUG POL’Y ALLIANCE (2017) available at <http://www.drugpolicy.org/issues/911-good-samaritan-fatal-overdose-prevention-law>.

²⁷⁵ *Id.* (Georgia Good Samaritan Law).

²⁷⁶ Terry Tibbett and Michael Jeffery, *Smart Justice and FASD in Alaska: From Prevention to Sentence Mitigation*, 63 FETAL ALC. SPECTRUM DISORDERS IN ADULTS: ETHICAL AND LEG. PERS. 169 (2015).

²⁷⁷ Caleb J. Banta-Green et al., *Police Officers’ and Paramedics’ Experiences with Overdose and Their Knowledge and Opinions of Washington State’s Drug Overdose–Naloxone–Good Samaritan Law*, 90 J. URB. HEALTH 1102 (2013).

²⁷⁸ *Id.*

²⁷⁹ See Banta-Green et al., *supra* note 220, at 97.

²⁸⁰ See Banta-Green et al., *supra* note 220, at 97.

²⁸¹ See Latimore & Bergstein *supra* note 35.

²⁸² Corey S. Davis et al., *Engaging Law Enforcement in Overdose Reversal Initiatives: Authorization and Liability for Naloxone Administration*, 105(8) GOV’T. LAW & PUB. HEALTH 1530, 1531 (2015) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4504282/>.

²⁸³ *The ‘Quincy Model’: Saving the Lives of Addicts*, BOSTON GLOBE (Apr. 21, 2014) available at <https://www.bostonglobe.com/opinion/editorials/2014/04/20/quincy-use-anti-overdose-medicine-has-become-national-model/1sC0FR4lsQ5btMdtW0BPTK/story.html>.

rapidly expanded to police forces across the country.²⁸⁴ Police are especially likely to be the first to arrive on the scene of an overdose in rural locales and other settings like tribal areas, where emergency medical service response times can be substantially longer than those of law enforcement personnel.²⁸⁵ Nationwide, law enforcement officers outnumber medical first responders by approximately a factor of three.²⁸⁶ Over twelve hundred²⁸⁷ police agencies have now trained and equipped officers to resuscitate individuals during overdose events, and they have done so in over one thousand overdose events.²⁸⁸

Aside from this direct role in rescue operations, law enforcement can also contribute to overdose prevention through other activities. These could include disseminating information about signs and symptoms of overdose²⁸⁹, advice on accessing naloxone,²⁹⁰ promoting Good Samaritan (criminal amnesty for overdose victims and witnesses who call for help) policies,²⁹¹ and facilitating linkage to drug treatment and other services.²⁹²

Drug user concerns about being arrested at the scene of an overdose may or may not be based on the correct assessment of legal risks.²⁹³ In fact, research suggests

²⁸⁴ See Davis et al., *supra* note 225; *Law Enforcement Naloxone Toolkit*, BUREAU OF JUS. ASSIST. (Accessed on Mar. 5, 2018) available at <https://www.bjatrainning.org/naloxone/engaging-law-enforcement-opioid-overdose-response-frequently-asked-questions>.

²⁸⁵ Daniel M. Lindberg, *EMS Response Times Are Double in Rural vs. Urban Areas*, JAMA SURG. (2017) [e-pub] available at <http://dx.doi.org/10.1001/jamasurg.2017.2230>.

²⁸⁶ Susan A. Chapman, et al., *EMS Workforce for the 21st Century: A National Assessment*, NAT'L. HIGHWAY TRAFFIC SAFETY ADMIN. 1, 39 (2008) available at http://healthandwelfare.idaho.gov/Portals/0/Medical/EMS/workforce_report_ems.pdf.

²⁸⁷ *US Law Enforcement Who Can Carry Naloxone*, N.C. HARM RED. COAL. (2018) available at <http://www.nchrc.org/law-enforcement/us-law-enforcement-who-carry-naloxone/>.

²⁸⁸ Tarlise Townsend, Freida Blostein, Tran Doan, Sammie Madson-Olson, Paige Galecki, and David Hutton, *Improving Naloxone Distribution in the Opioid Epidemic A cost-effectiveness analysis of naloxone distribution to first responders and laypeople*, ACADEMY HEALTH Annual Research Meeting June 27, 2017, available at https://academyhealth.confex.com/academyhealth/2017arm/mediafile/Presentation/Paper19853/Townsend_Naloxone_AcademyHealth.pdf (critiquing emphasis on law enforcement-based naloxone distribution programs).

²⁸⁹ David C. Lott and Jonathan Rhodes, *Opioid Overdose and Naloxone Education in a Substance Use Disorder Treatment Program*, 25(3) AM. J. ADDICT. 221, 225 (2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071651/>.

²⁹⁰ Rebecca E. Giglio, Guohua Li, & Charles J. DiMaggio, *Effectiveness of Bystander Naloxone Administration and Overdose Education Programs: A Meta-Analysis*, 2(10) INJ. EPIDEMIOLOGY 1 (2015) available at <https://link.springer.com/article/10.1186/s40621-015-0041-8>.

²⁹¹ Daniel I. Rees et al., *With a Little Help from My Friends: The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths*, NAT. BUR. OF ECON. RES. (2017) available at <http://www.nber.org/papers/w23171>.

²⁹² Jessica Reichert and Lily Gleicher, *Rethinking Law Enforcement's Role on Drugs: Community Drug Intervention and Diversion Efforts*, ICJIA (2017) available at <http://www.icjia.state.il.us/articles/rethinking-law-enforcement-s-role-on-drugs-community-drug-intervention-and-diversion-efforts>.

²⁹³ Banta-Green et al., *supra* note 220.

that many users' risk estimate is much higher than self-reported practices by police.²⁹⁴ Nevertheless, it is the public's perception that is the operative driver of behavior.

Another notable example is the Law Enforcement Assisted Diversion (LEAD)²⁹⁵ model. This intervention emerged as result of a deliberation process between criminal justice and public defender organizations imposed by a federal consent decree.²⁹⁶ The LEAD model offers police a structure for pre-arrest diversion that can be discretionarily applied to drug users and other non-violent offenders.²⁹⁷ This structure is distinct from other service linkage interventions in that it gives police the tools to facilitate access to a case manager, who then acts as a navigator for broad range of housing, job training, health, and other social services above and beyond treatment.²⁹⁸ It thus acknowledges the structural drivers of substance use.

“Knock and talk” is another example of law enforcement programs that take advantage of the fact that non-fatal overdoses are opportunities for critical intervention.²⁹⁹ A number of jurisdictions has adopted various forms,³⁰⁰ but these

²⁹⁴ Banta-Green et al., *supra* note 220; *See also* *Groundbreaking Heroin Overdose Prevention & Education (“HOPE”) Program Announced On Staten Island*, NYPD NEWS (Feb. 16, 2017) available at <http://nypdnews.com/2017/02/groundbreaking-heroin-overdose-prevention-education-hope-program-announced-on-staten-island/> (A growing number of departments are embracing these kinds of outreach activities. For instance, in the Staten Island precinct in New York, NYPD recently instituted a special unit that provides follow-up education and resources to overdose victims and their families.); *See also* Sean Horgan, 'Angel' Program Takes in First Patient, GLOUCESTER TIMES (Jun. 2, 2015) available at http://www.gloUCESTERtimes.com/heroin_epidemic/angel-program-takes-in-first-patient/article_0893fe12-0968-11e5-a5af-a316afe1daa6.html (Another innovation originating in Gloucester, MA promised amnesty from drug possession arrest to anyone who presents at the police station for help accessing treatment.) *See also* Schiff DM, Drainoni ML, Bair-Merritt M, Weinstein Z, Rosenbloom D. A police-led addiction treatment referral program in Massachusetts. *New England Journal of Medicine*. 2016 Dec 22;375(25):2502-3. *see also* *The Police Assisted Addiction and Recovery Initiative*, PAARI (2018) available at <http://paarius.org> (Numerous police departments have adopted similar discretionary schemes as part of the Police Assisted Addiction and Recovery Initiative (PAARI).)

²⁹⁵ *Law Enforcement Assisted Diversion (LEAD): Reducing the Role of Criminalization in Local Drug Control*, DRUG POL'Y ALLIANCE (Feb. 2016).

²⁹⁶ *About Lead*, LAW ENFOR. ASSIST. DIVERSION (LEAD) (Accessed on Mar. 5, 2018) available at <https://www.leadbureau.org/about-lead>.

²⁹⁷ *Id.*

²⁹⁸ *Id.*

²⁹⁹ Formica SW, Apsler R, Wilkins L, Ruiz S, Reilly B, Walley AY, *Post opioid overdose outreach by public health and public safety agencies: Exploration of emerging programs in Massachusetts*, 54 INT'L. J. OF DRUG POL. 43, 43-50 (2018); *see also* Gjersing L, Bretteville-Jensen AL. Are overdoses treated by ambulance services an opportunity for additional interventions? A prospective cohort study. *Addiction* 2015;110:1767-74.

³⁰⁰ Jennette Barnes, *New Bedford police, chaplains, counselors reach out to OD victims*, SOUTH COAST TODAY (2017) available at <http://www.southcoasttoday.com/news/20170103/new-bedford-police-chaplainscounselors-reach-out-to-od-victims>; Chris Mayhew, *Boone County starts overdose response team*, CINCINNATI ENQUIRER (2017) available at <http://www.cincinnati.com/story/news/local/boonecounty/2017/06/16/boone-county-starts->

efforts have developed organically and without formal evaluation or evidence. Expanding scope of policing is a possible downside

These efforts can offer unique benefits. Aside from positive implications for public health, police professionals often have close interaction with hard-to-reach groups that are most at risk for substance abuse and overdose.³⁰¹ They also promote operational collaboration with public health agencies, resulting in improved information sharing and other synergies.³⁰² In addition to direct public health benefits, police overdose response, public education, and referral programs can help improve trust, build legitimacy, and boost community relations.³⁰³

All of these innovations occurred in the context of broader criminal justice reform. The last decade has been characterized by a gradual bipartisan move in numerous jurisdictions away from the philosophy of harsh punishment and incarceration.³⁰⁴ This has included sentencing reforms, such as repealing mandatory minimums and three-strikes laws, as well as reducing the disparity in penalties for powder cocaine vis-a-vis crack.³⁰⁵ It has also included clemency and pardon for individuals incarcerated on drug-related charges.³⁰⁶

Drug courts represent one additional mechanism. In taking on addiction as part of the drug court system, jurists are basically taking on the role of medical professionals, which they are not technically licensed to do nor are most of them equipped to do. The results are tragic, as what has resulted is highly undesirable

[overdose-response-team/404410001/](https://www.washingtonpost.com/national/as-opioid-overdoses-rise-police-officers-become-counselors-doctors-and-social-workers/2017/03/12/85a99ba6-fa9c-11e6-be051a3817ac21a5_story.html%3Futm_term=.c2afe69c7454?utm_term=.e6320a067b48); Katie Zezima, *As opioid overdoses rise, police officers become counselors, doctors and social workers*, THE WASHINGTON POST (2017) available at https://www.washingtonpost.com/national/as-opioid-overdoses-rise-police-officers-become-counselors-doctors-and-social-workers/2017/03/12/85a99ba6-fa9c-11e6-be051a3817ac21a5_story.html%3Futm_term=.c2afe69c7454?utm_term=.e6320a067b48.

³⁰¹ Seema L. Clifasefi and Susan Collins, *LEAD Program Evaluation: Describing LEAD Case Management in Participants' Own Words*, HARM RED. RES. TREAT CEN. (2016) available at http://static1.1.sqspcdn.com/static/f/1185392/27320150/1478294794537/Specific-Aim-4-FINAL_UW-LEAD-Evaluation-Qualitative-Report-11.1.16_updated.pdf?token=4F5CJICgNKMr3PCXx5JnZAnD23Jg%3D.

³⁰² *Id.*

³⁰³ Diane Goldstein, *Harm Reduction Can Help to Heal Law Enforcement's Rift With the Public*, SUBSTANCE (Jan. 12, 2015) available at <https://www.substance.com/harm-reduction-can-help-to-heal-law-enforcements-rift-with-the-public/19290/>.

³⁰⁴ Joycelyn Pollock, Steven Glassner, & Andrea Krajewski, *Examining the Conservative Shift from Harsh Justice*, 4 LAWS 107, 107-8 (2015) available at <http://www.mdpi.com/2075-471X/4/1/107/pdf>

³⁰⁵ See generally Michael Tonry, *Remodeling American Sentencing A Ten-Step Blueprint for Moving Past Mass Incarceration*, 13 CRIM. & PUBLIC POL'Y 504 (2014).

