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OHIO STATE LAW JOURNAL

Volume 80, Number 4, 2019

SYMPOSIUM
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The Opioid Crisis and the Drug War at a Crossroads
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Thank you, Mr. Darnell, for that introduction. Thank you for inviting me to discuss the challenges surrounding the opioid crisis. The themes you have asked me to address today—opioids, drug enforcement and health policy—are similar to the topics I addressed last week at the Specialized Docket Conference. Opioids, drug enforcement, and health policy are at the heart of Specialized Dockets courts.

We could call it a Specialized Dockets Movement. That’s because Specialized Dockets are becoming the new face of our justice system. We now have 245 Specialized Dockets courts in 61 of Ohio’s 88 counties. More than half of those are drug courts . . . and nearly all the rest deal with drug issues borne by families, by veterans, and by those with mental illness. We have four human trafficking courts as well.

Most of the specialized dockets growth has occurred in recent years—actually, since most of you, the final year law students at least—began your first year of undergraduate work. This transformation has occurred so quickly because the judiciary of this state sized up the problem as it developed and acted on it. Courts are not the only State of Ohio institutions that have come to the aid of our citizens who are experiencing drug problems. Our governor expanded Medicaid; Ohio now spends one billion dollars in Medicaid expenditures, which has made a huge difference in the fight against drug addiction. The Ohio General Assembly enacted T-CAP, Targeted Community Alternatives to Prison legislation. That allows for fourth- and fifth-degree felons to remain in their communities and receive supervision locally. Funds are diverted from the Ohio Department of Rehabilitation and Corrections to the local courts on a per capita basis.

We have special programs in our state such as a multidisciplinary Hope Partnership Project, a program in Ross County designed to address the cycle of addiction for heroin and other addictive substances. The focus includes components of prevention and education, treatment, law enforcement, volunteer, faith-based and medical. The local, state, and federal agencies came together in an effort to fight the opioid epidemic ravaging Ross County. Because of the reemergence of meth, the program has branched out to include all drugs.

Law enforcement and treatment center officials are seeing a trend of drug users turning to methamphetamine out of fear of heroin’s deadly consequences. Numbers across the state and locally reflect that trend from samples sent to Ohio’s Bureau of Criminal Investigation (BCI). In 2016, the U.S. 23 Task Force reported it seized 44 grams of methamphetamine. Last year, it reported it seized

* Remarks prepared for delivery on Friday, October 19, 2018, at the Ohio State University Moritz College of Law, John Deaver Dranko Hall.
1130 grams of meth. The task force reported 101 total indictments in 2016 and 211 the following year. According to the Ohio Attorney General’s Office, the number of meth cases BCI has processed in recent years is trending upward. In 2015, the agency processed 2050 methamphetamine cases. The following year, the number jumped nearly 1000. Last year, the agency processed over 5300 methamphetamine cases, and as of February 1 this year, they have processed 912 cases. In comparison, the number of heroin cases the BCI has processed has gone down in recent years from 6832 in 2015 to 4193 in 2017.

We have established a coordinated care management program with our state Medicaid colleagues that improves access to medical and behavioral care for those in family dependency courts, drug courts and juvenile drug courts. We have a robust certification process for drug courts and all other Specialized Dockets courts so that best practices and compliance issues are observed. Ohio is on the receiving end of $112 million through federal grants from the Department of Justice through 2021 to expand treatment capacity. Violence Against Women Act (VAWA) grants enable female victims of violent crimes to receive help, treatment and counseling. Ohio is in line to receive $12 million from this grant.

Yes, our courts have acted appropriately—and swiftly and strongly. We have worked from the bottom up, and from the top down. Two years ago, the leadership and staff of the Supreme Court of Ohio convened a multi-state emergency summit meeting in Cincinnati that became an eight-state consortium called the Regional Judicial Opioid Initiative. These eight states are working across state and county lines because drug trafficking has no boundaries. We are sharing databases on prescription drugs, sharing best practices on helping families—including babies—battle addiction.

And each state is moving in multiple directions internally and with the other states—a giant collaboration of law enforcement, courts, legislatures, health centers, medical professionals, academics, scientists and social service workers. It is an enormous web of help—spurred to action by public employees, non-governmental organizations, foundations, and philanthropic groups.

We have seen results in year-by-year declines in prescription drug proliferation and abuse. Because “doctor shopping” has declined to record lows due to the mandatory prescription drug monitoring program, overdoses from prescription drugs is at a low as well.

Meanwhile, sadly, we have been reminded of the difficulty of the drug situation as users shift to illegal drugs like heroin. And then we see the return of meth in a big way in our state and imports of dangerous killer substances like fentanyl. Drug abuse in Ohio and our nation is a moving target. Yet, we are engaged. We are committed as a judiciary to fight this crisis.

These top down efforts by experts would not be possible without the boots on the ground—the bottom up work of first responders, health care workers, and our drug court judges and their staffs. Their caring and toil produces knowledge that can be shared and enhanced. That’s what’s happening in our 170 Ohio drug courts. Shared knowledge and understanding by judges, magistrates, treatment
professionals, peer mentors, probation offices and staff are making a difference in hundreds and hundreds of lives. These courts are producing graduates of their programs, one by one by one.

We have learned many things. One major takeaway is that Medication-Assisted Treatment—called MAT for short—has to be part of the drug court program for the individuals we are trying to help. This is because the effects of opiates on the addicted brain can be long-lasting and have to be addressed. This can only be accomplished through medication.

After decades of study of the biology of addiction, we know that human brains must be weaned off addictive substances. This is accomplished through supervised medication. This medication process can take a year or more, it must be supervised, and supervision must be enforced in some way. That’s because the addicted brain is not capable of “just saying no” when it comes to making that decision to stay strong and not abuse a drug, or to give in “just this one time.”

It takes the caring and the expertise of a drug court. When I finished my address here at OSU last week, four graduates of drug courts and a human trafficking court took the stage and testified to the effectiveness of court-supervised intervention. There are at least two avenues that do not work. One is locking people up without treatment. The other is depriving them of court-supervised treatment. I do not like that term “carrot and stick,” but it is shorthand for a cause-and-effect that is working in our drug courts. Faced with jail time or treatment, treatment has a fair chance of winning.

To those who say government has not done enough, I say, yes, we can do more and we should do more. But I also say, let’s pay attention to the people inside and outside of government who are making a difference, who are expanding the knowledge of what is working and what does not work, and who are helping people take back their lives. This is a hard business. It is hard because addictive chemicals are powerful. It is hard because so many of our fellow citizens are vulnerable. It is hard because drug dealers are efficient and creative and ruthless, and because drugs are so plentiful and available. So, what makes anyone think that something so hard can have an easy answer? Well, apparently, a lot of Ohioans are considering voting for an easy answer to this terribly complex problem.

It’s also a wrong answer and worse, a catastrophic answer. Issue 1 on the ballot right now has all the trappings of a progressive measure. But it’s actually regressive because its passage would set back the hard work of drug courts and all the people working to solve our drug crisis. For those of you who are law students, you are accustomed to navigating through the weeds of a legal argument to get to the truth. And that’s exactly what’s going on with the language of this proposed constitutional amendment. It is so flawed. If you dig deeply into it—and you should—you will see how bad it really is. It would handcuff judges in this state, and they would not be able to impose jail as an incentive to keep addicts on program. The result is that judges are precluded from helping people get their lives back in order.
Supporters say Issue 1 will direct $136 million dollars to drug treatment and crime victim programs by prohibiting jail or prison time for most low-level drug possession offenders. But there are no data to back up that promise. In fact, there are solid data that reveal that this will not happen. Just last week, the state Office of Budget and Management came out with a report that analyzed Issue 1 from top to bottom—every page, every sentence. This is a report that is mandated to come out on all ballot issues statewide.

Proponents say hundreds of millions of dollars a year will be carved out from the Department of Rehabilitation and Corrections budget and funneled to the treatment community in Ohio. Nothing can be further from the truth. That’s not just my opinion. This fiscal report lays it out. The report reveals that the costs associated with Issue 1 will outweigh the meager money saved. That’s right, it will raise costs. Issue 1 will raise costs on local government while failing to make savings at the state level. Ultimately, costs will be shifted to local governments, the report reveals. How is this possible? It’s basically the old “garbage in, garbage out” cliche about data collection. If you put in bad numbers, you produce more bad numbers.

Proponents talk as if hordes of Ohioans are in jail for drug possession. The fact is that not many people are going to prison for felony 4 and felony 5 drug possession charges alone. Less than fifteen percent of inmates are in prison for drug crimes, total. That’s all drug crimes, trafficking F1 to possession F5. There were only 662 people in an Ohio prison for F4 and F5 drug possession alone as of July 2018. That number is so low because of programs such as T-CAP, which I spoke about earlier. These programs are in place to prevent low-level offenders from going to prison—and these programs are obviously working.

Finally, the Department of Rehabilitation and Correction estimates that Issue 1 will only reduce the prison population by 900 prisoners over the next four years. For that small blip, we are considering gutting our drug courts, one of the most effective tools in combating the opioid crisis. Why do I say “gutting?” Because Issue 1 would take away the pressure of choosing between prison and treatment. Let me be clear. If Issue 1 passes, there will be no incentive for those who are addicted to get treatment. None.

Issue 1 sounds good. But it’s full of what I call false hope. For that reason, I call it “cruel.” Issue 1 proponents are saying “if you have a loved one in prison right now, he or she will get a twenty-five percent reduction in their sentence if Issue 1 passes.” The reality is they have to go through various programs to meet that requirement, and I am telling you—the prisons do not have these programs. And Issue 1 will not establish a way to implement and pay for those resources.

So telling a family that a loved one in prison will get a reduced sentence when the prisons do not have the resources—that’s cruel to me. When I hear proponents of Issue 1 say what we are doing across government is not working, it infuriates me. We need to do more, because the problem is so big. But our path is working. There must be an incentive for a user to begin treatment, and that incentive is the specter of jail time.
How do I know? Because the drug court graduates say so, and they point to the programs we put in place. These recovered Ohioans say that before their court-sponsored treatment, they just wanted their next fix. Treatment was not voluntary—because today’s drugs of abuse are powerful. Overcoming their effects is so, so hard. Because treatment is a life and death matter, Issue 1 becomes just that.

The Franklin County Coroner recently released a report detailing seven overdose deaths in eighteen hours. The coroner in Butler County came out against Issue 1—saying—these are her words, not mine—that the prisons will be empty but the morgues will be filled. These are strong words. But leaders in our communities know how dangerous the situation is and how Issue 1 would make a bad situation worse.

Issue 1 allows for possession of just under 20 grams of fentanyl to be treated as a misdemeanor—an amount that could kill up to 10,000 people. Keep in mind, two milligrams of fentanyl—that’s two one-thousandths of a gram—will kill you. Issue 1 would put not only nonviolent inmates back on the streets, but also every level of violent felon, except murder, rape, and child molestation. It would tie the hands of judges to deal with probationers who violate no contact orders with victims. It would take away input from victims on inmate release.

The proponents compare substance abuse disorder, addiction, to other diseases. We do not put diabetics or those suffering from heart disease in jail, so why addicts? At first you may think that’s an apt comparison, but diabetics do not steal or break into homes for insulin. And the drugs prescribed for heart disease or diabetes are done to help prolong your life, not kill you as heroin or fentanyl will. Putting more of these people on the street, instead of helping them in a supervised program, will not make anyone safer, least of all the addict.

Proponents of Issue 1 say any problems with Issue 1 can be fixed by statute. No. That’s not how it works. This is a proposed constitutional amendment. It’s not a proposed statute. You cannot roll this back. It would become a fixture in our state constitution, and a legislative road to fixing it would not exist. It would take another constitutional amendment to amend or repeal this flawed proposal.

Other states have tried reforming the treatment of low-level felony addicts. They have downsized their crimes to misdemeanors, but how they did it is the difference. Only Ohio would have a constitutional amendment written in stone. All the other states (twelve) use statutory changes, and they have retained in the judiciary the ability to impose incarceration when appropriate. Proponents are wrong when they say Issue 1 is a way to deal with—quote—“small amounts”—of drugs. I have seen it reported this way in news stories. It goes way beyond addressing “small amounts” of drugs.

Some letter writers and editorial writers have questioned why I, as Chief Justice, am out there talking about this subject. Aren’t judges supposed to be neutral? Yes, we are sworn to be fair and impartial. We also have a duty to become involved in dialogues on issues of law and justice. Just so you know, on April 5, 2002, more than sixteen years ago, the Board of Commissioners on Grievances and Discipline issued an opinion (Opinion 2002-3). I quote:
It is proper under Canon 2(A)(1) of the Ohio Code of Judicial Conduct for a judge to communicate to the public about a proposed state constitutional amendment regarding drug treatment in lieu of incarceration, to explain the proposed amendment, to compare it to current law, and to describe its potential impact on the constitution, the law, and the operation of the courts. At all times during public communications, a judge must maintain the dignity appropriate to judicial office and abide by the high standards of speech in Canon 7.

So, there you have it. I have a duty to speak out on Issue 1, and I hope you will join me in doing so. Many of you in this room are on social media. Please spread the word about Issue 1 because this is a public health emergency, before it is a legal one. We also cannot win the war against this crisis with judges having their hands tied behind their backs. The biggest problem in this ballot measure is that supporters with big money who give big promises, without the facts to support them, continue to pour money into Ohio to spread falsehoods. But these proponents with their out-of-state cash will not be here to deal with the repercussions of this disaster. They do not live here in our communities. They do not see the devastation up close. We do see the devastation, and the heartbreak.

Voting began last week and continues through November 6th. Please vote no and encourage your friends and family to do the same. Frame your arguments from the position of the legal expertise you are developing, but do not forget the human part of this as well. Thanks to all of you. God Bless, and now I will take your questions.
SOURCES FOR FURTHER READING*


* Ohio State Law Journal student editors, and not the Chief Justice, have compiled these sources. They are included to give readers the opportunity to learn more about this topic if they wish.


Seth W. Norman et al., *Drug Court Success*, 51 TENN. B.J. 16 (2015).
OHIO ATTORNEY GEN., DRUG USE PREVENTION EDUCATION RESOURCE GUIDE (July 2018).


OHIO CODE OF JUD. CONDUCT r. 3.1 cmt. 1 (OHIO SUPREME COURT 2015).

OHIO CONST. art. XVI, § 1.

OHIO DEP’T OF HEALTH, 2017 OHIO DRUG OVERDOSE DATA: GENERAL FINDINGS (Sept. 21, 2018) (click the search icon; then enter the name of this report), https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs#page=1&alpha=[https://perma.cc/2AQ9-ZC47].


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Judge James Shriver & Judge Taryn L. Heath et al., Participant Perspectives: How Treatment Court Saved My Life, Address Before the 2018 Supreme Court of Ohio Specialized Dockets Conference (Oct. 11, 2018).


SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (SAMHSA), MEDICATION-ASSISTED TREATMENT FOR OPIOID ADDICTION 9 (2014).


Opioid Multidistrict Litigation Secrecy

JENNIFER D. OLIVA

“I don’t think anyone in the country is interested in a whole lot of finger-pointing at this point, and I’m not either. People aren’t interested in depositions, and discovery, and trials.”

“Although it has many purposes and goals, litigation is a fact-finding device designed as a search for the truth.”

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* Associate Professor of Law, Seton Hall University School of Law; J.D., Georgetown University; M.B.A., University of Oxford; B.S., United States Military Academy. I thankfully acknowledge and appreciate thoughtful feedback from Elizabeth Chamblee Burch, Daniel Goldberg, Patrick McGinley, Nicolas Terry, Suzanne Weise, Valena Beety, and the Seton Hall University School of Law faculty.


Considerable attention has been devoted to the massive opioid multidistrict litigation (MDL), which consists of nearly 2000 federal court cases consolidated in the United States District Court for the Northern District of Ohio before Judge Dan Aaron Polster. Journalists have examined whether the plaintiff counties, municipalities, and tribes have pleaded viable causes of action against the defendant manufacturers, distributors, and chain pharmacies that stand accused of exacerbating the opioid crisis by misbranding, aggressively marketing, and failing to monitor, flag, and report suspicious shipments of prescription opioid pills. Pundits have speculated as to the scope of potential damages in play given that experts estimate that the crisis has cost the United States at least $1 trillion since 2001 and will cost an additional $500 billion through 2020 unless the country pursues strategies that curb the crisis.

And the media has enthusiastically covered the nefarious allegations that have been levelled at the opioid crisis’s most notorious villains: the wealthy Sacklers of Purdue Pharma—who have removed themselves from the opioid MDL in an attempt to shield their immense family fortune from liability by filing for bankruptcy protection.

Until recently, however, scant attention has been consigned to the opioid MDL’s most salient and, arguably, most disturbing feature: its insidious secrecy.

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understanding the plaintiffs’ allegations and legal arguments, the basic facts concerning the scope of corporate marketing, distribution, and sale of prescription opioids, and the DEA’s confounding failure to detect suspicious sales of the drugs and, thereby, mitigate diversion. This Article examines the events that instigated the opioid MDL’s secrecy, discusses the legal merits of the district court’s nondisclosure rulings in the mass tort public health litigation, analyzes the United States Court of Appeals for the Sixth Circuit’s decision vacating and remanding the district court’s nondisclosure rulings, discusses the district court’s disclosure-related decisions on remand, and, ultimately, contends that a trial court’s failure to make crucial evidence transparent in aggregate national health emergency lawsuits, like the opioid MDL, is likely to undermine the public health promoting outcomes such litigation aims to achieve.

II. DEA ARCOS DATABASE

The opioid MDL’s pervasive secrecy stems from the public entity plaintiffs’ request for discovery of critical prescription opioid transaction data contained in the federal Drug Enforcement Administration’s (DEA) Automation of Reports and Consolidated Orders System (ARCOS) database. The 1970 Controlled Substances Act (CSA) devised a closed chain of controlled substances distribution specifically designed to prevent the diversion of legal products into the illicit market. That system requires CSA Schedule II and III opioid manufacturers and distributors to submit reports detailing “every sale, delivery or other disposal” of prescription opioids to the DEA. These manufacturer and distributor opioid transaction disclosures are uploaded to the ARCOS database, which summarizes them into reports that can be used to identify suspicious orders and the potential diversion of prescription opioids.

ARCOS, therefore, is “an automated, comprehensive drug reporting system which monitors the flow of DEA controlled substances from their point of


11 Id. § 827(d)(1).

manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level.” 13 ARCOS data includes the following information for each CSA-regulated drug transaction: supplier’s name, DEA registration number, address, and business activity; buyer’s name, DEA registration number, and address; prescription drug code, transaction date, total dosage units, and total grams. 14 The CSA also imposes specific duties upon wholesale distributors to monitor, identify, halt, and report “suspicious orders” of prescription opioids. 15

III. MDL ARCOS PROCEEDINGS: PRODUCTION TO PUBLIC ENTITY PLAINTIFFS

The battle for access to the DEA’s ARCOS opioid data was set in motion prior to the opioid MDL’s existence. During an October 24, 2017 status conference involving nineteen opioid cases before the United States District Court for the Southern District of Ohio, the plaintiff Ohio counties and municipalities sought the court’s permission to subpoena the DEA to obtain pertinent opioid transaction information stored in the ARCOS database. 16 The district court granted that request but stayed discovery pending the United States Judicial Panel on Multidistrict Litigation’s (JPML) ruling on motions to create an opioid MDL. 17

The DEA promptly raised a dozen objections to the Ohio plaintiffs’ ARCOS subpoena. 18 The agency’s opposition to the data request relied primarily on a pair of troublesome contentions. First, the DEA claimed that production of historical ARCOS data “would reveal investigatory records compiled for law enforcement purposes, and [as such] interfere with [its Controlled Substances Act] enforcement proceedings.” 19 It further maintained that ARCOS disclosure would improperly reveal opioid manufacturer and distributor trade secrets and confidential business information and, consequently, cause those entities substantial competitive harm. 20 In other words, the DEA—a federal agency created by Congress to monitor and improve controlled substance-related public health outcomes— injected itself into the opioid litigation not to assist the public

14 Id. at ¶ 7.
17 Id. at 3.
18 Objections of the U.S. Dep’t of Justice, Drug Enforcement Admin. to Plaintiff’s Subpoena at 3–9, AmerisourceBergen Drug Corp., No. 2:17-cv-713, ECF No. 101.
19 Id. at 5.
20 Id. at 6.
entity plaintiffs but to advance the alleged privacy interests of the defendant pharmaceutical corporations that it is charged with regulating.

If a September 2019 Department of Justice (DOJ) Inspector General (IG) Report is any guide, the DEA also was motivated to intervene in the litigation to keep secret from the public its own massive failure to regulate the supply and distribution of prescription opioids.\textsuperscript{21} The DOJ IG Report levelled several damning accusations at the DEA, finding that the agency “was slow to respond to the significant increase in the use and diversion of opioids since 2000.”\textsuperscript{22} The Report further found that “DEA did not use its available resources, including its data systems and strongest administrative enforcement tools, to detect and regulate diversion effectively,” and “DEA policies and regulations did not adequately hold registrants accountable or prevent the diversion of pharmaceutical opioids.”\textsuperscript{23}

It is hardly any surprise, then, that the DEA robustly objected to any disclosure of its ARCOS data. In support of its data nondisclosure posture, the DEA pointed to the federal Privacy Act\textsuperscript{24} and Touhy regulations,\textsuperscript{25} which enumerate the factors that the agency must consider in response to requests for production of information.\textsuperscript{26} The Touhy regulations, however, do not require the DEA to withhold data even where, unlike the ARCOS information, it indisputably contains investigatory records or trade secrets. Instead, they expressly permit the DEA to produce such information so long as disclosure is required by the “administration of justice.”\textsuperscript{27} In determining whether an information request satisfies the “administration of justice” standard, the Touhy regulations mandate that the DEA consider, among other things, “[t]he seriousness of the violation . . . involved,” “[t]he past history . . . of the violator,” “[t]he importance of the relief sought,” and “[t]he importance of the legal issues presented.”\textsuperscript{28}

The plaintiffs’ ARCOS opioid transaction data requests appear to satisfy the administration of justice criteria. The nation’s drug use and overdose crisis has claimed hundreds of thousands of lives and, as previously noted, cost American taxpayers approximately a trillion dollars since 2001.\textsuperscript{29} And numerous of the

\begin{footnotesize}
\begin{enumerate}
\setcounter{enumi}{21}
\item See DOJ IG DEA OPIOIDS REPORT, supra note 9, at 13–27.
\item Id. at i.
\item Id.
\item 5 U.S.C. § 552a (2012).
\item 28 C.F.R. § 16.26 (2018). The Touhy regulations derive their name from United States ex rel. Touhy v. Ragen, in which the Supreme Court held that the head of a federal agency may determine on their sole authority whether to produce documents in response to a subpoena. 340 U.S. 462, 470 (1951).
\item Objections of the U.S. Dep’t of Justice, Drug Enforcement Admin. to Plaintiff’s Subpoena, supra note 18, at 5 (“DEA objects to the production of the requested information under DOJ’s [Touhy] regulations because it would violate the Privacy Act.” (citations omitted)).
\item Id. § 16.26(c).
\item Id. § 16.26(c)(1)–(4).
\item Mangan, supra note 5.
\end{enumerate}
\end{footnotesize}
MDL defendants’ pertinent “past history” is atrocious. The federal government has extracted hundreds of millions of dollars in fines and penalties from the opioid manufacturers and distributors as a result of their unlawful market-related behavior, and it has even criminally indicted certain defendants due to their opioid-related conduct. The DEA’s disclosure objections, however, made no mention of either the administration of justice rule or its factors, let alone contended that the rule was inapplicable to the plaintiffs’ ARCOS data request.

The DEA also ignored relevant and dispositive provisions of the federal Privacy Act that compromised its objections to ARCOS data production. Because the Privacy Act expressly exempts from its purview court-ordered discovery, it is legally impossible for data released pursuant to a district court order to violate the statute. And even if that was not the case, the Privacy Act permits the disclosure of agency records to any person upon “a showing of compelling circumstances affecting the health or safety of an individual.” Given that the plaintiffs have alleged that the defendants’ prescription opioid branding, distribution, and marketing behavior collectively and proximately caused a national health emergency resulting in the deaths of hundreds of thousands of people, the ARCOS data request arguably satisfies the Privacy Act’s health and safety exception.

Before the district court had an opportunity to rule on the DEA’s objections to the ARCOS subpoena, however, the JPML consolidated the sixty-four opioid cases then-pending across the federal districts and transferred them to the United States District Court for the Northern District of Ohio for pre-trial proceedings. Judge Dan Polster thereby inherited the ARCOS opioid data production feud. He entered into the fray by ordering the plaintiffs and DEA to attempt to reach a consensus regarding ARCOS data production. In so doing, the judge pointed to the DEA’s admission that it was willing “to continue discussions with plaintiffs concerning the disclosure of ARCOS data consistent with disclosures it has made to other requestors, e.g., state and local government

31 See Objections of the U.S. Dep’t of Justice, Drug Enforcement Admin. to Plaintiff’s Subpoena, supra note 18, at 3–9.
33 Id. § 552a(b)(8).
35 Transfer Order, supra note 34, at 1.
36 Id. at 4.
entities.”\(^{38}\) In other words, the DEA conceded that it had previously disclosed ARCOS data to public entities, including local governments, much like the opioid MDL plaintiffs.

After much back and forth, the DEA and MDL plaintiffs remained unable to resolve their differences. The plaintiffs sought data for each opioid transaction stored in the ARCOS database from January 1, 2006 through January 15, 2015, including the date of the transaction; the seller’s name, DEA registrant number, business activity, state, and transaction code; the buyer’s name, DEA registrant number, business activity, county, state, and zip code; and the drug code, manufacturer, dosage units, grams-weight, and quantity.\(^ {39}\) The DEA, on the other hand, would only agree to produce limited, de-identified opioid data devoid of any transactional information that would enable the plaintiffs to ascertain “(a) which manufacturers (b) sold what types of pills (c) to which distributors” or “(d) which distributors (e) sold what types of pills (f) to which retailers (g) in what locations.”\(^ {40}\)

Judge Polster held a February 26, 2018 hearing in a final push to nudge the public entity plaintiffs and DEA toward a mutually acceptable resolution to the ARCOS data production dispute.\(^ {41}\) When that effort proved futile, the judge made two important decisions. First, he put in place a protective order applicable to all ARCOS data.\(^ {42}\) Second, he issued an opinion, which determined the scope of ARCOS data that the court required the DEA to produce to the public entity plaintiffs.\(^ {43}\)

The district court’s ARCOS data protective order was sweeping. It demanded that any disclosed ARCOS information remain confidential, limited the use of that data to litigation and law enforcement purposes, and required the redaction or sealing of all court-filed documents, including pleadings, inclusive of such data.\(^ {44}\) The protective order also commanded the public entity plaintiffs to notify the DEA and MDL defendants immediately upon their receipt of any public records request for ARCOS data and, in a move to cement ARCOS data-related secrecy into perpetuity, ordered the public entity plaintiffs to either destroy or return to the DEA all ARCOS information produced during the litigation at the conclusion of those proceedings.\(^ {45}\)

\(^{38}\) Id. at 1–2 (quoting Objections of the U.S. Dep’t of Justice, Drug Enforcement Admin. to Plaintiff’s Subpoena, supra note 18, at 9).

\(^{39}\) Order Regarding ARCOS Data at 4, In re Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio Apr. 11, 2018), ECF No. 233.

\(^{40}\) Id. at 6.


\(^{42}\) Protective Order Re: DEA’s ARCOS/DADS Database at 1, In re Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio Mar. 6, 2018), ECF No. 167.

\(^{43}\) Order Regarding ARCOS Data, supra note 39, at 22.

\(^{44}\) Protective Order Re: DEA’s ARCOS/DADS Database, supra note 42, at 1–4.

\(^{45}\) Id. at 6–7.
The ARCOS data protective order, however, appears unlawful on its face. A federal court’s issuance of a protective order “is circumscribed by a long-established legal tradition which values public access to court proceedings.” Federal Rule of Civil Procedure (FRCP) 26(c) proscribes a federal court from granting a protective order unless the party that seeks protection—here, the DEA—establishes good cause. This means that, in order to be entitled to a protective order, the moving party is required to demonstrate with particularity and specificity that harm or prejudice will result if the protective order is not granted. Speculative and conclusory statements do not constitute good cause. Moreover, federal courts are not required to issue protective orders even where the party seeking protection demonstrates sufficient harm. Instead, upon such a showing of harm, the court is required to balance the public’s interest in disclosure against the protection-seeking party’s interest in secrecy.

