

# America's Favorite Antidote: Murder-By-Overdose in the Age of the Opioid Epidemic

by Leo Beletsky<sup>1</sup>

## I. INTRODUCTION

On April 14, 2010, Joshua Banka went on a bender in central Iowa.<sup>2</sup> 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 score heroin.<sup>3</sup> Banka, who had a long history of polysubstance use, had only recently turned to heroin and had not used it in six months.<sup>4</sup> A small-time drug dealer Marcus Burrage sold the couple one gram of heroin in a grocery store parking lot.<sup>5</sup> They cooked and injected some of the drug in the car immediately following the transaction, and then later upon returning home.<sup>6</sup> After Noragon had gone to sleep in the early hours of April 15, 2010, Banka injected another batch.

The next morning, Noragon found her partner's lifeless body in the bathroom 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.<sup>7</sup> Subjected to questioning, Noragon picked out Marcus Burrage out of a photo lineup as the dealer who had sold them the ill-fated bag of heroin the night before.

Burrage soon was apprehended and charged with heroin distribution. Having taken on this seemingly unremarkable case, federal prosecutors also added a hitherto seldom-used, but powerful enhancement under the Controlled Substances Act. This "sledgehammer" provision--§841(b)(1)(C)—mandates a sentence of 20 years to life in prison in cases when "death...result[s] from the use of the substance" unlawfully distributed by the accused.<sup>8</sup>

At trial, two toxicological experts testified to the presence of multiple substances

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<sup>2</sup> Burrage v. United States, No. 12-7515 (U.S. Jan. 27, 2014).

<sup>3</sup> Brief for the United States at 5, Burrage v. United States, No. 12-7515 (U.S. Jan. 27, 2014).

<sup>4</sup> Brief for the United States at 5 (*see supra* note 3).

<sup>5</sup> Brief for the United States at 6 (*see supra* note 3).

<sup>6</sup> Brief for the United States at 6 (*see supra* note 3).

<sup>7</sup> Brief for the United States at 6 (*see supra* note 3). (noting that the drugs included opioid analgesics and benzodiazepines)

<sup>8</sup> 21 U.S.C. §841(b)(1)(C) ("death . . . resulted from the use of the substance").

in Banka’s body at the time of death. In addition to heroin, this included metabolites of prescription opioid analgesics and benzodiazepines. As depressants, all of these drugs can synergize to slow a person’s central nervous system, including respiration control. Given this 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, and sentenced to the 20-year minimum sentence mandated under §841(b)(1)(C).<sup>9</sup>

After losing on appeal at the District and then the Circuit levels, this case was granted certiorari. At the US Supreme Court, Burrage’s contention that the statutory language in §841(b)(1)(C)’s “death results” enhancement requires “but-for” causation finally carried the day.<sup>10</sup> Writing for the unanimous<sup>11</sup> Court, the late Justice Scalia rejected the Government’s broad reading of the enhancement provision.<sup>12</sup>

In reaching this holding, Scalia also deliberated about the Government’s predictions that the provision’s narrow construction would “unduly limi[t] criminal responsibility” and run counter to public policy.<sup>13</sup> Beyond the retribution rationale, the Government also advanced a broader deterrence argument by prominently featuring the claim—made at the time of the statute’s passage—that “extremely stiff penalties [are] a way to send a clear message”<sup>14</sup> to drug dealers. The ultimate goal articulated by the provision’s drafters—and implied by the Government in *Burrage*—was to “prevent further drug-related deaths.”<sup>15</sup>

Scalia was characteristically acerbic in rejecting the Government’s “public policy disaster” logic. For one, he pointed out that federal prosecutors had had marked success applying §841(b)(1)(C) to other cases of multiple-drug toxicity, with the operative difference that the experts were less ambivalent about the fatal role of the substance in question.<sup>16</sup> Also, he noted, even if the prosecutors could not make the “death results” enhancement stick, the individual would still likely receive a stiff sentence just on the drug trafficking charge; this would likely be the case with Burrage. But Scalia never turned to the idea advanced by the Government that sentencing enhancements like §841(b)(1)(C) could function as a public health prevention tool.<sup>17</sup>

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<sup>9</sup> Burrage opinion at 1 (see supra note 2).

<sup>10</sup> Burrage opinion at 14-15 (see supra note 2) (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.)

<sup>11</sup> Justice Ruth Bader Ginsburg wrote a concurring opinion that Justice Sonia Sotomayor joined.

<sup>12</sup> Burrage opinion at 12 (see supra note 2)

<sup>13</sup> Burrage opinion at 12 (see supra note 2), quoting Brief for the United States at 24 (see supra note 3).

<sup>14</sup> Brief for the United States at 4 (see supra note 3).

<sup>15</sup> Brief for the United States at 4 (see supra note 3).

<sup>16</sup> Burrage opinion at 12-13 (see supra note 2).

<sup>17</sup> Perhaps a missed opportunity for public health-minded observers to submit an amicus brief.

Today's spiraling overdose rates compel urgent reevaluation of this notion. In what follows, I offer an interdisciplinary critique of "death results" and analogous provisions and prosecutions—what I will collectively call the "murder-by-overdose" interventions.<sup>18</sup> As the opioid epidemic has unfurled across the US, law enforcement agencies have deployed such provisions with rising frequency and fanfare. Counter to the mounting calls for a "public health approach," legislatures have expanded—or adopted totally new—provisions bolstering severe criminal justice interventions under the banner of public health. In many ways, the prosecution of Marcus Burrage is archetypal of this trend, distinguished by its unique facts and narrow holding,<sup>19</sup> but the case's ultimate resolution at the High Court did little to stem its tide.

Part I will provide an overview of the scope of the opioid "epidemic," tracing its decade-long 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. I will discuss the interplay of supply and demand drivers behind this crisis and the role of structural determinants of health in the crisis' outsized impact on economically-depressed, primarily white rural and suburban communities.

The US has long held criminal punishment to be an antidote to drug-related harms, but the opioid crisis has laid bare the folly of this approach. Instead, the mounting death toll has spurred a rhetorical reorientation towards a "public health-based" regime. Part II will review public health-driven policy and policing practice innovations that have emerged to support overdose prevention and rescue efforts. This includes laws providing limited immunity to overdose bystanders who call for help and programs that train police in overdose rescue and equip them with the opioid antidote naloxone.

Part III will focus on the doctrinal, normative, and instrumental reasons why murder-by-overdose provisions and their analogues have no place in the arsenal of overdose prevention interventions. After defining the origins and theoretical underpinnings of these mechanisms, I will advance several behavioral, economic, and empirical critiques. These critiques are supported by available data on the real-world application of these provisions. Ultimately, I shall argue that murder-by-overdose prosecutions are likely to fuel the very problem they purport to ameliorate. I will conclude by outlining a framework that effectively extracts substance use and its harms from the realm of criminal law interventions.

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<sup>18</sup> I use this term broadly to include provisions that encompass different criminal law constructs and mechanisms, such as "death results," drug induced homicide, and manslaughter.

<sup>19</sup> Quoting Attorney Cambell that the case had "unique facts in this particular case. ... There's not going to be an impact as great as the government was fearing...It shouldn't have a tremendous impact on how you can prosecute drug cases."

## II. THE OVERDOSE CRISIS: DEFINITIONS AND COMPETING NARRATIVES

Today, the United States is in the midst of the most devastating public health crisis in its recent history. Over 52,000 Americans were killed by drug overdose in 2015—an unprecedented increase of more than 300% since the turn of the century. The grim toll of overdose-related death and disability is propelled primarily by opioids. A drug family that includes both prescription analgesics and street drugs like heroin, opioids contribute to an average of nearly 100 Americans fatalities *every day*. The human toll of this crisis has impacted countless families,<sup>20</sup> communities, and businesses; its financial costs already number in tens of billions per year.<sup>21</sup> This section defines opioid overdose and provides a public health perspective on the causes of the crisis—a discussion critical to the design of effective interventions.

### a. Opioid Overdose, Defined

Opioids kill by depressing respiration, a process that can take up to 90 minutes or longer. Therefore, unlike other injury deaths, overdose typically leaves ample scope for intervention that can prevent the overdose event from turning fatal. The opioid agonist naloxone displaces opioids bound to mu receptors in the central nervous system. It reverses the respiratory depression, causing almost immediate withdrawal.<sup>22</sup>

In lay discourse, overdose is often conflated with opioid addiction. A small but significant (2-15%)<sup>23</sup> proportion of prescription drug users develop addiction, translating to increasing prevalence of risky non-medical use, such as snorting or injecting crushed pills. Ultimately, it is not possible to ascertain what proportion of overdose victims would have met the diagnosis of severe substance use disorder--the clinical definition of addiction. What we do know is that addiction is certainly not the sole risk factor for a fatal overdose. Polydrug use, especially the kind of mixing of opioids with other depressants like benzodiazepines that killed Jonathan Banka, vastly increases overdose risk. The risk of death doubles with every illicit drug consumed in combination with opioids.<sup>24</sup>

Another critical driver of risk for overdose is resuming drug use after periods of voluntary or forced abstinence.<sup>25</sup> Such abstinence could be related to drug

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<sup>20</sup> Find Poll data: 50% affected. In many hard-hit areas, much higher\*.

<sup>21</sup> Phillip O. Coffin and Sean D. Sullivan, *Cost-Effective of Distributing Naloxine 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).

<sup>22</sup> Sporer, *supra* note 11, at 443.