³⁰⁶ Ryan Reily, *Obama Grants Clemency For Drug Offenders, Including Four Who Were Set To Die Behind Bars*, HUFF. POST (Dec. 18, 2014) available at https://www.huffingtonpost.com/2014/12/17/obama-clemency-drug-defendants_n_6343722.html; See also Allie Malloy, *Obama Grants Clemency to 231 Individuals, Largest Single Day Act*, CNN (Dec. 20, 2016) available at <https://www.cnn.com/2016/12/19/politics/obama-clemency/index.html>.

from a health care and public health perspective. For example, many drug courts mandate that to be classified as “clean,” individuals are not on opioid maintenance therapy including medications like methadone and buprenorphine.³⁰⁷ These medications are FDA approved to treat opioid addiction and are the gold standard for such treatment, but evidently do not comport with what many drug court judges and administrators consider abstinence. Similar issues apply to other drugs that those under drug court supervision may be taking to address behavioral or mental health issues. This hampers the ability of individuals to follow the orders of actual medical professionals, resulting in substance misuse relapse, untreated mental health issues, and higher risk of overdose.

This folly in the drug court system has received considerable (though perhaps niche) attention as of late³⁰⁸ and there has been positive progress towards creating some semblance of standardization through the announcement earlier this year of federal requirements for courts to acquiesce to opioid maintenance therapy³⁰⁹ or risk losing federal funding, as well as a legislation in New York State with similar objectives.³¹⁰ The bottom line is that most these courts have done a very poor job of actually doing what they purport to be doing, which is helping those affected by addiction get the help those individuals need and deserve.

Ultimately, these innovations have certainly expanded the traditional criminal justice toolkit towards policies and practices closer aligned with public health

³⁰⁷ Marianne Møllmann and Christine Mehta, *Neither Justice nor Treatment: Drug Courts in the United States*, PHYSICIANS FOR HUMAN RIGHTS (2017) available at http://physiciansforhumanrights.org/assets/misc/phr_drugcourts_report_singlepages.pdf.

³⁰⁸ Jason Cherkis, *Dying To Be Free*, HUFFPOST (2015) available at <http://projects.huffingtonpost.com/dying-to-be-free-heroin-treatment>; Steven W. Varney JD, *Practicing Medicine Without A License: Medication-Assisted Treatment in the Courts*, THE FIX (2015) available at <https://www.thefix.com/practicing-medicine-without-license-medication-assisted-treatment-courts>.

³⁰⁹ Ryan Grim and Jason Cherkis, *Federal Government Set To Crack Down On Drug Courts That Fail Addicts*, HUFFPOST (2015) available at http://www.huffingtonpost.com/2015/02/05/drug-courts-suboxone_n_6625864.html.

³¹⁰ Ryan Grim and Jason Cherkis, *New York Law Blocks Judges From Practicing Medicine From The Bench*, HUFFPOST (2015) available at http://www.huffingtonpost.com/entry/common-sense-wins-in-ny_us_560ae76ce4b0dd8503097d54; See also Ojmarrh Mitchell et al., *Assessing the Effectiveness of Drug Courts on Recidivism: A Meta-Analytic Review of Traditional and Non-traditional Drug Courts*, 40 J. CRIM. JUST. 60 (2012) available at <https://jpo.wrlc.org/bitstream/handle/11204/1390/Assessing%20the%20Effectiveness%20of%20Drug%20Courts%20on%20Recidivism.pdf?sequence=3> (In the very rare instances (approximately 5%) that drug courts are used to promote evidence-based treatment modalities, they represent another possible criminal justice intervention in a shift away from incarceration towards service and support.); See also Erica Webster, *Proposition 47 Savings: Reinvest in California's Communities*, CNT ON JUVENILE AND CRIM. JUST. (2016) available at <http://www.cjcj.org/news/10052>; *Criminal Sentences. Misdemeanor Penalties*, Cal. Legis. Serv. Sec. 2, Prop. 47 (2014) (This movement has also included more holistic reforms such as California's Proposition 47 and 64, which reinvest savings from criminal justice reforms and de-incarceration in community-based health and social services.)

goals.³¹¹ Despite their symbolic and rhetorical importance, however, these changes have been relatively marginal and fragile.³¹² With the exception of substantial state policy shifts on marijuana and limited immunity provisions described above, the basic policy regime for drug control has remained intact.³¹³

Importantly, some of the most celebrated “public health approach” modalities within the criminal justice sector are relatively fragile because they are contingent on informal, institutional policy changes, rather than concrete reforms in black letter law.³¹⁴ Without a major public opinion shift to the predominant stigmatizing view of substance use, institutional architecture founded on coercive and punitive criminal justice approaches has remained in place.³¹⁵ Although government budgets saw some shifts towards harm and demand reduction, the enormous outlays on supply-side interventions and correctional costs have continued to dwarf these public health investments.³¹⁶

Despite these positive developments, the overarching framework remains the same. The failure to translate evidence into policy has meant that law—especially criminal law—and its enforcement is a major structural barrier to the deployment of proven public health strategies. The major reason for the failure to implement SFCs in the United States remains their posture vis-a-vis the Controlled Substances laws on both federal and state levels.³¹⁷

Even in the presence of limiting legal frameworks, enforcement discretion can provide space for considerable policy flexibility. Invested with the power to make such innovation possible, however, law enforcement professionals have often deployed it to retard overdose prevention and other harm reduction measures.

³¹¹ See Gifto and Tesema, *supra* note 252.

³¹² *Id.*

³¹³ *Id.*

³¹⁴ *Id.*

³¹⁵ *Id.*

³¹⁶ See Gifto and Tesema, *supra* note 252; see also Jim Parsons, *Minimizing Harm: Public Health and Justice System Responses to Drug Use and the Opioid Crisis*, VERA INSTITUTE (2017) available at https://storage.googleapis.com/vera-web-assets/downloads/Publications/for-the-record-public-health-justice-system-responses-opioid-crisis/legacy_downloads/Minimizing-Harm-Evidence-Brief.pdf

³¹⁷ Therese Fitzgerald, *Establishment of a Pilot Medically Supervised Injection Facility in Massachusetts*, MASS MED. SOC. (2017) available at <https://www.massmed.org/advocacy/state-advocacy/sif-report-2017/>;

Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in the United States*, 98(2) *AJPH* 231, 231-237 (2008); Bobby Allyn, *Wolf's reluctance to back Philly injection site leaves door open to U.S. crackdown*, WHYY (2018) available at <https://whyy.org/segments/wolfs-reluctance-to-back-philly-injection-site-keeps-door-open-to-u-s-crackdown/>; As matters stand, 29 states criminalize syringe possession, with only 11 of these states carving out exemptions for SEP and other syringe access measures. Similarly, policies governing methadone and buprenorphine access provide considerable barriers, including the fact that methadone maintenance is not covered by 16 states' Medicaid programs and no Medicare program covers this life-saving drug.

Prosecutors have spoken out against SIFs, parroting other politicians who have claimed—falsely—that the evidence base behind SCFs does not exhibit benefit sufficient for their deployment in the US.³¹⁸

Despite some positive developments noted above, police departments have opposed evidence-based measures like SEPs and SCFs as matters of both policy and practice. For instance, the Huntington, West Virginia police department has recently effectively shut down the syringe exchange program in that hard-hit city by placing untenable policy requirements;³¹⁹ a similar paradigm is underway in Orange County, CA and many other locales across the US. More broadly, law enforcement activities are understood as a major structural barrier to harm reduction measures in the realm of access to evidence-based drug treatment; syringe access; and naloxone access efforts.³²⁰

But perhaps the most vivid illustration of the flawed operationalization of the “public health approach” has been the expansion in scope of drug-induced homicide laws and prosecutions.³²¹ Although these measures are billed as overdose prevention, they lack the requisite elements incumbent on public health measures, namely evidence, or at the very least, solid promise, of positive impact.

III. DRUG-INDUCED HOMICIDE: AN INTERDISCIPLINARY CRITIQUE

The implied mission of criminal justice professionals and institutions is to safeguard the constituencies they serve.³²² Same goes for elected and administrative policymakers.³²³ Significant threats to that safety create a strong

³¹⁸See Bobby Allyn *supra* note X.

³¹⁹ *KCHD questions audit that ended needle exchange program certification*, WSAZ (2018) available at <http://www.wsaz.com/content/news/WSAZ-Investigates-Needles-Everywhere-474520733.html>

³²⁰See Leo Beletsky, et al, *Police Encounters Among Needle Exchange Clients in Baltimore: Drug Law Enforcement as a Structural Determinant of Health*. *American Journal of Public Health*. 2015;105(9):1872-9; See also Beletsky, Choice Architecture *supra* note X; See also Sonia Mendoza et al., *Shifting blame: Buprenorphine prescribers, addiction treatment, and prescription monitoring in middle-class America*, 53 *TRAN. PSYCH.* 465, 465-487 (2016) available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5540139/>.

³²¹ Jessica Eaglin calls this “Justices Expanding Reach”.

³²² *Mission & Priorities*, FBI (Accessed on Mar. 12, 2018) available at <https://www.fbi.gov/about/mission>; *Mission Statement*, N.J. STATE POLICE, (Accessed on Mar. 12, 2018) available at <http://www.njsp.org/about/mission-statement.shtml>; *Mission*, DEP’T. HOME. SEC. (Accessed on Mar. 12, 2018) available at <https://www.dhs.gov/mission>; *Who We Serve*, MASS. STATE POL. (Accessed on Mar. 12, 2018) available at <https://www.mass.gov/orgs/massachusetts-state-police>; *Who We Serve*, OFFICE OF ATT. GEN. MAURA HEALEY (Accessed on Mar. 12, 2018) available at <https://www.mass.gov/orgs/office-of-attorney-general-maura-healey>.

³²³ *Constituent Services*, MARCO RUBIO (Accessed on Mar. 12, 2018) available at <https://www.rubio.senate.gov/public/index.cfm/services>; *Find Assistance*, ELIZABETH WARREN,

impetus to mount decisive and remedial action, using persuasive policy narratives and resonant tropes. Such action is shaped by the choice architecture,³²⁴ where incentives can represent public approval, financial resources, and the legal and institutional policy environment.

When faced with the mounting death toll from opioid overdose, some criminal justice systems and professionals have innovated by adopting novel approaches, policies, and rhetorical tools.³²⁵ Change has been limited and largely symbolic, however, the overall choice environment has continued to offer a much clearer path to punitive responses.³²⁶ Pertinent to this article are legal provisions and their deployment against individuals who supply drugs to overdose victims. After defining them, I interrogate the deployment of these instruments from both theoretical and empirical perspectives.

A. Drug-induced Homicide: The Legacy of Len Bias

When Congress first enacted the Controlled Substances Act in 1970, section 401 establishing penalties for the distribution of controlled substances included no special “death results” enhancement.³²⁷ Nevertheless, concerns about heroin overdose did figure in the legislative debate about the law, with special concern about metropolitan youth, for whom heroin overdose was then one of the leading causes of death.³²⁸

As often happens in policymaking, impetus for reform came from an especially visible and shocking event. In 1986, a widely-admired rising basketball star Len Bias died of a cocaine overdose just two days after he had been drafted into the NBA.³²⁹ Set within the context of unfolding concern over crack in American inner-city, the “public outcry” about Bias’ death motivated the drafting of the new death results enhancement.³³⁰ It was this provision—§841(b)(1)(C)—that federal prosecutors would years later use to charge Marcus Burrage.³³¹

States would soon follow in adopting analogous instruments. Today, almost half U.S. state jurisdictions have a specific statute to facilitate drug-induced homicide

(Accessed on Mar. 12, 2018) available at <https://www.warren.senate.gov/services/findassistance>

³²⁴ Richard H. Thaler and Cass R. Sunstein, *Nudge: Improving Decisions about Health, Welfare, and Happiness* (2008).

³²⁵ See Giftos and Tesema, *supra* note 252.

³²⁶ *Id.*

³²⁷ *Brief for the United States*, *supra* note 3, at 3.

³²⁸ *Brief for the United States*, *supra* note 3, at 3.

³²⁹ Polcyn and Davis, *supra* note 167. (providing a picture of Bias on the cover of *Sports Illustrated* magazine, with the headline “Death of the Dream”).