The Federal Rules of Civil Procedure make no exceptions where, as here, the parties stipulate to a proposed protective order or agree to certain of its terms. The district court’s ARCOS protective order, however, makes no reference whatsoever to good cause. And it is entirely bereft of any findings or conclusions that could be fairly characterized as either a good cause analysis or a balancing of the respective interests at stake. The ARCOS data protective order, therefore, failed to comport with federal law.

In addition to issuing an overly broad and legally suspect protective order, the district court rejected the plaintiffs’ request for opioid transaction-specific information and limited the DEA’s production burden to the narrow subset of de-identified ARCOS data that the agency was willing to share. Specifically, the court ordered the DEA to

(a) provide Excel spreadsheets to Plaintiffs that (b) identified the top manufacturers and distributors who sold 95% of the prescription opiates (c) to each State (d) during the time period of January 1, 2006 through December 31, 2014 (e) on a year-by-year and State-by-State basis, along with (f) the

47 FED. R. CIV. P. 26(c)(1).
48 Nemir v. Mitsubishi Motors Corp., 381 F.3d 540, 550 (6th Cir. 2004) (quoting Gulf Oil Co. v. Bernard, 452 U.S. 89, 102 n.16 (1981) (“[A] protective order [is authorized] only under circumstances ‘which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense,’ the potential for which must be illustrated with ‘a particular and specific demonstration of fact, as distinguished from stereotyped and conclusory statements.’”).
49 MANUAL FOR COMPLEX LITIGATION (FOURTH) § 11.432 at 67 (2004) (“In assessing [protective order] requests, courts balance the potential harm to the party seeking protection against the requesting party’s need for the information and the public interest served by its release.”).
50 See FED. R. CIV. P. 26(c).
51 See Protective Order Re: DEA’s ARCOS/DADS Database, supra note 42, at 1–2.
52 Order Regarding ARCOS Data, supra note 39, at 5–6.
aggregate amount of pills sold and (g) the market shares of each manufacturer and distributor.\textsuperscript{53}

The district court, therefore, adopted the DEA’s data production proposal \textit{in toto}. Judge Polster, however, abruptly reversed course just five weeks later by overruling his own ARCOS data disclosure decision. In a written opinion, he concluded that the DEA had failed to satisfy its burden of demonstrating good cause to withhold the transaction-specific ARCOS data requested by plaintiffs under FRCP 45(d), which controls third-party subpoenas.\textsuperscript{54} Judge Polster characterized the DEA’s law enforcement interests and the defendants’ trade secret objections as speculative and conclusory and ordered the DEA to produce the opioid transaction information to the plaintiffs subject to the ARCOS protective order.\textsuperscript{55} Several issues salient to the court’s change-of-heart regarding the scope of ARCOS data that was subject to disclosure warrant emphasis.

First, the ARCOS opioid transaction information sought by the plaintiffs constitutes evidence central to proving or refuting their allegations that the defendants deliberately overflooded plaintiffs’ respective jurisdictions, e.g., counties, cities, towns, municipalities, and tribal nations with prescription opioids. ARCOS data identifying precisely how many and which type of pills each opioid manufacturer and distributor delivered to each retail pharmacy on specific dates would—and, ultimately, did—enable the plaintiffs to determine which entities they should name as defendants, permit the litigation “to proceed based on meaningful, objective data, not conjecture or speculation,” and “provid[e] invaluable, highly specific information regarding historic patterns of opioid sales.”\textsuperscript{56} As Judge Polster explained:

\begin{quote}
There is overwhelming need for the Plaintiffs in this case to learn the truth surrounding marketing and distribution of opioids, including what the manufacturers, distributors, retailers, and DEA knew and when they knew it; what, if anything, was kept, intentionally or unintentionally, away from the DEA and the public by defendants; and what, if anything, the DEA kept, intentionally or unintentionally, from the States, counties, and cities that have filed the MDL lawsuits.\textsuperscript{57}
\end{quote}

In other words, it was impossible for the public entity plaintiffs to glean “the extent to which each defendant and potential defendant engaged in the allegedly

\begin{itemize}
\item \textsuperscript{53} \textit{Id.} at 6.
\item \textsuperscript{54} \textit{Id.} at 19; see Fed. R. Civ. P. 45(d).
\item \textsuperscript{55} Order Regarding ARCOS Data, \textit{supra} note 39, at 16–17, 19.
\item \textsuperscript{56} Second Order Regarding ARCOS Data at 2, \textit{In re} Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio May 8, 2018), ECF No. 397.
\item \textsuperscript{57} Order Regarding ARCOS Data, \textit{supra} note 39, at 21.
\end{itemize}
fraudulent marketing of opioids, filling of suspicious orders, and diversion of drugs” without the ARCOS opioid transaction data.\footnote{Id. at 15.}

Second, the DEA’s ARCOS database does not comprise any law enforcement investigatory information or corporate trade secrets. ARCOS simply stores business-generated controlled substance transaction reports, including prescription opioid transaction reports, compiled and produced by controlled substance manufacturers and distributors.\footnote{See supra Part II.} ARCOS does not contain any law enforcement analysis or work-product or confidential business information or trade secrets, such as pill formulations.\footnote{Transcript of Feb. 26, 2018 Hearing, supra note 41, at 25 (“[T]his is simply DEA’s data because it’s been received by the government, but there’s absolutely nothing whatsoever that’s been generated by any government office or agent or employee.”).} Judge Polster did not mince words on this latter point, stating: “Where the pills went is not a trade secret.”\footnote{Id. at 15.} He was even less enthralled by the pharmaceutical defendants’ confidential business information argument, retorting that “market data over three years old carried no risk of competitive harm,”\footnote{Order Regarding ARCOS Data, supra note 39, at 17 (emphasis added).} and, in any event, “there shouldn’t be a lot of competition for distributing opioids.”\footnote{Transcript of Feb. 26, 2018 Hearing, supra note 41, at 52.}

Third, the DEA’s contention that the disclosure of historic ARCOS opioid transaction data would interfere with law enforcement interests is undermined by the staleness of the information requested, which was limited to the time period 2006–2014.\footnote{Order Regarding ARCOS Data, supra note 39, at 1.} The DEA is bound by the CSA’s five-year statute of limitations applicable to the prosecution of controlled substance offenses.\footnote{18 U.S.C. § 3282(a) (2012).} Consequently, the agency was unable to convince Judge Polster, a former federal prosecutor, that it had any viable enforcement interests in historic ARCOS data.\footnote{See Transcript of Feb. 26, 2018 Hearing, supra note 41, at 14.} As the judge acknowledged, “[W]hatever was going on in 2010, ’11, ’12, ’13, . . . there’s no law enforcement objective there now; that’s historic, but it’s important for this litigation.”\footnote{Id.} Bolstering that observation is a recently decided Minnesota federal district court opinion, which held that the release of at least five-year-old, company-specific ARCOS opioid transaction data carried little risk of competitive harm in a case involving a similar opioid information production dispute between the DEA and a plaintiff.\footnote{Madel v. United States, No. 13-2832, 2017 WL 111302, at *2 (D. Minn. Jan. 11, 2017).}

Finally, the MDL court’s ARCOS opioid transaction data production order articulates a questionable rationale to justify its refusal to compel the DEA to produce that very same information to the plaintiffs when they initially requested it much earlier in the litigation. The order concedes that the “[d]etailed
ARCOS data evidence [the plaintiffs demand] is relevant . . . to prove culpability [and] . . . for purposes of allocation of settlement funds.”69 It nonetheless goes on to explain that the court had initially sided with the DEA because the much more limited ARCOS data that the agency had agreed to produce was “sufficient to address the Court’s immediate focus on ‘forward-looking initiatives and actions to help ameliorate the opioid crisis.’”70 By “forward-looking initiatives and actions,” the court was referring to its unbridled enthusiasm for a rapid, global settlement devoid of protracted discovery or trials that might reveal to the public information that could either bolster or undermine the plaintiffs’ allegations against the defendants and, thereby, permit the public to critically assess any proposed settlement agreement between the parties.

Since the opioid MDL’s inception, Judge Polster has made it clear that his singular objective is to ensure that the parties settle the aggregate litigation pre-trial.71 At first blush, that goal seems unremarkable. The overwhelming majority of civil cases either settle or are dismissed pre-trial.72 Judge Polster, however, went to extraordinary lengths to try to corral a quick deal to resolve the aggregated federal opioid cases pre-trial and, thereby, avoid robust discovery and public trials.73

For example, during his very first gathering of the MDL parties, which he characterized as a “settlement conference,” Judge Polster compelled the entities on both sides of the litigation to engage in settlement negotiations.74 He also made public his preference that the parties reach a “rapid settlement rather than trying cases” and engaging in vigorous discovery so that communities across the country devastated by opioid use disorder and overdoses could receive funds to fight the crisis.75 And the judge was entirely transparent about his intentions during a January 9, 2018 public hearing, during which he said: “I don’t think anyone in the country is interested in a whole lot of finger-pointing, and I’m not either. People aren’t interested in depositions, and discovery, and trials.”76 He went on to declare: “[W]e don’t need a lot of briefs and we don’t need

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69 Order Regarding ARCOS Data, supra note 39, at 15 n.8.
70 Id.
71 Fisher, supra note 8.
72 See generally Theodore Eisenberg & Charlotte Lanvers, What is the Settlement Rate and Why Should We Care?, 6 J. EMPIRICAL LEGAL STUD. 111 (2009) (discussing the importance of gathering and analyzing data on settlement rates and the variability in settlement rates based on the type of case).
73 Howard M. Erichson, MDL and the Allure of Sidestepping Litigation, 53 GA. L. REV. 1287, 1289 (2019) (explaining that Judge Polster “took an unusually aggressive pro-settlement stance from the start”).
76 Transcript of Jan. 9, 2018 Hearing, supra note 1, at 4.
trials. . . . [N]one of them are . . . going to solve what we’ve got.”\textsuperscript{77} Professor Howard Erichson has characterized these remarks as “stunning statement[s] from a judge.”\textsuperscript{78} As the complex litigation expert aptly observed:

> It is one thing for a judge to say that abatement of the crisis is an important goal, that the federal MDL has a role to play in achieving this goal, that the judge intends to manage the litigation in a way that furthers this goal wherever possible, and that ultimately a negotiated resolution may be the best way to achieve this goal. \textit{It is quite another thing to forswear litigation and adjudication altogether.}\textsuperscript{79}

As already noted, Judge Polster expressly defended his initial refusal to grant the plaintiffs access to the opioid transaction data—in violation of, among other things, the Federal Rules of Civil Procedure—on the grounds that “only circumscribed information within the ARCOS database is necessary to facilitate settlement.”\textsuperscript{80} Forbes went so far as to publish an article about Judge Polster’s management of the opioid MDL entitled \textit{Judge Sees Litigation as Only an “Aid in Settlement Discussions” for Opioid Lawsuits}.\textsuperscript{81} That report describes Judge Polster as “peeved” that he was pressured to manage an MDL “litigation track” and schedule bellwether trials, which he described as “necessary to do” “but . . . not a substitute or replacement [for settlement] in any way.”\textsuperscript{82}

Judge Polster reiterated his aggressive pro-settlement, anti-litigation stance during an August 2, 2018 hearing, during which he made the following statements:

> I didn’t want this litigating track. The defendants insisted they wanted to file all these motions. I said, All right. . . .

> . . .

> So, you know, \textit{all this discovery and depositions and whatever, and a trial, will accomplish zero}. . . .\textsuperscript{83}

> . . .

\textsuperscript{77} Id. at 9.
\textsuperscript{78} Erichson, supra note 73, at 1291.
\textsuperscript{79} Id. (emphasis added).
\textsuperscript{80} Order Regarding ARCOS Data, supra note 39, at 7.
\textsuperscript{81} Fisher, supra note 8.
\textsuperscript{82} Id.
... I don’t want to be essentially encouraging the parties to spend all their efforts on this litigating track, because that... not only isn’t going to solve anything, I think it’s going to make resolution virtually impossible.84

Judge Polster continued to advocate for a global settlement even as the first bellwether trial loomed. In an September 11, 2019 decision certifying a “novel” MDL “negotiation class,” he wrote: “From the outset of this MDL, the Court has encouraged the parties to settle the case. Settlement is important in any case. Here, a settlement is especially important as it would expedite relief to communities so they can better address this devastating national health crisis.”85

Shortly thereafter, the distributor and retail pharmacy defendants moved Judge Polster to recuse himself from the MDL proceedings pursuant to 28 U.S.C. § 455(a), relying on, among other things, his numerous judicial and extra-judicial statements in support of a settlement and opposed to discovery and public trials.86

However well-intentioned, the court’s anti-litigation, settlement-at-all-costs approach suffered at least two noteworthy flaws insofar as the public entity plaintiffs’ ARCOS disclosure request was concerned. First, the plaintiffs simply could not assess the potential culpability—if any—of each of the opioid defendants without the ARCOS opioid transaction data. As the district court ultimately acknowledged, the plaintiffs could not even ascertain which opioid manufacturers, distributors, and retailers they should name as defendants without the ARCOS transaction data.87 This is because there simply was no other way to determine which of those entities were in the chain of distribution of prescription opioids that ended up being dispensed in the public entity plaintiffs’ respective jurisdictions.88 The failure of the DEA to provide the plaintiffs with the ARCOS opioid transaction information precluded the plaintiffs from engaging in well-informed settlement negotiations and, therefore, potentially undermined the court’s objective of reaching a rapid, global settlement.

Judge Polster’s initial refusal to disclose the ARCOS transaction data to the plaintiffs further indicates that he was persuaded by the defendants’ argument that the opioid MDL could be quickly settled so long as the plaintiffs had access to each defendant’s market share. While a market share approach might work in litigation involving defendants that manufacture near-fungible, health-harming

84 Id. at 29.
87 See Order Regarding ARCOS Data, supra note 39, at 6.
88 Id. at 6–7.
products like cigarettes,\textsuperscript{89} it is an inapt settlement model for the opioid MDL. Prescription opioids are not only legal, FDA-approved products, they are the best treatment modality for particular patients in certain circumstances.\textsuperscript{90} They are not per se defective, health-harming products like cigarettes. As a result, a market share-driven settlement could lead to inequitable outcomes by, for example, imposing a huge liability burden on a defendant with a large market share but relatively benign market behavior while permitting a defendant with a smaller market share that engaged in much more culpable conduct to free ride.

More problematic, Judge Polster’s desire for a quick settlement was immaterial to any lawful assessment of the plaintiffs’ entitlement to the ARCOS transaction data. Federal Rule of Civil Procedure 45, which governed the plaintiffs’ ARCOS data subpoena, does not flinch where a federal judge or a party or even, as in the opioid MDL proceedings, a federal agency third-party subpoena target believes that nondisclosure of indisputably pertinent information would help secure a fast resolution to the litigation.\textsuperscript{91} Instead, and in line with Judge Polster’s order requiring the DEA to produce the ARCOS opioid transaction data, Rule 45 requires courts to order third-party data custodians to produce all relevant information sought by subpoena exclusive of trade secrets, privileged data, or other confidential commercial information.\textsuperscript{92} In sum, the court’s eagerness to settle the litigation in no manner undermined the plaintiffs’ legal entitlement to relevant ARCOS information under the Federal Rules of Civil Procedure.

IV. MDL ARCOS PROCEEDINGS: PRODUCTION TO THE PUBLIC

Soon after the DEA produced the ARCOS opioid transaction information to the MDL plaintiffs, HD Media Company, which owns the Charleston Gazette-Mail, filed a West Virginia Freedom of Information Act request seeking the ARCOS transaction data from MDL plaintiff Cabell County, West Virginia.\textsuperscript{93}


\textsuperscript{90} See generally Deborah Dowell et al., CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, 65 MORBIDITY & MORTALITY WKLY. REP. 1 (2016) (recommending when to initiate or continue opioids for chronic pain outside of active cancer treatments, palliative care, and end-of-life care).

\textsuperscript{91} See FED. R. CIV. P. 45(d)(3).

\textsuperscript{92} Id.

\textsuperscript{93} United States of America’s Notice of Objections to Disclosure of ARCOS Data at 1, In re Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio June 11, 2018), ECF No. 603.
The Washington Post filed similar state public records requests directed at two Ohio county MDL plaintiffs.\(^94\) Consistent with the ARCOS protective order, the DEA and defendants were notified of those media requests and promptly objected to them on the same grounds that they had raised in opposition to the plaintiffs’ ARCOS subpoena.\(^95\) The DEA contended that, “While the United States understands the public interest in this case, the ARCOS data contains confidential commercial information about DEA registrants’ commercial activities, Privacy Act protected information, and Law Enforcement Sensitive Information.”\(^96\) Reflective of the level of secrecy that had infused the opioid MDL’s day-to-day proceedings since the court issued the ARCOS protective order, the DEA’s brief and affidavit in support of its objections to public disclosure of the ARCOS data—to which the media companies ultimately were required to respond—were so heavily redacted that they were difficult to evaluate on their merits.\(^97\)

In response to the DEA’s objections to their public records requests, the media companies intervened in the opioid MDL to petition the court to lift the ARCOS protective order and, thereby, provide the public access to the ARCOS opioid transaction data as well as the voluminous pleadings, motions, and other documents that had been filed under seal in the MDL pursuant to the protective order.\(^98\) The media companies maintained that Judge Polster had failed to make a good cause finding sufficient to support the ARCOS protective order,\(^99\) there existed a strong presumption in favor of open court records under longstanding precedent,\(^100\) the American public had a compelling interest in obtaining the information in the midst of a national public health emergency,\(^101\) and the public’s interest outweighed the DEA and defendants’ interest in secrecy.\(^102\) The media companies also argued that the law enforcement and competitive harms alleged by the DEA and defendants were speculative and conclusory.\(^103\) To bolster those claims, the media intervenors pointed out that neither the DEA nor the defendants could identify any harm attributable to detailed ARCOS

\(^{94}\) Id.
\(^{95}\) Id. at 1–2.
\(^{96}\) Id. at 2.
\(^{97}\) See generally United States of America’s Brief in Support of Objections to Disclosure of ARCOS Data, In re Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio June 25, 2018), ECF No. 663 (showing the redactions made to the brief).
\(^{100}\) Id. at 4–5.
\(^{101}\) Id. at 9–10.
\(^{102}\) Id. at 1.
\(^{103}\) Id. at 11–13.
opioid transaction data released to the public by a West Virginia trial court in 2016.104

Judge Polster denied the media companies’ request to release the ARCOS information.105 Notwithstanding his earlier ruling rejecting the DEA and defendants’ objections to disclosure of the ARCOS transaction data to the public entity plaintiffs, Judge Polster concluded that the DEA and defendants had demonstrated good cause sufficient to justify the ARCOS data protective order under Federal Rule of Civil Procedure 26(c)(1).106 In other words, the court flip-flopped on its ARCOS-related good cause determination for a second time in the litigation.

Cribbing directly from the DEA’s redacted brief in objection to ARCOS data production to the media companies, the court found that the information sought was “sensitive to pharmacies and distributors because it is confidential business information . . . and . . . sensitive from the DEA’s perspective because it is crucial to law enforcement efforts.”107 Notably absent from Judge Polster’s opinion denying the media companies access to the ARCOS data were his earlier admonitions that the DEA and defendants’ asserted interests carried no weight because, as he concluded, “market data over three years old carried no risk of competitive harm”108 and “it is untenable that exposure of the data will actually or meaningfully interfere with any ongoing enforcement proceeding.”109

Judge Polster’s order also denied the media companies access to the ARCOS opioid transaction data on the theory that such disclosure would violate the federal Freedom of Information Act (FOIA).110 In so doing, he engaged in judicial jiu-jitsu to avoid the inconvenient fact that the media companies sought the ARCOS data not pursuant to federal FOIA but under pertinent state law, specifically, the Ohio and West Virginia public records statutes. As he explained:

ARCOS data is not a record generated by the Counties that are, or may be, subject to state public records requests. It is a law-enforcement tool of the United States that it shares only with local law enforcement agencies to stem illicit drug-trafficking. Plaintiffs have gained the ARCOS data solely by virtue of the Court’s discovery processes. The data does not transmogrify into a

\[\text{Note:}
105 Opinion and Order at 12, In re Nat’l Prescription Opiate Litig., MDL No. 2804 (N.D. Ohio July 26, 2018), ECF No. 800.
106 Id. at 8.
107 Id. at 9–10.
108 Order Regarding ARCOS Data, supra note 39, at 17 (emphasis added).
109 Id. at 16.
110 Opinion and Order, supra note 105, at 10–11.\]
public record merely because it has been disclosed privately to the parties in this civil litigation.\footnote{Id. at 11.}

This line of reasoning is difficult to defend on several counts. As already explained, the media companies did not request the ARCOS opioid transaction data from either the DEA or any other federal entity under federal FOIA. Rather, they sought the information from West Virginia and Ohio counties pursuant to those states’ public records laws. Those public records laws, in turn, make clear that the ARCOS information did transmogrify into state public records upon their receipt by the West Virginia and Ohio counties.\footnote{See Ohio Rev. Code § 149.43(A)(1) (2019) (“‘Public record’ means records kept by any public office, including, but not limited to, state, county, city, village, township, and school district units . . . .”); W. Va. Code Ann. § 29B-1-2(4) (2015) (“‘Public record’ includes any writing containing information prepared or received by a public body, the content or context of which, judged either by content or context, relates to the conduct of the public’s business.”).}

It is further worth pointing out that the DEA has been a proponent of the notion that otherwise private records transmogrify into documents to which it is entitled when those records are transferred from private parties to public custodians in federal civil litigation. For example, the DEA has taken the position on several occasions in federal district court that individual patients lose their privacy interests in their medical prescribing records when state law compels those records to be transferred by a dispensing pharmacy to a state prescription drug monitoring program (PDMP).\footnote{U.S. Dep’t of Justice v. Utah Dep’t of Commerce, No. 2:16-cv-611-DN-DBP, 2017 WL 3189868, at *8 (D. Utah July 27, 2017); Or. Prescription Drug Monitoring Program v. U.S. Drug Enf’t Admin., 998 F. Supp. 2d 957, 966–67 (D. Or. 2014), rev’d, 860 F.3d 1228 (9th Cir. 2017).} According to the DEA, a retail pharmacy’s involuntary transfer of a patient’s prescribing records to the state PDMP database deprives that patient of standing to even object to the DEA’s warrantless access of the patient’s record.\footnote{See Or. Prescription Drug Monitoring Program, 998 F. Supp. 2d at 962–63.}

The point here is a simple one. Record transmogrification is not a one-way doctrine. It cannot be the case that records do not transmogrify when such a result might defeat a federal agency or corporate defendant’s desire for secrecy but do so when it would benefit a federal agency at the expense of an individual’s privacy interests. The DEA’s position that individual patient prescribing records transmogrify once they are stored in state PDMP databases is not a random example. The DEA and opioid manufacturer and distributor defendants expressly advanced the argument in the opioid MDL that the public entity plaintiffs ought to be required to mine their own state PDMP databases—rather than be granted access to the ARCOS opioid transaction data—in order to ascertain patterns of suspicious opioid sales and diversion.\footnote{Transcript of Feb. 26, 2018 Hearing, supra note 41, at 39–40.} Needless to say, and unlike the ARCOS database, state PDMP databases do not include any
opioid manufacturer and distributor transaction data. PDMPs track prescription opioid pills from the point of prescribing to the point of dispensing of the drug to the individual patient.116

V. SIXTH CIRCUIT ARCOS PROCEEDINGS

The media intervenors appealed the district court’s decision denying their request for the ARCOS opioid transaction data and myriad sealed or redacted opioid MDL documents to the United States Court of Appeals for the Sixth Circuit.117 The Sixth Circuit held that the district court’s determination that the DEA and defendants had shown “good cause” sufficient to prevent the Ohio and West Virginia counties from disclosing the ARCOS transaction data to the public constituted an abuse of discretion.118 The appellate court pointed out that “the best evidence that good cause did not exist for the Protective Order comes from the district court’s own balancing of the interests in disclosure versus nondisclosure” in its earlier order granting the public entity plaintiffs access to the ARCOS data.119

The Sixth Circuit characterized Judge Polster’s “complete about-face concerning the relevant interests at stake” in the ARCOS data production disputes as “bizarre.”120 The appellate court found it incredible that the district court would anchor its denial of the media companies’ requests for ARCOS information in the very same speculative and conclusory grounds that the court had previously and vigorously rejected: the defendants’ and DEA’s purported commercial and law enforcement-related harms.121 Writing for the majority of a split panel, Judge Clay opined that the district court had gotten things right in its opinion ordering the DEA to disclose the ARCOS data to the public entity plaintiffs in the first instance because “representatives of the public . . . have a substantial interest in disclosure of the ARCOS data, while the DEA and Defendants have only a lesser interest in avoiding potential harms that can be avoided by narrower, less categorical means.”122

The Sixth Circuit also questioned whether the district court was motivated to keep the ARCOS data secret so that it could deploy the possibility of future public disclosure as leverage in settlement discussions. The panel mused whether Judge Polster’s repeated statements in favor of a pre-trial settlement “suggest[ed] that at least part of the reason for the district court’s about-face on

116 See, e.g., Or. Prescription Drug Monitoring Program, 860 F.3d at 1232 (citing OR. REV. STAT. § 431A.860) (“[P]harmacies . . . are required to report electronically to the PDMP, among other things, the patient’s name, address, date of birth, and sex; the dispensing pharmacy’s identity; and the prescribing practitioner’s identity.”).
117 In re Nat’l Prescription Opiate Litig., 927 F.3d 919, 923 (6th Cir. 2019).
118 Id. at 931, 938.
119 Id. at 931.
120 Id. at 932–33.
121 Id.
122 Id. at 933.
what interests Defendants and the DEA have in nondisclosure of the ARCOS data might have been a desire to use the threat of publicly disclosing the data as a bargaining chip in settlement discussions.\footnote{In re Nat’l Prescription Opiate Litig., 927 F.3d at 933.} With regard to that possibility, the panel delivered a stinging rebuke: “If this was a motivation for its holding, then the district court abused its discretion by considering an improper factor. And even if this was not part of the district court’s motivation, it appears that the court abused its discretion by acting irrationally.”\footnote{Id. (internal citations and quotations omitted).}

Another point of contention for the Sixth Circuit was the district court’s failure to take into account the relevant consequences that flowed from the aforementioned West Virginia trial court’s release of West Virginia ARCOS opioid transaction data in 2016.\footnote{See id. at 933–34.} The media companies had argued in the district court that the aftermath of the West Virginia ARCOS disclosure favored public access to the MDL ARCOS opioid data because, while the release of the West Virginia information had provoked public and policymaker awareness about—and, for better or worse, action in response to—the opioid crisis, neither the DEA nor the defendants had suffered any harm.\footnote{HD Media Co., LLC’s Brief in Support of Public Disclosure of ARCOS Data, supra note 98, at 6–11.} In fact, and as HD Media brought to the district court’s attention, the West Virginia distributor defendants neither sought a stay of nor appealed the West Virginia trial court’s decision to release the ARCOS data to the public.\footnote{Id. at 3.}

The district court, of course, had not been moved by those arguments. It quickly disposed of the need to even evaluate the relative impacts of the release of the West Virginia ARCOS transaction information for two reasons. First, the court explained that the West Virginia request only sought to unseal second amended complaints, which are subject to a presumption of public access, and not data contained in discovery produced pursuant to a protective order, which are governed by the lower standard of good cause.\footnote{Opinion and Order, supra note 105, at 7.} In addition, the court contended that the West Virginia ARCOS disclosure was distinguishable from the media’s MDL ARCOS data request insofar as the distributor defendants in the West Virginia litigation only invoked competitive commercial harm in opposition to disclosure whereas, in the opioid MDL, the DEA “cites as a basis for nondisclosure, in addition to confidential commercial information, the need to protect law enforcement-sensitive information, which is a subject this Court takes very seriously.”\footnote{Id. at 7–8.}

The Sixth Circuit was not impressed with the district court’s reasoning. It pointed out that public disclosure of the West Virginia “specific transactional data has proved extremely effective and consequential in calling attention to the horrors of the opioid crisis” by, for instance, inciting the United States House of
Representatives Energy and Commerce Committee to investigate and issue a report about the crisis.\textsuperscript{130} As the record established, the \textit{Charleston Gazette-Mail}'s reporting based on the West Virginia ARCOS opioid transaction data “result[ed] in a Pulitzer Prize, a Congressional Committee report, and a broader public understanding of the scope, context, and causes of the opioid epidemic.”\textsuperscript{131} The panel also emphasized that the DEA’s inability to “point to any resulting harm [from the West Virginia ARCOS data disclosure] demonstrates that there is little chance of \textit{imminent} harm from disclosure of the [MDL] ARCOS data.”\textsuperscript{132} The appellate court, therefore, concluded that the DEA’s alleged “law enforcement interests do not seem very weighty”\textsuperscript{133} and ordered the district court to reconsider the protective order:

[T]he district court may entertain arguments by the DEA as to why particular pieces of ARCOS data that relate to specific ongoing investigations should not be disclosed; however, the district court shall not enter a blanket, wholesale ban on disclosure pursuant to state public records requests. Nor shall any modified protective order specify that the ARCOS data be destroyed or returned to the DEA at the conclusion of this litigation.\textsuperscript{134}

The Sixth Circuit went on to vacate all of the district court’s MDL orders that permitted numerous court records, including public entity plaintiff complaints, to be filed under seal or with redactions pursuant to the ARCOS protective order.\textsuperscript{135} The appellate court easily reached that result due to the significantly more robust right of public access that pertains to court records than that which applies to discovery produced pursuant to a protective order.\textsuperscript{136} American constitutional and common law afford court records a strong presumption of openness, which the panel explained “applies here with extra strength given the paramount importance of the litigation’s subject matter.”\textsuperscript{137}

It is also well-settled that, given the public’s presumptive right to access court records, judges are proscribed from sealing court documents without espousing specific findings and conclusions to justify nondisclosure—even when no party objects to a request to seal.\textsuperscript{138} As a recent media investigative report into court secrecy explained, “In [Judge] Polster’s court, as lawyers began fleshing out their cases against the opioid industry in amended complaints, they

\textsuperscript{130} \textit{In re Nat'l Prescription Opiate Litig.}, 927 F.3d at 934.
\textsuperscript{131} \textit{id.} at 938.
\textsuperscript{132} \textit{id.} at 936.
\textsuperscript{133} \textit{id.} at 936–37.
\textsuperscript{134} \textit{id.} at 938.
\textsuperscript{135} \textit{id.} at 939–40.
\textsuperscript{136} See \textit{Shane Grp., Inc. v. Blue Cross Blue Shield of Mich.}, 825 F.3d 299, 305 (6th Cir. 2016) (“[T]here is a stark difference between so-called ‘protective orders’ entered pursuant to the discovery provisions of Federal Rule of Civil Procedure 26, on the one hand, and orders to seal court records, on the other.”).
\textsuperscript{137} \textit{In re Nat'l Prescription Opiate Litig.}, 927 F.3d at 939.
\textsuperscript{138} \textit{Shane Grp., Inc.}, 825 F.3d at 306.
redacted details of the companies’ conduct. In almost every instance, Polster failed to provide on the record his reason for allowing the secrecy . . . .”139

Judge Polster’s opinion denying the media companies’ requests for the ARCOS opioid transaction data similarly provided no such findings or conclusions in support of nondisclosure.140 “[T]he district court[, therefore,] is pax facto abused its discretion.”141 Consequently, the Sixth Circuit ordered Judge Polster to re-evaluate every one of the documents he had allowed to be filed redacted or under seal with the following guidance:

The court is advised to bear in mind that the party seeking to file under seal must provide a “compelling reason” to do so and demonstrate that the seal is “narrowly tailored to serve that reason.” On remand, if the district court permits a pleading to be filed under seal or with redactions, it shall be incumbent upon the court to adequately explain “why the interests in support of nondisclosure are compelling, why the interests supporting access are less so, and why the seal itself is no broader than necessary.” In doing so, the district court is to pay special attention to this Court’s statement that “[o]nly the most compelling reasons can justify non-disclosure of judicial records.”