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<sup>24</sup> World Health Organization, *Prevention of Acute Drug-Related Mortality in Prison Population During the Immediate Post-Release Period* 10 (2014)

<sup>25</sup> 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

treatment, incarceration, or other factors. Upon resuming drug use, individuals' overdose risk skyrockets because of loss of tolerance to the drug; when an individual consumes a dose similar to what they had used prior to incarceration, the loss of tolerance can render that dose fatal. In the case of incarceration, the first two weeks, ex-prisoners' risk of overdose can be as high as 129 times the background rate.<sup>26</sup>

#### b. The “Vector Theory” of the Opioid Crisis

For decades, opioid overdose had been endemic in urban communities of color, pockets of deep poverty in Appalachia, and other limited settings.<sup>27</sup> Aside from periodic celebrity deaths and occasional spikes in fatalities among heroin users related to fluctuations in drug purity, overall prevalence of opioid overdose remained relatively constant; so did public apathy.<sup>28</sup> Stigma attached to illicit drug use and reinforced by criminal law—as well as class and racial prejudice—translated to the lack of any concerted public health response. This endemic phase of apathy would quickly come to an end as the sheer magnitude, geography and demographics—its “changing face”—would begin to attract mainstream attention it now so consistently receives.<sup>29</sup>

The accepted wisdom about the current opioid crisis—both among professional and lay observers—is a narrative based on what in Public Health is referred to as the “vector model of disease.” Rooted in the customary Public Health concern with infection control, this theory frames opioid drugs as a contagion. Like a flu virus, any exposure to the opioid supply carries a risk of disease and even death. Like a virulent infection, opioid fatalities have rapidly spread regionally and even internationally in a short period of time. This framing helps explain the wide popularity of the term “epidemic” to describe a crisis, despite its noted<sup>30</sup> technical inaccuracy.

The vector model narrative proceeds as follows: Towards the end of the 20<sup>th</sup> Century, American medicine was shaken by a series of revelations about the appalling societal levels of under-treated pain. This launched a well-intentioned drive to improve its management. Pain became the “fifth vital sign” and its self-assessment was introduced as a measure of consumer satisfaction, with

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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).

<sup>26</sup> Ingrid A. Binswanger et al., supra note 25, at 157, 160-61.

<sup>27</sup> 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).

<sup>28</sup> The occasional exception to this were deaths of celebrities struggling with heroin addiction

<sup>29</sup> 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, MEDICINE, AND PSYCHIATRY 664 (2016) <http://link.springer.com/article/10.1007/s11013-016-9496-5>; Theodore J. Cicero et al., supra note 27.

<sup>30</sup> Debates about the term have been active for some time. See, e.g.

implications for health care facilities' ratings and accreditation.<sup>31</sup> A movement towards “patient-centeredness” also catalyzed health care providers' focus on patient comfort and satisfaction.

Sensing a business opportunity, several drug makers engaged in aggressive physician detailing and direct-to-consumer marketing<sup>32</sup> to assuage concerns about the risks of dependence, addiction, and overdose inherent to opioid therapy. This included the creation of astro-turf “patient rights” groups that would use legitimate gaps in patient care to advance the agenda of the pharmaceutical industry. Some of these initiatives intentionally mislead prescribers about risks asserting, without much evidence, that new product formulations successfully minimized adverse side effects in treatment of chronic pain.<sup>33</sup>

These developments drove a rapid expansion in the availability of opioid analgesics. Prescribers readily relied on these medications to treat all kinds of pain, including acute, chronic, and palliative indications. Prescriptions were often made for medication courses that were substantially longer than necessary—epitomized in the narratives featuring high school athletes receiving a 30-day OxyContin supply for a sprained ankle. In addition to those acting in good faith, a small proportion of providers established “pill mills,” which issued opioid prescriptions regardless of the patients' actual medical need. As a result, the rate of opioid analgesic consumption more than tripled between 1999 and 2006<sup>34</sup> and continued to climb until 2013, albeit at a somewhat less neck-breaking pace.

With steep increases in exposure to these powerful depressants, the number of Americans experiencing accidental opioid poisonings began to grow. This has been attributed to the inherent habit-forming properties of these drugs and to the poor understanding of how to properly balance appropriate pain care with the risk of addiction and overdose. Ultimately, the rising popularity of opioid analgesics was closely trailed by an upward curve in opioid overdose fatalities.<sup>35</sup>

Around 2010—the year of Joshua Banka's untimely death at issue in *Burrage*—the second phase of the crisis began to take shape. After remaining stable for years, overdose deaths involving heroin spiked rapidly, tripling between 2010 and 2015.<sup>36</sup> The “vector model” attributes this transformation to rising rates of

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<sup>31</sup> Jane C. Ballantyne & Mark D. Sullivan, *Intensity of Chronic Pain — The Wrong Metric?* 373 N. ENGL. J. MED. 2098 (2015).

<sup>32</sup> Francis B. Palumbo & C. Daniel Mullins. *The Development of Direct-to-Consumer Prescription Drug Advertising Regulation*. FOOD AND DRUG LAW JOURNAL 423 (2002).

<sup>33</sup> Ironically, the same pitch was used to market heroin when it was first formulated by Bayer Laboratories as a less addictive form of morphine.

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<sup>36</sup> Rose A. Rudd et al., Ctrs. for Disease Control and Prevention, Morbidity & Mortality Weekly Report (MMWR), *Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010–2015* (2016), available at [https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm?mbid=synd\\_yahoohealth&s\\_cid=mm655051e1\\_w](https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm?mbid=synd_yahoohealth&s_cid=mm655051e1_w).

addiction among those taking opioid medications; once the users were exposed and seeking an ever-elusive high, prescription opioids would then act as a “gateway” to black market drugs, based on their ubiquitous availability and lower price relative to diverted prescription medications. This narrative is encapsulated in the often-cited statistic that “4 out of 5 new heroin users started with prescription drugs.”

Starting in 2014, the crisis spiraled into its third phase. Black market drugs—including heroin and counterfeit pills - became increasingly adulterated with illicitly-manufactured synthetic opioids, mainly fentanyl analogues. These substances can be clandestinely synthesized cheaply and with relative ease by anyone with the requisite knowledge of—and access to—chemical laboratory equipment. In the span of a single year, from 2014 to 2015, US deaths attributed to fentanyl analogues spiked by over 72% to almost 10,000.<sup>37</sup> In an increasing number of locales, these clandestinely-manufactured synthetics now constitute the primary drivers of fatal opioid poisoning.<sup>38</sup>

Under the vector model, the blame for this uncontained crisis rests squarely—and almost exclusively—with the drugs themselves and those who make them available to consumers. If were not for the unenlightened or unscrupulous behavior by health care providers and drug companies, this line of logic suggests we would not be in the situation we are in today. This logic certainly applies to contaminated food products.<sup>39</sup> However, aside from their habit-forming properties, the age-tested powerful relief opioids provide to sufferers of physical and emotional pain elucidate that they are nothing like unprocessed cheese.<sup>40</sup> Even a cursory examination of the demographic, epidemiological and economic evidence severely limits the explanatory power of this model as it applies to the opioid crisis.

### c. The Social Determinants Critique: Deaths of Despair

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<sup>37</sup> Ctrs. for Disease Control and Prevention, Morbidity & Mortality Weekly Report (MMWR), *Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010–2015* (2016), available at [https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm?mbid=synd\\_yahoohealth&s\\_cid=mm655051e1\\_w](https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm?mbid=synd_yahoohealth&s_cid=mm655051e1_w). (though some of this increase may have been caused by broader awareness and better surveillance of the problem).

<sup>38</sup> Massachusetts Department of Public Health, *An Assessment of Opioid-Related Deaths in Massachusetts* (2016), available at <http://www.mass.gov/eohhs/docs/dph/stop-addiction/dph-legislative-report-chapter-55-opioid-overdose-study-9-15-2016.pdf>; New York City Department of Health and Mental Hygiene, *Unintentional Drug Positioning (Overdose) Deaths Involving Heroin and/or Fentanyl in New York City, 2000-2015* (2016), available at <https://www1.nyc.gov/site/doh/about/press/pr2016/pr063-16.page>.

<sup>39</sup> Ctrs. for Disease Control and Prevention, *Multistate Outbreak of Listeriosis Linked to Soft Raw Milk Cheese Made by Vulto Creamery*, Ctrs. for Disease Control and Prevention, <https://www.cdc.gov/listeria/outbreaks/soft-cheese-03-17/index.html> (LAST VISITED MARCH 28, 2017).

<sup>40</sup> Ctrs. for Disease Control and Prevention, *supra* note 39.

Although it is a common refrain to say that the opioid crisis cuts across geographic and demographic fault lines, not all racial and economic groups have been uniformly affected. Areas and groups characterized by poverty, concentrated disadvantage, and poor economic opportunity have been noted to be at much higher risk. These statistics readily point to more fundamental underlying causes of the crisis.