³³⁰ *Brief for the United States*, *supra* note 3, at 3; See also Polcyn and Davis, *supra* note 167.

³³¹ See *Burrage v United States*, *supra* note 2.

prosecutions.³³² Although they all use an analogous instrumental framework, these provisions use a variety of criminal law constructs, including felony-murder,³³³ depraved heart offenses,³³⁴ or involuntary or voluntary manslaughter.³³⁵ At the extreme end of the punitive spectrum, there are first-degree murder provisions like West Virginia's which imposes sentences up to life in prison, and are eligible

³³² As of this writing, extant statutes include: Alaska (Alaska Stat. § 11.41.120(a)(3)); Colorado (Colo. Rev. Stat. § 18-3-102(e)); Florida (Fla. Stat. § 782.04(1)(a)(3)-(4)); Illinois (720 Ill. Comp. Stat. 5/9-3.3); Louisiana (La. Rev. Stat. Ann. § 14:30.1(3)); Michigan (Mich. Comp. Laws Ann. § 750.317a); Minnesota (Minn. Stat. § 609.195(b)); New Hampshire (N.H. Rev. Stat. Ann. § 318-B:26(IX)); New Jersey (N.J. STAT. ANN. § 2C:35-9); North Carolina (N.C. Gen. Stat. Ann. § 14-17(b)(2)); Pennsylvania (18 Pa. Cons. Stat. Ann. § 2506); Rhode Island (R.I. Gen. Laws § 11-23-6) (only applies to drug delivery to a minor); Tennessee (Tenn. Code Ann. § 39-13-210(a)(2)); Vermont (Vt. Stat. Ann. tit. 18, § 4250); Washington (Wash. Rev. Code Ann. § 69.50.415); West Virginia (W. Va. Code Ann. § 61-2-1, *State v. Jenkins*, 729 S.E.2d 250, 229 (W.Va. 2012) (death resulting from an overdose of a controlled substance and occurring in the commission of or attempt to commit a felony offense of manufacturing or delivering such controlled substance, subjects the manufacturer or deliverer of the controlled substance to the felony murder rule); Wisconsin (Wis. Stat. § 940.02(2)(a)); Wyoming (Wyo. Stat. Ann. § 6-2-108). Statutes also being utilized California (Cal. Penal Code § 192) (Involuntary manslaughter); Connecticut (Conn. Gen. Stat. Ann. § 53a-56); Georgia (Ga. Code Ann. § 16-5-3); Indiana (Ind. Code Ann. § 35-42-1-5); Iowa (Iowa Code Ann. § 707.5); Kentucky (Ky. Rev. Stat. Ann. § 507.050, *Lofthouse v. Com.*, 13 S.W.3d 236, 238 (Ky. 2000) (guilt of criminal homicide for furnishing controlled substances to one who subsequently dies from their ingestion depends upon proof)); Massachusetts (Mass. Gen. Laws Ann. Ch. 265 § 13, *Commonwealth v. Catalina*, 407 Mass. 779, 791, 556 N.E.2d 973 (1990) (person who furnishes drug to another, who voluntarily consumes it and dies as a result, may be liable for manslaughter because consumption of the drug was a foreseeable consequence of his actions); Maryland (Md. Code Ann., Crim. Law § 2-207); Missouri (Mo. Ann. Stat. § 565.024); Nevada (N.R.S. § 200.070, *Sheriff, Clark Cty. v. Morris*, 99 Nev. 109, 111, 659 P.2d 852, 854 (1983) (in context of unlawful sale of controlled substances resulting in death, second-degree felony-murder rule may be premised on either felonious intent provision or unlawful act); New York (N.Y. Penal Law § 125.10 & § 125.15); North Dakota (N.D. Cent. Code Ann. § 12.1-16-02); Ohio (Ohio Rev. Code Ann. § 2903.04); Texas (Tex. Penal Code Ann. § 19.02); Virginia (Va. Code Ann. § 18.2-33)

³³³ Fla. Stat. § 782.04(1)(a)(2)-(3).

³³⁴ Arelis R. Hernandez, *Selling opioids in this rural Maryland county could get you a murder charge*, THE WASHINGTON POST (Aug. 9, 2017) available at https://www.washingtonpost.com/local/md-politics/selling-opioids-in-this-rural-maryland-county-could-get-you-a-murder-charge/2017/08/09/cd3d3830-7d30-11e7-83c7-5bd5460f0d7e_story.html?utm_term=.b8bf821703bb; John Warton, *Jurors Deliberate Charges From St. Mary's Overdose Death*, CALVERT REC. (Oct. 26, 2017) http://www.somdnews.com/recorder/spotlight/jurors-deliberate-charges-from-st-mary-s-overdose-death/article_0c79fcd6-096f-501f-a1c3-45cceb1dc574.html; Alison Knezevich, *Maryland Prosecutors Pursue Manslaughter, Murder in Overdose Cases*, THE BALTIMORE SUN (Dec. 7, 2017) available at <http://www.baltimoresun.com/news/maryland/crime/bs-md-overdose-prosecutions-20171114-story.html>.

³³⁵ See Siegel *supra* 31; Maria Cramer, *Lynn Drug Dealer Convicted of Involuntary Manslaughter in Overdose Case*, BOSTON GLOBE (Sept. 28, 2017), available at <https://www.bostonglobe.com/metro/2017/09/28/drug-dealer-convicted-involuntary-manslaughter-overdose-case/wfeX2uhY0qFZ3HpAiEZzIO/story.html>; See also, Krsity Steward, *Man Who Mailed Heroin to 2 Who Died of Overdoses, Sentenced for Involuntary Manslaughter*, WLOS NEWS (Jan 17, 2017) available at <http://wlos.com/news/local/man-who-sold-heroin-to-two-who-died-of-overdoses-sentenced-for-involuntary-manslaughter>

for the death penalty.³³⁶

All of these provisions are in whole, or in part, strict liability statutes, presumably under the rationale that death from consumption of illicit substances is always foreseeable.³³⁷ None of the state or federal provisions require a financial exchange take place or carve out small-time dealers or fellow users from prosecution; those being charged with an underlying trafficking charge involving higher drug quantities may face stiffer penalties.³³⁸

In the context of the overdose crisis, an increasing number of jurisdictions have proposed entirely new, or enhanced drug-induced homicide provisions to add to their arsenal. The number of such proposals has more than doubled from three in 2012 to seven in 2016.³³⁹ Although none of the proposed statutes have yet been enacted, three of the proposed laws included special provisions mentioning fentanyl.³⁴⁰

B. Trends in Deployment of Drug-induced Homicide Prosecutions

Aside from the surging policy reform push, there have been concerted efforts to disseminate the prosecutorial strategy across the country. For instance, prosecutors have led workshops focused on how to conduct overdose death scene investigations to work up drug-induced homicide charges.³⁴¹ Similar instruction was offered through the High Intensity Drug Trafficking Area network (HIDTA) supported by the national Office of Drug Control Policy (ONDCP).³⁴² The U.S.

³³⁶ W. Va. Code Ann. § 61-2-1; There have been no death penalty sentences handed out in these cases.

³³⁷ *Commonwealth v. Catalina*, 556 N.E.2d 973 (Mass. 1990) (individual who provides a drug to a victim who then voluntarily consumes it and dies as a result, may be liable for manslaughter because consumption by the victim was foreseeable). Under the felony murder framework, the culpable mental state for the underlying crime “transfers” to the death and there is no need for independent malice. Therefore, purposefully selling a dangerous drug means you absorb the risks of that drug. But many states have abandoned the “pure” felony murder rule.

³³⁸ Lindsay LaSalle, *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*, DRUG POLICY ALL. (2017) available at http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf (describes financial exchange provisions and the structure of each state’s statute).

³³⁹ NY A.B. 8616 (2015), OH H.B. 270 (2015), IL S.B. 639 (2017), UT H.B. 309 (2018), IN S.B. 357 (2018), SC S.B. 83 (2017), and VA S.B. 66 (2016).

³⁴⁰ Andrew O’Reilly, *Drug Dealers Would Face Manslaughter Charges for Opioid Overdoses under Proposed Florida law*, FOX (Mar. 9, 2017), available at <http://www.foxnews.com/us/2017/03/09/drug-dealers-would-face-manslaughter-charges-for-opioid-overdoses-under-proposed-florida-law.html>.

³⁴¹ Patricia Daugherty, Nick Stachula, *Drug-Related Homicides: Investigative and Prosecutorial Strategies*, Police Department Law Enforcement Track, Rx and Heroin Summit Atlanta, Ga (2017).

³⁴² *Drug Related Homicides: Investigative and Prosecutorial Strategies*, HIDTA (2017) available at

Department of Justice specifically recommended prosecuting heroin dealers in cases of overdose by more actively utilizing the “death results” enhancement that was used in *Burrage*.³⁴³ In addition to these dissemination strategies, the infrastructure for these investigations has increasingly been reliant on interagency “task forces,” which have been funded by both criminal justice and public health funds earmarked for overdose crisis response.³⁴⁴

The principal supposed impact channel for the deployment of drug-induced homicide deployment is informational. It is no accident that “sending a message” is the stated legislative and prosecutorial objective of these instruments and their applications.³⁴⁵ This is why lawmakers, prosecutors and law enforcement officials package their policy narratives about these laws and prosecutions into press materials³⁴⁶ and hold high-profile press conferences³⁴⁷ when discussing drug-induced homicide charges and convictions. Whatever the eventual impact of the message, mass media plays a vital function in delivering this message to its audiences.³⁴⁸ Before proceeding to critique this approach it is worth assessing the intensity and content of these signals.

Accurate quantification of the actual deployment of these provisions is limited by a number of factors.³⁴⁹ In this article, I use as a proxy an analysis of online news

<http://ncric.org/files/EBF/Drug%20Related%20Homicides%2010172017%20San%20Ramon.pdf>.

³⁴³ US Department of Justice, National Heroin Taskforce: Final Recommendations (2015) available at <https://www.justice.gov/file/822231/download>.

³⁴⁴ Joseph Walker, *Prosecutors Treat Opioid Overdoses as Homicides, Snagging Friends, Relatives*, WSJ (2017) available at <https://www.wsj.com/articles/prosecutors-treat-opioid-overdoses-as-homicides-snagging-friends-relatives-1513538404>

³⁴⁵ See, e.g. note 14 *supra* and accompanying text.

³⁴⁶ See, e.g. U.S. Attorney’s Office, Southern District of New York, Department of Justice, *Sullivan County Man Sentenced In White Plains Federal Court To Over 21 Years In Prison For Distribution Of Heroin And Fentanyl Causing The Death Of An Individual* (2016), available at <https://www.justice.gov/usao-sdny/pr/sullivan-county-man-sentenced-white-plains-federal-court-over-21-years-prison>.

³⁴⁷ U.S. Attorney’s Office, Southern District of New York, Department of Justice, *Manhattan U.S. Attorney And NYPD Commissioner Announce Charges Against Narcotics Dealer Responsible For Heroin And Fentanyl Overdose Death* (2016), available at <https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-and-nypd-commissioner-announce-charges-against-narcotics-dealer>.

³⁴⁸ Lauren Krisal, *The Media Narrative Around Drug Use is Shifting, But the Harsh Policies for Drug Crimes are Not*, REASON (Feb. 21, 2016) available at <http://reason.com/blog/2016/02/21/the-media-narrative-around-heroin>; see also Stone, *supra* note X, at 158-9.

³⁴⁹ First, it is important to identify the correct variable of interest—one could consider the number of individuals convicted, charged, or arrested on suspicion of these crimes. Each of these sources is problematic. Published cases are easiest to track, but only a small proportion of state-level criminal convictions are published. In addition, there is substantial variability in publication selection criteria among jurisdictions. There is no centralized dataset to enable tracking the number of charge filings, arraignments, and other procedural steps in the criminal process; such undertaking is unworkable for the purposes of this article.

trends between 2000 and 2016. Although not always optimal in presenting a generalizable picture of real-world events, big data techniques analyzing online informational ecosystems are being used with increasing frequency and precision. The utilization of these techniques to track the deployment of a prosecutorial strategies is novel, however, and—to my knowledge—is being used in a law review article for the first time.