VI. THE IMPORTANCE OF TRANSPARENCY IN PUBLIC HEALTH LITIGATION

“The judge is the primary representative of the public interest . . . . He may not rubber stamp a stipulation to seal the record.”143

The Sixth Circuit’s ARCOS data opinion, which commanded the district court to conduct a lawful, public analysis of the competing arguments for and against public disclosure of the ARCOS opioid transaction information,144 was a victory for opioid MDL transparency. Judge Polster, in fact, reconsidered his decision to deny the media access to the ARCOS MDL information in toto and, in so doing, lifted the protective order as to the 2006-2012 ARCOS data.145 The Washington Post thereafter released a report about that data, which revealed that opioid manufacturers and distributors flooded the country with more than 76 billion prescription opioid pills during the six-year period at issue.146 The report

139 Lesser et al., supra note 3.
140 See In re Nat’l Prescription Opiate Litig., 927 F.3d at 939.
141 Id.
142 Id. at 940 (quoting Shane Grp., Inc., 825 F.3d at 305–06).
144 In re Nat’l Prescription Opiate Litig., 927 F.3d at 939–40.
contains a panoply of incredible statistics, including the fact that distributors and manufacturers sent 306 prescription pills per person per year to the tiny hamlet of Norton, Virginia.\textsuperscript{147}

While Judge Polster’s decision to release the 2006–2012 ARCOS data on remand was a welcome development in the opioid MDL, he has refused to revisit his decision not to release to the public more recent ARCOS information, industry suspicious order reports, and millions of other discovery documents and court records that remain sealed or redacted. As such, and for several reasons, the public should be concerned about the pervasive secrecy that has infected the litigation since its inception and continues to deny it, the real party in interest, access to critical health and safety evidence pertinent to the country’s drug use and overdose crisis.

A. The Public Has a Compelling Interest in Transparent Health and Safety Litigation

First, the public has a particularly compelling interest in transparency in the opioid MDL. The MDL represents public interest litigation in its purest form: its plaintiffs are taxpayer-funded public entities advocating in the federal courts on behalf of their constituents in an attempt to mitigate an ongoing national public health emergency.\textsuperscript{148} The public is not only footing the bill for the litigation, it is a direct party in interest to the proceedings. As The Washington Post aptly submitted to the Sixth Circuit, “This is not a ‘private’ dispute being litigated in public. Rather, it is a public dispute that is wrongly being litigated in private.”\textsuperscript{149}

The notion that the public has a fundamental interest in transparent court proceedings, of course, is neither a new nor novel concept even where, unlike in the opioid MDL, the public is not a direct party in interest to the proceedings. In fact, it is a longstanding, bedrock attribute of the Anglo-American justice system. “The roots of open trials reach back to the days before the Norman Conquest . . . in England,”\textsuperscript{150} which then “carried over into proceedings in colonial America.”\textsuperscript{151}

Over the years, American courts have waxed poetic about the public’s right to access the courts as well as the intrinsic purposes of that fundamental right. In 1894, the District of Columbia Circuit explained that “[a]ny attempt to maintain secrecy, as to the records of the court, would seem to be inconsistent with the common understanding of what belongs to a public court of record, to

\begin{itemize}
  \item \textsuperscript{147} \textit{Id.}
  \item \textsuperscript{148} \textit{In re Nat’l Prescription Opiate Litig.}, 927 F.3d at 923.
  \item \textsuperscript{151} \textit{Id.} at 508.
\end{itemize}
which all persons have the right of access.” Nearly a century later, the United States Supreme Court formalized the public’s First and Fourteenth Amendment rights to open criminal trials in *Richmond Newspapers, Inc. v. Virginia*, expounding that “[t]he crucial prophylactic aspects of the administration of justice cannot function in the dark; no community catharsis can occur if justice is ‘done in a corner [or] in any covert manner.’”

Three years after *Richmond Newspapers*, the Sixth Circuit extended the holding and reasoning of that case to civil proceedings in *Brown & Williamson Tobacco Corp. v. FTC*. Much like the opioid MDL ARCOS data appeal, *Brown & Williamson* provided the Sixth Circuit with an opportunity to assess the public’s right to access important public health information that had been mired in secrecy in the district court. The decision was provoked by cigarette manufacturer Brown & Williamson Tobacco Company’s (B&W) appeal of the district court’s dismissal of its suit to enjoin the Federal Trade Commission (FTC) from publishing damaging information about some of its tobacco products in the Federal Register. Specifically, B&W sought to restrain the FTC from announcing that the agency’s cigarette testing methodology had underestimated the amount of tar in B&W’s Barclay cigarettes and the amount of both tar and nicotine in B&W’s Kool Ultra and Kool Ultra 100’s cigarettes.

The Public Citizen Health Research Group (Public Citizen) filed an amicus brief on appeal asking the Sixth Circuit to lift the blanket seal that the district court had placed on all documents filed by the FTC, which B&W vigorously opposed. The appellate court sided with Public Citizen, holding that the seal violated the public’s common law and First Amendment rights to access court proceedings. The court explained that, “In either the civil or the criminal courtroom, secrecy insulates the participants, masking impropriety, obscuring incompetence, and concealing corruption.”

*Brown & Williamson* held that the public was entitled to the FTC court records because “[t]he subject of this litigation potentially involves the health of citizens who have an interest in knowing the accurate ‘tar’ and nicotine content of the various brands of cigarettes on the market” and “how the government agency has responded to allegations of error in [its] testing program.” The Sixth Circuit wound up its opinion with a straightforward observation: “[C]ommon sense tells us that the greater the motivation a

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155 See *id.* at 1172.
156 *Id.* at 1167–68.
157 *Id.*
158 See *id.* at 1169.
159 *Id.* at 1176.
160 *Brown & Williamson Tobacco Corp.*, 710 F.2d at 1179.
161 *Id.* at 1180–81.
corporation has to shield its operations, the greater the public’s need to know.”\textsuperscript{162} Not long after deciding \textit{Brown & Williamson}, the Sixth Circuit extended the presumption of public access to pre-trial civil discovery.\textsuperscript{163}

If the public’s right of access to court proceedings is longstanding, has expanded in scope over time, and appears to be robustly guarded by the federal appellate courts, then why the fuss? The unfortunate reality, which the opioid MDL ARCOS data dispute brings into sharp contrast, is that trial courts are highly likely to seal documents, issue blanket protective orders, and permit parties to secretly litigate cases that implicate public health and safety. A recent \textit{Reuters} investigative report targeting secrecy in mass tort litigation confirms this conclusion.\textsuperscript{164} \textit{Reuters’} analysis of Westlaw data from 3.2 million federal civil suits filed between 2006 and 2016 “revealed that judges allowed litigants to seal material in at least 65 percent of product-liability actions\textsuperscript{165} and, “over the past 20 years, judges sealed evidence relevant to public health and safety in about half of the 115 biggest defective-product cases.”\textsuperscript{166}

\textit{Reuters} further reported that, “[i]n 85 percent of the cases where . . . [public] health and safety information [was] under seal, judges provided no explanation for allowing the secrecy,”\textsuperscript{167} which is, as explained above, blatantly illegal. The judges that \textit{Reuters} interviewed conceded that they issued blanket seals without cause in cases of great public import because they were swamped with litigation and such practice expedited case resolution.\textsuperscript{168} As former United States District Judge Jeremy Fogel explained: “You’re overburdened. You’ve got a limited bandwidth. You have lawyers fighting about everything. And so, when they finally agree on something, you’re all too happy to accept that . . . [Therefore,] information that could have really made a difference sometimes doesn’t come to light.”\textsuperscript{169}

Retired West Virginia Trial Judge Booker T. Stephens similarly responded when asked why he had kept West Virginia ARCOS transaction data filed in the State’s case against OxyContin manufacturer Purdue Pharma under seal for twelve years before releasing it to the Charleston Gazette-Mail in 2016: “This case was sealed because both sides agreed and asked me to seal it.”\textsuperscript{170} He went on to say that, “Obviously[,] when you settle a case of this magnitude and of

\begin{thebibliography}{9}
\bibitem{162} Id. at 1180.
\bibitem{163}Meyer Goldberg, Inc. v. Fischer Foods, Inc., 823 F.2d 159, 162–64 (6th Cir. 1987) (“[A]s a general proposition, pretrial discovery must take place in the public unless compelling reasons exist for denying the public access to the proceedings.”) (quoting American Tel. & Tel. Co. v. Grady, 594 F.2d 594, 596 (7th Cir. 1978)).
\bibitem{164}See Lesser et al., \textit{supra} note 3.
\bibitem{166}Lesser et al., \textit{supra} note 3.
\bibitem{167}Id.
\bibitem{168}See id.
\bibitem{169}Id.
\bibitem{170}Id.
\end{thebibliography}
Judge Stephens’s remarks are as concerning as they are candid. Federal law is clear that, while “[a] corporation very well may desire that the allegations lodged against it in the course of litigation be kept from public view to protect its corporate image, . . . the First Amendment right of access does not yield to such an interest.” The fuss, in sum, is about the rampant secrecy in mass tort public interest litigation notwithstanding the law, which demonstrates that even well-settled, fundamental public rights can suffer substantial erosion if not vigorously defended.

B. Public Transparency Provides an Important Check on the Pro-Secrecy and Pro-Settlement Forces that Drive MDLs

Public disclosure also provides an important check on the incentives that promote secrecy and rapid settlements in general civil litigation, which are super-charged in mass tort MDLs like the aggregate opioid litigation. As the Sixth Circuit explained in Brown & Williamson:

[Public access provides a check on courts. Judges know that they will continue to be held responsible by the public for their rulings. Without access to the proceedings, the public cannot analyze and critique the reasoning of the court. The remedies or penalties imposed by the court will be more readily accepted, or corrected if erroneous, if the public has an opportunity to review the facts presented to the court. . . . [P]ublic access provides an element of accountability. One of the ways we minimize judicial error and misconduct is through public scrutiny and discussion.]

To be fair, it is not just trial judges that forego transparency in order to move cases forward and secure more expeditious settlements in run-of-the-mill civil litigation. Private, contingency-fee-compensated plaintiffs’ attorneys, who want a quick return on their up-front investment rather than protracted proceedings and are required by the rules of ethics to place primacy on their clients’ interests, are incentivized to agree to secret proceedings and confidential settlements that may not be in the public’s interest. Corporate defense attorneys are also motivated to keep their clients’ wrongdoing shielded from public scrutiny and seek confidential settlement agreements to protect their clients’ reputations.

171 Id.
173 Brown & Williamson Tobacco Corp. v. FTC, 710 F.2d 1165, 1178 (6th Cir. 1983).
174 Id.
175 See L. Elizabeth Chamblee, Unsettling Efficiency: When Non-Class Aggregation of Mass Torts Creates Second-Class Settlements, 65 L.A. L. REV. 157, 247 (2004) (“Plaintiffs’ attorneys receive a hefty contingency fee from each individual client, but have to negotiate only one settlement.”).
176 See id.
Certain features unique to MDLs, however, hyper-incentivize judges, lead plaintiffs’ counsel, and defendants to collude to reach quick, confidential, global settlements that often operate to the plaintiffs’ disadvantage and keep the public in the dark. After highlighting the extravagant paucity of MDL cases that ever proceed to trial, which is, precisely, “very few,” Judge William Young aptly observed that “the ‘settlement culture’ for which the federal courts are so frequently criticized is nowhere more prevalent than in MDL practice.” It is particularly important, therefore, to demand and enforce public transparency to curb the MDL’s settlement-above-all-else priorities.

Unlike class action litigation, which is governed by FRCP 23, the MDL process is subject to the 1968 Multidistrict Litigation Act. Pursuant to that statute, the Chief Justice of the United States Supreme Court appoints a panel of seven federal judges that has the power to transfer groups of cases that are pending across various federal district courts and involve a common question of fact to a single federal district court. That “transferor” court then coordinates and conducts consolidated pre-trial proceedings. The Multidistrict Litigation Act mandates remand of transferred cases to the original “transferee” courts once the pretrial proceedings have concluded in the MDL transferor venue.

In order to manage their massive dockets and avoid resource-depleting, direct interaction with thousands of plaintiffs’ lawyers, MDL judges appoint a small group of attorneys as “lead counsel.” Lead counsel are responsible for the defining events in the litigation, including “negotiating settlements and dictating trial strategy.” As a result, the lawyers who have primary access to the MDL judge, decide the key litigation maneuvers, and negotiate exclusively with defense counsel are not the attorneys who represent the overwhelming majority of plaintiffs forced to litigate their claims in MDL venues and away from their home districts.

MDL judges appoint the same “repeat players” over and over again to MDL leadership positions purportedly due to their specialized aggregate litigation expertise. “Once appointed, lead lawyers highjack the cockpit and restrict

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177 See id. at 170–71 (“[A]ll mass torts share three key features that contribute to the potential for collusion in settlements: ‘repeat player’ attorneys who routinely represent mass tort plaintiffs or defendants; aggregation before a single court; and a judge who wants to dispose of burdensome mass tort litigation.”).
180 Id. § 1407(a), (d).
181 Id. § 1407(b).
182 Id. § 1407(a).
183 ELIZABETH CHAMBLEE BURCH, MASS TORT DEALS: BACKROOM BARGAINING IN MULTIDISTRICT LITIGATION 17 (2019).
184 Id. at 18.
185 Id. at 19.
186 Id. (reporting that 74.6% of leadership positions on MDLs are filled with repeat players).
access to the judge.”  

MDL judge-selected lead counsel, of course, do not work on behalf of the aggregate group of plaintiffs pro bono. Instead, judges award lead attorneys “common-benefit” fees for their efforts, which are funded by the MDL plaintiffs who have, at least in theory, “benefited” from lead counsel’s work. Common benefit fees are a significant motivator for lead counsel, who control settlement negotiations, because those fees are often (1) hefty and well-eclipse contingency fees and (2) negotiated with defense counsel during settlement talks. As a result, the common-benefit fee arrangement often works to the advantage of lead counsel and the defendants at the expense of the MDL plaintiffs. As complex litigation expert and law professor Elizabeth Chamblee Burch has pointed out: “[B]y offering lead lawyers “‘red-carpet treatment on fees’ in return for favorable terms elsewhere,’ defendants can take advantage of lead attorneys’ control over settlement to strike deals that benefit the defendant and the plaintiffs’ leaders, but not the plaintiffs.”

Repeat player lead attorneys are also less likely to pursue litigation tactics that are disfavored by the MDL judge that appointed them, determines their common-benefit fee awards, and controls their potential future appointments to MDL leadership positions even when such tactics might not be in the plaintiffs’ best interests. Moreover, because contingency fee lead attorneys are heavily leveraged in up-front funding of MDL litigation, the longer MDL cases linger on the docket, the more likely lead attorneys are to suffer adverse financial consequences up to and including bankruptcy. Lead counsel, therefore, are dangerously incentivized to acquiesce to MDL judges that favor secrecy and rapid, global settlements at the expense of their clients’ and the public’s interest.

MDL lead counsel and defense attorneys also are incentivized to reach a global, pre-trial settlement in order to circumvent the MDL procedure that requires that cases be remanded to their home districts for trial. Lead counsel seek to avoid remand because the transfer of the litigation back to home district courts deprives them of having their fees determined by the MDL judge that they have worked so hard to please over the course of the MDL pre-trial proceedings. Remand, instead, relegates control over lead counsel fees to any

\[^{187}\text{Id.}\]
\[^{188}\text{Id.}\]
\[^{189}\text{BURCH, supra note 183, at 20.}\]
\[^{190}\text{Id. at 20–22.}\]
\[^{191}\text{Id. at 22 (quoting Charles Silver & Geoffrey P. Miller, The Quasi-Class Action Method of Managing Multi-District Litigations: Problems and a Proposal, 63 VAND. L. REV. 107, 109–10 (2010)).}\]
\[^{192}\text{Silver & Miller, supra note 191, at 109–10 (explaining “[t]he price of [lead counsel] impertinence” to the MDL Judge that appointed them).}\]
\[^{193}\text{BURCH, supra note 183, at 24–25.}\]
\[^{194}\text{28 U.S.C § 1407(a).}\]
\[^{195}\text{BURCH, supra note 183, at 26.}\]
number of independent home federal district court judges—none of whom lead counsel have had the exclusive opportunity to court during pre-trial proceedings.\textsuperscript{196}

Defense attorneys, on the other hand, disfavor remand because it requires them to either litigate against, or make piecemeal deals with, individual plaintiffs across the federal districts instead of resolving all of the cases against their clients once and for all in a global settlement.\textsuperscript{197} As Professor Burch points out, corporate clients strongly prefer the finality of a global settlement because it “reassures shareholders, puts [public relations] nightmares to rest, and returns focus to a company’s primary enterprise.”\textsuperscript{198}

Federal judges are also hyper-incentivized to push for expeditious settlements in MDL proceedings. The overwhelmingly majority of federal district court judges, 70\%, want to be assigned an MDL, and 80\% of those who have been assigned to one desire to be assigned to another.\textsuperscript{199} “Multidistrict litigations are plum judicial assignments; they involve interesting facts, media attention, and some of the nation’s most talented attorneys.”\textsuperscript{200} The federal panel that assigns MDLs rewards judges who resolve MDLs efficiently with additional MDL assignments and is unlikely to assign another MDL to a judge who failed to resolve a previous one quickly.\textsuperscript{201} Describing the pressure exerted on federal district court judges to rapidly resolve pending litigation, retired federal district court Judge Nancy Gertner wrote:

Decry the “vanishing trial,” but do everything you can to end cases as quickly and summarily as possible. Value efficiency above all, which mean[s] encouraging the parties in a civil case to settle, or those in a criminal case to plead guilty. Confidential settlements were always good no matter what the issue; don’t look too deeply to see if the issues were fairly litigated. Any closing after all is as good as any other.\textsuperscript{202}

In sum and for the reasons provided above, a quick, global, confidential settlement is the endgame for most MDL judges, lead plaintiffs’ counsel, and defense attorneys. Because MDL transparency provides a public check on the aggregate litigation’s heightened perverse incentives, it is of paramount importance.

\textsuperscript{196}See id.
\textsuperscript{197}See id.
\textsuperscript{198}Id. at 27.
\textsuperscript{199}Id. at 30.
\textsuperscript{200}Id.
\textsuperscript{201}BURCH, supra note 183, at 30.
\textsuperscript{202}Nancy Gertner, Opinions I Should Have Written, 110 NW. U. L. REV. 423, 428 (2016) (internal footnote omitted).
C. Transparent Discovery Is More Likely to Improve Public Health Policymaking than Secret Proceedings and Confidential Settlements

The public also should advocate for transparent health and safety litigation because history teaches that it is the disclosure of health crisis provoking and exacerbating facts—and not the award of settlement funds—that drive meaningful public health reform. The 1990s tobacco litigation, which culminated in a massive global settlement, provides an illustrative example. Research demonstrates that few of the significant tobacco-related public health gains that have been realized in the United States since the 1998 tobacco settlement are attributable to the litigation’s enormous Master Settlement Agreement (MSA) payouts. This is because states devoted only a small fraction of those proceeds to tobacco-related public health issues, instead, they diverted tobacco settlement money into their general funds and spent the vast majority of it closing budget gaps, keeping their Medicaid programs in the black, and supporting infrastructure projects.

Several tobacco-producing states actually expended their MSA tobacco settlement funds to subsidize the manufacture and marketing of tobacco. North Carolina, for example, dedicated 75% of its MSA settlement proceeds to just such efforts. Worse yet, “a recent study showed that higher MSA payments were actually associated with weaker tobacco control measures; because a state’s share of MSA funds was dependent on the number of smokers in the state and its estimated tobacco-related Medicaid expenditures, the MSA did not necessarily discourage diversion of funds to other purposes.”

There is a consensus among experts, on the other hand, that the public disclosure of damning internal tobacco industry documents enhanced tobacco control policy and, thereby, improved public health outcomes. A group of public health scholars asked Judge Polster to take into consideration the

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204 Brief of Amici Curiae in Support of Settlement with Favorable Public Health Outcomes, supra note 203, at 6–9.

205 Id. at 8–9.

206 See U.S. GEN. ACCOUNTING OFFICE, GAO-01-851, TOBACCO SETTLEMENT: STATES’ USE OF MASTER SETTLEMENT AGREEMENT PAYMENTS 34–36 (2001) (“Seven of the 13 tobacco states allocated $651 million of their MSA payments for assistance to tobacco growers and/or economic development projects.”).

207 Brief of Amici Curiae in Support of Settlement with Favorable Public Health Outcomes, supra note 203, at 8.

208 Id. at 7 (citing Jayani Jayawardhana et al., Master Settlement Agreement (MSA) Spending and Tobacco Control Efforts, 9 PLOS ONE 1, 13 (2014)).

209 Id. at 12–13.
mistakes and successes of the tobacco litigation in devising a public health-promoting opioid settlement in an MDL amici curiae brief. As they explained:

[T]he [tobacco] MSA required tobacco companies to open, at their expense, a website which includes all documents produced in state and other smoking and health related lawsuits, maintain it for 12 years, and add all documents produced in future civil actions involving smoking and health cases. These documents have been cited to in Congressional hearings on tobacco regulation and in rulemaking, and created the dataset for a significant bibliography of scholarship, including nearly 800 journal articles and 29 full books, which has influenced public health policy for tobacco prevention and beyond.\(^{210}\)

In sum, “the implementation of transparency provisions [in the tobacco MSA]” “clearly had a positive effect on tobacco control” and, therefore, is “regarded as [a] public health success[.]”\(^{211}\) It is certainly difficult to imagine the achievement of this country’s positive tobacco-cessation-related public health outcomes had the damning tobacco industry documents produced in discovery been placed under seal into perpetuity. It is, likewise, difficult to imagine that an opioid litigation settlement devoid of any document disclosure mandate will have a meaningful impact on the country’s drug use and overdose crisis, regardless of the size of the ultimate payout. A group of American medicine and public health historians recently filed an amici curiae brief in the opioid MDL that emphasized this significant concern:

[A]mici believe in the possibility of a successful settlement that could serve several critical interests of the public. Among these interests is access to information. The concealment of information about the abuse potential and distribution patterns of opioid painkillers allowed the opioid crisis to take root in the first place and to grow to its current dimensions. Since secrecy fueled the crisis, no just and genuinely remedial settlement can be reached unless it honors the public’s right to know and secures the conditions for its effective exercise into the future. As scholars, amici regard it as their mission to bring to light the largely hidden web of social and economic forces, corporate practices, cultural beliefs, and political decisions in which the victims of the crisis were trapped. . . . [A]mici . . . believe that a prospective settlement should take additional steps to guarantee full and permanent access to the records that will enable scholars and policymakers to develop evidence-based measures aimed at remedying the crisis in future years. A settlement exclusive of such provisions, amici fear, might entail yet another irreparable loss.\(^{212}\)

\(^{210}\) Id. at 13 (internal footnotes omitted).

\(^{211}\) Id. at 12.

D. Lack of Transparency in Cases Involving Ongoing Public Health and Safety Issues Can Kill

Both history and common sense also teach that, in cases like the opioid MDL that involve an ongoing public health emergency, secrecy can exacerbate crises and put lives at risk. There are, unfortunately, more examples of such phenomena than this Article has the space to re-tell. But for just one such instance of public health and safety litigation secrecy leading to unnecessary deaths, generally, and the entirely preventable deaths of children, specifically, we need look no further than the Remington Model 700 rifle litigation.

In the early 1990s, a plaintiff brought a personal injury case against gun manufacturer Remington Arms Company in the United States District Court for the District of Montana. The complaint alleged that a product defect in the firing mechanism of Remington’s popular 700-series bolt-action rifle caused the weapon to discharge without a trigger pull. The case, Aleksich v. Remington, settled in 1995 and was subsequently sealed in its entirety.

Richard Barber intervened in the Aleksich case on October 20, 2011 to petition the court to unseal the court records, contending that he, a member of the public, had a right to access the documents. Mr. Barber was on a very personal search for answers. “On October 23, 2000, [his] nine-year-old son, Richard Augustus ‘Gus’ Barber, was mortally wounded when the family’s Remington Model 700 rifle fired as his mother pushed the safety to the ‘off’ position in order to unload the gun.” At no time did Mrs. Barber touch the rifle’s trigger. As Mr. Barber’s heartbreaking investigation would reveal, numerous others, including several children, had been injured or killed by an unprovoked firing of a Remington 700 rifle and, in addition to the Aleksich case, several lawsuits had been filed well in advance of Gus’s death contending that the rifle’s firing mechanism was faulty.