Modern Public Health embraces economic, social, and other “structural” factors as “social determinants” of health.<sup>41</sup> Central to the social determinants framework is the recognition of wide disparities in health.<sup>42</sup> Although some differences in levels health may be due to biological factors (for example, life expectancy differences between the sexes), observed differences in disease prevalence and life expectancy based on racial, class, geographical and other arbitrary characteristics vividly demonstrate the influence of structural factors.<sup>43</sup> There are intuitive causal connections between poverty, lack of education, poor healthcare access, substandard housing, recreational, and employment environments on the one hand and health outcomes on the other. In addition, inequality in and of itself appears to play a role in generating stress, substance misuse, and other disease-forming processes. The shift from “individuals to systems” has been likened to Public Health’s “Copernican Revolution.”<sup>44</sup>

A comprehensive exploration of the links between structural determinants, pain, addiction, and overdose has been covered elsewhere<sup>45</sup> and is beyond the scope of this paper. What is pertinent to this discussion is that there is ample evidence pointing to the importance of social, economic, health care systems, and other factors as drivers of the opioid crisis. So, while the expansion in the availability of prescription analgesics certainly contributed to rising rates of overdose, an exclusive focus on that expansion misses the forest for the trees.

One powerful line of empirical research shedding light on this topic is an emerging series of analyses on “diseases of despair” in America. Coined by Princeton economists Anne Case and Angus Deaton, this term refers to the interconnected trends in fatal drug overdose, alcohol-related disease, and suicide. Since 1999, age-specific mortality attributed to “diseases of despair” has seen an “extraordinary” and “unanticipated” rise,<sup>46</sup> anomalous outside of war zones. The

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<sup>41</sup> WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* 13 (2009).

<sup>42</sup> WENDY E. PARMET, *supra* note 41, 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).

<sup>43</sup> David S. Jones et al., *The Burden of Disease and the Changing Task of Medicine*. 366 NEW ENG. J. MED. 2336 (2012).

<sup>44</sup> Rick Mayes & Thomas R. Oliver *Chronic Disease and the Shifting Focus of Public Health: Is Prevention Still a Political Lightweight?* 37 J. OF HEALTH OF POLITICS, POLICY, and Law 193 (2012).

<sup>45</sup> JOHANN HARI, *CHASING THE SCREAM: THE FIRST AND LAST DAYS OF THE WAR ON DRUGS* (2015).

<sup>46</sup> Anne Case and Angus Deaton, *Mortality and Morbidity in the 21st century* 8 (2017), available at [https://www.brookings.edu/wp-content/uploads/2017/03/6\\_casedeaton.pdf](https://www.brookings.edu/wp-content/uploads/2017/03/6_casedeaton.pdf).



trend was especially pronounced among middle-aged whites without a college degree, who are now dying earlier on average than their parents.<sup>47</sup> Additionally, what other researchers have called “the reversal of fortunes”<sup>48</sup> in life expectancy linked to structural factors saw rapid geographical diffusion over a brief time period, from being limited almost exclusively in the Appalachia and the Southwest in 2000, to being a nationwide problem by 2015.<sup>49</sup>

Alcohol, liver disease and—to a substantial degree—suicide are not directly attributable to the risks posed by opioid medications. Alarming parallel upward trends in those domains challenges the idea that opioid supply alone is the root cause of the overdose crisis. Case and Deaton attribute these unprecedented demographic shifts to deterioration in economic and social factors, linked primarily to the stagnation in real wages, decline in economic opportunity, and the economic shocks following the 2008 financial crisis.<sup>50</sup> Ultimately, they argue, these drastic demographic shifts are linked to cumulative deprivation following a long-term process of decline. This has culminated in the loss of hope for a better future that has hit white working-class Americans especially hard.

Neoliberal austerity deregulatory policies have accelerated these processes.<sup>51</sup> Government on all levels failed to do what was needed to prevent the opioid crisis and address the deep structural issues that have fueled it. Paradoxically, this frustration also propelled Trump to victory by making the case that government wasn't working.

Opioids are singular in their ability to provide fast, effective, and relatively cheap analgesia from discomfort that can be caused by a wide variety of physical and psychological trauma. By helping to recast “pain” as inclusive of economic hardship, social dysfunction, and similar unsettling trends, this research also advances alternative explanations for the rising demand for, and addiction to

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<sup>47</sup> Anne Case and Angus Deaton, *supra* note 46. Majid Ezzati et al., *5 The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States*. (2008). (noting that mortality rates of whites with no more than a high school degree, which were around 30 percent lower than mortality rates of blacks in 1999, grew to be 30 percent higher than blacks by 2015.)

<sup>48</sup> Ultimately, disparities are responsible for reversing overall life expectancy gains made in the last century.

<sup>49</sup> Anne Case and Angus Deaton, *supra* note 46. “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”

<sup>50</sup> Id. This paper has not been peer reviewed, but it fits with a broader literature on “reversal of fortunes” for large swaths of US population in terms of health outcomes tied to economic and other factors.

<sup>51</sup> Arne Ruckert & Ronald Labonté. *Health Inequalities in the age of Austerity: The Need for Social Protections Policies*. Social Science and Medicine (2017); Paradoxically, as divestment and dismantling of the social safety net has rendered governments on all levels ill-equipped to provide meaningful and effective protection from major community threats. Regulated industries have seized on this opportunity to advance policies based on laissez-faire economic principles. Ironically, the downward spiral in investment and regulation has fueled libertarian movements like the Tea Party. In the US, this has culminated with the surprise victory of Trump and handing Republican control of all three branches of the federal government, along with the overwhelming majority of governorships and state legislatures.

opioids in a structural context.

Another important contributor of the opioid crisis is the structure and function of the health care system. This is because, far beyond just being a potential source of harmful exposure to opioid drugs, health care can have a protective effect against precursors to opioid misuse and overdose. This includes provision of effective and affordable non-opioid pain care, mental health care, and risk-reduction interventions for individuals with substance use disorder.<sup>52</sup>

Yet, the US health care system is unprepared to play this function. Limited physician understanding of substance use disorder is well-documented: very few primary care physicians receive adequate training in this realm (although this could be changing).<sup>53</sup> Substance use screening and other risk reduction interventions are not systematic and may be disincentivized by insurance architecture and other financial pressures.<sup>78</sup> More generally, providers share general societal attitudes towards substance users as a difficult population not amenable to intervention.<sup>54</sup>

In addition, geographical barriers, inadequate health insurance coverage, and uneven distribution of medical resources may influence access to pain management services, preventative care, and substance use treatment.<sup>55</sup> Technical features like insurance pre-authorization requirements or provider compensation rates can substantially shape what care is provided, and to whom. Gaps in care can induce self-medication (for pain, as well as for drug withdrawal symptoms) and contributing to overdose risk. For instance, nationwide, access to evidence-based substance use treatment—a critical tool in the fight against opioid overdose—is available to only one in ten patients who require it. In hardest-hit states like West Virginia, state Medicaid rules prohibit coverage of methadone—a lifesaving maintenance medication that can cut overdose risk by over 50%.<sup>56</sup> The extent to which these and other protective functions of health care are accessible, appropriate, affordable, and of high quality is critical determinants of opioid overdose risk.

Finally, the demand for pain relief is clearly a function of the individual's overall

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<sup>52</sup> Sarah Bowman et al., *Reducing the Health Consequences of Opioid Addiction in Primary Care*. 126 Am J Med. (2013). <https://www.ncbi.nlm.nih.gov/pubmed/23664112>

<sup>53</sup> 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>

<sup>54</sup> Ling Ding et al., *Predictors and Consequences of Negative Physician Attitudes Toward HIV-Infected Injection Drug Users*. 165 Arch Intern Med 618-623 (2005).

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<sup>56</sup> Christine Vestal, *Still Not Enough Treatment in the Heart of the Opioid Crisis*, The Pew Charitable Trusts, <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/09/26/still-not-enough-treatment-in-the-heart-of-the-opioid-crisis> (last visited Mar. 29, 2017). (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.”)

health. Consider the example of obesity. Individuals who meet the definition of obesity are much more likely to suffer from other chronic health problems, including chronic pain. Rates of “overweight” and obesity have skyrocketed among Americans in the last four decades.<sup>57</sup>

Today, two thirds of American adults are overweight or obese.<sup>58</sup> Components of the an “obesogenic” factors include the individual’s nutritional, informational, and built environment.<sup>59</sup> This trend is closely related to changes in where and how Americans, live, work, and play. Spatial planning that does not allow for walkable or bikable space, as well as perception and experience of crime victimization impede non-pharmacologic obesity (and pain) management modalities that rely on physical activity. To the extent that being overweight elevates one’s vulnerability to acute and chronic pain, the numerous environmental elements operative in obesity begin to factor into the structural equation for the opioid crisis.

Although far from exhaustive, this overview of the “structural determinants” framework helps illuminate the reality that the conditions for the opioid crisis have deep, tangled roots. At a time of growing economic stress and social dysfunction, these broader forces drove demand for pain relief—where pain is broadly construed to encompass untreated physical and psychological trauma, concentrated disadvantage, and a pervasive sense of hopelessness. Given poor—or non-existent—access to alternatives, opioids became a quick and easy answer to complex problems. Tragically, for some, this relief comes at the ultimate price. The next section surveys the set of interventions that have been advanced to address the crisis in overdose fatalities.

### III. DRUG CONTROL IN THE AGE OF THE OPIOID CRISIS

#### a. The US Drug Control Regime and its Origins

Americans have always and today remain more open to pharmacological therapy and recreational drug use than residents of peer nations. 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. Around the turn of the 20th Century, social, cultural, and economic concerns spurred increasing efforts to regulate psychoactive substances; in large part, these efforts were animated by

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<sup>57</sup> Institute of Medicine (IOM). *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 Medicine* 866 (1998); Kevin Fiscella et al., *Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*. 283 *JAMA Psychiatry* 2579 (2000).