Based on the review of existing literature, the incidence of drug-induced homicide deployments has risen sharply since 2010.³⁵⁰ Predictably, the rise is especially notable in jurisdictions hard-hit by the overdose crisis, like those in Oregon,³⁵¹ New Jersey, New York State,³⁵² and Wisconsin (where their number doubled between 2012 and 2013).³⁵³ In many jurisdictions, it is enough to have simply shared a small amount of your drugs with the deceased to be prosecuted for homicide.

This signaling element makes media reports a key proxy for deployment of drug-induced homicide instruments. We conducted systematic news report searches mentioning key search terms³⁵⁴ for each year between 2000 and 2016. Manual review was conducted with each positive hit to avoid Type I error and code each entry on a set of characteristics, including state, relationship of the accused to the overdose victim, drugs implicated, and whether the story specified the resolution of the case. Since the dataset focused on online news reports, this information reflects a subsample of all media coverage. Analysis of these data confirm that the deployment of—and informational environment pertaining to—drug-induced homicide prosecutions has substantially shifted between 2000 and 2016.³⁵⁵

Between 2000 and 2006, online media coverage ranged from just a few articles annually, then beginning a sharp upward trend in 2009, increasing to a total of at least 43 related news articles in 2016 (see Figure 1).³⁵⁶ This spike in prosecutions mentioned coincided with sharp rises in overdose fatalities, and prescription opioid overdoses had just begun to enter the national conversation.³⁵⁷ The following sharp rise in drug homicide prosecutions closely mirrors the exploding

³⁵⁰ See LaSalle *supra* note X.

³⁵¹ Les Zaitz, *Drug Cartels in Oregon: 'Len Bias' Strategy a Potent Tool for Law Enforcement*, OREGON LIVE (Jun. 21, 2013) available at <http://www.oregonlive.com/pacific-northwest-news/index.ssf/2013/06/drug-cartels-in-oregon-len-bia.html>.

³⁵² U.S. Attorney's Office, *supra* note 285.

³⁵³ Polcyn and Davis, *supra* note 167.

³⁵⁴ See Appendix 1 for detailed methodology.

³⁵⁵ *Drug-Induced Homicide Charges (2000-2017)*, HEALTH IN JUS. (2018) available at <https://www.healthinjustice.org/time-trends>.

³⁵⁶ *Id.*

³⁵⁷ Holly Hedegaard, Li-Hui Chen, & Margaret Warner, *Drug-Poisoning Deaths Involving Heroin: United States, 2000–2013*, NCHS DATA BRIEF NO. 190 (2015), available at <https://www.cdc.gov/nchs/data/databriefs/db190.pdf>.

rates of heroin overdose deaths, and the resulting calls for solutions.³⁵⁸

Many of the states hardest hit by this surge in overdose fatalities, have also embraced drug-induced homicide prosecutions. Within my analysis, Ohio, which has seen 4,329 overdose deaths in 2016 alone,³⁵⁹ ranked as the leader in prosecutions, followed by Louisiana and Minnesota with 16 online media mentions.³⁶⁰ Both states have similarly been struggling to curb rising overdose mortality rates.

In addition to these geographic trends, my analysis considered the nature of the relationship between the accused and the deceased. Data suggests that half (107) of those charged with drug-induced homicide were not, in fact, “dealers” in the traditional sense but friends and partners to the deceased (see Figure 2). This contradicts the modal policy narrative, which frames these laws as a crucial overdose prevention mechanism for combating drug dealers as a way to control the opioid supply. However, bringing these cases to conviction requires a close nexus between the accused and the deceased,³⁶¹ as well as a relatively quick resolution to respond to community pressure. Thus, these prosecutions often ensnare those who are closest to the deceased, such as the partners, co-workers and friends.

Several cases illustrate the absurdity of such charges especially vividly. Consider the recent prosecution (August 2016) of Caleb Smith of Williamsport, Pennsylvania; Smith gave his girlfriend what he thought was a stimulant, but the drug turned out to be illicitly-manufactured fentanyl.³⁶² Feeling the weight of the charge, which carried a 20-year mandatory minimum sentence, Smith killed himself. He had no prior criminal history.³⁶³ Consider also that, in August 2017, Richard Gaworecki of Union, New York, was charged with criminally negligent homicide for selling a high school friend a bag of heroin that caused his fatal overdose.³⁶⁴ A local attorney familiar with that case told media that Gaworecki was

³⁵⁸ *Id.*

³⁵⁹ *Drug-Induced Homicide*, HEALTH IN JUST. (2018) available at <https://www.healthinjustice.org/geography>.

³⁶⁰ *Drug-Induced Homicide*, HEALTH IN JUST. (2018) available at <https://www.healthinjustice.org/visualize>.

³⁶¹ Demonstrating the chain of custody, but for causation, and other elements depending on the statutory design makes it unlikely that anyone but the most proximate link in the drug supply chain could be convicted. However, law enforcement can use the provisions to upcharge.

³⁶² Zachary Siegel, *Death by Prosecution: Was There a Bigger Player in Drug Case Involving Man Who Killed Himself After Federal Indictment?*, INJUSTICE TODAY (2018) <https://injusticetoday.com/murder-by-prosecution-was-there-a-bigger-player-in-drug-case-involving-man-who-killed-himself-724c2ad3e4f6>

³⁶³ *Id.*

³⁶⁴ See Zachary Siegel, *In an Upstate New York Community Wracked by Overdoses, Prosecutor Pursues Users in Homicides Cases*, INJUSTICE TODAY (2018) available at <https://injusticetoday.com/in-an-upstate-new-york-community-wracked-by-overdoses-prosecutor-pursues-users-in-homicides-cases-a0a9f473aaa8>,

selling small amounts of heroin to friends to financially support his own addiction.³⁶⁵ There are numerous similarly-tragic and senseless examples of drug-induced homicide prosecutions ensnaring partners, co-users, and others whose role in the illegal drug supply chain is incidental at best.³⁶⁶

In our dataset, of the 47% of the cases that do involve drug distribution by a “traditional” dealer, half (43) of the individuals were either Black or Hispanic, and selling to a white drug user.³⁶⁷ These statistics are not reflective of the racial demographics of the United States,³⁶⁸ nor drug dealers as a population.³⁶⁹ In view of that context, my findings suggest that drug-induced homicide charges are being selectively and disproportionately deployed to target people of color. This disparate application can further reinforce already dire racial disparities, particularly in the enforcement of drug laws and the length of sentencing for drug-related crimes.³⁷⁰ This is especially notable, given that findings reflect sentencing for people of color to be more than two years longer, on average, than for whites (see Figure 3).³⁷¹

To understand the extent to which this dataset of 263 online media mentions was reflective of the entire ecosystem of drug-induced homicide cases, I triangulated this sample with Pennsylvania’s state court records for 2016. While only 7 cases in Pennsylvania received online news coverage in 2016, state records reveal 89 prosecutions in the year alone.³⁷² This indicates that the extent to which these provisions are being utilized nationally is far greater than the reflected in the online news database.³⁷³

³⁶⁵ *Id.*

³⁶⁶ Zachary Siegel, INJUSTICE TODAY (2018) available at <https://injusticetoday.com/despite-public-health-messaging-law-enforcement-increasingly-prosecutes-overdoses-as-homicides-84fb4ca7e9d7>

³⁶⁷ Where race data was available. This also ties in with research on “race of victim” effect in capital charging.

³⁶⁸ Sonya Rastogi et al., *The Black Population: 2010*, U.S. CENSUS BUREAU (2011) available at <https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>.

³⁶⁹ Christopher Ingraham, *White People are More Likely to Deal Drugs, But Black People are More Likely to Get Arrested for It*, WASH. POST (Sept. 30, 2014), available at https://www.washingtonpost.com/news/wonk/wp/2014/09/30/white-people-are-more-likely-to-deal-drugs-but-black-people-are-more-likely-to-get-arrested-for-it/?utm_term=.f91f6c746800.

³⁷⁰ Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, HUMAN RIGHTS WATCH (2009) available at <https://www.hrw.org/news/2009/06/19/race-drugs-and-law-enforcement-united-states>.

³⁷¹ *Rates of Convictions (2000-2017)*, HEALTH IN JUS. (2018) available at <https://www.healthinjustice.org/dih-case-elements>.

³⁷² The Unified Judicial System Of Pennsylvania, *Drug Delivery Resulting in Death Citations at Five-year High* (2018) available at <http://www.pacourts.us/news-and-statistics/news?Article=959>; Comparing the total number of drug induced homicide cases filed in Pennsylvania, local media rarely covered them. So far, analyses tracking the uptick in cases have only analyzed media reports, which means they are happening at a much higher frequency than we so far documented.

³⁷³ *Drug-Induced Homicide Charges (2000-2017)*, HEALTH IN JUS. (2018); Our system of tracking

Now that I have established the trajectory and key elements of these interventions, I turn to a discussion the theoretical and empirical elements to estimate their probable impact. Such impact has never been evaluated empirically.

C. Mapping Drug-Induced Homicide onto Intended Objectives of Criminal Law

i. Deterrence

The primary objective stated by the vast majority of legislators and law enforcement is one of deterrence: to put drug dealers on notice in order to nudge—or scare—them away from black market activity (or, in case of substance-specific provisions, away from certain black-market activity), thus averting future harm.³⁷⁴ The operative mechanism for this intervention is the severity of punishment (typically mandated by the statute) imposed for supplying drugs to overdose victims.³⁷⁵

There is a rich literature on the impact of punishment in general, and mandatory minimums in particular on criminal behavior.³⁷⁶ This literature suggests that the signaling intended in the drafting and application of these harsh provisions fails, for several reasons. First, the Law and Economics model of criminal punishment conceptualizes the deterrent effect to be a function of penalty's severity and the individual's perceived risk of getting caught.³⁷⁷ Literature suggests that the drug dealers' actual risk of apprehension is very low, but that their perception of being apprehended also under-estimates this already low risk.³⁷⁸

Second, in order for the deterrence effect to become operational under the Law and Economics model, there must be a stable and transparent informational

drug-induced homicide cases is being automated and will continue updating visual analyses of these cases on www.healthinjustice.org going forward.

³⁷⁴ John H. Tucker, *Angela Halliday was a Junkie. Does That Make her a Murderer?*, RIVERFRONT TIMES (Aug. 4, 2011) <https://www.riverfronttimes.com/stlouis/angela-halliday-was-a-junkie-does-that-make-her-a-murderer/Content?oid=2495594>, (Madison County's State Attorney states, "We intend to absolutely make an example of these people in public. I want to scare people from getting into this.")

³⁷⁵ Sally Quillian Yates, *Addressing the Heroin and Opioid Crisis*, 64(5) U.S. ATTORNEY'S BULL. (2016) available at <https://www.justice.gov/usao/file/895091>.

³⁷⁶ Michael Tonry, *The Mostly Unintended Effects of Mandatory Penalties: Two Centuries of Consistent Findings*, 38 CRIME & JUS. 65 (2009).

³⁷⁷ Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76(2) J. POL. ECON. 169, 180-84 (1968) available at https://link.springer.com/chapter/10.1007/978-1-349-62853-7_2.

³⁷⁸ *Public Safety Aspects of the Heroin Abuse Epidemic*, PEW CHARITABLE TRUSTS (2015) available at <http://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2015/07/public-safety-aspects-of-the-heroin-abuse-epidemic>.

environment about the components of the penalty calculus.³⁷⁹ The imposition of the drug-induced homicide provisions depends on several nested events, each with an unknown (and unknowable) probabilistic setting.³⁸⁰ This includes the probability that the drug provided will cause an overdose, whether the overdose will be fatal, whether the toxicology will identify the drug, and link it to the dealer. Each of these nested probabilities is neither stable nor transparent. For instance, the vast majority of overdoses are due to polydrug toxicity.³⁸¹ Even if the dealer could predict the risk profile of their own product, they have no way of predicting what other substances the user may consume at a later time and how these substances may interact with the product.

Another source of uncertainty is related to the structure and function of the criminal justice system, which makes the possible punishment remote and unlikely, in contrast to being swift and certain—which are suggested by behavioral theory to be crucial to interventions that utilize negative incentives.³⁸²

Third, Behavioral Economics provides an additional basis for critique.³⁸³ If the aim is to use enhanced punishment as an additional imposed cost to drug dealing, nudging the individual towards a suitable and less costly alternative.³⁸⁴ This implies that the person impacted is indeed a “drug dealer”—a somewhat ambiguous notion, given the fluidity of transactional relationships between drug users.³⁸⁵ From a structural perspective, many street-level dealers—the kinds of actors who are typically on the receiving end of these penalties—engage in subsistence black market activity precisely because of the lack of other suitable employment alternatives.³⁸⁶

Fourth, there is basis to question whether or not the “rational actor model” is

³⁷⁹ See Becker, *supra* note 308.