During the fifteen years between the Aleksich settlement and Mr. Barber’s motion to unseal the Aleksich records, Remington refused to either recall the 700 rifle or issue a safety warning about its firing mechanism. Instead, the company continued to manufacture the rifle. Mr. Barber, therefore, intervened in Aleksich to unseal the court records with the “hope that once the information in the . . . court file is made public, Remington will finally have no

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213 Brief in Support of Richard Barber’s Motion to Unseal Aleksich Court Filings at 1, Aleksich v. Remington, No. CV-91-5-BU-PGH (D. Mont. 2012), ECF No. 427.
214 Id.
215 Id.
216 Brief in Support of Richard Barber’s Motion to Intervene at 1, Aleksich v. Remington, No. CV-91-5-BU-PGH (D. Mont. 2011).
217 Id.
218 Id.
219 Id. at 1–2.
220 See id. at 2, 4.
221 See id.
choice but to issue an adequate safety warning, recall these fire controls from the market, and/or remove them from production altogether.”

The timing of Mr. Barber’s intervention was provoked by a CNBC documentary entitled Remington Under Fire: A CNBC Investigation, which premiered on October 20, 2010. Among other things, the documentary profiled the following documents that had been produced by Remington in the Aleksich case and sealed by the trial judge:

- An internal memorandum from Remington’s lead engineer Mike Walker, dated December 3, 1946, warning of a “theoretical unsafe condition” involving the Model 700’s safety, which is the mechanism that is supposed to keep the gun from firing accidentally.
- An internal memorandum from a Remington test engineer, dated April 9, 1947, noting that the Model 700 could fire “by pushing the safety to the ‘off’ position,” which was “very dangerous from a safety and functional point of view.”
- An internal memorandum from Mike Walker, dated August 16, 1948, where Walker proposed a change in his original design that would have incorporated a blocking device to keep the Model 700’s trigger mechanism from falling out of alignment.
- A 1948 internal memorandum from Remington executives, noting that Walker’s proposed change to incorporate a blocking device “is the best design,” but concluding that “its disadvantages lay in the high expenditure required to make the conversion,” which—according to the same memorandum—would have been 5.5 cents per gun.
- A memorandum from Remington’s patent attorney, dated August 31, 1948, noting, “Our usual potential liability for the safety of our product is augmented somewhat by our knowledge that some Model 721 safeties have misfunctioned [sic] . . . . However, our liability does not seem out of proportion to the advantage of retaining the present . . . construction, pending receipt of further complaints from the field.”
- An internal memorandum from a Remington research manager, dated March 18, 1975, noting that Remington “could duplicate” the fire control problems on a Model 700 rifle that had been returned to the factory.

These documents, which the Aleksich court had sealed into perpetuity before Mr. Barber’s intervention, demonstrate that Remington knew that the Model 700 rifle contained a faulty firing mechanism as early as the 1940s, that is, some

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222 Brief in Support of Richard Barber’s Motion to Intervene, supra note 216, at 4.
223 Id. at 7.
224 Id. at 7–8.
five-plus decades before the rifle claimed young Gus Barber’s life. Remington also was well-aware that replacing the faulty firing mechanism with the “best design” was entirely feasible but would cost 5.5 cents per rifle, and, therefore, simply refused to either warn the public about the potentially deadly design flaw or recall the weapon.225 The company’s response to the CNBC documentary was entirely disingenuous but predictable for a going concern that had grown comfortable with getting away with murder: “[T]he Model 700, including its trigger mechanism, has been free of any defect since it was first produced . . .”226

The stark reality is that countless individuals and children were needlessly wounded or killed by a product whose manufacturer knew was defective and potentially deadly for sixty-plus years. Equally concerning, the Montana Federal District Court went out of its way to ensure that the company could continue to cover up the Model 700 rifle defect by placing the entire litigation under seal indefinitely.227 During the fifteen years that the important public health and safety information produced by Remington in Aleksich remained under seal, of course, Mr. Barber’s young son, Gus, fell victim to court-ordered secrecy while Remington continued to manufacture the Model 700.228 As the above-discussed Reuters investigation into opioid litigation court secrecy concluded:

The trail of hidden evidence running through the opioid crisis is emblematic of a pervasive and deadly secrecy that shrouds product-liability cases in U.S. courts, enabled by judges who routinely allow the makers of those products to keep information pertinent to public health and safety under wraps. And since nearly all such cases are resolved before trial, the evidence often remains secret indefinitely, robbing consumers of the chance to make informed choices and regulators of opportunities to improve safety.229

E. Transparency in Complex Health and Safety Litigation Can Inform and Shift Sticky Narratives that Provoke Problematic Policymaking

On a related note, transparency in complex, public health litigation, like the opioid MDL, can operate to shift sticky—but incomplete or inaccurate—public narratives regarding the causal forces of a health crisis and, thereby, provoke more thoughtful, evidence-based public health policymaking. Transparent discovery and trials, after all, promote “true and accurate fact finding.”230 As scholars have pointed out, the media, policymakers, and public have adopted an

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225 See id.
226 Id. at 8.
227 Brief in Support of Richard Barber’s Motion to Unseal Aleksich Court Filings, supra note 213, at 1.
228 See id. at 2–3.
229 Lesser et al., supra note 3.
overly simplistic narrative about the opioid crisis that the epidemiological data simply does not support. That popular narrative goes as follows: prescription opioid manufacturers flooded communities with their products and used deceptive marketing tactics to advance the belief that those products were not addictive; doctors, in turn, overprescribed prescription opioids, which led to massive diversion and rampant addiction and, ultimately, hundreds of thousands of entirely preventable prescription opioid overdose deaths.

This narrative not only animates the opioid MDL but has provoked the enactment of supply-side, law-enforcement-centric laws and policies, including the ubiquitous creation of prescription drug monitoring programs that the DEA and other law enforcement agencies routinely sweep through to crack-down on prescription opioid prescribers and so-called opioid overutilizers or “doctor shoppers.” The threat of criminal and administrative prosecution and its concomitant potential loss of livelihood has incentivized doctors to either force their opioid patients to quickly taper off the drugs, which is ineffective at treating narcotic dependency, or, worse, abandon those patients altogether. Rapid, forced opioid tapering and patient abandonment motivated by vigorous enforcement.


233 Oliva, supra note 231, at 6.

law enforcement monitoring, in turn, compelled many patients with a
dependency on prescription opioids to substitute those FDA-regulated
medications for unregulated—and much more powerful and dangerous—illicit
substances, such as heroin and fentanyl, to avoid the crushing symptoms of
“dopesickness,” which itself can be fatal.235

This more complex narrative in no way implies that profit-driven
prescription opioid manufacturers and distributors should be absolved of their
significant contributions to the crisis. The West Virginia ARCOS opioid data
that Judge Stephens eventually unsealed in 2016 certainly supports the claim
that the opioid defendants flooded small, rural Appalachian towns with
prescription opioids while the DEA sat on its hands.236 And as we now know,
the national level ARCOS opioid transaction information, which the DEA and
defendants went to great lengths to keep under wraps in the opioid MDL,
indicates that the MDL pharmaceutical industry defendants engaged in similar
behavior in communities across the country.237

The point here is that the dominant narrative, which points the blame
exclusively at the over-supply of prescription opioids and provoked
policymakers to implement crackdown laws and regulations instead of an
evidence-based harm reduction response, seems to have caused considerably
more harm than good. Since the implementation of numerous supply-side
crackdown tactics, including rampant PDMP surveillance, opioid prescribing
has precipitously declined while opioid-related overdose deaths, the

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237 See DIVERSION CONTROL DIV., DRUG ENF’T ADMIN., supra note 12.
overwhelming majority of which are attributable today to illicit substances—and not prescription pills—has continued to climb.238 Patients with well-documented, crippling pain conditions have been forced to suffer due to tapering and physician abandonment.239 And the opioid crisis is beginning to be eclipsed by the surge in other illicit drug-related deaths, including methamphetamine and cocaine, across the country.240

The argument here is that, had the American public known the truth about the deceptive marketing practices of the opioid defendants and the addictive qualities of prescription opioids earlier in the crisis, policymakers might have been forced to respond to that information before the situation developed into a full-blown national health emergency. And perhaps policymakers would have been inclined to implement more thoughtful, evidence-based, public health-promoting responses if they had had the opportunity to tackle the crisis before it spiraled out of control. It is possible, for instance, that transparency would have nudged the public to ask hard questions about the DEA’s role in the crisis and insist on controlled-substance-related agency reforms instead of immediately turning to the DEA and law enforcement for solutions. As it turns out, there is simply nothing like a well-hyped American controlled substance “emergency” that creates hysteria and provokes knee-jerk demands for a law-enforcement-driven, supply-side crackdown on the culprit class of drugs accompanied by little concern for widespread collateral damage.

VII. CONCLUSION

As the opioid MDL and recent investigative reporting reveal, American health and safety litigation continues to be shrouded in secrecy to the public’s detriment and to the benefit of negligent regulators and profit-driven

238IQVIA INST., MEDICINE USE AND SPENDING IN THE U.S.: A REVIEW OF 2017 AND OUTLOOK TO 2022 12 (Apr. 2018) (explaining that prescription opioid volumes peaked in 2011 and have since declined by 29% and that 23.3 billion fewer MMEs were dispensed to patients on a volume basis in 2017); Dasgupta et al., supra note 232, at 183 (“Overdose deaths attributable to prescription opioids have not decreased proportionally to dispensing.”).


corporations for no legitimate legal reason. The courts routinely, without cause, issue blanket protective orders and place key health and safety documents produced in litigation under seal into perpetuity in the name of efficiency and in violation of federal law. This Article contends that the public should be aware of—and concerned about—this ongoing travesty of justice beyond its sheer illegality. Among other things, it argues that the public has a compelling interest in transparent health and safety litigation, such transparency provides an important check to the perverse incentives that drive secrecy and confidential settlements in MDL proceedings, transparency is more likely to improve public health policymaking than secrecy and confidential settlements, nondisclosure of public health and safety information can exacerbate public health crises and risk lives, and transparency in public health litigation can help inform and shift the prevailing narrative about a public health crisis and, thereby, provoke more informed, evidence-based policymaking.

It seems that Judge Polster was onto something when, in comparing the opioid crisis to a plague, he asserted that disclosure of the ARCOS data “is a reasonable step toward defeating the disease” because the information exposes “how and where the virus grew.”241 Hopefully, he takes his own advice seriously going forward in the opioid MDL and orders the disclosure of the millions of litigation documents and court records that remain secret, under seal, and/or redacted. Perhaps even more important, and as at least two amici curiae have argued, history makes clear that it is highly unlikely that an opioid MDL settlement will have any laudable impact on the country’s drug use and overdose crisis unless it mandates the disclosure and preservation of the litigation documents into perpetuity.242 The law requires the federal courts, after all, to place the public’s interest in transparency and public health over a corporate defendant’s or a government agency’s self-interested secrecy.

241 Order Regarding ARCOS Data, supra note 39, at 21–22.
242 See, e.g., Brief of Amici Curiae in Support of a Settlement Agreement Including Broad Transparency Provisions in the Interest of Future Research, supra note 212, at 7 (“Since secrecy fueled the crisis, no just and genuinely remedial settlement can be reached unless it honors the public’s right to know and secures the conditions for its effective exercise into the future.”).
Settling the Score: Maximizing the Public Health Impact of Opioid Litigation

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I. INTRODUCTION

Despite rising media coverage and public awareness, the opioid crisis continues to outpace efforts to mitigate its harms.¹ The Centers for Disease Control and Prevention most recently estimated that drug overdoses took 70,237 lives in 2017, an increase of almost ten percent over the previous year, with nearly 48,000 of such deaths attributable to opioids.² While illicit opioids are

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¹ See Allison L. Pitt et al., Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic, 108 AM. J. PUB. HEALTH 1394, 1398 (2018) (modeling policy impact to find that “[f]or some policies and time horizons, the increase in heroin–related deaths may exceed the reduction in opioid pill-related addiction deaths, despite overall gains in quality of life”); Max Blau, STAT Forecast: Opioids Could Kill Nearly 500,000 Americans in the Next Decade, STAT (June 27, 2017), https://www.statnews.com/2017/06/27/opioid-deaths-forecast/ [https://perma.cc/6BRS-C7UA] (averaging expert forecasts of opioid overdose deaths to conclude that the peak of the crisis has not passed).

responsible for a growing share of opioid overdose deaths, many individuals’ opioid misuse and addiction originated from prescription painkiller use. A concerning overlap between prescription opioid and illicit opioid use exists, such that “the prescription opioid epidemic could at least double the number of heroin users in the United States by 2025.”

The crisis’s historic rates of addiction and overdose have prompted a panoply of legal and public health responses. Federal and state administrative agencies have prioritized monitoring, enforcement, spending programs related to opioid prescribing, and, more recently, addiction treatment. Law enforcement agencies are acting in tandem in the criminal realm, prosecuting a mix of defendants, including corporate executives, pharmaceutical retailers, physicians, pharmacists, and persons with opioid addiction. Nonprofit

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3 See Puja Seth et al., Overdose Deaths Involving Opioids, Cocaine, and Psychostimulant—United States, 2015–2016, 67 CTRS. FOR DISEASE CONTROL & PREVENTION: MORBIDITY & MORTALITY WKLY. REP. 349, 349 (2018). The most significant contributor to the rise in opioid deaths was notoriously dangerous synthetic opioids like fentanyl, followed by heroin. Id. at 350–51, 352, 353. “Fentanyl, an opioid 80 times more potent than heroin, was brought to market in the United States as Duragesic® by Janssen Pharmaceuticals. . . . In the early 1990s, drug dealers began mixing fentanyl with heroin to produce a greater high. . . . By 2016, [for example,] half of overdose deaths in Illinois were fentanyl-related.” Richard D. deShazo et al., Backstories on the US Opioid Epidemic. Good Intentions Gone Bad, an Industry Gone Rogue, and Watch Dogs Gone to Sleep, 131 AM. J. MED. 595, 599 (2018) (internal footnotes omitted).


5 BONNIE ET AL., supra note 4, at 213–14.

6 See generally The Federal Response to the Opioid Crisis: Hearing Before the S. Health, Educ., Labor, and Pensions Comm., 115th Cong. (2017) (statement of Dr. Francis Collins, Director, National Institutes of Health) (describing how federal agencies, including HHS, SAMHSA, CDC, NIH, and FDA, are responding to the crisis). See also Stephen Barlas, U.S. and States Ramp Up Response to Opioid Crisis, 42 PHARMACY & THERAPEUTICS 569, 569 (2017) (noting that state agencies “have been just as active” as federal ones, expanding prescription monitoring and access to overdose-reversal medication).

7 See, e.g., Rachel L. Rothberg & Kate Stith, The Opioid Crisis and Federal Criminal Prosecution, 46 J.L. MED. & ETHICS 292, 295–97 (2018) (describing DEA and DOJ criminal prosecutions related to opioids, including the criminal case of Purdue Pharma executives, and other cases against medical providers); Y. Tony Yang & Rebecca L. Haffajee, Commentary, Murder Liability for Prescribing Opioids: A Way Forward?, 91 MAYO CLINIC PROC. 1331, 1331 (2016) (discussing a novel theory of criminal liability in the opioid context, where a physician is charged with murder for opioid overdose deaths that resulted from reckless prescribing practices); Katie Zezima & Sari Horwitz, Federal, State Authorities Step Up Fentanyl Prosecutions as Drug Drives Spike in Overdoses, WASH. POST (June 7, 2018), https://www.washingtonpost.com/national/federal-state-authorities-step-up-fentanyl-
organizations and charitable foundations are fundraising and publishing reports to mitigate opioid harms.\textsuperscript{8} Private sector corporations are donating profits to these efforts and seeking to innovate other potential products that treat pain non-addictively or effectively manage addiction.\textsuperscript{9}

Garnering substantial attention is the spate of lawsuits brought against the companies responsible for supplying the prescription opioid market. The litigation examines the connection between the products manufactured, distributed, and marketed by major pharmaceutical brands (and approved for safety by the Food and Drug Administration (FDA)) and the millions of persons addicted to opioids.\textsuperscript{10} The scope and frequency of the lawsuits, as well as their public health emphasis, prompt comparisons to the massive tobacco litigation of the 1990s.\textsuperscript{11} That litigation ultimately brought the four largest cigarette manufacturers to the table to negotiate a “Master Settlement Agreement” (MSA) worth hundreds of billions.\textsuperscript{12} Whether the opioid litigation will resolve similarly remains to be seen.

Indeterminacy notwithstanding, the potential significance of a global opioid settlement agreement cannot be understated. On the one hand, an MSA could bring substantial money—much more than the federal government has yet invested even taking into account its latest Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities
(SUPPORT) Act—and change behavior to ameliorate opioid harms. On the other hand, such an agreement could actually fail to promote public health goals if it mimics the use of funds from the tobacco MSA.

But, history does not have to repeat itself. This Article responds to skeptics of a potential global opioid settlement agreement by proposing terms that would further public health goals. While a blockbuster agreement is uncertain, it appears increasingly likely that an MSA of some sort will be reached in the multi-district litigation where the emphasis has been on improving health and other life outcomes in the midst of the crisis. This Article proceeds by providing an overview of the opioid litigation in Part II. Part III discusses lessons that can be drawn from past settlements—both the tobacco MSA and prior smaller opioid settlements. Part IV conceptualizes what form an MSA might take, outlining how damages and behavior change components could be structured to maximize public health benefits. Part V offers some concluding thoughts.

II. THE OPIOID LITIGATION, IN BRIEF

At the federal, state, and local levels, plaintiffs are pursuing litigation to hold pharmaceutical industry interests accountable for the costs of the opioid epidemic. The diverse array of claimants includes private classes of consumers; hospitals and healthcare organizations; the federal government; state attorneys general; and local and tribal governments. The defendants are

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14 See Carr et al., supra note 11, at 209–10 (contending that the tobacco MSA funds were misused, and arguing that “[f]ew reasons exist to believe a similarly styled opioid MSA would produce better results” than the tobacco MSA did); Terry & Hoss, supra note 11 (cautioning that “[s]takeholders should not wait for the worst aspects of the tobacco settlement to be replayed,” and generally critical that “plaintiffs and their lawyers seem keen to capture funds now”).


largely pharmaceutical manufacturers, distributors, and retailers. Depending on the defendant, the suits differ in theories of liability asserted. Among other claims, manufacturers are accused of misrepresenting the addictive nature of opioid products in marketing campaigns and detailing efforts, and failing to adequately warn consumers about the potential for addiction; distributors are alleged to have violated federal duties to monitor and report suspicious prescription ordering activity; retailers are sued for negligently filling suspicious prescription orders despite “red flags.” The actions also vary in the relief sought. Beyond just money damages, the government plaintiffs typically seek to enjoin the defendants’ future conduct: forbidding the companies from continuing their misrepresentations of the risks posed by opioid treatment of chronic pain or failing to report suspicious prescription orders despite “red flags.”

Some recent cases also name healthcare industry groups as defendants, as well as pharmacy benefit management companies. See, e.g., Amended Complaint and Jury Demand at 36, Cty. of Webb v. Purdue Pharma, L.P. et al., 1:18-op-45175-DAP (N.D. Ohio Sept. 17, 2018); Complaint at 62–70, Employer-Teamsters Local Nos. 175 & 505 Health & Welfare Fund et al. v. Purdue Pharma L.P. et al., 1:18-OP-45446 (N.D. Ohio Apr. 17, 2018); Complaint at 2–5, City of Charleston v. Joint Comm’n on Accreditation of Health Care Orgs., 2:17-cv-04267 (S.D. W. Va. Nov. 2, 2017);.

Accordingly, Plaintiffs seek to enjoin the defendants from continuing their misrepresentations of the risks posed by opioid treatment of chronic pain or failing to report suspicious prescription orders despite “red flags.” The actions also vary in the relief sought. Beyond just money damages, the government plaintiffs typically seek to enjoin the defendants’ future conduct: forbidding the companies from continuing their misrepresentations of the risks posed by opioid treatment of chronic pain or failing to report suspicious prescriptions and requiring restitution payments for any profits gained from these illegal practices.

17 See Haffajee & Mello, supra note 4, at 2301–04. Some recent cases also name healthcare industry groups as defendants, as well as pharmacy benefit management companies. See, e.g., Amended Complaint and Jury Demand at 36, Cty. of Webb v. Purdue Pharma, L.P. et al., 1:18-op-45175-DAP (N.D. Ohio Sept. 17, 2018); Complaint at 62–70, Employer-Teamsters Local Nos. 175 & 505 Health & Welfare Fund et al. v. Purdue Pharma L.P. et al., 1:18-OP-45446 (N.D. Ohio Apr. 17, 2018); Complaint at 2–5, City of Charleston v. Joint Comm’n on Accreditation of Health Care Orgs., 2:17-cv-04267 (S.D. W. Va. Nov. 2, 2017);


19 See Nora Freeman Engstrom et al., Suing the Opioid Companies, STAN. L. SCH. BLOGS: LEGAL AGGREGATE (Aug. 30, 2018), https://law.stanford.edu/2018/08/30/q-and-a-with-mello-and-engstrom/ [https://perma.cc/3UP6-MC8S] (describing the claims against distributors as alleging a failure “to monitor, detect, investigate, and report suspicious orders of prescription drugs, even though reasonably prudent suppliers would have done so and the federal Controlled Substances Act requires suppliers to maintain effective controls against diversion of controlled substances to illicit markets”).

20 Kelly K. Dineen & James M. DuBois, Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?, 42 AM. J.L. MED. 7, 31 (2016) (describing how doctors may be liable for violating the Controlled Substances Act when “ignore[ning] many warning signs and red flags and consciously eschew[ing] performing the most rudimentary screening that would have revealed many . . . patients’ ruses”) (quoting United States v. Katz, 445 F.3d 1023, 1031 (8th Cir. 2006)).

 Defendants have responded in turn by challenging the chain of causation between their own conduct and the intervening actions of healthcare providers and patients.\textsuperscript{22} Further, manufacturers often raise preemption defenses, arguing that the FDA’s approval of the drugs for safety preempts state-based claims.\textsuperscript{23} During the early 2000s, the first wave of opioid litigation characterized by personal injury suits waged against Purdue Pharma was largely subsumed by these defenses.\textsuperscript{24} More generally, the imbalance of resources between the individual plaintiffs and the well-resourced pharmaceutical industry defendants often proved fatal.\textsuperscript{25} The ongoing current wave, however, appears more viable.\textsuperscript{26} Those cases, currently being litigated, can be grouped into two categories: class action suits and suits in which a government is plaintiff.\textsuperscript{27} The class action vehicle helps level the resources brought to bear by parties and allows plaintiffs to overcome some of the procedural obstacles faced by the first wave of individual suits. For example, demonstrating the causal connection between a manufacturer’s business practices and an alleged harm is generally easier for a group of hundreds of similarly situated people than at the individual level.\textsuperscript{28} With a state or local government as the plaintiff, the injury is redefined.
as one to public coffers and environment, avoiding some of the causation challenges and affirmative defenses that stymied individual claims.\textsuperscript{29}

A significant milestone in the wave of government suits that could pave the way towards a tobacco litigation-like MSA was the consolidation of over 150 cases brought by state and local governments in federal court under multidistrict litigation (MDL) in the northern district of Ohio in December 2017.\textsuperscript{30} While it is difficult to generalize about the many different suits with unique complaints, numbering over 2000 as of September 2019,\textsuperscript{31} they consistently seek compensation for the damage arising from improper marketing and distribution of prescription opioid medications into cities, states, and towns across the nation.\textsuperscript{32} Plaintiffs allege the defendants are responsible for opiate diversion into their communities;\textsuperscript{33} violated Racketeer Influenced and Corrupt Organizations (RICO) statutes, consumer protection laws, and state analogues to the Controlled Substances Act (CSA).\textsuperscript{34} The lawsuits also regularly assert common

\textsuperscript{29}Id. ("Because the government itself is claiming injury and seeking restitution... these suits avoid defenses that blame opioid consumers or prescribers [and they] garner substantial publicity.").

\textsuperscript{30}Transfer Order at 1–4, In re Nat’l Prescription Opiate Litig., No. 1:17-md-02804-DAP (N.D. Ohio Dec. 12, 2017). N.D. Ohio was chosen from several options due to its “strong factual connection to this litigation” after it “experienced a significant rise in the number of opioid-related overdoses in the past several years and expended significant sums in dealing with the effects of the opioid epidemic.” Id.

\textsuperscript{31}Andrew Joseph, Purdue Pharma Filed for Bankruptcy. What Does It Mean for Lawsuits Against the Opioid Manufacturer?, STAT (Sept. 16, 2019), https://www.statnews.com/2019/09/16/if-purdue-pharma-declares-bankruptcy-what-would-it-mean-for-lawsuits-against-the-opioid-manufacturer/ [https://perma.cc/TZ4E-5JXT]. Indeed, one facet of this difficulty is the many different methods by which the complainants calculate damages. For example, New Jersey’s complaint against Purdue Pharma estimates $290 million has been spent from state coffers on opioids (including Medicaid, workers’ compensation, and employee and retiree health programs). Terry & Hoss, supra note 11. By contrast, the City of Tacoma estimated damages by quantifying how “the opioid crisis has increased the city’s spending across health care, social services, emergency services, and public safety,” and has implemented a new tax increase to raise $10 million annually to fund opioid spending. Id.

\textsuperscript{32}Transfer Order, supra note 30, at 1.

\textsuperscript{33}"[D]iversion" refers to “the unlawful channeling of regulated pharmaceuticals from legal sources to the illicit marketplace.” James A. Inciardi et al., Mechanisms of Prescription Drug Diversion Among Drug-Involved Club- and Street-Based Populations, 8 PAIN MED. 171, 171 (2007). Diversion is a major factor contributing to the opioid epidemic and can be both exacerbated or minimized by the conduct of pharmaceutical companies. See Kathryn L. Hahn, Strategies to Prevent Opioid Misuse, Abuse, and Diversion that May Also Reduce the Associated Costs, 4 AM. HEALTH & DRUG BENEFITS 107, 111 (2011); Nora D. Volkow & Thomas A. McLellan, Commentary, Curtailing Diversion and Abuse of Opioid Analgesics Without Jeopardizing Pain Treatment, 305 JAMA 1346, 1346 (2011).

\textsuperscript{34}See supra notes 21, 23 and accompanying text; Haffajee & Mello, supra note 4, at 2302–03; Gluck et al., supra note 15, at 353, 355.
law claims of public nuisance, negligence, negligent misrepresentation, fraud, and unjust enrichment.\textsuperscript{35} The federal judge overseeing the MDL, Judge Dan Aaron Polster, has garnered attention for an unorthodox approach: implementing an aggressive trial schedule and explicitly calling for a major settlement agreement.\textsuperscript{36} While his tactics may be overly ambitious given the litigation’s complexities and even overreaching for a court of law, they do weigh in favor of a potentially significant MDL settlement.\textsuperscript{37} But questions remain about which parties that settlement might involve, and whether it will be on the same historic scale as the tobacco MSA.\textsuperscript{38} A global settlement that resolves the pending liability comprehensively could appeal to both sides: the pharmaceutical industry could avoid extensive, costly, and image-battering suits, while government plaintiffs could gain sorely needed resources, perhaps swiftly.\textsuperscript{39} The private plaintiffs’ firms litigating on behalf of state attorneys general and local governments mostly on a contingency basis, however, may have perverse incentives to maximize their profits over costs, rather than achieve the most just outcome for their clients.\textsuperscript{40}

MDL settlement prospects are limited by challenges unique to the posture of the litigation. Hundreds of opioid cases are not subsumed in the MDL, and rather reside—often by design to gain local tactical advantages—in state or tribal courts.\textsuperscript{41} This complicates the endgame of an MSA, given that

\textsuperscript{35} See supra notes 21, 23 and accompanying text; Haffajee & Mello, supra note 4, at 2302.


\textsuperscript{37} Hoffman, supra note 36 (“These are bold things for a judge to say and it’s exciting and intriguing to follow,” said Abbe R. Gluck, a professor at Yale Law School . . . . But to say that his goals are ambitious would be an enormous understatement.”).

\textsuperscript{38} See Gluck et al., supra note 15, at 360.

\textsuperscript{39} Id. (“Defendants have an interest in a global settlement that resolves all their liability in one shot . . . . [and] state Attorneys General[] will be attracted to early settlement and quick gains, . . . .”).

\textsuperscript{40} See Andrew Harris et al., Justice for Opioid Communities Means Massive Payday for Their Lawyers, BLOOMBERG (July 25, 2018), https://www.bloomberg.com/graphics/2018-opioid-lawsuits/ [https://perma.cc/5H5A-MCN2]. Plaintiffs’ attorneys on such cases work on a “contingency fee” basis, meaning they work the case for no-money-down in exchange for a stake in the award if successful. See id. The fees at stake in the opioids cases typically range between 25–33% of total recovery. Id. On the upper end of projections for the hypothetical value of the opioids litigation, this could mean a “$12.5 billion payday” for the plaintiffs’ firms. Id.