<sup>58</sup> IOM *Obesity Report*, at X (see *supra* note 57)

<sup>59</sup> James O. Hill et al., *Obesity and the environment: where do we go from here?* 299 *Science* 853 (2003). Over the last several decades, the nutritional value of food and beverages has shifted to higher simple sugar content. Portions in retail and restaurant offerings have grown considerably. Another notable aspect of the food environment is food and beverage advertising, which is pervasive and highly-targeted

disciplinarian and moralistic impulses, unmoored from evidence-driven policy-making. 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.<sup>60</sup>

During the initial period of the development of drug control, public health regulation was almost exclusively limited to the biggest public health threat--infectious disease. In contrast, regulation of psychoactive substances was seen as primarily an issue of commodity control to prevent the citizenry from succumbing to a stigmatized, moral failing. This commodity regulation view was exemplified by the initial placement of drug control under the purview of the Treasury Department on the federal level. 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.

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. The first national law relating to opioid control was the Harrison act of 1914, which established a system for pigovian taxation and supply control of opioids. The same law 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.<sup>61</sup>

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. The Act established a distinct architecture for the regulation of “drugs of abuse,” based on their “accepted medical use” and “potential for abuse.” Thanks in large part by concerted efforts by the Department of Justice, all states would eventually adopt a close analogue of the federal CSA

In 1973, as part of this major overhaul, FDA ceded legal and functional authority over many enforcement activities to the newly-created Drug Enforcement Administration (DEA). The DEA would be charged with using criminal justice tools to suppress the illicit production and trafficking of drugs in the United States. The Agency would also create a risk schedule and a “closed system” for pharmaceutical products deemed to have substantial addictive potential in order to prevent their abuse and diversion.

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. Nonetheless, the DEA as well as its state analogues lacked the scientific expertise available to the FDA. Given the historical roots, these

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<sup>60</sup> \*Marijuana (Mexicans), cocaine (blacks), and opium (Chinese)

<sup>61</sup> Webb v. United States, 429 U.S. 96 (1919)

agencies and other government units including law enforcement conceptualized its role as focused on the specific substances of abuse, rather than the structural issues that may drive problematic drug use.

With this vector-driven commodity focus, US drug control came to be organized around two categories of policy and enforcement interventions: supply reduction and demand reduction. Rooted in Law and Economics discourse, this model concerns itself with microeconomic levers to calibrate the relationship between supply, demand, price, and quantity. It also employs administrative and criminal law tools to maintain a “closed system” for opioids and other controlled substances, with tight controls on their availability in health care settings to prevent misuse and diversion.

There is little evidence that DEA efforts to monitor and regulate medical and pharmacy practices as they relate to addictive substances have helped our health care system achieve the purported balance between adequate access to pain care and diversion control. The Agency’s regulation of substance use treatment providers contributes to this sector’s dismal quality and coverage.<sup>62</sup> In the years since the establishment of this drug control framework, the availability and purity of dangerous addictive substances on the American black market has only increased, and their prices have fallen. This, despite enormous investment in domestic and international supply reduction operations. Finally, The DEA closely tracks and exerts active authority over prescriber practices. Yet, starting in the late 1990’s, it failed to effectively regulate mounting physician over-utilization of opioid analgesics that has facilitated unprecedented rates of severe opioid dependence.

On the demand reduction side, treatment access and quality in this country remains dismal, as primary health care systems’ approach to problematic substance use. Other policies and activities such as school drug education and exclusion of people with substance use from various government benefit schemes long advanced by US drug control efforts have been conclusively shown to be counterproductive. Many, like the DEA’s Youth Dance Program have never been properly evaluated using appropriate metrics and research methodology. Ultimately, however, a substantial body of research evidences that supply reduction interventions employed (and supported) by US drug control organs have resulted in major collateral detriment in spheres of overdose, injection-related bloodborne infection, drug-related violence, and mass incarceration.

The impact of drug control policy on the explosion of the US penal system cannot be understated. Since the 1980s, the number of Americans behind bars has risen by 500%.<sup>63</sup> At the peak of the national incarceration boom in 2009, there were

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<sup>62</sup> 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

<sup>63</sup> Lauren-Brooke Eisen and James Cullen, Breannan Center for Justice, *Update: Changes in State Imprisonment* (2016), available at

approximately seven million Americans under the supervision of the correctional system, with more than twelve million cycling in and out of jails.<sup>64</sup>

Much of this surge is attributed to the “War on Drugs,” as well as to the sharp defunding and dismantling of publicly-financed mental health and substance use treatment resources.<sup>65</sup> Many of those imprisoned for drug crimes meet the clinical definition of substance use disorders, and exhibit mental health comorbidities. Rehabilitative services in correctional settings are severely lacking; access to evidence-based maintenance therapy for those with opioid use disorder is virtually non-existent.<sup>66</sup>

Racial and economic disparities characterize this paradigm. In 2010, individuals sentenced to state prisons for drug-related crimes were disproportionately poor people of color.<sup>67</sup> 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.<sup>68</sup>

#### b. Supply Reduction Interventions to Curb the Opioid Crisis

As a reflection of this broader context, US response to the opioid crisis has been primarily focused on supply reduction. The dominance of the “vector model” narrative of the opioid crisis in health care, policy and public imagination triggered multi-pronged efforts to roll back patient access to opioids. The structural determinant framework makes clear, however, that the opioid overdose crisis did not rise—nor will it fall—solely (or even principally) as a consequence of lax, unscrupulous prescribing and pharmaceutical marketing. Framing health care providers and pharmaceutical companies as “pushers” calls up a familiar, but hollow trope that glosses over critical structural issues that helped spark—and continue to fuel the crisis.

In internalizing the iatrogenic narrative about the crisis, providers faced both internal and external pressure to quickly reduce opioid access. Mechanisms like

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<https://www.brennancenter.org/sites/default/files/analysis/UpdateChangesinStateImprisonment.pdf>

<sup>64</sup> LAUREN E. GLAZE & ERIKA PARK, BUREAU OF JUSTICE STATISTICS: U.S. DEP’T OF JUSTICE, *CORRECTIONAL POPULATIONS IN THE UNITED STATES*, (2012), available at <http://www.bjs.gov/content/pub/pdf/cpus11.pdf>; AMY L. SOLOMON ET AL., THE URBAN INSTITUTE, *LIFE AFTER LOCKUP: IMPROVING REENTRY FROM JAIL TO PRISON* xv (2008), available at [http://www.urban.org/uploadedpdf/411660\\_life\\_after\\_lockup.pdf](http://www.urban.org/uploadedpdf/411660_life_after_lockup.pdf).

<sup>65</sup> Michelle McKenzie et al., *Overcoming Obstacles to Implementing Methadone Maintenance for Prisoners: Implications for Policy and Practice*, 5 J. OPIOID MGMT 219 (2009).

<sup>66</sup> Beletsky, Leo et al., *Fatal Re-Entry: Legal and Programmatic Opportunities to Curb Opioid Overdose Among Individuals Newly Released from Incarceration*, 7 *Northeastern Univ. L. J.* 753 (2015).

<sup>67</sup> E. ANN CARSON & WILLIAM J. SABOL, BUREAU OF JUSTICE STATISTICS: U.S. DEP’T OF JUSTICE, *PRISONERS IN 2011* (2012) available at <http://www.bjs.gov/content/pub/pdf/p11.pdf>.

<sup>68</sup> 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).

patient contracts and random drug tests, when 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. 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.<sup>69</sup> Faced with the risk of judgement and criminalization, patients with unmet physical or mental health needs would be deterred from seeking care altogether.

For the many opioid users whose dependence had been already established, efforts to rapidly restrict access proved catastrophic. Inadvertently, but predictably, this strategy led many patients to transition from legitimate opioid supplies to black market supplies. This had major implications for overdose morbidity and mortality, as well as for initiation of injection and its sequelae.<sup>70</sup>

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,<sup>71</sup> prescription monitoring and supply reduction efforts have had a measurable impact.<sup>72</sup> Some of these interventions have been associated with reductions in opioid overdose mortality linked to prescription medications.<sup>73</sup> But with the exception in one methodologically-flawed study,<sup>74</sup> the ability of supply-side approaches to curb overall opioid overdose rates has been scarcely evaluated, let alone established.

Tragically, supply reduction interventions were not balanced with the commonsense 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. Predictably, opioid dependence and addiction did not simply recede with the contraction in the availability of opioid pills. Instead,

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<sup>69</sup> Peter Grinspoon, *Free Refills* (2016)

<sup>70</sup> Steffanie A. Strathdee and Chris Beyner, *Threading the Needle--How to Stop the HIV Outbreak in Rural Indiana*, 373 *N Engl J. Med* 397 (2015).

<sup>71</sup> 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 *Journal of the American Heart Association* 1 (2017).

<sup>72</sup> 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>.