³⁸⁰ Sonya Rastogi et al., *The Black Population: 2010*, U.S. CENSUS BUREAU (2011) available at <https://www.census.gov/prod/cen2010/briefs/c2010br-06.pdf>.

³⁸¹ Shane Darke, *Opioid Overdose and the Power of Old Myths: What We Thought We Knew, What We Do Know, and Why it Matters*, 33(2) DRUG & ALC. REV. 109, 112 (2014) available at <https://onlinelibrary.wiley.com/doi/pdf/10.1111/dar.12108>.

³⁸² Mark Kleiman & Angela Hawken, *Fixing the Parole System*, 24 ISSUES IN SCIENCE & TECHNOLOGY 45, 45-52 (2008).; *Why Swift Certain And Fair?*, SWIFT CERTAIN AND FAIR (Accessed on May 4, 2018), available at <http://www.swiftcertainfair.com/why-swift-certain-and-fair/>.

³⁸³ See *Nudge supra* note X.

³⁸⁴ Frank Chaloupka & Rosalie Liccardo Pacula, *Economics and anti-health behavior: the economic analysis of substance use and abuse* (Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers: 2000); Warren Bickel & Rudy Vuchinich, *Reframing Health Behavior Change With Behavioral Economics* (Hillsdale, NJ: Lawrence Erlbaum Associates; 2000).

³⁸⁵ Jonathon Caulkins & Peter Reuter, *Illicit Drug Markets and Economic Irregularities*, 40 SOCIO-ECONOMIC PLAN. SCI. 1, 1-14 (2006).

³⁸⁶ Jeff Winkler, *Drug dealer explains economics of selling part-time*, HUFFINGTON POST (Aug. 14, 2017) available at https://www.huffingtonpost.com/2012/08/14/drug-dealer-economics-part-time_n_1775811.html.

applicable as an empirical matter. Some of those impacted by these prosecutions—including many of the “dealers”—may themselves be affected by severe forms of substance use disorder. No matter whether or not one ascribes to a fully medicalized BDMA described above, there is little question that individuals with substance use disorder do not comport with the Classical Economics view of *homo economicus*.³⁸⁷ This substantially undermines the application of Law and Economics model of deterrence in this realm.³⁸⁸ If assume the rational actor model is operative, this leads to an absurd result, because a rational seller who depends on a consistent clientele would never intentionally sell a product that cuts his consumer base.³⁸⁹

Fifth, the additional cost may also be conceptualized to incentivize a shift away from a certain drug supply chain that is especially risky (e.g. because the product is laced with fentanyl).³⁹⁰ This depends on two factors: 1. knowledge of the contents in the product, and ability to shift to an alternative supplier. Neither of these conditions typically reflect reality. Low-level dealers rarely know the contents of the product in their supply chain, or can predict its risk.³⁹¹ These contents also frequently fluctuate—often as a result of interdiction activities and other law enforcement efforts to disrupt the market.³⁹² This further complicates any rational decision-making. Even if they did contemplate such a shift, the dynamics of the drug trafficking organizations make it highly difficult to shift one’s source to other suppliers.³⁹³ Such behavior would be irrational, especially since the dealer would have little information about the relative risk of alternative supply chains. In other words, the concepts of free entry and exit that would make market principles applicable to this situation do not apply.

From an empirical perspective, we saw a massive failure of this choice architecture model in the context of the powder cocaine vs. crack cocaine

³⁸⁷ Redonna Chandler, Bennet Fletcher and Nora Volkow, *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 JAMA (2009)183, 183-190.

³⁸⁸ Christine Jolls, Cass R. Sunstein, and Richard Thaler, *A behavioral approach to law and economics*, 50 STAN. LAW REV. 1471, 1471-1550 (1998).

³⁸⁹ David Hillier, *We Asked Dealers if They Care About Their Customers' Safety*, VICE (2017) available at https://www.vice.com/en_us/article/bjxz4v/we-asked-dealers-if-they-care-about-their-customers-safety.

³⁹⁰ Jennifer J. Carrol, et al., *Exposure to fentanyl-contaminated heroin and overdose risk among illicit opioid users in Rhode Island: A mixed methods study*, 46 INTL. J. DRUG. POL 136-145 (2017).

³⁹¹ *Public Data Presentation for Synthetic Cathinones, Synthetic Cannabinoids, and Fentanyl and Fentanyl Analogues Amendments*, UNI. STATES SENTEN. COM (2018) available at https://www.ussc.gov/sites/default/files/pdf/research-and-publications/data-briefings/2018_synthetic-drugs.pdf.

³⁹² Daniel Ciccarone, *Editorial for “US Heroin in Transition: Supply Changes, Fentanyl Adulteration and Consequences”*, 46 INTL. J. DRUG POL. 107 (2017).

³⁹³ Leo Beletsky and Corey Davis, *Today’s fentanyl crisis: Prohibition’s Iron Law, revisited*, 46 INTL. J. DRUG POL. 156, 156-9 (2017).

disparity.³⁹⁴ This provision did not impact the availability or consumption of crack, but did fuel mass incarceration of mostly impoverished African-American men.³⁹⁵

ii. Incapacitation

The incapacitation objective of enhanced and prolonged mandatory sentences is similarly vulnerable to several critiques. It has long been discredited by empirical research,³⁹⁶ though it is now resurgent at the center of some states' and the current federal administration's strategy to combat the overdose crisis.³⁹⁷ Microeconomic theory suggests that, in view of inelastic demand, raising the financial and other costs will not shift demand or reduce supply.³⁹⁸ This has been soundly supported by evidence of drug market behavior. In view of mass incarceration of people in the drug trade over the last 30 years, the availability and potency of drugs on the black market has increased, while and price have decreased.³⁹⁹ In view of lack of suitable alternatives, so long as there is demand for a black-market product, both the product supply and the labor supply will be filled by ready replacements.

The stated objectives for some policy and prosecutorial deployments is to incapacitate major dealers, not street-level sellers. The feasibility of this is questionable. As *Burrage* and other cases⁴⁰⁰ illustrate, evidentiary parameters constrain the scope of application of these provisions.⁴⁰¹ These constraints affect not just the considerations of contributory effect of specific substances—a consideration that some states have attempted to address by including contributory effect as a qualifier for culpability—but also the ability of prosecutors to go up the chain to incapacitate “drug kingpins.”⁴⁰² In his opinion in

³⁹⁴ Carl Hart, *High Price: A Neuroscientist's Journey of Self-Discovery That Challenges Everything You Know About Drugs and Society* (New York, NY: 2013).

³⁹⁵ *Id.*

³⁹⁶ Rucker Johnson and Steven Raphael, *How Much Crime Reduction Does the Marginal Prisoner Buy?*, 55 J.L. & ECON. 85 (2012), (proposing that long-term incarceration demonstrates the law of diminishing returns); See also Michael Jacobsen, *Downsizing Prisons: How to Reduce Crime and End Mass Incarceration* (2005); Bruce Western, *Punishment and Inequality in America* (2006).

³⁹⁷ Memorandum from the Office of the Attorney General for All Federal Prosecutors, *Commitment to Targeting Violent Crime*, at 2 (March 8, 2017) available at <https://www.justice.gov/opa/press-release/file/946771/download>, stating, in face of evidence to the contrary, that “disrupting and dismantling ... drug organizations through prosecutions under the Controlled Substances Act can drive violent crime down.”

³⁹⁸ Steven R. Hursh, *Behavioral Economics of Drug Self-Administration: An Introduction*, 33(2) DRUG & ALC. DEP. 165, 166 (1993) available at <https://www.sciencedirect.com/science/article/pii/037687169390058X>.

³⁹⁹ Richard Cowan, *How the Narcs Created Crack*, 38 NTNL. REV. 26, 26-31(1986).

⁴⁰⁰ *Santillana v. Upton*, 846 F.3d 779 (5th Cir. 2017).

⁴⁰¹ David Ovalle, *Drug dealers as murderers? Proposed Florida law targets sellers fueling overdose crisis*, MIAMI HERALD (2017) available at <http://www.miamiherald.com/news/local/crime/article136809238.html>.

⁴⁰² Anthony Borrelli, *DRUG RAIDS: \$40K in heroin seized, 7 jailed*, PRESSCONNECTS (2016) available at <https://www.pressconnects.com/story/news/public-safety/2016/07/28/drug-raid-police-hit-endwell-home/87624896/> (DA said these were big players who aren't going to be

Burrage, Scalia provided an engaging illustration of this problem in terms of lawyers of causation that can be attributed for hitting a home run.⁴⁰³

The analysis of the cases suggests that the application of drug-induced homicide provisions is constrained by evidentiary concerns only to tightly proximate individuals.⁴⁰⁴ The deployment of these charges is further mediated by a highly-imprecise, under-resourced, and variable system of toxicological forensic analysis in the US.⁴⁰⁵ Finally, from a historical perspective, the emergence of the overdose crisis just as the U.S. had reached the zenith of mass incarceration on drug-related offences severely undercuts the broader incapacitation rationale.

iii. Retribution

Retribution is arguably the most central objective of these interventions, whereby the action itself and its communication is designed to assure those bereaved by the particular overdose that “justice is being done.”⁴⁰⁶ By speaking to members of the public—or specific segments thereof—these actors are also seeking to shape the policy narrative in a reassuring way to signal that someone is being held responsible for the victim’s death, as well as for the ongoing carnage.⁴⁰⁷

The actual application of the retribution rationale is probably the most aligned out of all of the implied objectives. Many—though by no means all⁴⁰⁸—victims’

replaced anytime soon... led to slight dip in ODs that month, but next month, ODs were at the highest they'd been)

⁴⁰³ *Burrage* Slip Decision, at 7. “Consider a baseball game in which the visiting team’s leadoff batter hits a home run in the top of the first inning. If the visiting team goes on to win by a score of 1 to 0, every person competent in the English language and familiar with the American pastime would agree that the victory resulted from the home run. This is so because it is natural to say that one event is the out-come or consequence of another when the former would not have occurred but for the latter. It is beside the point that the victory also resulted from a host of other necessary causes, such as skillful pitching, the coach’s decision to put the leadoff batter in the lineup, and the league’s decision to schedule the game. By contrast, it makes little sense to say that an event resulted from or was the outcome of some earlier action if the action merely played a nonessential contributing role in producing the event.”

⁴⁰⁴ *Id.*

⁴⁰⁵ Valena Beety, *The Overdose/Homicide Epidemic*, ___ GA. STATE U. L. REV. ___ (forthcoming 2018)

⁴⁰⁶ Zachary Siegel, *In an Upstate New York Community Wracked by Overdoses, Prosecutor Pursues Users in Homicides Cases*, INJUSTICE TODAY (2018) available at <https://injusticetoday.com/in-an-upstate-new-york-community-wracked-by-overdoses-prosecutor-pursues-users-in-homicides-cases-a0a9f473aaa> (DA discusses rationale for drug-induced homicide prosecutions.)

⁴⁰⁷ *Memorandum To United States Attorneys*, OFF. ATT. GEN (2018) available at <https://www.justice.gov/file/1045036/download> (Attorney General Jeff Sessions sends memo requesting action to execute drug dealers).

⁴⁰⁸ Daniel Denvir, *Heroin, Murder, and the New Front in the War on Drugs*, VICE (Sept. 28, 2015), available at https://www.vice.com/en_us/article/qbxwnp/heroin-murder-and-the-new-front-in-the-war-on-drugs-928.

families and others express support⁴⁰⁹ for drug-induced homicide prosecutions. But considering many of accused are themselves marginalized and may suffer from addiction, the application of this intervention only further traumatizes already vulnerable people.⁴¹⁰ This pattern fits with the broader critique of “the politics of victimhood,” which uses the victims’ rights frame to rationalize policy narratives that emphasize retributive, rather than rehabilitative approaches.⁴¹¹ The impetus for responsive action would be much more productively utilized if applied towards evidence-driven interventions,⁴¹² rather than demonstrative punitive actions that are likely to cause more harm than good.