\textsuperscript{41} See Gluck et al., supra note 15, at 359 (describing how West Virginia and the Cherokee Nation sought “to avoid being pulled into the MDL” by emphasizing that state law predominates over their cases); Terry & Hoss, supra note 11 (speculating that “some cities
defendants’ primary incentive to settle is to avoid drawn-out courtroom battles and costs by resolving all litigation simultaneously. It may well be that the factors that drove the tobacco companies to the settlement table in the 1990s do not pose a sufficient degree of pressure on the opioid defendants. Instead, opioid defendants might prefer to holdout for a bargain settlement or even opt for trial, especially since certain key plaintiff legal theories are novel and untested. Despite these uncertainties, recent developments provide hope for an historic resolution.

III. LESSONS FROM PAST ADDICTIVE PRODUCT SETTLEMENTS

Should a comprehensive resolution to the opioid litigation materialize, an important objective at the forefront of Judge Polster’s mind concerns the optimal forms of relief to maximize public health benefits. Scholarly theories conflict regarding the value of litigation as a tool for regulation and regarding the are staying out of the federal MDL” because they are “betting on a higher payday before their state courts,” given that the MDL will rack up “administrative costs and attorneys’ fees” and damages will be “split among hundreds of plaintiffs”); see also Andrew Joseph, Why Houston and Other Cities Want Nothing to Do with the Massive National Opioid Lawsuit, STAT (Mar. 27, 2018), https://www.statnews.com/2018/03/27/houston-national-opioid-lawsuit/ [https://perma.cc/AB5T-XZQU].

Hoffman, supra note 36 (“The defendants will most likely insist on a settlement that would resolve most, if not all, the state lawsuits as well as the federal ones.”).

Terry & Hoss, supra note 11 (noting that the following differences between the tobacco and opioid litigations “may yet encourage the defendants to litigate instead of settle or depress the settlement amount”: the opioid manufacturers are fewer and of lesser value than “Big Tobacco” was; the “heterogeneous nature” of losses by opioids differ from the “relatively simple” tobacco cases; the MSA settlement talks were simplified because tobacco had “no health benefit,” whereas any opioid settlement would be complicated by opioids’ continued beneficial role in healthcare).

See Jef Feeley, Opioid Deal in West Virginia May Spur More Agreements, BLOOMBERG (May 2, 2019), https://www.bloomberg.com/news/articles/2019-05-02/mckesson-settles-west-virginia-opioid-sales-claims-for-37-mln [https://perma.cc/XP88-M9NX]. For example, though many government plaintiffs assert claims against the major pharmaceutical distributors for violations of duties under the CSA, it remains an open question whether violations of the CSA can give rise to an independently enforceable cause of action. See Gluck et al., supra note 15, at 356. Similarly, claims against healthcare industry groups, like the Joint Commission, that argue collusion with pharmaceutical companies or against pharmaceutical benefit managers, or that argue negligent authorization of coverage for unnecessary prescriptions, are theories of first impression. Id. at 356–57. It also remains to be seen how far manufacturer’s preemption defense, contending that FDA approval of opioid products preempts state-based tort liability, may extend. See generally Marcia Boumil, FDA Approval of Drugs and Devices: Preemption of State Laws for “Parallel” Tort Claims, 18 J. HEALTH CARE L. & POL’Y 1 (2015).

See Hoffman, supra note 36.

Two decades have passed since the 1998 Tobacco Master Settlement Agreement, allowing for retrospective assessment of the agreement’s successes and failures. This Part considers those findings, as well as the terms of opioid settlements previously reached, to generate insights for a potential opioid MSA.

A. The Tobacco Master Settlement Agreement

After years of fruitless litigation, the four major tobacco manufacturers were finally forced to compromise when a coalition of forty-six state attorneys general and six other U.S. jurisdictions, rather than classes of private plaintiffs, rallied around a novel liability theory to recover government Medicaid and other costs incurred from spending on tobacco-related morbidity and mortality. To help the states’ case, damning whistleblower evidence, in the form of the Tobacco Papers, emerged to establish that tobacco companies knew of their products’ addictive properties and nevertheless conspired to suppress this
information and mislead consumers. Settlement talks were initiated in 1996 and finalized in 1998 among the governments that were ultimately party to the litigation. In exchange for tortious immunity, the agreement required industry to pay approximately $246 billion in penalties to state and local governments over a twenty-five year period, plus an additional $9 billion per year in perpetuity thereafter, though it was virtually silent as to how those funds should be spent. It also imposed injunctive requirements on tobacco marketing, particularly to young consumers. The complex terms of the agreement have given rise to an entire body of case law litigating the scope of the settlement’s requirements for each state that ratified it.

The tobacco MSA marked a turning point in the decades-long campaign to regulate tobacco more stringently. The settlement agreement stands as the largest ever settlement implemented in the U.S. and has been characterized by anti-smoking advocates as “the most significant increase in spending on tobacco prevention and cessation in history.” The MSA’s advertising enjoiners included mandatory funding for a massive “countermarketing” campaign led by the American Legacy Foundation. To pay for the costs of the MSA, tobacco

52 See MSA OVERVIEW, supra note 51, at 3. See generally Master Settlement Agreement, supra note 51.
53 For example, the MSA famously marked the death of the “Joe Camel” advertising campaign. See Schroeder, supra note 50, at 294.
55 Robert S. Wood, Tobacco’s Tipping Point: The Master Settlement Agreement as a Focusing Event, 34 POL’Y STUD. J. 419, 425, 431 (2006) (concluding that the MSA was a “tipping event” that “represents genuine policy change” and that will “have lasting institutional impacts”).
57 Schroeder, supra note 50, at 295; see also MICHAEL, PERTSCHUK, SMOKE IN THEIR EYES 221 (2001) (“[T]he single most fundamental change in the history of tobacco control in the history of the world.”) (quoting Matt Myers of the Campaign for Tobacco-Free Kids).
58 Schroeder, supra note 50, at 295 (identifying the prominent “truth” campaign as funded by the MSA).
companies raised prices on cigarettes significantly, initiating a corresponding decrease in demand that achieved, to a limited degree and albeit indirectly, the ultimate goal of smoking prevention and cessation.\(^5\)

But even at the time of the settlement’s implementation, there were critics skeptical of the litigation’s capacity to bring about authentic policy change.\(^6\) In the years since, policy advocates and researchers alike have widely criticized the MSA as failing to sufficiently reduce harms from tobacco, even though it did effectively impose a large monetary penalty against the industry.\(^6\) Many argue that MSA funds were insufficiently tethered to the goal of reducing smoking rates and were instead diverted into state coffers for unrelated, inefficient purposes like servicing debt and closing budget shortfalls.\(^6\) Further, because the states were granted MSA payments from tobacco companies prospectively in perpetuity, without spending stipulations, many states securitized their future payments into bonds for more immediate cash on hand.\(^6\) For public health activists who hoped the MSA might mark the end of “Big

\(^{59}\) Id. But see Gregory W. Traylor, Note, Big Tobacco, Medicaid-Covered Smokers, and the Substance of the Master Settlement Agreement, 63 Vand. L. Rev. 1081, 1101–14 (2010) (arguing that the cigarette price increases caused by the MSA resulted in Medicaid-covered smokers essentially “footing the bill” of the tobacco manufacturers’ MSA payments).

\(^{60}\) LaFrance, supra note 48, at 189 (describing why the American Cancer Society filed a brief opposing the settlement agreement, and arguing that the costs of the settlement for “Big Tobacco” would be “passed on to an addicted consumer base,” such that industry would “self-insure against the injuries it inflicts and continue its course of destructive conduct” without “genuine improvement in the nation’s health”).

\(^{61}\) See, e.g., Jayani Jayawardhana et al., Master Settlement Agreement (MSA) Spending and Tobacco Control Efforts, PLOS One 1, 15, 18 (2014) (using empirical methods to find “that MSA payments were negatively associated with overall measure of strength of tobacco control in states” because “the longer range objective of reducing tobacco use is often ignored when revenue allocation decisions are made by state legislatures”); Jim Estes, Opinion, How the Big Tobacco Deal Went Bad, N.Y. Times (Oct. 6, 2014), https://www.nytimes.com/2014/10/07/opinion/how-the-big-tobacco-deal-went-bad.html [https://perma.cc/6YMT-UBMB] (criticizing that states used MSA funds for projects such as construction of shipping docks, a public golf course sprinkler system, and a county jail, while projected to spend only 1.9% of MSA revenues on tobacco prevention programs in 2014).

\(^{62}\) See U.S. Gov’t Accountability Office, GAO-07-534T, States’ Allocations of Payments from Tobacco Companies for Fiscal Years 2000 through 2005 6 (2007) (finding that, from 2000 to 2005, only 3.5% of total MSA revenues were spent on tobacco control programs, while 22.9% went towards state budget gaps, 7.1% towards “general purposes,” and 6% towards “infrastructure”); Haile & Krueger-Andes, supra note 47, at 146 (“In 2011 the states collectively used less than 2% of their annual MSA payments for smoking control and prevention programs.”); Walter J. Jones & Gerard A. Silvestri, Commentary, The Master Settlement Agreement and Its Impact on Tobacco Use 10 Years Later: Lessons for Physicians About Health Policy Making, 137 CHEST 692, 697 (2010) (“It is clear that the MSA has not resulted in a[n] . . . intensification of state tobacco control efforts, because . . . MSA resources have been significantly diverted from tobacco control and treatment into other state policy activities.”).

\(^{63}\) See Schroeder, supra note 50, at 295.
Tobacco” forever, this financial symbiosis instead “created perverse incentives for the states to keep the tobacco industry financially healthy.” While there are some who view the benefits of the tobacco MSA as outweighing the costs, several cautionary takeaways emerge that can be applied to a global opioid settlement.

B. Past Opioid Settlements

The specter of the tobacco MSA looms over the contemporary opioid litigation. The similar addictive properties of the substances and cumulative volume of cases brought by most state attorneys general, as well as local governments naturally raise comparisons between the opioid and tobacco litigation. Some fear that a global opioid settlement would fall prey to certain features embodied in the tobacco MSA that benefitted industry, failed to improve the public’s health, or both. Pointing to a handful of settlements from the first wave of opioid litigation, critics argue that there is already evidence that opioid settlements are ineffective as a direct public health response to opioid addiction (see Tables 1–3). For example, in 2007, a multistate coalition of 27 state attorneys general reached a $19.5 million settlement agreement with Purdue. The settlement is largely viewed as a failure, given its relatively paltry damages award and that the opioid epidemic only continued to accelerate afterwards. Moreover, pharmaceutical companies apparently continued the

64 Id. at 295 (quoting anti-smoking advocate Matt Myers as viewing the tobacco industry as the “winner” of the litigation because of the perverse incentives in the states’ relationship with the manufacturers).

65 See, e.g., Michael Givel & Stanton A. Glantz, The “Global Settlement” with the Tobacco Industry: 6 Years Later, 94 AM. J. PUB. HEALTH 218, 224 (2004) (“Far from representing ‘missed opportunities,’ the global settlement proposal, the subsequent debates leading to its rejection, the MSA, the ongoing litigation in the area, and the policies that have been developed since 1997 have advanced tobacco control substantially.”).

66 See Terry & Hoss, supra note 11 (“How the settlement funds from the 1990s tobacco litigation have been distributed provides a cautionary precedent [for the opioid litigation].”); Carr et al., supra note 11, at 207 (“[A] similar agreement [to the tobacco MSA] in the [opioid] context would be unlikely to substantially reduce opioid-related morbidity and mortality absent contemporaneous comprehensive regulatory reform.”).

67 See, e.g., Carr et al., supra note 11, at 208 (highlighting how “[d]espite these legal consequences” from the first wave of litigation, “some [opioid] manufacturers allegedly continued to use misleading and illegal practices” that gave rise to the second wave); Terry & Hoss, supra note 11 (criticizing West Virginia’s use of settlement funds from a 2004 agreement reached with Purdue Pharma).


very practices that were litigated despite the settlement’s inclusion behavior change requirements, namely making misrepresentations about the addictiveness of opioid products.\textsuperscript{70} One attorney from the Oregon Attorney General’s office, the office that led the coalition, recently testified to Congress that the settlement “did not require Purdue to take sufficient remedial action” because the government attorneys “did not fully appreciate the severity of the opioid epidemic and the long-lasting effects of Purdue’s [OxyContin] promotion.”\textsuperscript{71}

A West Virginia case provides another example of missed opportunity. The state police received a $44 million portion of the criminal asset forfeiture payment made to the Department of Justice following its 2007 prosecution of Purdue Pharma executives.\textsuperscript{72} A portion of that payment went to the construction of a 12,000 foot police academy training facility, featuring a gymnasium and combat training room, and remodeling projects including replacement of stucco exteriors with brick.\textsuperscript{73} For skeptics of the public health value of settlement makers-legal-action/ [https://perma.cc/6HSV-HYSY] (“The company had to pay nearly $20 million but there has been, in the words of one assistant attorney general, ‘tremendous buyer’s remorse’ that the settlements did not extract more money, accountability or change in the prescribing culture.”).

\textsuperscript{70} Carr et al., supra note 11, at 208 (“Despite these legal consequences, some [opioid] manufacturers allegedly continued to use misleading and illegal practices. In 2015, Purdue settled lawsuits brought by New York and Kentucky alleging improper marketing of OxyContin—nearly the same allegations to which the company had pled guilty in federal court 8 years before.”).

\textsuperscript{71} Examining the Opioid Epidemic: Challenges and Opportunities, Hearing Before the S. Comm. on Fin., 114th Cong. 11 (2016) (“Had I so known, I would have advocated for a settlement which would have required more extensive remedial action by Purdue to correct the inappropriate prescribing patterns for opioids. . . ”). Id. at 42.

\textsuperscript{72} W. VA. GOVERNOR’S OFFICE, PLAN FOR A DRUG-FREE WEST VIRGINIA 6 (Jan. 2008), https://djec.wv.gov/grant-programs/Specialized%20Programs/PPF/Documents/Purdue%20Pharma%20Plan.pdf [https://perma.cc/DG5F-52DF] [hereinafter W. VA. GOVERNOR’S REPORT] (documenting WVSP’s portion of the asset forfeiture payment, noting that “[f]ederal asset forfeiture funds, considered to be proceeds of criminal activities, are often shared by the federal government with state and local law enforcement authorities that have contributed to the investigation and/or prosecution of federal crimes”).

agreements, this provides a straightforward illustration of squandered opportunity that hearkens back to a repetition of tobacco MSA mistakes.

Reviewing more recent settlements, however, paints a more mixed picture. Several cases from the ongoing current wave of opioid litigation have settled and seem to indicate an ambition among the stakeholders to avoid repeating past mistakes. For example, in a 2015 Purdue Pharma $24 million settlement with the State of Kentucky (paid out over eight years), funds are required by court order to go towards a public health fund for initiatives like addiction treatment. Imposition of a “restricted fund” is one tactic for ensuring that settlement monies go towards meaningful and related purposes, and it improves upon the highly fungible state tobacco MSA payments. Moreover, embodying requirements in the court order, as opposed to the settlement agreement, renders the terms enforceable by the court itself—moving the settlement further from the law of contract and closer to something like a binding consent decree enforced by the judiciary.

The reality may be more nuanced. For an example of the critique, see West Virginia activist and journalist Marianne Skolek, whose daughter died from an OxyContin overdose, asking “if the families of those addicted and dying from West Virginia’s prescription drug epidemic prefer dumbbells over drug treatment facilities.” Skolek, supra note 73. But the funds the West Virginia State Police used for their training facility were exclusively from the Department of Justice (DOJ) criminal asset forfeiture payment, not the settlement, from Purdue Pharma. See W. VA. GOVERNOR’S REPORT, supra note 72, at 6–7. Those payments of seized criminal proceeds go directly to the state police budget as opposed to general state coffers. Id. Moreover, they are subject to strict regulatory guidelines from the DOJ, and in this case DOJ specifically pre-approved the funds’ usage for “law enforcement training,” “law enforcement equipment and operations,” and “law enforcement facilities and equipment,” in addition to “drug education and awareness programs.” Id. While one might argue that all $44 million should have been spent on allaying West Virginia’s addiction crisis, $5 million on facilities and renovations is not necessarily a scandal, given that “U.S. Department of Justice asset forfeiture funds are typically used to support general law enforcement purposes.” Id. at 6.

Terry & Hoss, supra note 11 (invoking the West Virginia State Police remodeling project as raising “a most sobering precedent” from the tobacco MSA).


See Anthony DiSarro, Six Decrees of Separation: Settlement Agreements and Consent Orders in Federal Civil Litigation, 60 AM. U. L. REV. 275, 277–79 (2010) (explaining the sliding-scale distinctions between settlement agreement and consent decree, noting that “[t]he first distinction . . . is the mode of enforcement,” such that “an injunction in the consent decree makes non-compliance with the settlement terms contempt of court” while “failure to comply with a settlement agreement is simply a breach of contract”).
A more recent example of a state opioid litigation settlement in which funds have been earmarked for restricted purposes is that between the State of Oklahoma and Purdue Pharma.\textsuperscript{79} The settlement, valued at about $270 million, requires that $102.5 million go to Oklahoma State University’s center for addiction that specializes in research and education on addiction, and the Sackler family (not party to the suit) will donate an additional $75 million over five years to the center.\textsuperscript{80} Approximately $60 million will go towards attorneys’ fees, and $12.5 million will go directly to counties and municipalities to help pay for their costs attributable to the crisis.\textsuperscript{81} Finally, $20 million has been earmarked to pay for addiction treatment medicines.\textsuperscript{82} Although the overall amount of this settlement may have been lower than the costs of the crisis, due to bankruptcy threats posed by Purdue that would have significantly reduced any amounts recovered by Oklahoma,\textsuperscript{83} the specific uses of the bulk of the funds to ameliorate opioid harms is a step in the right direction. Moreover, Purdue agreed to stop promoting opioids in Oklahoma in perpetuity.\textsuperscript{84} The agreement may be an indication of industry defendants’ increasing openness to settle.\textsuperscript{85} Since Purdue reached its agreement with Oklahoma, manufacturer defendant Teva also settled with the State in the days leading up to trial in exchange for an $85 million payment.\textsuperscript{86} In the same period, the West Virginia Attorney General’s Office announced its own $37 million settlement with distributor McKesson, with funds limited to “support of state initiatives to combat the opioid epidemic.”\textsuperscript{87} That settlement has received criticism from some in the


\textsuperscript{81} Consent Judgment as to the Purdue Defendants, supra note 79, at 10.

\textsuperscript{82} Id.

\textsuperscript{83} Hoffman, supra note 80.

\textsuperscript{84} Consent Judgment as to the Purdue Defendants, supra note 79, at 8–9.


\textsuperscript{87} Press Release, McKesson Reaches Settlement with State of West Virginia on Opioid Order Monitoring and Reporting, McKesson (May 2, 2019), https://www.mckesson
state—U.S. Senator for West Virginia Joe Manchin labelled it a “sweetheart deal” for McKesson—who view the payout as paltry when compared to West Virginia’s opioid-related costs or even to Oklahoma’s collection of hundreds of millions from Purdue.88

In addition to distinct approaches to settlement payments, some third wave opioid settlements impose novel behavior change requirements on pharmaceutical defendants. In particular, a series of settlements obtained by the Department of Justice (DOJ) implement innovative enjoinders that go beyond generic prohibitions against the litigated conduct. The first settlement arose from a 2012 investigation of Cardinal Health by several U.S. Attorneys’ Offices and the DEA.89 Prosecutors utilized a legal theory that increasingly appears in new opioid suits and many of the MDL actions: imposing liability against a major pharmaceutical distributor for failing to comply with “suspicious order” reporting requirements under the CSA.90 To avoid litigation, Cardinal entered into an administrative agreement with the government to cooperate with the investigation.91 The investigation culminated in settlement payments of $34 million and $10 million in 2016,92 and reinforced several enjoinders included in an earlier 2012 settlement.93 Those terms primarily included enhanced terms of

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88 See Feeley, supra note 44.
93 See SETTLEMENT AGREEMENT, supra note 92, at 7 (“This Agreement is not intended to and does not supersede the obligations contained in the May 2012 Administrative Memorandum of Agreement.”).
CSA compliance and internal corporate reforms that facilitate oversight of large orders of opioid medications.94

The DOJ achieved a similar result using the same theory of liability against another major pharmaceutical distributor: McKesson Corporation.95 McKesson was originally investigated in 2008 and entered an agreement to pay a civil penalty for reporting violations.96 McKesson continued to violate CSA reporting duties, however, particularly with regards to oxycodone and hydrocodone, giving rise to a renewed investigation.97 That investigation culminated in a record-setting $150 million penalty for CSA violations.98 Like Cardinal, McKesson faced punishment beyond just monetary fines and agreed to make consequential changes to its business practices.99 Most significantly, McKesson implemented a “first of its kind” independent monitor system partnership with DEA to ensure compliance.100 While McKesson’s initial

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94 2012 CARDINAL MOA, supra note 91, at 3–4. Specifically, Cardinal agreed to raise its quality control standards and processes, create a new corporate body for monitoring large volume orders of regulated pharmaceuticals, comply with more stringent monthly reporting requirements to the DEA, and a temporary suspension of its CSA license for distributing narcotic medications. Id.


96 Id.


99 McKesson Press Release, supra note 95. Four McKesson distribution centers were subject to suspensions ranging from 1–3 years, McKesson MOA, supra note 97, at 5–7, and the company “agreed to enhanced [CSA] compliance terms for the next five years . . . [and] to specific, rigorous staffing and organizational improvements; periodic auditing; and stipulated financial penalties for failing to adhere to the compliance terms.” McKesson Press Release, supra note 95.

100 McKesson Press Release, supra note 95; see also COMPLIANCE ADDENDUM 1 (2017), https://www.justice.gov/opa/press-release/file/928481/download [https://perma.cc/H9KT-J4UF]. Under the system, McKesson is subject to “enhanced compliance,” McKesson Press Release, supra note 95, with the CSA for a five-year period, using “customer specific” and geographic data to supplement its standard monthly reports. COMPLIANCE ADDENDUM, supra note 100, at 4. Its implementation required creation of multiple new corporate departments and committees for compliance, subject to special independence and compensation restrictions; new corporate training and ethics policies; an outside “Independent Review Organization,” a three-member panel of experts on pharmaceuticals and substance control that conducts an annual audit. See COMPLIANCE ADDENDUM, supra note 100, at 1, 4–17, 22–30. The system reports back to the DEA throughout each process. See id. at 22–30.
bucking of its 2008 agreement with the government is paradigmatic of the settlement agreement critique, this subsequent agreement illustrates the potential to ingrain systemic change.

The federal government obtained several additional settlement agreements for CSA violations outside the distribution context that also reveal opportunities for meaningful accountability.\(^\text{101}\) DOJ’s $35 million settlement with Mallinckrodt, among the largest producers of generic oxycodone, was novel because it extended enforcement of CSA reporting requirements to a manufacturer.\(^\text{102}\) Like Cardinal and McKesson, Mallinckrodt failed to report “suspicious orders” to the DEA and its lackluster system for monitoring such orders allegedly violated its legal duties.\(^\text{103}\) Government enforcers in this investigation honed in on the pharmaceutical industry practice of offering “chargebacks”—essentially customized discounts offered to buyers based on downstream purchasing data.\(^\text{104}\) Because the data is provided to the manufacturer after the sale of regulated medications has taken place, it was previously not provided to the DEA in CSA reports.\(^\text{105}\) In what the DOJ termed a “groundbreaking” development, Mallinckrodt agreed to an unprecedented data sharing agreement with the DEA that includes downstream purchasing data, facilitating oversight on “the next level in the supply chain.”\(^\text{106}\)

The final examples of model settlement agreements come from DOJ’s extension of the CSA theory to the retailer space. In 2017, DOJ obtained an $11.75 million settlement with Costco based on monitoring violations in their pharmacy outlets.\(^\text{107}\) Costco pharmacies filled incomplete prescriptions, filled prescriptions from noncompliant practitioners, and failed to maintain proper records at stores and “central fill locations.”\(^\text{108}\) Like the previous agreements, this settlement required more than just payment: Costco invested more than


\(^\text{102}\) Id. (“This is the first settlement of its magnitude with a manufacturer of pharmaceuticals resolving nationwide claims that the company did not meet its obligations to detect and notify DEA of suspicious orders . . . .”).


\(^\text{104}\) See Mallinckrodt Settlement Agreement, supra note 104, at 5.

\(^\text{105}\) Mallinckrodt Press Release, supra note 101; see also Mallinckrodt Settlement Agreement, supra note 104, at 4–9.


\(^\text{108}\) Id.
$100 million in a revamped pharmacy management system to facilitate CSA compliance, implemented a new internal audit system requiring internal corporate reorganization and external cooperation, and agreed to a three year period of unfettered DEA access to inspect facilities.\textsuperscript{109} The same year, and under the same theory, DEA achieved a $3 million settlement with Safeway.\textsuperscript{110} The investigation was triggered when DEA was tipped off to an internal theft of a large supply of hydrocodone.\textsuperscript{111} Finding that the practices that allowed such a loss to go unreported were widespread across the company’s pharmacies, DEA implemented similar compliance requirements as in the Costco agreement.\textsuperscript{112}

Time will tell if the behavior change strategies deployed by the federal government will lead to better outcomes than in previous opioid settlements. The strategy, however, demonstrates that settlement agreements are more than mere payments and penalties to dispose of a lawsuit. They are a flexible tool that can incorporate systemic, enforceable terms of change, bounded only by the thoughtfulness and willingness of the contracting parties.

C. Priorities in an Opioid Master Settlement Agreement

Examples of previous public health regulatory settlements provide both aspirational and cautionary guidance on crafting effective terms for an opioid MSA. It is reasonable to assume that any settlement would include both monetary compensation and behavior change requirements. Other residual benefits of this type of public health litigation—even absent a settlement—include building public awareness about opioid harms and spurring other government activity, namely in the legislative and executive branches.\textsuperscript{113} This part, however, focuses on master settlement monetary and behavior change components, conceptualizing what form and substance these components could take to maximize public health impacts. We also briefly address several related questions that complicate any such MSA, including what magnitude monetary damages might reach, which parties may negotiate the terms of a settlement, and how the terms would best be enforced.

\textsuperscript{109} See id.
\textsuperscript{111} Id.
\textsuperscript{112} See id.; Nate Raymond, Safeway to Pay $3 Million to Resolve U.S. Drug Probe, REUTERS (July 18, 2017), https://www.reuters.com/article/us-safeway-probe/safeway-to-pay-3-million-to-resolve-u-s-drug-probe-idUSKBN1A32BB [https://perma.cc/4M76-LB44] (“In addition to paying $3 million, Safeway will also implement a compliance agreement reached with DEA to prevent future notification lapses.”).
\textsuperscript{113} See Haffajee & Mello, supra note 4, at 2305; Jacobson & Warner, supra note 46, at 788–90; Parmet & Daynard, supra note 46, at 445.
1. Monetary Damages

a. Damages Award Magnitude

A settlement with the pharmaceutical industry cannot be expected to match the overall cost of the opioid epidemic, given that industry is only one of many contributing parties. However, the magnitude of overall epidemic costs provides benchmarks for the value of a master settlement.

Studies estimating the economic burden of the opioid epidemic vary widely.\(^{114}\) Conservative estimates find annual costs increasing from around $75 billion in 2013 up to almost $100 billion in 2017, for a total cost of the epidemic since 2001 of $1 trillion.\(^{115}\) More inclusive valuations find annual costs alone total half a trillion dollars, with compounded costs of the epidemic therefore in the multiple trillions.\(^{116}\) The economic cost studies largely cluster around these two poles; whether or not a given study accounts for the value of lost lives largely accounts for the difference in cost magnitude estimated.\(^{117}\) On the lower end, studies estimate costs by primarily valuing health care costs, looking to the disproportionate health care burdens imposed by people who misuse opioids relative to those who are similarly situated but do not.\(^{118}\) On the upper end, studies also consider economic losses, such as foregone labor and criminal justice system costs, and noneconomic costs arising from lost lives.\(^{119}\)


\(^{116}\) See WHITE HOUSE REPORT, supra note 114, at 8.

\(^{117}\) See id. at 3 (“Previous studies and estimates fail to fully account for the lives lost to overdose.”).

\(^{118}\) See Carrie McAdam-Marx et al., COSTS OF OPIOID ABUSE AND MISUSE DETERMINED FROM A MEDICAID DATABASE, 24 J. PAIN & PALLIATIVE CARE PHARMACOTHERAPY 5, 6 (2010).