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<sup>74</sup> Patrick et al, HA PDMP (2017). The analysis fails to control for an important source of confounding--namely, other policies or interventions that may have been implemented at the same time as the PDMP policies they seek to analyze. As the authors rightly note, changes in PDMP policies are often spurred by legislative and public concerns about OD. Given this momentum, PDMP laws like provider mandates or other efforts to enact or "beef up" the PDMPs are often part of a broader package of legislative and program response, like naloxone access, drug treatment scale-up, OD awareness education, etc. To isolate the impact of PDMP policies, one would want to control for those other possible factors. The authors' model controls only for unemployment and education, however, without regard for other (often contemporaneous) interventions that, it bears emphasis, are \*designed\* to suppress OD rates in the state.

affected individuals turned to cheaper, more accessible, and more potent black market opioid alternatives in unprecedented numbers.<sup>75</sup> Unintended, but foreseeable (and sometimes directly foreseen<sup>76</sup>), 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.<sup>77</sup> Many also became shut out from the health care system and the risk-reduction intervention that it potentiated.<sup>78</sup>

As heroin began to devastate largely white, non-urban communities, its advent spurred renewed emphasis on—and investment in—interdiction. 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.<sup>79</sup> On the domestic front, law enforcement leaned on its toolkit of harsh criminal penalties to disrupt the black market for opioids. The escalation in supply-reduction efforts also included high-profile drug murder-by-overdose prosecutions like Murray Burrage’s. 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.<sup>80</sup> With heroin consumption rising quickly and supply-reduction measures mounting, the advent of fentanyl—the more potent, more easily manufactured, and more deadly—heroin alternative market was just a matter of time.<sup>81</sup>

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<sup>75</sup> Theodore J. Cicero et al., *supra* note 27; 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*. 2013 *Drug Alcohol Depend* 95 (2013).

<sup>76</sup> Joshua Vaughn, *2016 Crime Review: Heroin deaths rise as prescription policies go into effect*, *The Sentinel*, Feb 12, 2017, [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](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) (last visited March 29, 2017). (One of the most shocking articulation of their 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.”)

<sup>77</sup> Theodore J. Cicero et al., *supra* note 27.

<sup>78</sup> Rose A. Rudd et al., *supra* note 36; Theodore J. Cicero et al., *supra* note 27.

<sup>79</sup> Drug Enforcement Administration, US Department of Justice, *National Drug Threat Assessment Summary* (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](http://www.pewtrusts.org/~media/assets/2015/02/borderenforcement_brief_web.pdf).

<sup>80</sup> Bryan Polcyn and Stephen Davis, *The legacy of Len Bias: Police treating overdoses as homicides*, October 31, 2013, <http://fox6now.com/2013/10/31/the-legacy-of-len-bias-police-treating-drug-ods-as-homicides/>.

<sup>81</sup> 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, <http://www.latimes.com/opinion/op-ed/la-oe-0114-hari-iron-law->



I have already discussed how interventions informed by a singular focus on stemming 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 only interventions advanced to prevent opioid fatalities in the context of the current crisis. Before turning to an in-depth analysis of murder-by-overdose, it is useful to first examine innovative public health-driven interventions that emerged in response to the crisis.

### c. Emergence of a Public Health Approach

Public Health focuses on data-driven responses and precautionary principle. The public health response evolved organically in view of the crisis. In the realm of demand reduction, this approach included increased public and provider education. A number of such informational campaigns focused on about opioid misuse and overdose prevention. 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. Medical schools and other health care institutions have been recruited to build provider capacity to provide competent care for people affected by substance use disorder.

Demand reduction efforts also focused in increasing access to evidence-based maintenance therapy. One of the definitive paradoxes of the opioid 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. To address this, the Affordable Care Act strengthened parity provisions and included substance use treatment as an essential health benefit. Medicaid expansion made such services accessible to many more low-income and disabled Americans. The previously imposed 100-patient cap for prescribers of the maintenance drug buprenorphine was recently lifted to 250 patients. As a result, the uptake of maintenance therapy grew substantially between 2008 and 2015.<sup>82</sup>

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. Opioids kill by depressing respiration, a process that can take up to 90 minutes or longer. 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 help.

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[drug-prohibition-20160114-story.html](#).

<sup>82</sup> \*

Opioid-caused respiratory depression can be effectively reversed outside of a medical setting by rescue breathing and the administration of naloxone—an opioid antidote.<sup>56</sup> This drug has no psychoactive properties or abuse potential. The basic intervention 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. 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. Participants are usually given naloxone at the training to carry with them; programs have provided both injectable and intranasal formulations. Naloxone co-prescription with opioid medications and pharmacy dispensation represents another route of access, such efforts have been slow to catch on.<sup>83</sup>

Reported serious side-effects of lay naloxone administration are extremely rare, and are usually associated with the onset of withdrawal symptoms or health problems unrelated to naloxone.<sup>72</sup> Importantly, participant users have also been reported to reduce drug use and be more receptive to initiating drug treatment than non-participants. These initiatives have been well-received by drug users and other participants, including family members, partners, and friends of both medical and non-medical opioid users.<sup>73-75 7684</sup> By saving an estimated X lives in the US, they have shown to reduce opioid overdose rates and be cost-effective—even despite recent major spikes in the cost of naloxone.<sup>85</sup>

In the U.S., naloxone was first distributed to drug users in 1999 through underground programs in Chicago and San Francisco.<sup>86</sup> As of 2014, there were over 200 community-based programs were operating in 47 U.S. states.<sup>87</sup> Originally focused on marginalized heroin users, these efforts have been based in harm reduction agencies, such as syringe exchange initiatives, but have expanded to include other settings serving at-risk populations, including methadone management therapy clinics, detox centers, homeless shelters, correctional settings, and government agencies. At the time of writing, 38 states had passed laws to facilitate naloxone access among bystanders, including providing civil

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<sup>83</sup> Beletsky, Leo et al., *Physicians' Knowledge of and Willingness to Prescribe Naloxone to Reverse Accidental Opiate Overdose: Challenges and Opportunities*, 84 J Urban Health 126 (2007).

<sup>84</sup> 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. Journal of Drug Policy 186 (2010) and Traci Green et al., *Social and structural aspects of the overdose risk environment in St. Petersburg, Russia*, 20 Int'l. Journal of Drug policy 270 (2009).

<sup>85</sup> Phillip O. Coffin and Sean D. Sullivan, *supra* note at 21.

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<sup>87</sup> Eliza Wheeler et al., Ctrs. for Disease Control and Prevention, *Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014 (2015)* available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6423a2.htm>.

immunity to lay first responders and naloxone prescribers.<sup>88</sup>

There also appear to be circumstances under which even a timely response to a 911 call will be too late. Black market drugs obtained from illegal sources vary in purity, composition, and are more likely to be administered non-medically, vastly accelerating the onset of overdose symptoms. 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.<sup>89</sup> 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.

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. 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. Although we will never know for sure, but 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.

Lay administration of naloxone is a vital step, but the optimal response to an overdose is timely medical intervention. 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. Companions of overdose victims delay or resist contacting 911 because of concerns about police contact and various legal consequences.<sup>90</sup>

In the context of this article's focus, this fear of legal consequences to overdose victims or bystanders bears some discussion. By default, dispatcher systems in most US jurisdictions distribute emergency calls regarding suspected overdoses to law enforcement. Depending on the emergency response design, 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. Police involvement at overdose scenes may result in arrests on drug, parole violation, weapons, and other charges. It may also lead to loss of child custody, violation of leave conditions, and other legal consequences rooted in pervasive stigmatization of substance use, but not directly linked to criminal law.

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<sup>88</sup> [www.Lawatlas.org](http://www.Lawatlas.org)

<sup>89</sup> Ctrs. for Disease Control and Prevention. *Nonpharmaceutical Fentanyl-Related Deaths—Multiple States, April 2005–March 2007*. *MMWR - Morbidity & Mortality Weekly Report* (2008) available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm>.

<sup>90</sup> TR at 2, 60, 61

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.<sup>91</sup> 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.<sup>92</sup> 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.

#### d. Redefining the Role of Criminal Justice Law and Practice

Public health-focused innovation in response to the opioid crisis has even impacted the stalwart focus on supply reduction laws and enforcement interventions. 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.<sup>93</sup> 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 opioid crisis. The impetus for change was, at times, externally catalyzed through both carrots (e.g. grant programs) or sticks (e.g. US Department of Justice consent decree).

As a result, the discourse around the opioid crisis had begun to reflect an intention to respond to the opioid crisis as a “public health problem, and not just a criminal problem.”<sup>94</sup> Despite some indications of a shift in the opposite direction on the federal level, 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.

To remove barriers to help seeking, 26 U.S. states have now passed laws that reduce the legal consequences of calling 911.<sup>95</sup> As part of a comprehensive overdose package, New Mexico enacted one of the first such laws providing immunity to both the caller and the victim from drug possession charges.<sup>96</sup> However, this law and all others are limited to drug possession charges, and do not extend to drug trafficking charges. Some of the more progressive provisions

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<sup>91</sup> Amy S.B. Bohnert et al., *Characteristics of Drug Users who Witness Many Overdoses: Implications for Overdose Prevention*, 120 *Drug Alcohol Depend* 168 (2012).

<sup>92</sup> Amy S.B. Bohnert et al., *supra* note at 90.

<sup>93</sup> Beletsky Leo 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. Journal of Drug Policy* 267 (2005).

<sup>94</sup> For instance, President Barack Obama reaffirmed his Administration's in a speech to the National Rx and Heroin Summit <http://www.c-span.org/video/?407358-1/president-obama-remarks-prescription-drug-abuse> \*List others

<sup>95</sup> <http://lawatlas.org/datasets/good-samaritan-overdose-laws> \*

<sup>96</sup> <http://lawatlas.org/datasets/good-samaritan-overdose-laws> \*

also cover parole violations and actual arrest, not just charges.<sup>97</sup>

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.”<sup>64</sup> 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.<sup>98</sup>

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. When comparing the risk of arrest an overdose event, users’ assessment is magnitudes higher than that of police.<sup>99</sup> Officers report using their enforcement discretion to not arrest or charge individuals for various violations, even if these are not covered by Good Samaritan or other amnesty mechanisms.<sup>100</sup> 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.