Finally, the application of a harsh sentence for an action considered by most to be a minor offence violates the principle of proportionality.⁴¹³ Relating back to Kant’s equality principle, proportionality is inherent to the proper application of retributive actions. Surely, a death of any person is tragic. Singling out friends, dealers, or doctors who may have contributed to that fatality is both unfair and misplaces the blame in a way that muddles effective remedial action.

iv. Population health impact

In addition to the theoretical and empirical critiques articulated above, the discussion of public health imperatives and structural drivers of the crisis implies additional concerns.⁴¹⁴ Treating every overdose event as a crime scene and charging overdose witnesses with drug-induced homicide can deter help-seeking during overdose emergencies.⁴¹⁵ Higher-intensity enforcement measures and a renewed focus on legislation extending drug trafficking sentences run at cross purposes to 911 Good Samaritan laws and other amnesty measures.⁴¹⁶ From the public health point of view, the benefit of saving the life of an overdose victim outweighs any retributive, deterrent, or other criminal justice rationale for

⁴⁰⁹ Joshua Miller, *AG’s Opioid Proposal Targets Fentanyl Trafficking*, THE BOSTON GLOBE (Aug. 17, 2015), available at <https://www.bostonglobe.com/metro/2015/08/17/maura-healey-proposes-new-law-targeting-opioid-traffickers/geOZTEmdm51C6KX9eeOKhK/story.html>.

⁴¹⁰ Daniel Denvir, *The Opioid Crisis Is Blurring the Legal Lines Between Victim and Perpetrator*, SLATE (2018) available at <https://slate.com/news-and-politics/2018/01/the-opioid-crisis-is-blurring-the-legal-lines-between-victim-and-perpetrator.html>.

⁴¹¹ *Moraff: The Politics of Victimhood*, SIMPLE JUSTICE (2018) available at <https://blog.simplejustice.us/2018/05/10/moraff-the-politics-of-victimhood/> (quoting Ronald Reagan ““The crime epidemic threat [that] has spread throughout our country . . . is in large measure a cumulative result of too much emphasis on rights of the accused,” said Reagan in a 1983 speech promoting his package of anti-crime measures. “We should be proud that our constitutional system protects the rights of the accused, but over the past few years that system has allowed the safeguards protecting the rights of the innocent to be torn away.””).

⁴¹² See Denvir, *supra* note 342, at 14.

⁴¹³ Sullivan, E. Thomas, and Richard S. Frase. *Proportionality Principles in American Law: Controlling Excessive Government Actions*. OXFORD UNIVERSITY PRESS (2009).

⁴¹⁴ See Dasgupta, *supra* note 110.

⁴¹⁵ See Latimore & Bergstein *supra* note 35.

⁴¹⁶ *Id.*

prosecuting bystanders for their potential role in a non-malicious overdose event.⁴¹⁷

It is no accident that, despite their prominent place in materials put forward by other agencies on the overdose crisis,⁴¹⁸ the former Surgeon General's landmark report on the overdose crisis *Facing Addiction* does not mention drug-induced homicide laws and prosecutions as an overdose prevention strategy: they aren't.⁴¹⁹ In fact, these interventions run at direct cross-purposes with public health approaches designed to encourage help-seeking during overdose events and improve access to drug treatment and other services.

Perhaps most importantly, because law enforcement perceives them as an effective signaling vehicle, these efforts receive wide media coverage.⁴²⁰ This substantially magnifies their impact on the attitudes and perceptions of the members of the public. Contrast this to Good Samaritan laws, which typically receive little exposure and are only marginally known and understood by the members of the public.⁴²¹ Lack of clarity about the technical implications of these competing provisions likely leads to over-estimate of legal risk. This scrambling of competing behavioral signals may, in part explain the relatively anemic impact of Good Samaritan laws on help seeking observed thus far.⁴²²

Although Good Samaritan laws hold promise, their impact is limited by several factors. First, they only apply to a limited set of drug possession violations, typically involving small-scale drug possession; state laws also have no bearing on criminal liability under federal law.⁴²³ Secondly, the vast majority of drug users, the general public, and even many police officers may not be aware of such laws.⁴²⁴ In this context, aggressive and mounting application of criminal prosecutions following overdose events totally thwart any positive public health

⁴¹⁷ See Giftos and Tesema, *supra* note X.

⁴¹⁸ See, e.g. US Department of Justice, National Heroin Taskforce: Final Recommendations (2015) available at <https://www.justice.gov/file/822231/download>.

⁴¹⁹ U.S. Department of Health and Human Services, *Facing Addiction in America: Surgeon General's Report on Alcohol, Drugs, and Health* (2016) available at <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>.

⁴²⁰ Zachary Siegel, *Despite "Public Health" Messaging, Law Enforcement Increasingly Prosecutes Overdoses as Homicides*, INJUSTICE TODAY (2017) available at <https://injusticetoday.com/despite-public-health-messaging-law-enforcement-increasingly-prosecutes-overdoses-as-homicides-84fb4ca7e9d7>.

⁴²¹ Caleb J. Banta-Green et al., *Police Officers' and Paramedics' Experiences with Overdose and Their Knowledge and Opinions of Washington State's Drug Overdose- Naloxone- Good Samaritan Law*, 90(6) J. URB. HEALTH 1102 (Dec. 2013) available at <http://www.ncbi.nlm.nih.gov/pubmed/23900788>.

⁴²² See *Help From Friends*, *supra* note 319 and accompanying text.

⁴²³ *Opioid Overdose: Addressing the Growing Problem of Preventable Deaths*, DRUG POL'Y ALL. (2015) available at https://www.unodc.org/documents/ungass2016/Contributions/Civil/DrugPolicyAlliance/DPA_Fact_Sheet_Opioid_Overdose-Addressing_a_National_Problem_June2015.pdf.

⁴²⁴ See Banta-Green et al., *supra* note 353.

impact of Good Samaritan legislation and other efforts to encourage overdose witnesses to come forward.⁴²⁵

But the application of these provisions may further isolate users, increasing their overdose risk.⁴²⁶ One of the principal harm reduction strategies for preventing fatalities is to encourage users to not use alone.⁴²⁷ In heroin user networks, drugs are often consumed in social settings that include the dealer. These social settings are preventative against fatal overdose, but additional legal concerns about drug-induced homicide prosecution may disrupt this practice.

To be clear, we do need accurate and timely information about dangerous street drugs and prescription drug patterns.⁴²⁸ But the work of gathering and applying this information must be done with a clear vision for the life-saving goal in our effort to mount an effective response to the overdose crisis. I must acknowledge what we have learned by now from experience: that wielding the stick of criminal justice against street-level drug use does little to stem it, while also driving users underground, away from helping hands.⁴²⁹

More fundamentally, public health policies and practices that have characterized innovation in the criminal justice sector necessitate recasting of criminal justice institutions and practitioners as supporters rather than enforcers. To be successful, police naloxone programs require bystanders to call for help in most cases. Outreach efforts by police teams require people to open their doors and listen. Angel programs require that users feel comfortable voluntarily approaching police for help accessing support resources.⁴³⁰ These programs also require police to work in partnership with public health and other sectors.⁴³¹ By reinforcing the role of criminal justice institutions and practitioners as proponents of punishment and stigmatization, these interventions undermine this marginal shift.

It is also imperative to mention that the application of these interventions also appears to violate racial justice. Although the racial profiles of the accused were seldom available, preliminary analysis suggests that drug-induced homicides

⁴²⁵ Merris Badcock, *Critics say charging fentanyl dealers with murder could backfire*, WPTV (2017) available at <https://www.wptv.com/news/region-c-palm-beach-county/critics-say-charging-fentanyl-dealers-with-murder-could-backfire>.

⁴²⁶ See Latimore & Bergstein, *supra* note 35.

⁴²⁷ *Overdose Prevention Tips*, HARM REDUCTION (Accessed on April 14, 2018) available at http://harmreduction.org/wp-content/uploads/2012/11/HRC_ODprevention_worksheet9.pdf.

⁴²⁸ Daniel, Ciccarone, *Fentanyl in the US heroin supply: a rapidly changing risk environment*, 46 INTL J. DRUG POL 107, 107-111 (2017).

⁴²⁹ Corey Davis, Damika Webb, and Scott Burris, *Changing law from barrier to facilitator of opioid overdose prevention*, J. 41 J. LAW, POL. & ETH. 33, 33-36 (2013).

⁴³⁰ *For Addicts and their Friends, Families, and Caregivers*, GLOUCESTER POL. DEPT., (Accessed on April 14, 2018) available at <https://gloucesterpd.com/addicts/>.

⁴³¹ For Treatment Providers, PAARI (Accessed on April 14, 2018), available at <http://paariusa.org/providers/>.

prosecutions disproportionately target people of color.⁴³² For instance, Marcus Burrage is Black,⁴³³ while Joshua Banka was Caucasian.⁴³⁴ These patterns harken back to the most egregious elements of the War on Drugs.

From the public health perspective, the racial dynamics of these prosecutions may also inadvertently worsen disparities in access to care. For example, disparate application of these prosecutions may further undermine trust in police among people of color.⁴³⁵ To the extent that criminal justice institutions and actors can now facilitate access to assistance, this distrust can create a service barrier for those groups. So, although an Angel program may work in Gloucester, MA, it may not have the same level of uptake in a locale like Ferguson, MO.⁴³⁶

Surging reliance on drug-induced homicide charges is also a dangerous distraction, which threatens to crowd out other evidence-driven efforts.⁴³⁷ Aside from being likely counter-productive, these prosecutions are resource-intensive (consider, for example, the certain extreme outlays of US Government in *Burrage*).⁴³⁸ Many public health agencies and nonprofits already operate in an environment of extreme scarcity.⁴³⁹ This is compounded by mounting calls for austerity and additional cuts, as well as other factors like declining tax base. At the same time, the price of naloxone is rising, as it is being distributed to law enforcement agencies as first in line for OEND measures.⁴⁴⁰ Although it may make

⁴³² *Drug-Induced Homicide*, HEALTH IN JUSTICE. (2018) available at <https://www.healthinjustice.org/demographics>.

⁴³³ Grant Rodgers, *U.S. High Court Reverses Iowan's Drug Conviction*, THE DE MOINES REGISTER (Jan. 27, 2014) available at <http://www.desmoinesregister.com/story/news/crime-and-courts/2014/01/28/us-high-court-reverses-iowans-drug-conviction/4956117/>.

⁴³⁴ Joshua Abraham Banka, Legacy Guestbook (2010) available at <http://www.legacy.com/obituaries/name/joshua-banka-obituary?pid=1000000142045292&view=guestbook>.

⁴³⁵ Hutto, Jonathan W., and Rodney D. Green. "Social Movements Against Racist Police Brutality and Department of Justice Intervention in Prince George's County, Maryland." *Journal of Urban Health* 93, no. 1 (2016): 89-121.

⁴³⁶ Nancy La Vigne, Jocelyn Fontaine, and Anamika Dwivedi, *How Do People in High-Crime, Low-Income Communities View the Police?*, URBAN INSTITUTE (2017) available at https://www.urban.org/sites/default/files/publication/88476/how_do_people_in_high-crime_view_the_police.pdf (describes the general distrust in police in high-crime, low-income communities);

⁴³⁷ Bandy Lee et al., *Connecting criminal justice, mental health, and family support for better delivery of human services*, INTL. J. PUB. HEA (2018).

⁴³⁸ Zachary Siegel, "You Want to Get Them While the Teardrops are Warm" Prosecutors Swap Strategies for Turning Overdose Deaths into Homicides, IN JUSTICE TODAY (2017), available at <https://injusticetoday.com/you-want-to-get-them-while-the-teardrops-are-warm-prosecutors-swap-strategies-for-turning-942a783ae87c>; (describes prosecutors discussing successful strategies and methods for prosecuting drug-induced homicide cases).

⁴³⁹ Wendy Mariner, *Rationing health care and the need for credible scarcity: why Americans can't say no*, 85 AMER. J. PUB. HEALTH 1439, 1439-1445 (1995).

⁴⁴⁰ Daniel Denvir, *These Pharmaceutical Companies Are Making a Killing Off the Opioid Crisis*, THE NATION (2017) available at <https://www.thenation.com/article/these-pharmaceutical->

us feel like we are making progress by punishing specific individuals for overdose events, public resources are too limited to be spent on policy theater.