\(^{119}\) See WHITE HOUSE REPORT, supra note 114, at 3 (“Studies that only include healthcare expenditures typically capture none of the value of lives lost, and studies that account for earnings losses among those who die account for only a fraction of the loss from such mortality. . . . As earnings do not take into account other valuable activities in life besides work.”); Howard G. Birnbaum et al., ESTIMATED COSTS OF PRESCRIPTION OPIOID
latter category of studies that value lost lives, productivity losses from opioid fatalities represent the majority of the epidemic’s costs.\textsuperscript{120} By 2015, for example, 2 million “prime-age” workers were inactive due to opioid use, slowing economic growth by 0.6% and costing the economy an estimated $1.6 trillion.\textsuperscript{121} The next greatest categories of costs are productivity losses from nonfatal opioid misuse, health care costs related directly to overdoses, indirect health care costs, criminal justice system administration, child and family assistance, and losses to the education system.\textsuperscript{122}

When costs are broken down by sector of the economy, studies show that individuals and the private sector bear the majority of the burden, followed by the federal government, then by state and then local governments.\textsuperscript{123} This breakdown finds that the federal, state, and local government portion of the burden has held at roughly half of costs per year, including half of the $95.8 billion cost in 2016 alone.\textsuperscript{124} Compounded since 2001, this constitutes approximately $500 billion of the $1 trillion total costs—only projected to exponentially grow in the coming years.\textsuperscript{125} Because the plaintiffs in the current wave of opioid litigation are typically the government itself, this metric could be a useful barometer for master settlement negotiations, assuming most or all government plaintiffs come to the table.\textsuperscript{126} Added to this $500 billion from

\begin{quote}
\textsuperscript{120} See Rhyan, \textit{supra} note 115.
\textsuperscript{121} Gitis, \textit{supra} note 119.
\textsuperscript{122} See Rhyan, \textit{supra} note 115.
\textsuperscript{123} Id. (finding the individual costs are predominantly from lost wages; private sector from health care costs; federal, state, and local governments from additional expenditures on health care, social services, education, and criminal justice, as well as lost tax revenue).
\textsuperscript{124} See \textit{id}.
\textsuperscript{125} See \textit{id}.
\textsuperscript{126} Indeed, even though the United States is not a party to the opioid MDL, it is formally participating in settlement negotiations as a designated “friend of the Court.” See United States’ Motion to Participate in Settlement Discussions and as Friend of the Court at 1, \textit{In re Nat’l Prescription Opiate Litig.}, No. 1:17-md-02804 (N.D. Ohio Apr. 02, 2018) (unopposed motion approved by Judge Polster on June 19, 2018); United States’ Memorandum in Support of Its Motion to Participate in Settlement Discussions and as Friend of the Court at 3, \textit{In re Nat’l Prescription Opiate Litig.}, No. 1:17-md-02804 (N.D. Oh. Apr. 02, 2018) (“The United States’ substantial financial stake in combatting the opioid epidemic has implications for the proper allocation of any monetary settlement of the claims asserted in the multi-district litigation.”); Statement of Interest of the United States at 3, \textit{In re Nat’l Prescription Opiate Litig.}, No. 1:17-md-02804 (N.D. Oh. Mar. 01, 2018) [hereinafter Statement of Interest] (justifying the federal government’s interest in the MDL by pointing to “substantial costs from the opioid epidemic,” including the 2013 single-year estimate of total costs as}
2001–2017 is the projected $250 billion from 2017–2020 incurred by governments—for a cumulative total of about $750 billion.\textsuperscript{127} And this figure does not take into account future costs beyond 2020, which could be quite substantial, or individual costs that could be factored into a settlement as discussed in Part III.C.1.b.\textsuperscript{128} In short, a realistic figure for the master settlement could reasonably reach at least $50 billion to hundreds of billions, similar to the tobacco MSA, if shared responsibility, other defenses, or bankruptcy threats do not reduce that sum substantially.\textsuperscript{129}

b. Compensating the “Injured Parties”

Compensatory damages awarded in tort litigation are classically understood to serve competing goals: compensation, deterrence, and punishment or corrective justice.\textsuperscript{130} In the public health and regulatory contexts, litigation damages are often also relied on by legislatures and executive agencies as a means for private enforcement of public regulations and mass injuries.\textsuperscript{131} As in the tobacco litigation, the opioid litigation conceives of addiction to opioids as a kind of “mass” injury not unlike asbestos exposure, damages compensation for which shifts the costs of injuries from victims to responsible parties.\textsuperscript{132} As

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\item $78.5 billion and citing the Council of Economic Advisors’ upper-end estimate, supra note 114).
\item \textsuperscript{127} See Rhyan, supra note 114.
\item \textsuperscript{128} Even estimates that place greater emphasis on the value of human life might more representatively quantify the true societal impact of the epidemic but are likely untenable in the context of a litigation resolution. See WHITE HOUSE REPORT, supra note 114, at 3–5 (noting that many federal administrative agencies each have unique metrics for valuing human life, that the superiority of any given method is contested, and that even the number of lives lost to opioids is itself uncertain).
\item \textsuperscript{129} See Harris et al., supra note 40 (estimating an MDL settlement to reach $50 billion).
\item \textsuperscript{130} Gary T. Schwartz, Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice, 75 TEX. L. REV. 1801, 1801 (1997) (describing the “major camps of tort scholars,” some seeing “tort liability as an instrument aimed largely at the goal of deterrence, commonly explained within the framework of economics,” and for others seeing “tort law as a way of achieving corrective justice between the parties”).
\item \textsuperscript{131} See David Rosenberg, The Causal Connection in Mass Exposure Cases: A “Public Law” Vision of the Tort System, 97 HARV. L. REV. 849, 854 (1984) (“Although Congress and the states have enacted a host of regulatory programs in recent years, most of these programs delegate a significant portion of the public enforcement burden to private damage actions. . . . Such actions are . . . the sole means by which victims of mass exposure accidents may recover for their losses.”).
\end{itemize}
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in mass tort regulatory litigation, an opioid settlement should seek to achieve meaningful compensation for injured parties.\textsuperscript{133} 

Here, determining who is “injured” is not straightforward. The government plaintiffs represent and litigate on behalf of their constituents, but the injuries they allege are to public coffers and the public welfare.\textsuperscript{134} This was the case in the tobacco litigation, where the attorneys general used costs to state Medicaid systems to finally force the tobacco industry to the negotiating table, and where the MSA payments were negotiated to remedy the states’ injuries.\textsuperscript{135} Even though pursuing government injuries provides a promising vehicle for successfully holding opioid industry actors accountable, private parties ought not be excluded from compensation considerations. The tobacco MSA teaches that state awards are unlikely to trickle down to the pocketbooks of the very individuals most directly injured by industry’s wrongdoing.\textsuperscript{136} And as aforementioned, individual costs from the opioid epidemic are substantial, estimated to roughly equal total government costs.\textsuperscript{137}

Therefore, an opioid MSA, if negotiated successfully and equitably, would take a bifurcated approach to compensation. Ideally, a settlement award would be split between negotiated payments to the government plaintiffs and a system for direct compensation of injured individuals.\textsuperscript{138} Articulating detailed

\textsuperscript{133} Though, it is worth noting, even money going solely to state coffers would not be “wasted,” given that money is fungible and the crisis has directly impacted many state and local governments’ bottom lines. See Paula Seligson & Tim Reid, \textit{Unbudgeted: How the Opioid Crisis Is Blowing a Hole in Small-Town America’s Finances}, REUTERS (Sept. 27, 2017), https://www.reuters.com/article/us-usa-opioids-budgets/unbudgeted-how-the-opioid-crisis-is-blowing-a-hole-in-small-town-americas-finances-idUSKCN1BU2LP [https://perma.cc/E728-PKGY].

\textsuperscript{134} See Statement of Interest, supra note 126, at 3–4.

\textsuperscript{135} Parmet & Daynard, supra note 46, at 440 (“[T]he attorneys general sought compensation for the costs of smoking-related illnesses paid by the states . . . ”).


\textsuperscript{137} See Rhyan, supra note 115.

\textsuperscript{138} Canada’s opioid litigation provides an example. There, when consolidated consumer class actions against Purdue Pharma settled for $20 million (Canadian), the settlement agreement provided that after a $1 million payment to insurers, the remaining $19 million would be divided among affected members of the public who are approved for compensation by an appointed claims administrator. See OXYCONTIN AND OXYNEO NATIONAL SETTLEMENT AGREEMENT 15 (Mar. 8, 2017) (Can.), http://www.siskinds.com/cms files/PDF/Pharmaceutical/Oxycontin/Oxy_Settlement_Agreement_Signed_March-8-17.pdf [https://perma.cc/Y4SQ-J73E] [hereinafter CANADIAN SETTLEMENT AGREEMENT]. The compensation program has not yet been implemented, as courts in each province had to
guidelines for either scheme is beyond the scope of this Article, but past missteps can help avoid future ones. Unlike in the tobacco MSA negotiations, the federal government could lead any comprehensive opioid MSA negotiations, be it as a party to the MDL or in its current capacity as a party to settlement negotiations.\textsuperscript{139} The tobacco negotiations, which took place in a hurried and high-pressure context, illustrated the risk that state self-interests predominate over more targeted resolutions designed to serve tort litigation goals.\textsuperscript{140} The federal government’s involvement in a more measured negotiating environment could assist with alleviating conflicts of interest.

Individual compensatory schemes also raise a myriad of complex, though not insurmountable, issues related to fairness and administrability. An opioid victim’s compensation fund overseen by a specially formed administrative body is an excellent option, and would not be without precedent.\textsuperscript{141} Carefully crafted causation and evidentiary standards could ensure that injured applicants are not blocked from compensation if they misused their medications, while also warding off illegitimate claims and ensuring fairness for the pharmaceutical companies paying into the fund.\textsuperscript{142} Depending on the category of claimant and

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individually approve the settlement, and a Saskatchewan court denied approval pending revisions. See Perdikaris v. Purdue Pharma, 2018 SKQB 86, ¶¶ 71–72 (Can. Sask. Q.B.).

\textsuperscript{139} See supra note 126 and accompanying text; U.S. GEN. ACCOUNTING OFF., GAO-01-851, \textit{Tobacco Settlement; States’ Use of Master Settlement Agreement Payments} 10 (2001) (describing how an “earlier more far-reaching proposal[,]” which would have created a fund for the states administered by the federal government, fell through, leaving “states [to] resume[] negotiations” that led to the MSA, a “scaled-down version [that] did not require federal action to be implemented”).

\textsuperscript{140} See Dreveskracht, supra note 47, at 295–96 (2015) (describing how “a hurried three months of negotiations” led to the original 1997 settlement proposal, followed by the 1998 proposal that allowed for “non-settling states to participate . . . if they opted in within seven days—a time limit that ‘offered almost no opportunity for public health critics to mount an effective response’ and ‘placed overwhelming economic and political pressure on attorneys general [sic] to join’”) (quoting ALLAN BRANDT, \textit{THE CIGARETTE CENTURY: THE RISE, FALL, AND DEADLY PERSISTENCE OF THE PRODUCT THAT DEFINED AMERICA} 431 (2007)).

\textsuperscript{141} For example, the Canadian Settlement Agreement includes procedures for an administrative system for evaluating claims and assigning compensatory value to different injuries. \textit{Canadian Settlement Agreement}, supra note 138, at 36–44 (attaching Exhibit B, the Compensation Protocol, and Schedule A, the Claims Administration Protocol). The compensation protocol assigns applicants “points” based on their alleged injuries (Fatal overdose, 500 points; non-fatal overdose, 150 points; loss of custody of children, 100 points; loss of employment, 10–100 points based on income level; etc.), and the claims administration protocol provides guidelines for evaluating the sufficiency of an applicant’s evidence. \textit{Id.; see also} Jon D. Hanson et al., Smokers’ Compensation: Toward a Blueprint for Federal Regulation of Cigarette Manufacturers, 22 S. ILL. U. L.J. 519, 535–50 (1998) (providing “real-world” models of compensation fund programs).

injury (wrongful death claim on behalf of victim’s estate? healthy claimant seeking compensation for lost wages or health care costs? claimant presently seeking addiction services?), payment could take the form of direct monetary awards or subsidized services. Indeed, similar proposals were put forward as resolutions to the tobacco litigation prior to the MSA’s implementation. The task of designing such a system, and formulating a government payment scheme that is sufficiently proscribed, is surely immense, but the result is vital for obtaining a litigation resolution that is directly tied to the crisis harms.

c. Allocation of Settlement Funds

Because the opioid crisis is ongoing and only worsening as measured by the prevalence and severity of many associated harms, Judge Polster has articulated the sage intention to carefully allocate potential settlement resources, including funds, in the negotiation process. He hopes to meaningfully abate the opioid crisis now and going forward, rather than simply repair past harms. Uniquely, he views comprehensive settlement as a vehicle to sweep aside procedural formalities and defenses inherent in litigation, and instead focus efforts on maximizing public health impact. He sees the judiciary’s role in the MDL as remedying perceived failures among other government branches to adequately address the crisis.

So, what should an abatement fund designed to mitigate opioid nuisances prioritize? Adopting an epidemiological framework for public health harm prevention at three levels of exposure is helpful in prioritizing fund allocation. First, resources can be allocated to primary and secondary prevention, or towards preventing harms prior to individual opioid exposure or when individuals have been exposed but have not yet developed the disease of addiction, respectively. Second, albeit more pressingly, resources can be

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143 See Abrams, supra note 142, at 169.
145 See generally Hoffman, supra note 36 (exploring the broad variety of resources Judge Polster is considering while exploring an opiate settlement).
146 See id.
147 See id.
148 See id.
149 See generally Andrew Kolodny et al., The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction, 18 ANN. REV. PUB. HEALTH 559, 565–
allocated to tertiary prevention efforts, or those that seek to prevent further harm to individuals in which opioid use disorders are firmly entrenched.\textsuperscript{150} These tertiary prevention efforts aim to prevent overdose, progression of disease, and other adverse life outcomes resulting from addiction.\textsuperscript{151}

Allocation of funds into tertiary prevention efforts will address many acute, severe harms of the epidemic, where an infusion of money intelligently allocated and on a magnitude not yet invested by the federal government and states could quickly save lives and avoid serious harms.\textsuperscript{152} First, opioid overdose deaths have risen dramatically since 2000; from 2012 to 2016, these deaths increased 80\% to reach 42,249 deaths (or almost 116 persons per day).\textsuperscript{153} Indications suggest that opioid-specific deaths maintained or increased further in 2017–2018.\textsuperscript{154} The most direct way to avert these deaths is by making naloxone, the opioid overdose-reversal drug which is highly effective when administered quickly, more widely available.\textsuperscript{155} Many states and communities have already expanded access to naloxone by equipping first responders, family, and friends with the drug.\textsuperscript{156} As well, Medicaid and other insurance expansions have made coverage for the product more robust and are correlated with decreased harms.\textsuperscript{157} Nevertheless, access is still woefully inadequate—particularly given that the opioid overdoses attributable to synthetic fentanyl have increased most dramatically since 2012 (675\% increase) and require a

\begin{thebibliography}{150}
\bibitem{Kolodny2019} Kolodny et al., supra note 149, at 568–69.
\bibitem{SUPPORT2019} See SUPPORT Act, supra note 13; \textit{THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION & THE OPIOID CRISIS 8, 37–39 (2017)}.
\bibitem{Haffajee2018a} Haffajee & Frank, supra note 150, at 768 (2018); see Seth et al., supra note 3, at 349.
\bibitem{Sources2019} See sources cited supra note 1.
\bibitem{Haffajee2018b} Haffajee & Frank, supra note 150, at 767.
\bibitem{Abouk2019} \textit{Id.; see also} Rahi Abouk et al., \textit{Association Between State Laws Facilitating Pharmacy Distribution of Naloxone and Risk of Fatal Overdose}, 179 JAMA INTERNAL MED. 805, 806 (2019).
\end{thebibliography}
naloxone dose at least five times greater than that typically available to be successfully reversed.\textsuperscript{158} Conservatively estimating that about fifteen naloxone doses dispensed result in one life saved\textsuperscript{159}—and given the statistics that between 2.1 and 6 million Americans have an opioid use disorder (OUD),\textsuperscript{160} almost 150,000 emergency department visits were due to opioid overdoses in 2017,\textsuperscript{161} and almost 48,000 opioid overdoses resulted in deaths in 2017\textsuperscript{162}—likely millions of additional doses of naloxone are needed at costs that overwhelm states and localities.\textsuperscript{163} Substantial amounts of settlement funds could go towards these costs, with the federal and allied state governments potentially stepping in to negotiate lower prices than the persistently high prices for naloxone.\textsuperscript{164}

Another ripe opportunity for tertiary prevention fund investment is evidence-based opioid addiction therapy, particularly to rural areas. Only 20% to 40% of the millions with OUD receive addiction treatment, a fraction of whom receive evidence-based treatment.\textsuperscript{165} A combination of medication and behavioral therapy, or medication-assisted treatment (MAT), is considered the gold standard for treating OUDs.\textsuperscript{166} Clinical trials have demonstrated that three medications for OUD (MOUD)—methadone, buprenorphine, and extended release naltrexone—reduce opioid use, overdose, and other adverse health

\begin{itemize}
\item \textsuperscript{158} Haffajee & Frank, supra note 150, at 767–68.
\item \textsuperscript{159} Frank & Fry, supra note 157.
\item \textsuperscript{162} Drug Overdose Deaths, supra note 2.
\item \textsuperscript{163} Haffajee & Frank, supra note 150, at 767.
\item \textsuperscript{164} See Ravi Gupta et al., The Rising Price of Naloxone—Risks to Efforts to Stem Overdose Deaths, 375 NEW ENG. J. MED. 2213, 2214–15 (2016); Frank & Fry, supra note 157.
\item \textsuperscript{166} See Robert P. Schwartz et al., Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009, 103 AM. J. PUB. HEALTH 917, 920–21 (2013) (finding that “increased access to [buprenorphine, a drug often used for MAT,] . . . may have significantly contributed to the reduction in heroin overdose deaths [in Baltimore]‘’); Lembke & Chen, supra note 165, at 990 (discussing the efficacy of MAT-related therapy).
\end{itemize}
outcomes. For example, methadone and buprenorphine treatment were associated with 53% and 37% reductions, respectively, in all-cause mortality among patients with OUD as compared to those receiving no MOUD in the twelve months following nonfatal overdose. However, rural areas are particularly lacking in MAT and MOUD providers, with a majority of rural counties still lacking a physician with a buprenorphine waiver, and many more lacking a methadone provider. Also particularly lacking in robust MAT are criminal justice settings, including when patients transition out of these settings and are at vastly increased risks for overdose.

Barriers to more robust opioid addiction treatment abound and notably involve a lack of behavioral health and primary care practitioners willing or trained to provide this treatment. But funding could directly address many of

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167 See Richard P. Mattick et al., Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence, 2014 COCHRANE DATABASE SYSTEMATIC REV. 1, 19–20; Richard P. Mattick et al., Methadone Maintenance Therapy Versus No Opioid Replacement Therapy for Opioid Dependence, 2009 COCHRANE DATABASE SYSTEMATIC REV. S 1, 10–11; Suzanne Nielsen et al., Opioid Agonist Treatment for Patients with Dependence on Prescription Opioids, 317 JAMA 967, 967 (2017); Suzanne Nielsen et al., Opioid Agonist Treatment for Pharmaceutical Opioid Dependent People, 2016 COCHRANE DATABASE SYSTEMATIC REV. S 1, 23; Schwartz et al., supra note 166, at 920. See generally Marc A. Schuckit, Review Article, Treatment of Opioid-Use Disorders, 375 NEW ENG. J. MED. 357, 361–366 (2016) (surveying MOUD treatments and efficacies).


169 C. Holly A. Andrilla et al., Geographic Distribution of Providers with a DEA Waiver to Prescribe Buprenorphine for the Treatment of Opioid Use Disorder: A 5-Year Update, 35 J. RURAL HEALTH 108, 110 (2018); see also Rebecca L. Haffajee et al., Characteristics of U.S. Counties with High Opioid Overdose Mortality and Low Capacity to Deliver Medications for Opioid Use Disorder, 2 JAMA NETWORK OPEN e196373, at e196373 (2019).

170 See Haffajee et al., supra note 169, at e196373; Rebecca L. Haffajee et al., Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment, 54 AM. J. PREVENTIVE MED. S230, S232–33 (2018); Jeffrey H. Samet et al., Perspective, Methadone in Primary Care—One Small Step for Congress, One Giant Leap for Addiction Treatment, 379 NEW ENGL. J. MED. 7, 8 (2018).


173 See Brendan Saloner et al., Moving Addiction Care to the Mainstream—Improving the Quality of Buprenorphine Treatment, 379 NEW ENG. J. MED. 4, 4 (2018); Samet et al., supra note 170, at 7. See generally Haffajee et al., supra note 170, at S237–38 (addressing barriers for many healthcare providers to provide buprenorphine treatment); Sarah E. Wakeman & Michael L. Barnett, Primary Care and the Opioid-Overdose Crisis—Buprenorphine Myths and Realities, 379 NEW ENG. J. MED. 1 (2018) (providing solutions for mobilizing primary care providers to offer buprenorphine).
these barriers and expand treatment by financing: public payer coverage of MAT;\textsuperscript{174} provider incentives to practice in rural areas;\textsuperscript{175} clinician time and fees associated with MAT training;\textsuperscript{176} updated curriculum changes in graduate and continuing medical education around opioid prescribing and addiction treatment;\textsuperscript{177} infrastructure to provide MAT via telemedicine (assuming regulatory hurdles are overcome) and/or integrated care models;\textsuperscript{178} and robust MAT provisions in criminal justice settings and upon transition into society.\textsuperscript{179}

Additional financial investments that would address downstream harms involve reducing the incidence of infectious disease transmissions—an increasingly common comorbidity that accompanies opioid injection use.\textsuperscript{180} For instance, Hepatitis C infections nationally, which had enjoyed a steady decline of 87\% between 1992 and 2009, increased by 167\% since 2010.\textsuperscript{181} Outbreaks of HIV have also been connected to the opioid crisis,\textsuperscript{182} for instance to injecting Opana in Scott County, Indiana.\textsuperscript{183} These infections could be prevented or minimized with clean syringes (including at safe injection facilities),\textsuperscript{184} MAT, and increased surveillance/detection efforts—all of which cost money.\textsuperscript{185} For example, providing the approximately 700,000 persons with heroin use disorders who are potentially injecting with clean needles would cost $14 million per year.\textsuperscript{186} Establishing safe injection facilities would be more controversial and costly,\textsuperscript{187} but these facilities have been shown in a number of studies to reduce the incidence of infectious diseases and minimize overdose harms.\textsuperscript{188}


\textsuperscript{175}Haffajee et al., supra note 170, at S238.

\textsuperscript{176}See id. at S236.

\textsuperscript{177}Id. at S238.

\textsuperscript{178}Haffajee & Frank, supra note 150, at 768; Y. Tony Yang et al., Commentary, Telemedicine’s Role in Addressing the Opioid Epidemic, 93 MAYO CLINIC PROC. 1177, 1180 (2018).

\textsuperscript{179}Wakeman & Rich, supra note 171, at 223.

\textsuperscript{180}Haffajee & Frank, supra note 150, at 767.

\textsuperscript{181}Id.


\textsuperscript{184}See Jennifer Ng et al., Does Evidence Support Supervised Injection Sites?, 63 CANADIAN FAM. PHYSICIAN 866, 866 (2017); Gonsalves & Crawford, supra note 182.

\textsuperscript{185}Haffajee & Frank, supra note 150, at 767–68.

\textsuperscript{186}Id. at 767.

\textsuperscript{187}See id.

\textsuperscript{188}See Jennifer Ng et al., supra note 184, at 866; German Lopez, A Study Questioning the Evidence for Safe Injection Sites Has Been Retracted, VOX (Aug. 22, 2018),
Finally, to reduce tertiary harms, settlement money could help support the growing number of children affected by opioid overdose and misuse.\(^\text{189}\) After declining by almost 30% from 1999 to 2012, foster care rates have increased from 2012 to 2016 nationally by approximately 7%.\(^\text{190}\) Most evidence from foster care administrators suggests this increase is largely attributable to parents with opioid addiction, some of whom overdose fatally, who are no longer able to care for their children.\(^\text{191}\) As well, money could be invested into providing supports to reunite families torn apart by opioid addiction—including therapy, MAT, housing, and job supports for parents affected. Treatment for pregnant and postpartum mothers and babies with neonatal opioid withdrawal syndrome was addressed in the SUPPORT Act.\(^\text{192}\)

Evidence-based upstream harm prevention efforts also are reasonable candidates for MSA fund allocation. These could include money for prescription drug monitoring programs (PDMP) that embody features shown to reduce high-risk opioid prescribing and even overdoses,\(^\text{193}\) including building in technology to make referrals to addiction treatment providers and training providers to react to PDMP information without turning patients away.\(^\text{194}\) Pain clinic regulation is also a viable candidate for fund infusion, where the evidence shows that when enforced, these laws reduce high-risk prescribing.\(^\text{195}\)

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\(^{189}\) Haffajee & Frank, supra note 150, at 767.


\(^{191}\) See generally Julia Lurie, Children of the Opioid Epidemic Are Flooding Foster Homes. America Is Turning a Blind Eye., MOTHER JONES (July/Aug., 2017), https://www.motherjones.com/politics/2017/07/children-ohio-opioid-epidemic [https://perma.cc/9HYV-B4DP] (“Largely because of the opioid epidemic, there were 30,000 more children in foster care in 2015 than there were in 2012 . . . .”).

\(^{192}\) SUPPORT Act, supra note 13, §§ 1005, 7061–65.


\(^{195}\) See Tatyana Lyapustina et al., Effect of a “Pill Mill” Law on Opioid Prescribing and Utilization: The Case of Texas, 159 DRUG & ALCOHOL DEPENDENCE 190, 195 (2016); Lainie Rutkow et al., Original Investigation, Effect of Florida’s Prescription Drug Monitoring
d. Behavior Change Requirements

Monetary relief is essential for offsetting the epidemic’s considerable economic burden, but a master settlement’s injunctive terms are just as vital. Monetary relief alone is likely incapable of reversing upwards trends of opioid addiction and overdose.\(^\text{196}\) The only major settlement from the first wave of opioid litigation was largely inconsequential,\(^\text{197}\) perhaps in part due to its uninspired behavior change provisions. Any comprehensive settlement to the opioid litigation should include provisions that ensure transparency, monitoring, and enforceability.

One challenge that injunctive terms can remedy is the general opacity that surrounds government settlement agreements.\(^\text{198}\) While funds secured through the work of the DOJ may be subject to disclosure requirements, state victories are generally less transparent.\(^\text{199}\) Because settlement agreements are typically not published on public litigation dockets, discovering the exact terms agreed to between a state attorney general’s office and a corporate defendant can be challenging.\(^\text{200}\) Interested parties are often left only with press releases announcing that an agreement was reached, which may be skewed in the

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\(^{196}\) See Carr et al., supra note 11, at 210 (arguing that a monetary penalty’s most likely impact is increased pricing, but “such a result is unlikely to substantially affect opioid-related morbidity and mortality because health insurers, not consumers, pay most prescription drug costs”).

\(^{197}\) See supra notes 67–70 and accompanying text.

\(^{198}\) David Luban, Settlements and the Erosion of the Public Realm, 83 GEO. L.J. 2619, 2648 (1995) (“Parties consummate settlements out of public view. The facts on which they are based remain unknown, their responsiveness to third parties who they may affect is at best dubious, and the goods they create are privatized and not public. Settlements are opaque.”).

\(^{199}\) W. VA. GOVERNOR’S REPORT, supra note 72, at 7 (explaining that “federal asset forfeiture funds are distinct from the settlement funds that were collected by the West Virginia Attorney General’s Office” and that the spending plans for the former category of funds were being publicly outlined, while the latter were not, because of “strict U.S. Department of Justice guidelines”). Even at the federal level, however, settlement transparency remains a problematic area giving rise to reform efforts. See Senators Warren and Lankford Introduce Truth in Settlements Act to Increase Transparency of Federal Agency Settlements, ELIZABETH WARREN (May 16, 2017), https://www.warren.senate.gov/newsroom/press-releases/senators-warren-and-lankford-introduce-truth-in-settlements-act-to-increase-transparency-of-federal-agency-settlements [https://perma.cc/9JJ5-U87P].