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. First introduced as a tool for law enforcement in New Mexico in 2004 and popularized as the “Quincy Model” after its successful adoption in 2010, it has recently expanded to police forces across the country. 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. Nationwide, law enforcement officers outnumber medical first responders by approximately a factor of three. Over twelve hundred<sup>101</sup> police agencies have now trained and equipped officers to resuscitate overdose victims, reversing over one thousand overdose events.

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 overdose, advice on accessing naloxone, promoting Good Samaritan (criminal amnesty for overdose victims and witnesses who call for help) policies, and facilitating linkage to drug treatment and other services.

Drug user concerns about being arrested at the scene of an overdose may or may

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<sup>97</sup> GA Good Sam Law <http://lawatlas.org/datasets/good-samaritan-overdose-laws>

<sup>98</sup> 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 Urban Health 1102 (2013).

<sup>99</sup> Caleb J. Banta-Green et al., *supra* note at 97.

<sup>100</sup> Caleb J. Banta-Green et al., *supra* note at 97.

<sup>101</sup> <http://www.nchrc.org/law-enforcement/us-law-enforcement-who-carry-naloxone/>

not be based on the correct assessment of legal risks.<sup>102</sup> In fact, research suggests that many users' risk estimate is much higher than self-reported practices by police. Nevertheless, it is the public's perception that is the operative driver of behavior.

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. Another innovation originating in Gloucester, MA promises amnesty from drug possession arrest to anyone who presents at the police station for help accessing treatment. More than three dozen police departments have adopted similar discretionary schemes as part of the Police Assisted Addiction and Recovery Initiative (PAARI).<sup>103</sup> Drug courts, when used to promote evidence-based treatment modalities, offer another promising criminal justice intervention<sup>104</sup> in a shift away from incarceration towards service and support.

Another notable innovation is the Law Enforcement Assisted Diversion (LEAD)<sup>105</sup> model. This intervention emerged as result of a deliberation process between criminal justice and public defender organizations imposed by a federal consent decree. The LEAD model offers police a structure for pre-arrest diversion that can be discretionarily applied to drug users and other non-violent offenders. 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. It thus acknowledges the structural drivers of substance use.

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. They also promote operational collaboration with public health agencies, resulting in improved information sharing and other synergies. In addition to direct public health benefits, police overdose response, public education, and referral programs can help improve trust and community relations.

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. This has included sentencing reforms, such as repealing mandatory minimums and three-strikes laws, as well as reducing the disparity in penalties for

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<sup>102</sup> Caleb J. Banta-Green et al., *supra* note at 97.

<sup>103</sup> PAARI.org

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<sup>105</sup> <http://www.drugpolicy.org/resource/law-enforcement-assisted-diversion-lead-reducing-role-criminalization-local-drug-control>

powder cocaine vis-a-vis crack.<sup>106</sup> It has also included clemency and pardon for individuals incarcerated on drug-related charges. Finally, this movement has included more holistic reforms such as California's Proposition 47 that reinvests savings from criminal justice reforms and de-incarceration in community-based health and social services.<sup>107</sup>

A number of challenges remain before the "public health approach" rhetoric can be more fully translated into evidence-based policies and policing practice. First, contrary to Public Health's concern with evidence, with few exceptions the impact of these public health-oriented criminal justice initiatives remains unclear.<sup>108</sup> Initial evidence on Good Samaritan laws is mixed,<sup>109</sup> but recent analyses suggest positive impact on opioid overdose prevalence.<sup>110</sup> Evaluations of LEAD pilot suggests that program exposure is associated with less recidivism, better health outcomes, and cost savings.<sup>111</sup>

Nonetheless, as we struggle to contain this crisis, their rapid dissemination has proceeded organically in the near-absence of robust evaluation that could inform their design and tailoring. For example, it is not clear whether training and equipping police to conduct overdose rescues is equally cost-effective in urban areas already well-served by professional medical response, as it is in rural or tribal locales where medical first responders arrive with substantial delay.

More critically, these innovations have certainly expanded the traditional criminal justice toolkit towards policies and practices closer aligned with public health goals. Despite their symbolic and rhetorical importance, these changes have been marginal. 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.

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. 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. Although government budgets

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<sup>106</sup> See, generally, Michael Tonry, *Remodeling American Sentencing A Ten-Step Blueprint for Moving Past Mass Incarceration*, 13 *Criminology & Public Policy* 504 (2014).

<sup>107</sup> <http://www.cicj.org/news/10052> Prop 47 Statute

<sup>108</sup> LEAD Evaluation <http://leadkingcounty.org/lead-evaluation/>

<sup>109</sup> Caleb J. Banta-Green et al., *supra* note at 97.

<sup>110</sup> Daniel I. Rees et al., *The National Bureau of Economic Research, With a Little Help from My Friends: The Effects of Naloxone Access and Good Samaritan Laws on Opioid-Related Deaths* (2017) available at <http://www.nber.org/papers/w23171> (noting that "we find that the adoption of a NAL is associated with a 9 to 11 percent reduction in opioid-related deaths. The estimated effect of GLSs on opioid-related deaths is of comparable magnitude, but not statistically significant at conventional levels.")

<sup>111</sup> <http://leadkingcounty.org/lead-evaluation/>

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.

### III. MURDER-BY-OVERDOSE: AN INTERDISCIPLINARY CRITIQUE

The stated mission of criminal justice professionals and institutions is to safeguard the constituencies they serve. Same goes for elected and administrative policymakers. Significant threats to that safety create a strong impetus to demonstrate decisive and remedial action. Such action is shaped by the choice architecture, including incentives like 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 and policies. Change has been limited and largely symbolic, however, the overall choice environment has continued to offer a much clearer path to punitive responses. 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. Murder-By-Overdose: 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.<sup>112</sup> 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.<sup>113</sup>

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.<sup>114</sup> 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.<sup>115</sup> It was this provision-- §841(b)(1)(C)--that federal prosecutors would years later use to charge Marcus Burrege.

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<sup>112</sup> Brief for the United States at 3 (see supra note 3).

<sup>113</sup> Brief for the United States at 3 (see supra note 3).

<sup>114</sup> Bryan Polcyn and Stephen Davis, *supra* note 80. (providing a picture of Bias on the cover of *Sports Illustrated* magazine, with the headline “Death of the Dream”)

<sup>115</sup> Brief for the United States at 3 (see supra note 3); See also Bryan Polcyn and Stephen Davis, *supra* note 80.



States would soon follow in adopting analogous instruments. Today, almost half US state jurisdictions have a murder-by-overdose law.<sup>116</sup> Although they all use the same instrumental framework, these provisions use a variety of criminal law mechanisms, including felony-murder;<sup>117</sup> depraved heart offences,<sup>118</sup> or involuntary or voluntary manslaughter.<sup>119</sup> At the extreme end of the punitive spectrum, there are among these laws capital one provisions like West Virginia's which imposes sentences up to life in prison, and are eligible for the death penalty.<sup>120</sup>

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.<sup>121</sup> With very few exceptions,<sup>122</sup> the provisions do not 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.<sup>123</sup>

In the context of the opioid crisis, an increasing number of jurisdictions have proposed entirely new, or enhanced murder-by-overdose provisions to add to their

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<sup>116</sup> \*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); 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)); Louisiana (La. Rev. Stat. Ann. § 14:30.1(3)); 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); Michigan (Mich. Comp. Laws Ann. § 750.317a); Minnesota (Minn. Stat. § 609.195(b)); 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 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).

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<sup>120</sup> \*W. Va. Code Ann. § 61-2-1; there have been no death penalty sentences handed out in these cases.

<sup>121</sup> \* *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)

<sup>122</sup> \*

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arsenal. The number of such proposals has more than doubled from three in 2012 to seven in 2016.<sup>124</sup> Although none of the proposed statutes have yet been enacted, three of the proposed laws included special provisions mentioning fentanyl.<sup>125</sup>

b. Trends in Murder-By-Overdose Deployment: Assessing the Public's Informational Environment

The principal impact channel for the deployment of murder-by-overdose deployment is informational. It is no accident that “sending a message” is the stated legislative and prosecutorial objective of these instruments and their applications.<sup>126</sup> This is why lawmakers, prosecutors and law enforcement officials often issue press releases<sup>127</sup> and hold high-profile press conferences<sup>128</sup> when discussing murder-by-overdose. Whatever the eventual impact of the message, mass media plays a vital function in delivering this message to its audiences. Before proceeding to critique this approach it is worth assessing the dose and content of these signals.

Accurate quantification the actual deployment of these provisions is limited by a number of factors.<sup>129</sup> I use two sources of data as imperfect proxies: 1. a news trend analysis, and 2. secondary sources that track these cases on the local level.

Based on a review of existing literature, the incidence of murder-by-overdose deployments has risen sharply since 2010. Predictably, the rise is especially notable in jurisdictions hard-hit by the overdose crisis, like those in Oregon,<sup>130</sup>

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<sup>124</sup> York (AB 8616), Ohio (HB 270), and Virginia (HB 615, SB 66)\*

<sup>125</sup> Andrew O'Reilly, *Drug Dealers Would Face Manslaughter Charges for Opioid Overdoses under Proposed Florida law*, Mar. 9, 2017, <http://www.foxnews.com/us/2017/03/09/drug-dealers-would-face-manslaughter-charges-for-opioid-overdoses-under-proposed-florida-law.html>.