Prosecutors shape the policy environment in numerous ways. By exercising enforcement discretion and communicating (or choosing not to communicate) the particular parameters of that discretion, they define the import of black letter law in the lived experience of the entities under their jurisdiction.⁴⁴¹ Meanwhile, they also wield enormous political clout through lobbying, donations, and other mechanisms.⁴⁴² Other law enforcement actors, including law enforcement unions also exercise enormous influence over elections and political deliberations of criminal justice and drug law reform. These law enforcement groups have stood in opposition--and continue to impede--important public health reforms and programs. This includes current prosecutorial opposition to the opening of SCFs, as well as police opposition to the continued operation of SEPs.

Drug-induced homicide is perhaps the most vivid illustration of a larger structural problem. Doubling down on punishment and coercion as an antidote to drug crises has been the go-to choice for criminal justice actors. Other law enforcement actions in this realm have included vast scale-up in drug interdiction efforts, charges levied against overdose victims for “inducing panic,” and advent of new operating policies to detain overdose victims for admission to treatment.⁴⁴³ Legislative efforts have paralleled such law enforcement activity, advancing involuntary commitment, involuntary treatment, and other coercive mechanisms.⁴⁴⁴ Urgent actions are needed to challenge these efforts on both the individual (i.e.

companies-are-making-a-killing-off-the-opioid-crisis/.

⁴⁴¹ See e.g. Kreit, supra note X, at 351 (describing the impact of the Ogden and other Department of Justice memoranda on the cannabis industry).

⁴⁴² Josie Duffy Rice, *Prosecutors Aren't Just Enforcing the Law — They're Making It*, IN JUSTICE TODAY (2018) available at

[https://injusticetoday.com/prosecutors-arent-just-enforcing-the-law-they-re-making-it-](https://injusticetoday.com/prosecutors-arent-just-enforcing-the-law-they-re-making-it-d83e6e59f97a)

[d83e6e59f97a](https://injusticetoday.com/prosecutors-arent-just-enforcing-the-law-they-re-making-it-d83e6e59f97a); See also Brandon Peterson, *Dogged by Stephon Clark Shooting, Sacramento DA Faces a Tough Run*, MOTHER JONES (2018) available at

<https://www.motherjones.com/crime-justice/2018/04/stephon-clark-shooting-sacramento-district-attorney-anne-schubert-faces-tough-run/>.

(highlighting the close and dysfunctional relationships between police organizations and DAs, who are supposed to act as checks on police abuse).

⁴⁴³ S.2635 (115th Congress, 2017-2018).

[https://www.congress.gov/bill/115th-congress/senate-](https://www.congress.gov/bill/115th-congress/senate-bill/2635/text?q=%7B%22search%22%3A%5B%22Judiciary%22%5D%7D&r=1)

[bill/2635/text?q=%7B%22search%22%3A%5B%22Judiciary%22%5D%7D&r=1](https://www.congress.gov/bill/115th-congress/senate-bill/2635/text?q=%7B%22search%22%3A%5B%22Judiciary%22%5D%7D&r=1).

⁴⁴⁴ Leo Beletsky, Wendy E. Parmet, & Ameet Sarpatwari, *Expanding Coercive Treatment is the Wrong Solution for the Opioid Crisis (Updated)*, HEALTH AFFAIRS (Feb. 11, 2016), available at <https://www.healthaffairs.org/doi/10.1377/hblog20160211.053127/full/>; See also Beletsky et al., *Involuntary treatment for substance use disorder: A misguided response to the opioid crisis*, HAR. HEA. BLOG (2018) available at <https://www.health.harvard.edu/blog/involuntary-treatment-sud-misguided-response-2018012413180>; See also John C. Kramer, *The State Versus The Addict: Uncivil Commitment*, 50 B.U.L Rev 1 (1970) (noting that California's involuntary treatment system was indistinguishable from correctional settings).

criminal defense) and structural (policy and prosecutorial reform) levels.⁴⁴⁵

IV. CRISIS AS OPPORTUNITY: REVISIONING U.S. DRUG CONTROL FOR THE 21st CENTURY

Choosing the right remedy is dependent on first being able to accurately identify the ailment. By failing to properly “diagnose” the problem, we have thus far largely failed in formulating effective remedies. Not dissimilar to the way that half-measures and inadequate treatment regimens can cause infections to mutate into more virulent strains, short-sighted interventions to curb overdose have primarily focused on reducing prescription opioid supply because that was believed to be the primary culprit of the crisis.⁴⁴⁶ These interventions included crackdowns on unscrupulous providers, new prescription course limits and guidelines, prescription monitoring efforts, and reformulation of medications to make them more difficult to misuse.⁴⁴⁷

Despite modest shifts towards a public health frame, the policy and programmatic response to the crisis indicates that the change has remained largely rhetorical. Policymakers, prosecutors, and police have continued to draw on the arsenal of carceral and punitive tools in mounting the response. These actions reflect established dynamics of policy theater,⁴⁴⁸ where public figures tend towards actions that are visible and noteworthy, regardless of their ultimate impact.⁴⁴⁹ Such actions are characterized by immediate benefits in terms of elevated public approval and community well-being, but deferred actual cost.⁴⁵⁰ Conversely, actions that have high cost but deferred benefit face a clear disadvantage in the face of a crisis. Victims’ “rights” are often invoked to support these punitive measures, but perspectives of victim families are truly mixed; the voices of those expressing preferences for more lenient and therapeutic responses typically go unheeded.⁴⁵¹ Such continued and relapsing reliance on approaches that lead to

⁴⁴⁵ To this end, Health in Justice Action Lab at Northeastern University School of Law is currently developing a Defense Toolkit to assist counsel in defending individuals charged with drug-induced homicide and similar crimes. See <https://www.healthinjustice.org/drug-induced-homicide>

⁴⁴⁶ Preventing Opioid Overdoses among Rural Americans, CDC (2018) available at <https://www.cdc.gov/ruralhealth/drug-overdose/policybrief.html>.

⁴⁴⁷ See Dasgupta, *supra* 155.

⁴⁴⁸ Sara Sun Beale. "The news media's influence on criminal justice policy: How market-driven news promotes punitiveness." *Wm. & Mary L. Rev.* 48 (2006): 397.

⁴⁴⁹ See Siegel, *supra* 31.

⁴⁵⁰ See Beale, *supra* 391.

⁴⁵¹ Peter Haden, *The Controversy Over Charging Drug Dealers With Murder After Overdoses*, NPR (2017) available at <https://www.npr.org/2017/06/17/533327584/the-controversy-over-charging-drug-dealers-with-murder-after-overdoses>; Responses from the deceased families varies widely across cases. See Heidi Kinchen, 'We don't want this to destroy your life:' Parents seek 2nd shot for man who gave daughter deadly drug, THE ADVOCATE (2015) available at

negative consequences in our policy response to drug crises is indeed akin to the very definition of addiction.⁴⁵²

This analysis fits squarely within the discourse on the urgent need for criminal justice reform, especially as it relates to systems-level change in areas like the outsized power of prosecutors as arbiters of public policy. More fundamental paradigm shifts are needed to address this—and prevent future—crises. A better theoretical and practical vision for the “Public Health Approach” to the overdose crisis is necessary. Such an approach implies a move away from a Law and Economics-based framework towards a population health policy framework. As Wendy Parmet articulates, population health considerations should animate judicial and policy decisionmaking.⁴⁵³ Conceptualization of law as vested with the historical, ethical, and instrumental ammunition to pursue this goal implies that the welfare of populations, rather than solely individuals, be used as the unit of legal analyses.⁴⁵⁴ Her conceptualization of the population-based legal framework also implies the need to internalize and integrate public health epistemology into law in the form of probabilistic and epidemiological thinking.⁴⁵⁵ But public health law has not yet re-entered the mainstream of American Jurisprudence. In his opinion in *Burrage*, Scalia passed on the opportunity to engage in population-based legal analysis,⁴⁵⁶ in the way that he had often engaged in analyses on economic and other topics.⁴⁵⁷

Since the heyday of major disease threats, public health in general and public health regulation in particular have been victims of their own success. As the tangible threats of communicable disease have receded, the impact of public health interventions has become less visible and more diffuse.⁴⁵⁸ Just as public

http://www.theadvocate.com/baton_rouge/news/communities/article_92728236-e945-5475-a67b-dbc3937eb9c8.html (Mother of deceased asked for leniency in sentencing and a second change for the accused); Ed Damon, *Woman sentenced for overdose death*, BENNINGTON BANNER (2018) available at <http://www.benningtonbanner.com/stories/woman-sentenced-for-overdose-death.529531> (Family asked for leniency in sentencing); Snejana Farberov, *Michigan couple are sentenced in the death of 16-year-old neighbor who overdosed on fentanyl-laced heroin in a trailer park*, DAILYMAIL (2018) available at <http://www.dailymail.co.uk/news/article-5473849/Michigan-couple-sentenced-heroin-overdose-death-teen-neighbor.html> (Family asked for the maximum sentencing to be brought against the accused).

⁴⁵² AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: FIFTH EDITION 483-485 (2013)

⁴⁵³ See Wendy E. Parmet, *supra* note 384, at 2, 52-53.

⁴⁵⁴ *Id.*

⁴⁵⁵ See Wendy E. Parmet, *supra* note 384, at 2.

⁴⁵⁶ See, generally Wendy E. Parmet, *supra* note 384.

⁴⁵⁷ Alejandro Chafuen, *Supreme Court Justice Scalia Delivers An Important Talk On Economics*, FORBES (Jun. 5, 2013) available at <https://www.forbes.com/sites/alejandrochafuen/2013/06/05/supreme-court-justice-scalia-delivers-an-important-talk-on-economics/#7dad613681d1> (Scalia discusses economic theories, how the law affects free-market enterprise, and economic freedom for people and corporations)

⁴⁵⁸ See Wendy E. Parmet, *supra* note 384.

health science and public health research are generating an increasingly robust evidence base, the ability to translate this evidence into policy and practice is eroding.

The “prevention paradox”⁴⁵⁹ is that the impact of successful public health and other preventative interventions is often in avoidance of a potential harm; it is therefore virtually “invisible.” In contrast to medicine or criminal law, the beneficiaries of public health efforts are often unidentified, and the benefits temporarily removed from the actions by years, if not decades.⁴⁶⁰ Costs of these diffuse benefits to unnamed beneficiaries are nonetheless borne by all taxpayers, who tend to resent them.⁴⁶¹ Finally, aside from highly-visible catastrophic events, the rationale driving public health action is often based on probabilistic evidence that is in conflict with many people’s understanding of what causes ill health or their moral views and values.⁴⁶² Americans generally favor the idea of investing in public health prevention;⁴⁶³ when asked about specific program expenditures, however, support markedly diminishes to a relatively small minority of respondents.⁴⁶⁴

Criminal law interventions do not suffer from many of the same “prevention paradox” problems.⁴⁶⁵ They are highly visible, decisive, and do not require the kind of leap of faith about prevented harm that is critical to bolster public health prevention policies.⁴⁶⁶ Criminal law interventions like successful prosecutions build on persuasive, if simplistic policy narratives, creating a perception of a tangible success to a number of key stakeholders.⁴⁶⁷ Those directly affected by the overdose may experience a sense of vindication.⁴⁶⁸ These interventions also map onto constructs that have face validity and reflect social and moral attitudes, broadly understood as “common sense.”⁴⁶⁹ Prosecutorial and law enforcement

⁴⁵⁹ Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 PUB. HEA. POL. FORUM 1607, 1609 (1997).

⁴⁶⁰ David Hemenway, *Why We Don't Spend Enough on Public Health*, 362 NEW ENG. J. MED 1657 (2010).

⁴⁶¹ *Forum Topic: Should taxpayer money be spent on Narcan?*, THE CHRONICLE OF HIGHER EDUCATION (2018) available at <https://www.chronicle.com/forums/index.php?topic=204879.15>; taxpayers upset about paying for naloxone.

⁴⁶² Robert Blendon & John Benson, *The Public and the Conflict over Future Medicare Spending*, 369 NEW ENG. J. MED 1066, 1066-1073 (2013).

⁴⁶³ Robert Blendon et al., *Americans' Conflicting Views About The Public Health System, And How To Shore Up Support*, 29 HEALTH AFFAIRS (2010) available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0262>.

⁴⁶⁴ *Id.*

⁴⁶⁵ Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 PUB. HEA. POL. FORUM 1607, 1609 (1997).

⁴⁶⁶ Thomas Oliver, *The Politics Of Public Health Policy*, 27 ANN. REV. PUB. HEA. 195, 195-233(2006).

⁴⁶⁷ William J. Stuntz, *The Pathological Politics of Criminal Law*, 100 MICHIGAN LAW REVIEW 505, 507 (2001).