\(^{200}\) See Judith Resnik, Uncovering, Discovering How the Public Dimensions of Court-Based Processes Are at Risk, 81 CHI.-KENT L. REV. 521, 555 (2006) (explaining that litigation dockets may not reflect that settlement was reached because rules of procedure allow parties to “conclude agreements by dismissals,” meaning they arrive at a mutually agreeable resolution to the litigation, unilaterally file notices of dismissal with the court, and then outside of court “specify the relevant terms in contracts”).
direction of flattering the party volunteering the information. In other cases, nondisclosure provisions in the agreement may very well prohibit publication of the terms. While the settlement terms themselves would reveal whether the funds were restricted to certain policy initiatives, that information is only useful to the extent that the funding can be traced, another impossible task if funds are liquidated into a state’s general treasury. Any future opioid settlements could improve upon past agreements simply by including disclosure provisions for the agreements themselves and for expenditures of the funds.

Relatedly, a comprehensive settlement should include provisions allowing for public monitoring and enforcement of the agreement’s requirement(s). DOJ’s recent series of opioid settlements demonstrate how the agreements can require the creation of new corporate bodies dedicated to monitoring and compliance with settlement terms. Moreover, the second wave settlements endorse an approach closer to a judicially enforceable consent decree as opposed to a purely private contract agreement. An opioid settlement agreement should include a court order that would allow any state party to the agreement to bring a contempt of court action against any defendant that fails to fulfill its

201 See Mallinckrodt Press Release, supra note 101; McKesson Press Release, supra note 95.

202 Resnik, supra note 200, at 555 (noting that parties can “bargain for privacy/secrecy” by “conditioning [their] settlements on nondisclosure of information”); Luban, supra note 198, at 2649 (describing the “widespread practice of secret settlements”). Further, settlement secrecy provisions can enable further shrouding of litigation documents that would otherwise be public: “discovery confidentiality clauses are routinely included as a predicate to the initial disclosures,” such that “settlement may hinge on agreements to make data inaccessible.” Resnik, supra note 200, at 555–56; see also Luban, supra note 198, at 2649 (offering a typical example of secret settlement that includes “a promise of secrecy and the return of the discovery materials”). Indeed, this appears to have occurred in the opioid context during the West Virginia Attorney General’s 2004 negotiations with Purdue Pharma. See David Armstrong, Drug Maker Thwarted Plan to Limit OxyContin Prescriptions at Dawn of Opioid Epidemic, STAT (Oct. 26, 2016), https://www.statnews.com/2016/10/26/oxycontin-maker-thwarted-limits/ [https://perma.cc/Q356-9QVB] (revealing previously sealed court documents from the case showing that settlement without admission of liability allowed Purdue to conceal damaging information about marketing practices exchanged during discovery); see also Patrick Radden Keefe, The Family That Built an Empire of Pain, NEW YORKER (Oct. 23, 2017), https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain [https://perma.cc/A7T5-7KZU] (detailing litigation between the State of Kentucky and Purdue Pharma that ended in a settlement that was a “coup” for Purdue, in part because “in settling, the company sealed from public view both [the company President’s] deposition and internal documents obtained through discovery”).

203 See generally supra notes 92–93, 98–100, 105, 108 and accompanying text (describing several pharmaceutical companies’ settlement agreements with compliance requirements that include administrative oversight mechanisms).

204 See, e.g., McKesson Press Release, supra note 95.
obligations. By requiring that states make public how opioid settlement funds are utilized, and then providing a mechanism for monitoring and enforcing the obligations of both the government and industry alike, an opioid master settlement could avoid some of the missteps of the tobacco MSA.

Of course, a comprehensive settlement would include a myriad of behavior change requirements beyond the broad structural suggestions outlined here. Enjoiners would require strict compliance with federal laws (including the CSA’s reporting requirements and the FDCA’s marketing requirements), constrain how funds can be spent, limit marketing and lobbying tactics around prescription opioids (both direct-to-consumer and to professionals), and establish the creation of new initiatives and programs devoted towards treating addiction, innovation of new pain and addiction therapies, and helping with structural determinants of disease (e.g., housing and employment services for those in recovery). Just as the tobacco MSA ended advertising campaigns like “Joe Camel,” and started public service marketing projects like the “Truth” campaign, an opioid settlement should require the creation and funding of projects dedicated to addiction prevention and public and professional education. By ensconcing these more specifically tailored initiatives in legal structures that require transparency, monitoring, and enforcement, the opioid settlement agreement programs will be accountable to the public and true to their intent.

IV. CONCLUSION

Litigation holds significant public health potential in addressing the opioid crisis if pursued intelligently and thoughtfully. The sheer magnitude and costs of opioid harms and lack of resources governments have to put or (in the case of the federal government) are willing to allocate towards them make clear the need for additional supports. Who better to contribute to these costs than companies that have profited tremendously from opioid analgesic sales and helped to create a population dependent and addicted to opioids for treatment of chronic pain and other conditions? The collateral damage from the influx in prescription opioid supply has only partially manifested and will expand into

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205 See DiSarro, supra note 78, at 282–86 (noting that contempt-of-court claims can be adjudicated more quickly and efficiently than breach-of-contract and provide more potential remedies).
206 See id. at 286 (noting that the limitations on potential obligations in settlement agreements “are limited only by the creativity of the parties’ counsel and the desires of the settling parties”).
207 See Schroeder, supra note 50, at 294–95.
the next generation as babies born with neonatal opioid withdrawal syndrome and children of parents with opioid addiction experience health and life costs, and society experiences long-term workforce deficits. While opioid manufacturers, distributors, and pharmacies are not solely to blame, their liability for public health harms that governments and individuals currently and in the future will bear is challenging to dispute given mounting epidemiological evidence and internal evidence of marketing and sales practices. Nevertheless, even as smaller settlements and a potential MSA are forthcoming, carefully earmarking monetary settlement funds and outlining behavior change requirements (as some past opioid settlements have done) are critical steps towards maximizing the value and impact of this litigation endeavor.

Of course, litigation is not a panacea. Continued efforts to achieve comprehensive legislative solutions to the opioid epidemic akin to and beyond the SUPPORT Act should be supported, along with other evidence-based and carefully crafted governmental and non-governmental activities. But an opioid MSA would not come at the opportunity cost of those efforts, as the various public health response fronts are not competing in a zero-sum game. Instead, an MSA could provide an infusion of funds and behavior changes needed to help finally turn the corner on the crisis’s unrelenting expansion.
## APPENDIX

Table 1: Representative Opioid Settlements & Terms: Manufacturer Settlements

<table>
<thead>
<tr>
<th>Case</th>
<th>Plaintiffs</th>
<th>Defendants</th>
<th>Allegations</th>
<th>Settlement Terms (Monetary; Injunctive)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Manufacturer Settlements</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2007 Settlement between 27 State AGs and Purdue Pharma</td>
<td>Attorneys General for OR, AZ, AR, CA, CT, ID, IL, KY, LA, ME, MD, MA, MT, NE, NV, NM, NC, OH, PA, SC, TN, TX, VT, VA, WA, WI and DC</td>
<td>Purdue Pharma</td>
<td>Misrepresentations in off-label marketing of OxyContin Failure to adequately disclose OxyContin’s risk for abuse and diversion</td>
<td>$19.5 million settlement payout, divided among the states Cease false, misleading, or deceptive claims regarding OxyContin Cease excessive or abusive advertising practices and all off-label marketing Establish internal abuse-and-diversion detection program</td>
</tr>
<tr>
<td>2015 Commonwealth of Kentucky v. Purdue Pharma L.P. (Kentucky state court)</td>
<td>Office of the Kentucky Attorney General</td>
<td>Purdue Pharma &amp; Abbott Laboratories</td>
<td>Misrepresentations in marketing activities promoting OxyContin from 1996 to 2001</td>
<td>$24 million paid out in installments over eight years Court order implementing settlement agreement requires payments go to a restricted fund for public health initiatives including addiction treatment</td>
</tr>
<tr>
<td>Case</td>
<td>Plaintiffs</td>
<td>Defendants</td>
<td>Allegations</td>
<td>Settlement Terms (Monetary; Injunctive)</td>
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<td>-----------------------------------------</td>
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</tbody>
</table>
| **2017**  Settlement between United States and Mallinckrodt | U.S. Department of Justice; U.S. Drug Enforcement Administration | Mallinckrodt LLC | Failure to identify and report suspicious orders to the DEA, particularly regarding oxycodone, in violation of the Controlled Substances Act (CSA)  
Additional CSA violations from recordkeeping practices at manufacturing plants | $35 million settlement payment  
Enter novel “parallel agreement” with the DEA to monitor and allow access to downstream purchasing information, or “chargeback” data  
Comply with additional monitoring and recordkeeping procedures to prevent diversion |
| **2019**  Settlement between State of Oklahoma and Purdue | Office of the Oklahoma Attorney General | Purdue Pharma | Overstatement of efficacy of opioid pain medications coupled with misrepresentation of risks of addiction  
Deceptive marketing; public nuisance; False Claims Act violations; Consumer Protection Act violations | $270 million settlement:  
$102.5M towards new center for addiction at Okla. State Univ. from Purdue; additional $75M donation to the Center directly from Sackler family; $60M in attorneys’ fees; $12.5M directly to Okla. counties and municipalities; $20M towards supplying addiction treatment medications |
<table>
<thead>
<tr>
<th></th>
<th>Case</th>
<th>Plaintiffs</th>
<th>Defendants</th>
<th>Allegations</th>
<th>Settlement Terms (Monetary; Injunctive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturer Settlements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cease promotion and marketing of opioids in Oklahoma</td>
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<td></td>
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<td></td>
<td></td>
<td>Assist law enforcement with any diversion investigations</td>
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</tbody>
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Table 2: Representative Opioid Settlements & Terms: Distributor Settlements

<table>
<thead>
<tr>
<th>Case</th>
<th>Plaintiffs</th>
<th>Defendants</th>
<th>Allegations</th>
<th>Settlement Terms (Monetary; Injunctive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 Settlement between United States and Cardinal</td>
<td>U.S. Department of Justice; U.S. Drug Enforcement Administration</td>
<td>Cardinal Health</td>
<td>Failure to identify and report suspicious orders of opioid medications in violation of the CSA &lt;br&gt; Failure to meet recordkeeping responsibilities under the CSA</td>
<td>$44 million in total payments to the United States &lt;br&gt; Comply with CSA reporting requirements at temporarily heightened standard &lt;br&gt; Implement new internal structures for monitoring compliance</td>
</tr>
<tr>
<td>2016 Settlement between United States and McKesson</td>
<td>U.S. Department of Justice; U.S. Drug Enforcement Administration</td>
<td>McKesson Corporation</td>
<td>Failure to comply with 2008 agreement with DOJ for reporting violations under the CSA, particularly regarding oxycodone and hydrocodone &lt;br&gt; Inadequate design and implementation of detection and reporting system under CSA &lt;br&gt; Failure to protect against diversion of narcotic medication at a dozen distribution centers</td>
<td>Comply with CSA reporting requirements at temporarily heightened standard &lt;br&gt; Implement new internal structures for monitoring compliance &lt;br&gt; Suspend operations at four distribution centers for period of 1–3 years &lt;br&gt; Implement “first of its kind” internal monitoring system featuring independent review board &lt;br&gt; Comply with heightened CSA standards for 5-year period</td>
</tr>
</tbody>
</table>
Table 3: Representative Opioid Settlements & Terms: Pharmacy Retailer Settlements

<table>
<thead>
<tr>
<th>Case</th>
<th>Plaintiffs</th>
<th>Defendants</th>
<th>Allegations</th>
<th>Settlement Terms (Monetary; Injunctive)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Retailer Settlements</strong></td>
<td></td>
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<tr>
<td>2017 Settlement between United States and Costco</td>
<td>U.S. Department of Justice; U.S. Drug Enforcement Administration</td>
<td>Costco Wholesale; Costco Pharmacies</td>
<td>Improperly filled prescriptions that were non-compliant with CSA requirements; Violating CSA recordkeeping provisions at pharmacies and distribution centers</td>
<td>$11.75 million settlement payment to the United States; Invest in new pharmacy back-end management system to facilitate CSA compliance; Implement internal audit system with 3-years of unfettered access for DEA inspections</td>
</tr>
<tr>
<td>2017 Settlement between United States and Safeway</td>
<td>U.S. Department of Justice; U.S. Drug Enforcement Administration</td>
<td>Safeway, Inc.</td>
<td>Alaska pharmacy locations lost track of tens of thousands of hydrocodone tablets due to inadequate monitoring; Insufficient compliance with CSA monitoring requirements to prevent diversion at pharmacies across the company</td>
<td>Invest in new pharmacy back-end management system to facilitate CSA compliance; Implement internal audit system with 3-years of unfettered access for DEA inspections; Implement monitoring and reporting systems for CSA compliance; Comply with heightened standards for temporary punitive period</td>
</tr>
</tbody>
</table>
Prosecuting Opioid Use, Punishing Rurality

VALENA E. BEETY*

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I. INTRODUCTION

The opioid crisis spotlights rural communities, and accompanying that bright light are long-standing, traditional biased tropes about backwards and

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*Professor of Law, Arizona State University Sandra Day O’Connor College of Law. Thank you to Jennifer Oliva, Lisa Pruitt, Pamela Metzger, Maybell Romero, and Lauren Sudeall, my compatriots in rural legal scholarship and rural criminal justice.

backwoods White Appalachians. These stereotypes conflate rurality with substance use disorder as the next progression in dehumanizing stereotypes. Widespread attention to our nation’s use disorder crisis, however, also brings an opportunity to recognize these fallacious stereotypes and to look more closely at the criminal legal systems in rural communities. In this Article, I use drug-induced homicide—what has become a popular prosecutorial charge in response to the opioid crisis—as a prism to identify and critique the failings in rural criminal courts more broadly. This Article includes modest recommendations that acknowledge and respond to these inadequacies while attempting to preserve people’s constitutional rights and decrease opiate-related overdoses.

Drug-induced homicide converts an overdose to murder. The basic concept of drug-induced homicide is as follows: a drug user overdoses and the criminal justice system charges the drug distributor with homicide. In this regime, drug distribution often includes the simple act of sharing the illicit substance between two parties; under the circumstances, fate and tolerance levels frequently are the only distinctions between the person who lives and the person who dies. The person who dies becomes a martyr, regardless of any previous condemnation of her substance use, while the person who lives is charged as a murderer.

Under the Supreme Court case <i>Burrage v. United States</i>, prosecutors of federal drug-induced homicide charges must establish that the individual drug shared by the co-user, or distributor, in such circumstances, was the exclusive “but-for” cause of death. In other words, under <i>Burrage</i>, prosecutors are required to eliminate any other health ailment or drug in the decedent’s bloodstream as the cause of death in order to proceed on a charge of drug-induced homicide. This prerequisite to a charge of drug-induced homicide, however, is only tested when—and if—the prosecutor’s evidence is presented to a jury at trial.

Pretrial, state prosecutors often rely on death certificates that list the cause of death as overdose and the manner of death as homicide without performing a

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2 Please note that I capitalize White and Black when I am referring to peoples. THE CHICAGO MANUAL OF STYLE ¶ 8.38 (17th ed. 2017).
5 See Drug-Induced Homicide Defense Toolkit, supra note 4, at 6.
6 <i>Burrage v. United States</i>, 571 U.S. 204, 211 (2014) (quoting MODEL PENAL CODE § 2.03(1)(a) note on subsec. (1) (AM. LAW INST. 1985)) (“[But-for causation] represents ‘the minimum requirement for a finding of causation when a crime is defined in terms of conduct causing a particular result.’”).
toxicology report, let alone an autopsy. County coroners, who are elected public officials with no required medical or scientific training, routinely complete these death certificates. This nonscientific “evidence,” of course, can be used to pressure a defendant to plead guilty. Such a guilty plea on the part of the defendant eliminates the prosecutor’s duty to establish the but-for cause of death or even insist that the state or municipality conduct an autopsy. Drug-induced homicide charges have a required scientific underpinning: the prosecution needs specific scientific evidence, which demonstrates that the defendant’s shared drugs were the but-for cause of the victim’s death, and defense attorneys can challenge the charge if such scientific evidence is not presented. That critical requirement, however, is rarely tested by a trial.

In a previous piece, I discussed the troubling role of unscientific coroner findings on cause and manner of death in drug-induced homicide cases and the dramatic disparity between coroner and medical examiner systems. Medical examiner systems with trained doctors function predominantly in cities and high population counties, while elected, and frequently scientifically untrained, coroners generally serve rural communities. Experts have rebuked the coroner system as unscientific and “anachronistic” dating back to at least 1928. I have also written on defense strategies for defense attorneys representing a client.

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8 See id. at 987.
9 Id. at 992.
10 See id. at 999.
11 See id. at 1004.
12 See id.
13 Beety, supra note 7, at 985.
14 See id. at 1004 (“The combination of political motives and under-educated and under-funded coroners serving as death investigators leads to faulty forensic determinations of the manner of death—homicide—and also questionable determinations of the cause of death—opiod overdose—as the scientific underpinnings of a drug-induced homicide charge.”).
16 Clarissa Bryan, Beyond Bedsores: Investigating Suspicious Deaths, Self-Inflicted Injuries, and Science in a Coroner System, 7 NAELA J. 199, 216 (2011) (“If leading scientists in 1928 deemed the coroner system ‘anachronistic,’ it is difficult to justify its continued operation today. The apparent shortfall of the system to engage medical science in the performance of death investigations is simply unacceptable.”); see also Alex Breitler, ‘Too Much Power’: Rethinking Sheriff-Coroner Role, RECORDNET.COM (Dec. 9, 2017, 4:26 PM), http://www.recordnet.com/news/20171209/too-much-power-rethinking-sheriff-coroner-rol [https://perma.cc/M4Z6-R8AC] (“As early as 1928, even before the advent of modern forensic science, experts began recommending that the office of coroner be abolished in favor of scientifically trained staff. Almost 90 years later, this advice appears to have been ignored in some areas, where coroners may be eligible for election simply by being registered voters with clean criminal records.”).
charged with drug-induced homicide. Those solutions are practical; they acknowledge the problems in drug-induced homicide prosecutions and the opportunities to present robust defenses.

This Article, instead, explores how drug-induced homicide is a window into the unique form of criminal justice that operates in largely insular, sparsely populated rural areas. The “smallness” of rural communities and their courts is problematic because, among other things, very few new attorneys return to their rural communities to practice. Indeed, most Americans now live in an urban or suburban area. The few attorneys who do return to their rural roots have no choice but to adopt a practice involving a diverse range of cases. Often, these returning attorneys are either solo practitioners or partners in two-lawyer firms, who take court-appointed criminal cases while litigating family law, social security, property, and other civil matters. One can imagine how these rural attorneys are incentivized to prioritize their cases involving paying clients and those that are court-ordered in a judicial system that regularly runs out of funds for court-appointed attorneys and binds their payments over until the next fiscal year.

For similar reasons, a rural area’s legal community is unlikely to be characterized by turnover or change in leadership. Both prosecutors and defense attorneys, who are in the good graces of the local bar and bench, routinely maintain their positions for years, if not decades, and act as repeat players cementing courtroom practices. There may be no recognized conflict of interest where a small town judge, who is married to the chief of police, signs warrants issued by her husband’s deputy officer; that is simply the way things work.

17 See Drug-Induced Homicide Defense Toolkit, supra note 4, at 3 (“This Toolkit is intended to serve as an informational guide for defense counsel and other interested parties working to mount a defense for individuals charged with drug-induced homicide or similar crimes resulting from overdoses.”).

18 See id. (“The creation of this toolkit was spurred by two related trends: (1) information . . . about pervasively inadequate defense being provided to many individuals charged with these crimes, and (2) widespread efforts by prosecutors to disseminate information and tools that aid other prosecutors and law enforcement in investigating and bringing drug-induced homicide and related charges.”).


21 Anders W. Lindberg, We’re in Big Trouble: The Issue of Timely Payment of Court Appointed Counsel, 4 W. VA. L. REV. 121, 128 (2009).

get done in rural communities. In fact, in rural counties, lawyers who serve as judges in one county may serve as prosecutors in the adjacent county. This practice places defense attorneys in the unenviable position of having to decide how to best challenge an opposing prosecutor, who very well might be ruling on their motions in a different case. Finally, in certain rural counties, it is a common practice for prosecutors to meet with defendants pre-arraignment to try to work out a deal—that is, before the defendant is assigned an attorney to advance that individual’s interests. This practice commonly results in a slew of defendants prepared to plead guilty at arraignment, notwithstanding the well-settled fact that plea negotiations are a critical stage in criminal proceedings during which defendants are entitled to counsel.

In this Article, I address problems particular to rural communities roiled by the opioid crisis, and I acknowledge the undue burdens on rural people of color in rural criminal legal systems. Simply stated, in my proposed solutions I contend that rural communities should eliminate drug-induced homicide offenses and expand Good Samaritan laws to protect eyewitnesses to overdoses and encourage life-saving interventions. I advocate for the decriminalization of witnessing these overdoses. I further recommend the enactment of legislation that establishes coroner training or, in the alternative, separates the roles of coroner and sheriff because such reforms could prove vital depending on the needs of the community. I argue that the focus of coroners and medical examiners should be shifted from criminalization and prosecutions to promoting positive public health outcomes, consistent with coroners’ and medical examiners’ professional obligations. I maintain that such reforms will result in fewer overdose deaths, mitigate shame and obfuscation, and open a door toward evidence-based responses to the ongoing crisis.

II. OPIOID CRISIS

A. Rurality and Race

Americans are socialized to envision rural peoples as ethnically monolithic: all the same and all White. Yet rural areas can be diverse, and not all are fairly

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27 Judy Melinek et al., National Association of Medical Examiners Position Paper: Medical Examiner, Coroner, and Forensic Pathologist Independence, 3 ACAD. FORENSIC PATHOLOGY 93, 97 (2013) (“Unlike with crime laboratory examinations, which are usually generated to determine guilt or innocence, the medicolegal death investigation is primarily a public health effort.”).
characterized as White dominant. The prevailing vision of White rurality excludes Black Americans in the “Black Belt” across the Deep South, Latinx communities in the Rio Grande Valley on the border of Texas and Mexico, and indigenous North Americans in the rural Southwest and West. Nearly 90% of Black Americans living in rural (nonmetropolitan) areas are in the South and, according to the most recent census, the indigenous peoples of North America are more likely to reside in rural (nonmetropolitan) areas than metropolitan ones (1.9% v. 0.8%). National statistics, therefore, reject the notion that rurality is monolithically White and noninclusive of diverse communities.

Rural areas, however, are aligned in their high concentration of poverty. In particular, rural communities are far too often dominated by generational or persistent poverty. Rural poverty is predominantly equated with unemployment, lack of transportation, and lack of access to adequate healthcare. The rural areas mentioned above—the Black Belt, the Rio Grande Valley, and the North

28 See Mara Casey Tieken, There’s a Big Part of Rural America Everyone’s Ignoring, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/opinions/theres-a-big-part-of-rural-america-that-everyones-ignoring/2017/03/24/d06d24d0-1010-11e7-07d9521f6b5_story.html [https://perma.cc/72M2-99MQ] (“In defining rural white America as rural America, pundits, academics and lawmakers are perpetuating an incomplete and simplistic story about the many people who make up rural America and what they want and need.”).


30 Id. at 124–25.


32 BROWN & SCHAFFT, supra note 29, at 193 (“[N]onmetropolitan poverty rates have been consistently higher than metropolitan poverty rates throughout the last thirty years.”) (internal citations omitted); see also Steven M. Virgil, Community Economic Development and Rural America: Strategies for Community-Based Collaborative Development, 20 J. AFFORDABLE HOUSING & CMTY. DEV. L. 9, 25 (2010) (“The irony of rural America plays out in many ways. Although most of the nation’s raw materials and food comes from rural communities, these same communities face a stunning lack of resources for themselves. There are fewer people, fewer dollars, less infrastructure, reduced access to technical assistance, and persistent poverty in the places that typify rural America.”).

33 See BROWN & SCHAFFT, supra note 29, at 190 (“[R]ural poverty is especially persistent and intractable when the people left behind live in places that have been left behind.”).

34 See id.; see also Lexy Gross, The Opioid Epidemic and Rural America: Why the USDA Should Lead the Response, 10 KY. J. EQUINE AGRIC. & NAT. RESOURCES L. 257, 262 (2018) (“Nearly forty percent of U.S. counties did not have a substance-use disorder treatment facility in 2016. Among the most rural counties, fifty-five percent did not have a treatment facility. In counties with facilities, few had medication-assisted treatment. In one survey of patients attending medication-assisted treatment at a methadone clinic, people on average traveled sixty minutes per visit almost daily and nearly half were relying on public transportation. A lack of transportation, weather, cost, and other reasons were named as barriers to getting treatment.”).
American indigenous peoples’ reservations—are all areas of persistent poverty.\textsuperscript{35}

Notably, poverty rates for people of color are higher in rural areas than in urban locales. Professors Brown and Schafft note in their book, \textit{Rural People and Communities in the 21st Century}, that “[i]n nearly every instance, nonmetropolitan poverty rates are higher for all racial and ethnic groups and age categories.”\textsuperscript{36} Thus, “for most minority groups, minority status and nonmetropolitan residence represents a ‘double jeopardy,’ dramatically increasing the risk of experiencing poverty.”\textsuperscript{37}

Poverty particularly impacts people of color in rural communities; people of color are also notably overrepresented in the criminal legal system.\textsuperscript{38} Rural criminal legal systems are underfunded but their dysfunction has largely been overlooked because of their small size and low population.\textsuperscript{39} Despite their relatively low population, rural communities have steadily and increasingly incarcerated defendants at a rate higher than suburban and urban communities, such that today, rural communities incarcerate the most people.\textsuperscript{40}

\textsuperscript{35} Other areas of generational poverty are Appalachia and the Ozarks. \textit{See Brown \& Schafft, supra note 29, at 193 (“[P]ersistently poor rural counties are not randomly distributed throughout rural America. Rather they concentrate in less-developed regions including the Rio Grande Valley, Appalachia, and the Mississippi Delta.”).}

\textsuperscript{36} Brown \& Schafft, supra note 29, at 126.

\textsuperscript{37} Id.

\textsuperscript{38} Megan Stevenson \& Sandra Mayson, \textit{The Scale of Misdemeanor Justice}, 98 B.U. L. REV. 731, 759 (2018) (“The black arrest rate is at least twice as high as the white arrest rate for disorderly conduct, drug possession, simple assault, theft, vagrancy, and vandalism. The black arrest rate for prostitution is almost five times higher than the white arrest rate, and the black arrest rate for gambling is almost ten times higher.”).

\textsuperscript{39} \textit{See} Lindberg, \textit{supra} note 21, at 25.

B. Opioid Crisis

Overdoses are the number one cause of accidental death nationally—and have exceeded motor vehicle-involved deaths.41 Similar to the prevailing narratives of rurality, the narrative of the opioid crisis is dominated by Whiteness in rurality. This exclusionary narrative ignores that indigenous North American communities saw a larger increase in overdose deaths between 1999 and 2015 than any other group.42 The dominant narrative also ignores the fact that people of color in urban cities are overdosing at a faster rate than individuals in the suburbs and rural areas.43 Finally, this narrative disregards the data that proves that substance use disorder affects all people, of all classes, of all distinctions, across the United States.44

The White-washing of the opioid crisis was likely provoked because the crisis revolved around prescription pill overdoses. This is because physicians were more reticent to prescribe prescription opioids to people of color.45 This biased health care treatment relies on antiquated but persistent stereotypes about race and pain tolerance.46 As a result, prescribers and dispensers have historically ensured that White people have far easier access to prescription opioids than their non-White counterparts.47


42 Native American Overdose Deaths Surge Since Opioid Epidemic, ASSOCIATED PRESS (Mar. 14, 2018), https://www.apnews.com/81eb3ae96c2b4f6a6ae2722ce50f0672d2 [https://perma.cc/4T68-8DNQ] (explaining that the increase in opioid overdose deaths among Native Americans from 1999–2015 was higher than any other ethnic group during the same period); see also Elizabeth Weeks & Paula Sanford, Financial Impact of the Opioid Crisis on Local Government: Quantifying Costs for Litigation and Policymaking, 67 U. KAN. L. REV. 1061, 1079 (2019) (“The opioid crisis has had an especially severe impact in tribal nations. At a hearing before the Committee on Indian Affairs, chief medical officer of the Indian Health Service (IHS) reported that American Indians and Alaska Natives had the highest drug overdose death rates in 2015. Also, between 1999 and 2005, Native Americans’ deaths by overdose increased by ‘more than 500 percent.’” (footnote omitted)).