<sup>126</sup> See, e.g. ft X supra and accompanying text.

<sup>127</sup> 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>.

<sup>128</sup> 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>.

<sup>129</sup> 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.

<sup>130</sup> Les Zaitz, *Drug Cartels in Oregon: 'Len Bias' Strategy a Potent Tool for Law Enforcement*, Oregon Live, June 21, 2013, [http://www.oregonlive.com/pacific-northwest-news/index.ssf/2013/06/drug\\_cartels\\_in\\_oregon\\_len\\_bia.html](http://www.oregonlive.com/pacific-northwest-news/index.ssf/2013/06/drug_cartels_in_oregon_len_bia.html) (last visited March 29, 2017).

New Jersey, New York State,<sup>131</sup> and Wisconsin (where their number doubled between 2012 and 2013).<sup>132</sup> In many jurisdictions, it is enough to have simply shared a small amount of your drugs with the deceased to be prosecuted for homicide. [Additional review secondary sources quantifying trends in deployment]

This signaling element makes media reports a key proxy for deployment of murder-by-overdose instruments. We conducted systematic news report searches mentioning key search terms<sup>133</sup> 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, whether the story specified the resolution of the case, and whether an alternative view was presented. Our empirical analysis of mass media coverage confirms that the informational environment pertaining to murder-by-overdose has substantially shifted between 2000 and 2016.<sup>134</sup> [more on findings here]

Now that we have established the content and dosage of this intervention, we discuss the theoretical and empirical elements to estimate its probable impact. Such impact has never been evaluated empirically.

c. Criminal Law Objectives: Deterrence, Incapacitation, and Retribution

i. Deterrence

The primary communications 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. The operative mechanism for this intervention is the severity of punishment (typically mandated by the statute) imposed for supplying drugs to overdose victims.

There is a rich existing literature on punishment in general and mandatory minimums in particular on criminal behavior. 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

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<sup>131</sup> U.S. Attorney's Office, *supra* note 127.

<sup>132</sup> Bryan Polcyn and Stephen Davis, *supra* note 80.

<sup>133</sup> \*

<sup>134</sup> Specifically, there were X relevant items in 2000. After X, items saw a sharp increase, culminating in X items by 2016. The sharpest increases were seen in X and X states. Of these items, X% related to arrests, charges, and criminal trials involving murder-by-overdose, while X% related to conviction or post-conviction issues. In terms of case characteristics, X% involved an accused who was a friend or family member, X% involved a minor drug dealer, and X% involved a major drug trafficker. Overall, only X% of the stories included critiques or alternative views of the approach.

conceptualizes the deterrent effect to be a function of penalty's severity and the individual's perceived risk of getting caught. 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.

Second, in order for the deterrence effect to become operational under the Law and Economics model, there must be a stable and transparent informational environment about the components of the penalty calculus. The imposition of the murder-by-overdose provisions depends on several nested events, each with an unknown (and unknowable) probabilistic setting. 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 poly-drug toxicity. 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.<sup>135</sup>

Third, Behavioral Economics provides an additional basis for critique. 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. This implies that the person impacted is indeed a "drug dealer"--a somewhat ambiguous notion, given the fluidity of transactional relationships between drug users. 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.

Fourth, there is basis to question whether or not the rational actor model is modally applicable here. Some--though by no means all--of those impacted by these provisions may themselves be affected by severe forms of substance use disorder, which by definition implies that the individual is unable to respond to cues about the negative consequences of their behavior. This fact alone completely undermines the application of Law and Economics model in these cases.

Conversely, if we do assume the rational actor model is operative, this undermines the rationale for murder-by-overdose instruments from a different angle. This is because a rational seller who depends on a consistent clientele would never intentionally sell a product that cuts his consumer base.

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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). 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. These contents also frequently fluctuate--often as a result of interdiction activities and other law enforcement efforts to disrupt the market. This further complicates any rational decisionmaking. Even if they did contemplate such a shift, the dynamics of the drug trafficking organizations make it highly difficult to shift to alternative suppliers. 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 disparity. This provision did not impact the availability or consumption of crack, but did fuel mass incarceration of mostly impoverished African-American men.

#### 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,<sup>136</sup> though it is now resurgent at the center of new Administration's strategy to combat the opioid crisis.<sup>137</sup> Microeconomic theory suggests that, in view of inelastic demand, raising the financial and other costs will not shift demand or reduce supply. 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 of drugs on the black market has increased, purity and price have decreased. 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 new entrants.

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 cases<sup>138</sup> illustrate, evidentiary parameters constrain the scope of application of these provisions. These constraints affect not just the considerations of contributory effect of specific substances—a

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<sup>136</sup> Rucker Johnson and Steven Raphael, *How Much Crime Reduction Does the Marginal Prisoner Buy?* 55 *Journal of Law and Economics* 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)

<sup>137</sup> <https://www.justice.gov/opa/press-release/file/946771/download> at 2, 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."

<sup>138</sup> \*

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.” In his decision in *Burrage*, Scalia provided an entertaining illustration of this problem in terms of lawyers of causation that can be attributed for hitting a home run.<sup>139</sup> The analysis of the cases suggests that the application of these provisions is constrained by evidentiary concerns only to tightly proximate individuals (and small number of cases). From a historical perspective, the emergence of the opioid crisis just as US had reached the zenith of mass incarceration severely undercuts the incapacitation argument.

### iii. Retribution

Retribution is another key 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.” By speaking to members of the public--or specific segments thereof--these actors are also seeking to reassure that someone is being held responsible for the victim’s death, as well as for the ongoing carnage.

The actual application of the retribution rationale is probably the most aligned out of all of the implied objectives. Many--though by no means all<sup>140</sup>--victims’ families and others express support<sup>141</sup> for murder-by-overdose 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. The impetus for responsive action would be much more productively utilized if applied towards evidence-driven interventions,<sup>142</sup> 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. This principle 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

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<sup>139</sup> *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.”

<sup>140</sup> [https://www.vice.com/en\\_us/article/heroin-murder-and-the-new-front-in-the-war-on-drugs-928](https://www.vice.com/en_us/article/heroin-murder-and-the-new-front-in-the-war-on-drugs-928)

<sup>141</sup> <https://www.bostonglobe.com/metro/2015/08/17/maura-healey-proposes-new-law-targeting-opioid-traffickers/geOZTEmdm5IC6KX9eeOKhK/story.html>

<sup>142</sup> [https://www.vice.com/en\\_us/article/heroin-murder-and-the-new-front-in-the-war-on-drugs-928](https://www.vice.com/en_us/article/heroin-murder-and-the-new-front-in-the-war-on-drugs-928)

fatality is both unfair and misplaces the blame in a way that scrambles remedial action.

iv. Public health impact/cross purposes.

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. Treating every overdose event as a crime scene and charging overdose witnesses with drug-induced homicide can deter help-seeking during overdose emergencies. 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. 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 prosecuting bystanders for their potential role in a non-malicious overdose event.

It is no accident that the Surgeon General's landmark report on the opioid epidemic Facing Addiction does not mention murder-by-overdose laws and prosecutions as an overdose prevention strategy: they aren't. 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. 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.<sup>143</sup> 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.<sup>144</sup>

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. Secondly, the vast majority of drug users, the general public, and even many police officers may not be aware of such laws.<sup>145</sup> In this context, aggressive and mounting application of criminal prosecutions following overdose events totally thwart any positive public health impact of Good Samaritan legislation and other efforts to encourage overdose witnesses to come forward.

But the application of these provisions may further isolate users, increasing their

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<sup>143</sup> See Banta Green, Beletsky, et al., *Supra* note X at X.

<sup>144</sup> Help From Friends, See *supra* note X at X.

<sup>145</sup> <http://www.ncbi.nlm.nih.gov/pubmed/23900788>

overdose risk. One of the principal harm reduction strategies for preventing fatalities is to encourage users to not use alone. 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 murder-by-overdose prosecution may disrupt this practice.

To be clear, we do need accurate and timely information about dangerous street drugs and prescription drug patterns. 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 opioid crisis. We 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.

More fundamentally, the 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. 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. These programs also require police to work in partnership with public health and other sectors. By reinforcing the role of criminal justice institutions and practitioners as proponents of punishment and stigmatization, these interventions undermine this fragile 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 murder-for-overdose prosecutions disproportionately target people of color. For instance, Marcus Burrage is Black,<sup>146</sup> while Joshua Banka was Caucasian.<sup>147</sup> 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. 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 work in Ferguson, MO.

Finally, the application of murder-by-overdose threatens to crowd out other

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<sup>146</sup> Grant Rodgers, U.S. high court reverses Iowan's drug conviction. The De Moines Register. Jan. 27, 2014 <http://www.desmoinesregister.com/story/news/crime-and-courts/2014/01/28/us-high-court-reverses-iowans-drug-conviction/4956117/>

<sup>147</sup> <http://www.legacy.com/obituaries/name/joshua-banka-obituary?pid=1000000142045292&view=guestbook>



evidence-driven efforts. Aside from being likely counter-productive, these prosecutions are resource-intensive (consider, as an extreme example the US DOJ outlays on *Burrage*). Many public health agencies and nonprofits already operate in an environment of extreme scarcity. This is compounded by mounting calls for additional cuts, as well as other factors like declining tax base and the rising price of naloxone. Although it may make us feel like we are making progress by punishing specific individuals for overdose events, public resources are too limited to be spend on policy theater.