⁴⁶⁸ Although not always—some groups advocate for reconciliation etc.

⁴⁶⁹ William Neuman, *De Blasio's Plan for Safe Injection Sites Faces Many Hurdles*, NYT (2018)

incentives are highly aligned with such actions, rather than prevention or “public health” approaches.⁴⁷⁰

And yet, investment in public health regulation and infrastructure produces not only improvements in quality of life and its duration, but also substantial return on investment.⁴⁷¹ These data have supported arguments for shoring up existing and building new tools to pursue population health under a new framework.⁴⁷² Public health advocates have maintained that, in the context of wider social change on the national and global levels, emerging public health threats require agility and authority in public health programming and regulatory response.⁴⁷³ In addition, methodological advances in public health science and its increasingly interdisciplinary toolkit have made it possible to generate evidence that helps to tailor interventions on the individual, network, or community levels.⁴⁷⁴

A corollary development has been in the field of public health law research, where sophisticated empirical methods are being used to assess the direct or incidental impact of laws on health.⁴⁷⁵ Today, more than at any other time, the growing empirical evidence base can be used to shape policy decisions.⁴⁷⁶ Given that the evidence has already established several key elements of a policy response that holds most promise, these tools should be brought to bear on the overdose crisis.

Beyond the most immediate interventions, the structural determinant framework is critical to engage in addressing root causes. For instance, better access to health care, reducing income inequality, and assuring healthy work and living environments are all critical to meaningful efforts to address the overdose crisis and other drug-related harms. However, it is important to situate the resulting action agenda in the broader legal, economic, and political climate. There is currently substantial opposition to the kinds of tax policy, regulatory policy, and social policy actions that hold the most promise to advance this agenda. The use of labels like “totalitarianism” or “nanny-statism” is routinely mis-directed at

available at <https://www.nytimes.com/2018/05/04/nyregion/nyc-safe-injection-sites-opioids.html>.

⁴⁷⁰ See Stuntz *supra* note X.

⁴⁷¹ Glen P. Mays and Sharla A. Smith, *Evidence Links Increases in Public Health Spending to Declines in Preventable Health*, 30 HEALTH AFFAIRS (2011).

⁴⁷² See e.g. Lindsay F. Wiley, *Rethinking The New Public Health*, 69 WASH. & LEE L. REV. 207 (2012) (advocating for re-consideration of the use of public nuisance theory to pursue public health objectives); See also Lainie Rutkow and Stephen P. Teret, *The Potential For State Attorneys General To Promote The Public's Health: Theory, Evidence, And Practice*, 30 ST. LOUIS U. PUB. L. REV. 267 (2011) (discussing the emergent role of *parens patriae* law suits).

⁴⁷³ James G. Hodge Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93 (1998); see also Wendy E. Parmet, *supra* note 384, at 212-14.

⁴⁷⁴ Mayes and Oliver, *supra* note 81, at 191.

⁴⁷⁵ See, e.g. Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1651-52 (2011).

⁴⁷⁶ Michelle Mello and Katheryn Zeiler, *Empirical Health Law Scholarship: The State of The Field*, 96 GEO. L.J. 649, 656 (2008).

government attempts to impact structural determinants of health.⁴⁷⁷ With increasing prominence in policy and political discourse, Nozick’s neo-Lockean notion of the “minimal state” translates in the dismantling of public health protections and other elements that may be protective against opioid misuse and overdose.⁴⁷⁸ The regulatory fabric of command-and-control, speech, financial, and other regulatory mechanisms the government uses to accomplish these goals are precipitously eroding.

Addressing structural determinants also implies a communitarian vision. This will flow against the current political climate. The “every man for himself” stark individualism attacks the social contract that is foundational to the theory and practice of Public Health.⁴⁷⁹ Rhetorically, individualism stands in direct opposition to a communitarian framework that animates prevention, planning, and resource allocation mandates of public health practice.⁴⁸⁰ This framing also encourages the view of classes, races, and regions different from one’s own as “the other.”⁴⁸¹ The trope of individualism also runs counter to government efforts to ameliorate one of the most significant public health challenges of our time—health disparities.⁴⁸² The prevalence of opinion in some circles that “too much attention” is expended on the problems facing the African-American community may further distance support for interventions that address structural determinants of health.

Drawing on the maxim that “no crisis should go to waste,” the overdose crisis presents a unique opportunity to deploy population-based health legal analysis in rethinking how we regulate drugs. The crisis has vividly demonstrated that the systems we have in place fail to meet patient needs in appropriate access to pain, substance use treatment, and other pharmacotherapy, while the regulation of black markets for drugs could hardly be any more harmful.

Despite overlapping mandates and functions, the DEA and the FDA now each consume annual federal appropriations of about five billion dollars. Aside from an opportunity to improve public health outcomes and generate significant cost-savings, several current trends further rationalize the exploration of FDA-DEA consolidation. The regulatory landscape for marijuana is undergoing a historic transformation. Simultaneously, the calls to advance a “public health approach” to drug misuse imply a move away from the criminal justice-based framework that serves as the DEA’s operational mandate. Some of the principal challenges to such consolidation, however, would include the extensive legal reforms that

⁴⁷⁷ Consider the example the FDA rules mandating the inclusion of a balanced set of information about the risks and benefits of prescription drugs in television advertising. The benefits are usually touted by images of healthy, happy people, lush landscapes, or other pleasing visuals. There are no images of actors doubled-over with stomach pain or experiencing other unpleasant side-effects to communicate the risks, however.

⁴⁷⁸ Robert Nozick, *Anarchy, State, and Utopia*, at 26-8 (1974).

⁴⁷⁹ Dabney P. Evans, *The Right to Health: The Next American Dream*, in *THE RIGHT TO HEALTH: A MULTI-COUNTRY STUDY OF LAW, POLICY AND PRACTICE* 233 (Brigit Toebes eds., 2014).

⁴⁸⁰ *Id.*, at 242-43.

⁴⁸¹ *Id.*, at 242.

⁴⁸² Evans, *supra* note 423, at 245.

would be necessary to effectuate it.

Adoption of a public health approach to drug regulation must also include a re-design of the Controlled Substances Act. The negative impact of this statutory regime and criminal law in general goes beyond its instrumental collateral harms. I have to confront the reality that the core function of criminal law is normative, intended to stigmatize drug use and drug users. Decades after *Robinson*, this criminal law framework remains largely in place. If the goal is to reduce stigma, then revisiting the criminal law framework must be part of that imperative.

V. CONCLUSION

As the overdose crisis lays bare, history has proven drug control regulation rooted in supply-side interventions a dismal failure. Widespread adoption and aggressive enforcement of punitive drug laws has done little to reduce drug-related harms. In the context of the overdose crisis, an increasing number of jurisdictions have proposed entirely new, or enhanced drug-induced homicide provisions. Both in their design and their application, these provisions promise to do far more harm than good. Notably, this analysis reframes the need for criminal justice reform as a public health imperative, critical to improving the response to the worst drug crisis in America's history.

VI. APPENDIX: VISUALIZING DRUG-INDUCED HOMICIDE PROSECUTIONS 2000-2017

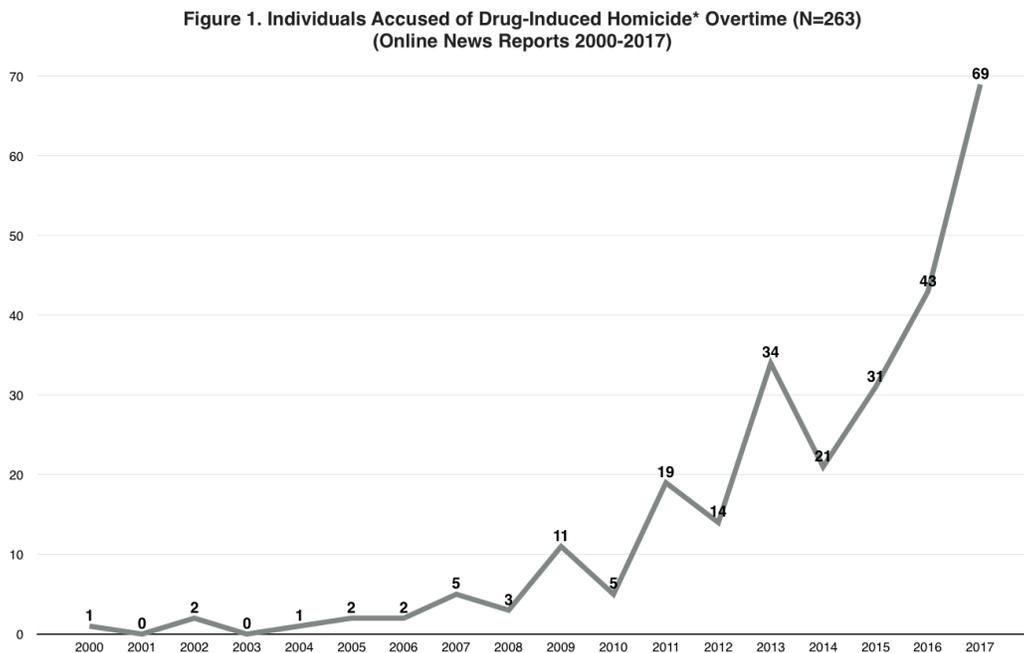


Figure 2. Accused-Deceased Dyads in Drug-induced Homicide* Cases, by Relationship (N=213) (Online News Reports 2000-2017)

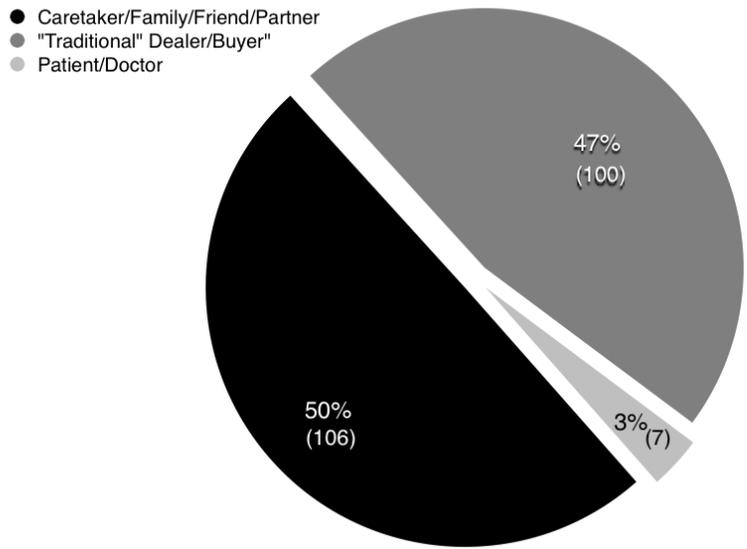


Figure 3. Dealer-Deceased Dyads in Drug-induced Homicide* Cases, By Race (N=86) (Online News Reports 2000-2017)

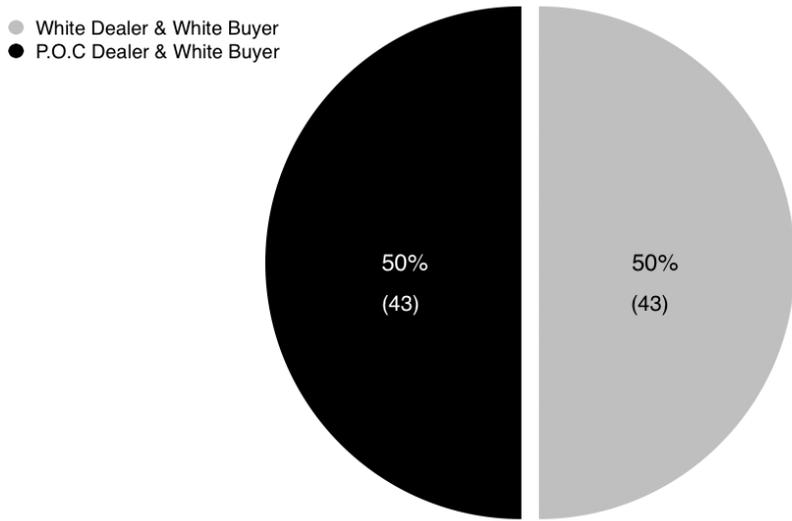


Figure 4. Average Sentence for Individuals Charged with Drug-induced Homicide*, By Race (N=114) (Online News Reports 2000-2017)