The phenomenon of doubling down on punishment as an antidote to the opioid crisis is much broader than murder-for-overdose: Murder-by-overdose interventions are perhaps the most vivid and potentially impactful illustration of a larger pendulum swing back towards punitive and coercive measures. 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 such victims for admission to treatment. Legislative efforts have paralleled such law enforcement activity, advancing involuntary commitment, involuntary treatment, and other coercive mechanisms.<sup>148</sup>

#### IV. HARMONIZING PUBLIC HEALTH AND CRIMINAL JUSTICE TO CURB THE OPIOID CRISIS

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. 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.

Despite a marginal and symbolic shifts towards public health frameworks, lawmakers, prosecutors, and police have continued to drawing on the arsenal of familiar tools of compulsion available to them. These actions reflect established dynamics of “policy theater,” where public figures tend towards actions that that are visible and noteworthy, regardless of their ultimate impact. Such actions are characterized by immediate benefits in terms of elevated public approval and community well-being, but deferred actual cost. Conversely, actions that have high cost but deferred benefit face a clear disadvantage in the face of a crisis. We don’t know whether the public approves of these actions--there is no poll that

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<sup>148</sup> <http://healthaffairs.org/blog/2016/02/11/expanding-coercive-treatment-is-the-wrong-solution-for-the-opioid-crisis/>

could shed light on this. Perspectives of victim families are mixed.

A more fundamental paradigm shifts are needed to address the crisis. A better theoretical and practical vision for the “Public Health Approach” to the opioid crisis is necessary. Such an approach implies a move away from a Law and Economics-based framework towards a population health policy framework. In her book *Populations, Public Health, and the Law*, Wendy Parmet proposes a framework of “population-based legal analysis.”<sup>149</sup> Tracing the historical significance of the *salus populi suprema lex maxim*,<sup>150</sup> Parmet calls for a renewed focus on public health as one of the central goals of law—a consideration that should permeate judicial and policy decisionmaking.<sup>151</sup> The 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. 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.<sup>152</sup> But public health law has not yet re-entered the mainstream of American Jurisprudence. Scalia passed on the opportunity to engage in population-based legal analysis,<sup>153</sup> in the way that he had often engaged in analyses on economic and other topics.<sup>154</sup>

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.<sup>155</sup> Just as public 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”<sup>156</sup> 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 temporally removed from the actions by years, if not decades. Costs of these diffuse benefits to un-named beneficiaries are nonetheless borne by all taxpayers, who tend to resent them. 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. In public opinion polling, Americans are generally

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<sup>149</sup> Ogden, Prevalence of overweight in US; JAMA (2006); Wendy Parmet, *supra* note 41 at 51-54

<sup>150</sup> See section X\* above

<sup>151</sup> Wendy E. Parmet, *supra* note 41. at 2, 52-53

<sup>152</sup> Wendy E. Parmet, *supra* note 41, at 2..

<sup>153</sup> See, generally Wendy E. Parmet, *supra* note 41.

<sup>154</sup> Provide some examples here

<sup>155</sup> Wendy E. Parmet, *supra* note 41.

<sup>156</sup> PHTP, and 23

favorably disposed to the idea of investing in public health prevention; when asked about specific program expenditures, however, support markedly diminishes to a relatively small minority of respondents.

Criminal law interventions don't suffer from many of the same "prevention paradox" problems. 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. Criminal law interventions like successful prosecutions create a perception of a tangible success to a number of key stakeholders. Those wronged by the action typically experience a sense of vindication and catharsis.<sup>157</sup> Prosecutors' and police officers' incentives are highly aligned with such actions, rather than prevention or "public health" approaches.

However, investment in public health regulation and infrastructure produces not only improvements in life expectancy, but also substantial return on investment.<sup>158</sup> They have used these data to argue for shoring up existing and building new tools to pursue population health under this "new" framework.<sup>159</sup> They 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.<sup>160</sup> 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.<sup>161</sup>

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.<sup>162</sup> Today, more than at any other time, the growing evidence base from empirical research into the interaction of law and health can be used to shape policy decisions.<sup>163</sup> These tools should be brought to bear on the opioid crisis.

The structural determinant framework is also important in the context of broader legal and political climate. The evidence that individual choice is shaped by the environment warrants effective government intervention to configure that choice

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<sup>157</sup> Although not always—some groups advocate for reconciliation etc.

<sup>158</sup> Mays GP and Smith SA. Evidence Links Increases in Public Health Spending to Declines in Preventable Health. *Health Affairs*. 2011. 30:8\* (accessed March 2017).

<sup>159</sup> 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)

<sup>160</sup> Hodge Implementing modern public health goals through government\*; see also Wendy E. Parmet, *supra* note 41, at 212-13-4.

<sup>161</sup> Rick Mayes & Thomas R. Oliver, *supra* note 44, at 191.

<sup>162</sup> 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)

<sup>163</sup> Michelle Mello & Elizabeth Zeiler, EMPIRICAL HEALTH LAW SCHOLARSHIP: THE STATE OF THE FIELD 96 *Geo. L.J.* 2004 at 656

architecture.<sup>164</sup> But there is substantial opposition to such actions. The use of labels like “totalitarianism” or “nanny-statism” is routinely mis-directed at government attempts to impact structural determinants of health.<sup>165</sup> 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.<sup>166</sup> The regulatory fabric of speech, financial incentive, and other mechanisms the government uses to accomplish these goals are increasingly threadbare.

Addressing structural determinants also implies a communitarian vision. This will flow against 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. Rhetorically, individualism stands in direct opposition to a communitarian framework that animates prevention, planning, and resource allocation mandates of public health practice. This framing also encourages the view of classes, races, and regions different from one’s own as “the other.” Recalling the overwhelmingly negative views on social welfare and redistributive policies,<sup>167</sup> 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. 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 opioid crisis presents a unique opportunity to rethink the current architecture for regulating drugs in the United States. An instrumentalist analysis of its current design suggests that the FDA could logically re-integrate the regulatory authority over controlled substances it ceded to the DEA, while delegating its law enforcement functions to the Department of Justice. Despite overlapping mandates and functions, these agencies now each consume annual federal appropriations of about three 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 historical transformation. Simultaneously, the current Administration has pledged to advance a “public health approach” to drug abuse, initiating divestment from a criminal justice-based framework that serves as the DEA’s operational mandate. Some of the principal challenges to such

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<sup>164</sup> Scott Burris, *The Invisibility of Public Health: Population-Level Measures in a Politics of Market Individualism*, 87 AM. J. PUB. HEALTH 1607, 1608 (1997)

<sup>165</sup> 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, luscious 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.

<sup>166</sup> Robert Nozick, *Anarchy, State, and Utopia*, Basic Books (1974) at\*

<sup>167</sup> See supra note X and accompanying text

consolidation, however, would include the extensive legal reforms that would be necessary to effectuate it, including changes to the Controlled Substances Act.

- a. Systemic Shift needed: what a true public health approach looks like:
  - i. take criminal justice out of the equation. If it is a public health problem, criminal justice needs to take a subordinate role to public health
  - ii. Invest in prevention, especially structural determinants
  - iii. Change metrics and incentives. Make policy evidence-driven
  - iv. Improve messaging on public health prevention. Theater and narratives as important as evidence
  - v. Stigma runs hand in hand with criminalization and prosecution. Cannot address one without the other.
  - vi. Encourage policy surveillance and sound public health law research.
- b. Public health approach should be based on public health theory. Three levels of prevention Primary, secondary, and tertiary. All three are important. Primary prevention is concerned with structural determinants, so should be emphasized
- c. We know what works to address the opioid crisis in the short term. Program and policy steps needed:
  - continued fatality prevention
  - Methadone, naltrexone, and buprenorphine are currently FDA-approved and cut overdose risk by 50%.<sup>168</sup> Decades of research has demonstrated these regimens to be safe, effective and cost-effective across social, geographic, and other settings and diverse populations.<sup>169</sup> Can include heroin-assisted therapy, showing great promise in trials in Europe and Canada.
  - Safe consumption facilities<sup>170</sup>
  - Law enforcement officials can do a lot to increase awareness about and access to key life-saving measures.

## V. CONCLUSION

As the opioid crisis lays bare, history has proven supply side approaches to be an experiment that was a significant misstep. Would Banka or those in his shoes be saved? Not this “policy disaster.” Application of murder-by-overdose and its

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<sup>168</sup> National Institutes of Health, *Effective Medical Treatment of Opiate Addiction*, 15(6) N.I.H. CONS. STATEMENT 1, 4, 21 (1997); see also Physicians & Lawyers for Nat’l Drug Policy, Alcohol and Other Drug Problems: A Public Health and Public Safety Priority 40–41 (2008).

<sup>169</sup> National Institutes of Health, *Effective Medical Treatment of Opiate Addiction*, 15(6) N.I.H. CONS. STATEMENT 1, 4, 21 (1997).

<sup>170</sup> Beletsky, et al The Law and Politics of Safe Injection Facilities in the United States AJPH (2008)

analogues will do nothing to curb the opioid overdose crisis. While we dither, it is going to get worse. As it is driven by structural factors, the opioid crisis is likely to continue and accelerate in the coming decades, especially under the current political climate.