45 See DAYNA MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE 69 (2015).

46 Id. at 114–15; see also DEIRDRE COOPER-OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY 124 (2017).

47 MATTHEW, supra note 45, at 69.
The trajectory of the opioid crisis, however, has moved on from prescription pills to heroin and other drugs laced with fentanyl. The leading cause of death now is street-based synthetic opioids like fentanyl and carfentanil, which are tremendously more powerful than pills and even heroin, and are particularly prevalent in polysubstance overdoses. As the U.S. government has threatened doctors prescribing painkillers with criminal investigation, doctors have curtailed their opioid prescribing and, therefore, forced those dependent on prescription opioids to resort to riskier street drugs, heightening the overdose crisis.

Certain urban and suburban communities have implemented innovative and progressive responses to this evolving crisis. These strategies, which include the introduction of harm reduction measures, such as clean needle exchanges, safe injection sites, and the development of third or fourth generation drug courts, represent the playbook of largely coastal cities. Rural communities, on the other hand, often wrestle with a morality/science dichotomous view of substance use disorder that may preclude harm reduction strategies. A morality framework of substance use, in fact, is prevalent nationwide.

A morality framework conceptualizes substance use disorder (SUD) as a moral failing and a personal problem to be overcome by individual strength of character and willpower. The scientific evidence of SUD as a brain-altering disease is ignored under this regime. In the morality framework, people with

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49 Synthetic Opioid Overdose Data, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 19, 2018), https://www.cdc.gov/drugoverdose/data/fentanyl.html [https://perma.cc/24C7-GMSW] (“In 2017, more than 28,000 deaths involving synthetic opioids . . . occurred in the United States, which is more deaths than from any other type of opioid.”).


53 See Leo Beletsky, America’s Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis, 2019 UTAH L. REV. 833, 842 (2019).
SUD are deserving of punishment and incarceration instead of health care treatment. Individuals struggling with SUD are often “treated” solely within the criminal justice system. Even where rural communities have implemented drug courts, with the goal of treating the underlying disorder rather than criminally punishing individuals for their use disorder, defendants are, more likely than not, sent to jail to “dry out.”

During the November 2018 election, an Ohio ballot initiative proposed to change the state constitution in order to (1) eliminate prison time for a drug possession charge until the third offense and (2) reduce drug possession from a felony to a misdemeanor. This initiative was widely viewed as funded by outsiders such as Mark Zuckerberg, the Facebook CEO. Judges across Ohio denigrated the initiative, including the Chief Justice of the Ohio Supreme Court, for failing to allow courts to have a “stick” as well as a “carrot” with which to treat drug offenders. Emotional judges argued that incarceration is a tool for overcoming addiction, despite studies on the harmful social and physical effects of even short-term stays in jail. Prison systems’ lack of substance use disorder treatment can even turn deadly when incarcerated individuals who are suffering narcotics dependency experience severe withdrawal. Terrifyingly, the most dangerous time for an individual with substance use disorder is immediately upon release from jail, when their tolerance is lowered and they are particularly susceptible to overdose. Notwithstanding this reality, the Ohio

54 See generally Ursula Castellano, Courting Compliance: Case Managers as “Double Agents” in the Mental Health Court, 36 L. & SOC. INQUIRY 484, 506–07 (2011) (reasoning for jail time that imprisonment will “dry out” the defendant, who suffers from alcoholism).


61 Please note that I use the singular they when referring to someone whose gender is unknown or irrelevant. THE CHICAGO MANUAL OF STYLE ¶ 5.48 (17th ed. 2017); Position Statement on Gender and Pronouns, NAT’L COUNCIL TCHRS. ENG. (Oct. 25, 2018), http://www2.ncte.org/statement/genderfairuseoflang/ [https://perma.cc/BGH9-XVZ6].

62 Beletsky, supra note 53, at 842.
ballot initiative failed overwhelmingly and the State—which suffers one of the highest overdose rates per capita in the country—continues to condemn people convicted of first-time, low-level drug offenses to incarceration.63

The morality view of substance use disorder frequently interweaves poverty with shame.64 In rural communities, the shift from focusing on the supply side of illicit substances—the “dealers”—to the demand side—the “users”—exposes the lack of jobs, and SUD as a “disease of despair.”65 A focus on the demand side likewise shows the efficacy of medically assisted treatment, or MAT treatment, for people who use illicit substances, and may encourage courts and small governments to adopt harm reduction strategies.66 Recovering users in rural communities often falter due to insufficient treatment beds, a lack of treatment options, and sometimes insurmountable transportation issues.67 Rural communities with fewer resources are less able to effectively distribute the limited resources they have available, which makes the implementation of evidence-based harm reduction strategies all the more critical.68

63 Ohio Issue 1, supra note 55.

64 See Beletsky, supra note 53, at 846.

65 See KENNETH JOHNSON, CARSEY INSTITUTE, DEMOGRAPHIC TRENDS IN RURAL AND SMALL TOWNS IN AMERICA 20–25 (2006); see also Tanvi Misra, Why the Rural Opioid Crisis Is Different From the Urban One, CITYLAB (Feb. 14, 2019), https://www.citylab.com/equity/2019/02/opioid-epidemic-data-drug-addiction-deaths-urban-rural/582502/ [https://perma.cc/9C7U-ZLUV] (quoting Syracuse University sociologist Shannon Monnat) (“I really do want to push back against this cliché that addiction does not discriminate . . . . The physiological processes that underlie addiction themselves may not discriminate, but the factors that put people in communities at higher risk are not spatially random.”).

66 See Beletsky, supra note 53, at 861–62.

67 JOHNSON, supra note 65, at 30.

68 See Gross, supra note 34, at 257 (“Former Georgia governor, now-Secretary of Agriculture Sonny Perdue has said the challenge of combating widespread addiction is magnified in rural areas ‘where there are fewer resources [with which] to mount an effective response.’” (footnote omitted)). See generally Virgil, supra note 32, at 14–18 (“A functional measure may also be used to define [rural] communities. Such a measure would include the prevalence and persistence of poverty, the availability of useful resources, and the investment that is made by both the private philanthropic and public sectors. Areas with combined high prevalence and persistence of poverty, low levels of resources for local use, and low levels of investment can be identified as rural without conflicting with more quantitative measures.”).
III. LOW FUNDING IN RURAL CRIMINAL LEGAL SYSTEMS LEADS TO REPEAT PLAYERS AND CAPTURED DEFENSE ATTORNEYS AND PROSECUTORS

A. Prosecutors as Repeat Players

A handful of repeat players dominate rural criminal courtrooms and, therefore, reinforce entrenched patterns of behavior. Prosecutorial power is often consolidated among only a few local attorneys, many of whom run unopposed in local elections. These prosecutors are repeat litigants, influencing pretrial actions and resolutions by “advocating for interpretations of rules and decisions that favor long-term litigation objectives.” These long-term litigation objectives include reducing criminal trials and concomitant criminal procedure rights of defendants. Likewise, prosecutors’ consistent introduction of unreliable evidence, such as coroner death certificates, ultimately creates patterns of familiarity and acceptance. Such repeat behavior provokes judges to rely on their own precedent of accepting unreliable evidence from prosecutors. These judges are most frequently former local prosecutors and, as such, are steeped in the same, non-inquisitorial culture.

Rural prosecutors may also be hired through Requests for Proposals (RFPs), which is a competitive bidding process. Problems with such rural RFPs are legendary. For example, resource-poor towns are financially incentivized to hire the lowest bidder and, thereby, pay the least amount possible for the representation. The low salary, in turn, incentivizes prosecutors to bring more

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69 Oliva & Beety, supra note 22, at 121 (“Not only are judges likely to be former prosecutors, prosecutors are ‘repeat players’ in criminal litigation and, as such, routinely support reduced pretrial protections for defendants.”).
71 Oliva & Beety, supra note 22, at 128 (quoting Ion Meyn, The Unbearable Lightness of Criminal Procedure, 42 AM. J. CRIM. L. 39, 47 (2014)).
72 See Brandon L. Garrett, Aggregation in Criminal Law, 95 CAL. L. REV. 383, 400 (2007) (“In our current criminal system, repeat players generate the means to achieve vast economies of scale resulting in fewer criminal trials and therefore fewer opportunities to vindicate criminal procedural rights at trial.”).
73 Oliva & Beety, supra note 22, at 129–30 (“[P]rosecutors consistently introduce the same evidence in criminal cases, encouraging judges in criminal proceedings to rely on precedent. Over time, this has created a discrepancy in how trial judges rule on scientific evidence in civil versus criminal settings that cannot be explained by a difference in substantive law or the applicable rules of evidence.”).
76 Id. at 188.
charges and attendant fees against a defendant in order to raise funds. In Ferguson, Missouri, for example, the local prosecutor told police to arrest local suspects on every charge possible while routinely recommending higher fines and opposing probation.\textsuperscript{77} Missouri state law mandates that city prosecutors be hired through a competitive bidding process, and that the lowest bidder is entitled to the contract.\textsuperscript{78} When resource-poor towns cannot afford to hire a full-time elected prosecutor, prosecutors may serve part-time.\textsuperscript{79} Similar to court-appointed defense attorneys, these prosecutors spend the majority of their time engaged in private practice in order to make a living.\textsuperscript{80}

Ferguson, Missouri, a town of 20,000 people, and its surrounding towns exemplify this conundrum: the same person often is a part-time prosecutor in municipal court in one county and also a judge in the neighboring county.\textsuperscript{81} Defense attorneys litigate in an untenable position because should they advocate for their client against the prosecutor in case A, the prosecutor may punish their client in case B, where the prosecutor is the judge. This untenable dynamic is likely another reason why the 2015 Department of Justice Report on Ferguson found that its municipal courts issued a staggering number of arrest warrants—9000 in 2013 alone—often stemming from minor infractions, like traffic tickets.\textsuperscript{82} In Ferguson, the system mounted fines and lengthened jail time for those who were unable to pay or obtain adequate representation, resulting in an environment where both Blackness and poverty were functionally criminalized.\textsuperscript{83}

B. Court-Appointed Defense Attorneys

Rural communities are less likely to have a state-established public defender office and more likely to rely entirely on court-appointed attorneys to represent indigent defendants in criminal cases. Such court-appointed attorneys are likely to appear in front of the local judge repeatedly, and rely on that judge to continue to assign cases to them. The court-appointed attorney’s livelihood is necessarily dependent on remaining in the good favor and graces of the local judge. That collusive dependency dynamic, of course, can create perverse incentives for court-appointed attorneys to satisfy the interests of the sitting judge at the

\textsuperscript{77} Id. at 201–03.
\textsuperscript{78} Id. at 165.
\textsuperscript{79} Id. ("For other counties, cities, towns, and local governments of similar size, hiring a full-time prosecutor or district attorney is often cost-prohibitive, if not impossible, given scarce financial resources.").
\textsuperscript{80} See id. at 171.
\textsuperscript{81} Joy, supra note 24, at 25 (describing widespread judge and attorney conflicts of interest in municipal courts surrounding St. Louis).
\textsuperscript{83} See id.
expense of the client. For example, Putnam County, West Virginia, currently has no public defender office.\textsuperscript{84} The county likewise as of 2018 had not had a criminal trial in five years.\textsuperscript{85} Necessarily, unless the charges were dismissed by the prosecutor, every single charged defendant in Putnam County between 2013 and 2018 pled guilty—an expedient resolution but only questionably in the best interests of every defendant.\textsuperscript{86}

In some states, statutes or other court rules require trial courts to appoint attorneys to represent defendants on direct appeal as well as during pretrial and trial proceedings. In the interest of the court-appointed attorney’s caseload in such jurisdictions, such as rural West Virginia, the trial courts will resentence a defendant again and again in order to restart the clock to manipulate the timing of a direct appeal.\textsuperscript{87} The defendant, of course, remains incarcerated throughout this time.\textsuperscript{88} Indeed, under this regime, certain defendants have waited more than five years to have their direct appeal filed with the West Virginia Supreme Court of Appeals,\textsuperscript{89} even when the time to appeal is limited to 120 days under the court rules.\textsuperscript{90} While this flexibility to resentence in small jurisdictions may seem appropriate on its face, patterns of behavior contrary to the interests of defendants seem to be the norm.

Finally, court-appointed attorneys frequently receive minimal oversight for their representation of clients. A state agency counts the submitted billed hours from the attorney.\textsuperscript{91} For example, West Virginia’s Public Defender Services holds court-appointed attorneys accountable for billing more than twenty-four


\textsuperscript{85} E-mail from Dana F. Eddy, Exec. Dir., W. Va. Public Defender Servs., to Valena Beety, Professor of Law, Sandra Day O’Connor Coll. of Law (Oct. 25, 2019, 10:28 EST) (on file with author).

\textsuperscript{86} See id.

\textsuperscript{87} See, e.g., State v. Peterson, 799 S.E.2d 98, 100 n.1 (W. Va. 2017) (“Defendant Peterson was convicted in August 2008. On October 30, 2008, the circuit court appointed Defendant Peterson an appellate lawyer, Luke Styer. Mr. Styer failed to file an appeal during the five and a half years that he represented Defendant Peterson. As the circuit court noted in its April 29, 2014, order: ‘Luke Styer, Esq., was appointed to assist Defendant in appealing his conviction for this matter on October 30, 2008. To date, and following numerous resentencing orders, Defendant’s appellate counsel has yet to file an appeal. In the interest of justice, this Court does relieve Luke Styer as counsel of record[.]’”).

\textsuperscript{88} See id. at 100.

\textsuperscript{89} Id. at 100 n.1.

\textsuperscript{90} W. VA. R. APP. P. 5(f) (“Unless otherwise provided by law, an appeal must be perfected within four months of the date the judgment being appealed was entered in the office of the circuit clerk . . . from which the appeal is taken or the Supreme Court may, for good cause shown, by order entered of record, extend such period, not to exceed a total extension of two months, if a complete notice of appeal was timely and properly filed by the party seeking the appeal.”).

\textsuperscript{91} See, e.g., W. VA. PUB. DEFENDER SERVS., INDIGENT DEFENSE COMMISSION REPORT 20 (2018).
hours a day.\footnote{See Debra Cassens Weiss, Lawyer Accused of Billing Over 24 Hours in a Day Suspended; But Official Said Others Were Worse, A.B.A. J. (Apr. 26, 2017), http://www.abajournal.com/news/article/lawyer_accused_of_billing_over_24_hours_in_a_day_suspended_but_official_said_others_were_worse [https://perma.cc/Z8F9-8MD2].} Instead, the true arbiter of the court-appointed attorney’s representation is the local judge. Again, judges are themselves repeat players in the local criminal legal system.\footnote{Olivia & Beety, supra note 22, at 121; supra Part I.} Judges are few in number and often well-known.\footnote{Robert G. Foster, The View from Above, 80 Mich. B.J. 44, 46 (2001) (“For instance, my first contested campaign for the judgeship cost a sum total of $997, simply because the candidates were already well known in our small community.”).} In rural communities, one judge may serve multiple counties as part of a circuit.\footnote{West Virginia Judicial Circuit Court Map, W. Va. JUDICIARY, http://www.courts.wv.gov/public-resources/court-information-by-county.html [https://perma.cc/2JTS-RWDC].} Combined, a small group of poorly funded repeat players can incapacitate criminal legal systems in rural areas.

C. Lack of Attorneys in Rural Communities

The repeat players issue couples with the lack of attorneys in rural communities more broadly.\footnote{Hannah Haksgaard, Rural Practice as Public Interest Work, 71 Me. L. Rev. 209, 213 (2019) (“The glut of lawyers in urban areas is in sharp contrast to the lawyer shortage in small towns and communities.” (citations omitted))).} A small bar provides limited local options for court-appointed criminal cases. Indeed, the Monongalia County Circuit Court in West Virginia recently mandated that all attorneys admitted to the bar for less than two years and living in the county must take court-appointed cases.\footnote{In re: Attorneys Required to Accept Court Appointments (Sept. 26, 2018), https://moncountybar.us9.list-manage.com/tracking/track?u=d5cfa913420c64c73123f1f00&id=ed5d7a4179&e=584a5e81b5 [https://perma.cc/8WP8-KUSM]. On September 26, 2018, the Circuit Court of Monongalia County entered an Administrative Order, which requires “all attorneys who have been admitted to practice in West Virginia for two years or less who are located in and/or practicing in Monongalia County ... to represent indigent clients by serving on the Court Appointed list for Monongalia County.” Id.} Whether it benefits defendants to have more court-appointed attorneys available—but most of whom have very limited trial or practice experience—remains to be seen. Perhaps as rural counties continue to lose population,\footnote{Shrinking Population in More than a Third of Rural U.S. Counties, SCIENCE DAILY (Feb. 6, 2019), https://www.sciencedaily.com/releases/2019/02/190206115611.htm [https://perma.cc/F57X-3X9N].} mandated service will become one of the only options.

D. Lack of Intermediary Courts and Oversight for Lower Courts

Further compounding the issue of independent representation is not only the lack of oversight for court-appointed attorneys, but the potential lack of
oversight for lower courts within the legal system. Rural states with a smaller population are the primary remaining states to not have intermediary appellate courts. West Virginia, a state that is severely impacted by the opioid crisis, has no intermediary appellate court. Every defendant has one appeal to the highest court, the West Virginia Supreme Court of Appeals (WVSCA). Until 2010, the WVSCA could issue a one-word order in response to an appeal: “Refused.” The result of these decisions meant a defendant, even if convicted and sentenced to life in prison without parole, would never have true state appellate review. In 1992, the U.S. Court of Appeals for the Fourth Circuit found that this structure did not violate a defendant’s due process rights under the United States Constitution.

In sum, the lack of resources available in rural communities negatively impacts the functioning of local criminal legal systems and the defendants who are processed through it. Urban communities have public defender offices, with trained attorneys who specialize in representing criminal defendants; rural communities have court-appointed attorney systems, where a criminal defendant is represented by someone who may never have had a criminal trial before, or may be far more interested in a will or property dispute case with paying clients.

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103 Evick, supra note 100, at 246; see also Billotti v. Legursky, 975 F.2d 113, 115 (4th Cir. 1992). In 2010, facing increasing pressure and initiative by the legislature to create an intermediary appellate court, the West Virginia Supreme Court of Appeals agreed to issue a written opinion for every case that came before it. See Press Release, State of W. Va. Supreme Court of Appeals, supra note 102. The West Virginia Supreme Court of Appeals consists of five justices, who routinely receive over a thousand appeals each year. SUPREME COURT OF APPEALS OF W. VA. CLERK’S OFFICE, QUICK REFERENCE FACTS 1 (Jan. 2019), http://www.courts+wv.gov-supreme-court/clerk/statistics/17-18QuickFacts.pdf [https://perma.cc/WER8-PVWJ].
104 See generally Robin Runge, Addressing the Access to Justice Crisis in Rural America, A.B.A. HUM. RTS. MAG. (July 1, 2014), https://www.americanbar.org/groups/crsj/publications/human-rights_magazine_home/2014_vol_40/vol_40_no_3_poverty/access_justice_rural_america/ [https://perma.cc/JZ65-Z6FN] (“[T]he lack of public defenders in rural areas of the United States has a drastic impact on basic constitutional rights. In these rural states, the nearest public defender or prosecutor may be hundreds of miles away.”).
cases on the side or alternatively rely solely on court-appointed criminal cases, being deferential to the judge who appoints them as counsel.\footnote{105} Urban communities have trained medical examiners with a scientific background; rural communities have elected coroners with no training or prerequisites.\footnote{106} Rural areas simply do not have the same resources: they do not have the same personal capital, financial capital, or educational capital.\footnote{107} These can lead to individuals being wrongly incarcerated and wrongly sentenced.

\section*{IV. Drug-Induced Homicide Charges in Rural Communities}

Within these rural criminal legal systems, prosecutors charge illegal substance users with drug-induced homicide.\footnote{108} Drug-induced homicide is the distribution or sharing of an illicit substance with someone who at some point later in time overdoses from the use of that specific illicit substance.\footnote{109} Half of people charged with drug-induced homicide are friends or acquaintances of the deceased, sharing the drug themselves.\footnote{110} Nationally, some states have rushed to create drug-induced homicide charges, largely as a response to the growing overdose numbers and particularly to overdoses by fentanyl.\footnote{111} The sentencing ranges in these statutes can vary from ten years\footnote{112} to forty years,\footnote{113} but all play into the traditional rhetoric of “tough-on-crime” legislation and prosecutions.\footnote{114} Indeed, they resonate and replicate President Trump’s call for the death penalty for drug distributors.\footnote{115}

As one example, prosecutors in North Carolina reinvigorated and restored their old drug-induced homicide statute, which was originally created to address the crack-cocaine “epidemic” in the 1980s.\footnote{116} North Carolina has now passed a
new statute, enacting the heightened charge of “Death by Distribution.”\textsuperscript{117} Other states, such as Ohio and Pennsylvania, also created new statutes to harshly criminalize the sharing of drugs resulting in an overdose.\textsuperscript{118}

Unfortunately, the politicized image for who is arrested, charged, and convicted for “dealing drugs” diverges dramatically from reality.\textsuperscript{119} As noted in national news coverage in 2018, individuals with substance use disorder are those most likely to be charged, convicted, and serving long sentences for their addiction.\textsuperscript{120} An overdose is recharacterized as a homicide, with the co-user or low-level “supplier” of the drug to blame.\textsuperscript{121} Charges of drug-induced homicide carry strict liability—they do not require any intent on the part of the defendant.\textsuperscript{122} Whether the defendant intended for the decedent to die by taking the drugs is irrelevant to the prosecutor and to the court.\textsuperscript{123} Whether the decedent died because the drug was laced with fentanyl or because the decedent did not have sufficient tolerance levels is likewise immaterial; despite the rhetoric on fentanyl, the co-user can be charged with homicide in either situation.\textsuperscript{124}

Why are police and prosecutors spending time on these drug-induced homicides, when the clearance rates nationally for actual homicides are abysmally low?\textsuperscript{125} Because drug-induced homicide is an easy case in which a prosecutor can obtain a conviction. The declared victim is known, the designated perpetrator is known, the prosecutor can offer a plea to something less than homicide, and the case will be done.\textsuperscript{126} As Justice Kennedy notably

\textsuperscript{117} See N.C. GEN. STAT. § 14-18.4 (2019).
\textsuperscript{118} See Drug-Induced Homicide, supra note 108 (noting that the two most active states in pursuing drug-induced homicide charges were Ohio and Pennsylvania).
\textsuperscript{119} See Beletsky, supra note 53, at 874.
\textsuperscript{121} See Beletsky, supra note 53, at 869–74.
\textsuperscript{122} See Beety, supra note 7, at 990–91.
\textsuperscript{123} See id.
\textsuperscript{124} See Drug-Induced Homicide Defense Toolkit, supra note 4, at 31 (discussing the increased potency of heroin laced with fentanyl and the overdose risk associated with post-sentence reentry into society).
\textsuperscript{126} See, e.g., Russell M. Gold et al., Civilizing Criminal Settlements, 97 B.U. L. REV. 1607, 1614–15 (2017) (“A defendant agrees to plead guilty to one or more criminal charges in return for some sort of concession by the prosecutor. A prosecutor might agree to reduce
stated in *Missouri v. Frye*, our system is “for the most part a system of pleas.”127 Within that system, the injustice of systematized guilty pleas in prosecutions that cannot legally stand at trial is readily apparent in drug-induced homicide cases.128

A. Problem of Proof

Drug-induced homicide charges are actually quite difficult to prove, should they go to trial. Federally, the defendant is not accountable for homicide if another drug in the decedent’s system, a combination of drugs, health issues, or supplements, caused the death.129 In these cases, the influence of a coroner, forensic pathologist, and toxicologist becomes tremendously important. If the decedent has multiple drugs in their system, it can be nearly impossible to pinpoint which of these drugs caused the actual death and was the “but-for” cause of death, as required by the Supreme Court.130 And yet the confluence of court-appointed attorneys, repeat players in rural courthouses, and rural county coroners can lead to disproportionate punishment for rural defendants in these cases.

B. Coroners in Rural Communities

Rural America is most reliant on coroner systems. Most, if not all, cities have medical examiners—trained medical practitioners and forensic pathologists—who determine cause and manner of death.131 Rural counties, except for those in Michigan and Arizona, which have a medical examiner for every county,132 either outsource the job to a medical examiner not located in the county or rely on a county coroner.133 A coroner is a locally elected resident

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128 See Gold et al., *supra* note 126, at 1617 (“Prosecutors have massive leverage to force defendants to plead guilty rather than proceed to trial. This leverage is a product of harsh penalties and overlapping criminal codes.” (citations omitted)).
130 See id. at 207.
131 See Beety, *supra* note 7, at 994.
who meets the minimum age requirements; no medical background is required.\textsuperscript{134}

Overdose deaths in particular expose underequipped death investigation systems in rural areas. Coroners are not performing toxicology reports on all decedents for whom they label the cause of death as “overdose.”\textsuperscript{135} Furthermore, to the extent a toxicology report is run, the test is often a limited and less expensive toxicology test, intended only to detect if a prescription opioid is in the decedent’s system.\textsuperscript{136} This limited toxicology report fails to detect any other illicit substances—or legal substances such as alcohol—that may be in the decedent’s system and may have caused or contributed to the death.\textsuperscript{137} This limited toxicology report, like the coroner’s death certificate declaring the death to be an overdose and a homicide, can be used by the prosecution for drug-induced homicide charges.\textsuperscript{138} These death investigations are not necessarily impartial—and are not necessarily scientific.\textsuperscript{139}

\textsuperscript{134} NAT’L RESEARCH COUNCIL, supra note 15, at 247 (“Typical qualifications for election as a coroner include being a registered voter, attaining a minimum age requirement ranging from 18 to 25 years, being free of felony convictions, and completing a training program, which can be of varying length. The selection pool is local and small . . .”).\textsuperscript{135} See Beety, supra note 7, at 995 (“In Pennsylvania, where county coroners determine both the manner and cause of death, ‘determining causation related to overdoses is subjective and can vary widely depending on the investigative efforts/abilities of the coroner and the evidence available for review, which results in inherent difficulties in making causation decisions.’ Some deaths in Pennsylvania have been reported as overdoses with no toxicology reports.” (internal citations omitted)).\textsuperscript{136} See Martha J. Wunsch et al., Opioid Deaths in Rural Virginia: A Description of the High Prevalence of Accidental Fatalities Involving Prescribed Medications, 18 AM. J. ADDICTION 1, 2, 9 (2009) (describing the ability for examiners to tailor toxicological examinations); see also Joseph A. Prahlow et al., Drug Overdose Deaths and Toxicology Tests: Let’s Talk, C. AM. PATHOLOGISTS TODAY (Dec. 2018), https://www.captodayonline.com/drug-overdose-deaths-and-toxicology-tests-lets-talk/ [https://perma.cc/U43P-2GR] (“Despite a thorough investigation and the attention given to the circumstances of a death, questions about the cause of death may persist in some cases. A collaborative effort among the [medical examiner and coroner] community, clinicians, hospital pathologists, and laboratories—especially when there is suspicion of drug-related involvement—is critical in ensuring that these deaths are categorized accurately and the certification of death is appropriate.”).\textsuperscript{137} See Beety, supra note 7, at 987.\textsuperscript{138} See id. at 999 (explaining confirmation bias as the selective gathering of information, so that “[a]ny evidence that would be inconsistent with the defendant as a murderer—for example, evidence that the shared drug may not have been the but-for cause of the decedent’s death—is dismissed as irrelevant or unreliable” (citations omitted)).\textsuperscript{139} Bryan, supra note 16, at 210 (“Lay coroners rely heavily on the external condition of the deceased and any available medical records when determining cause and manner of death. At best, this approach is divorced from the scientific method (which requires a standardization of methods of investigation and the use of reliable modes of testing and inquiry) and relies too heavily on instinct, practical experience, or the completeness of medical records. At worst, it is completely ad hoc and involves a large potential for bias if the county coroner knows the deceased or their family.”).
In reality, coroners are absolutely overwhelmed by the mass overdose deaths occurring in their counties. While medical examiner offices are recognized by the National Response Plan as responsible for managing the deceased from a hazardous event and receive (or are entitled to) specialized training for mass overdoses, coroners receive no such training. A Bureau of Justice Statistics Special Report on Medical Examiners and Coroners’ Offices noted the disparate and inadequate educational and training requirements and resources. Without resources, and in a political as well as health crisis, coroners are in a difficult situation facing an impossible task of scientifically documenting deaths with no funds, no scientists, and little political capital. Many coroners recognize how under-trained and under-staffed their offices are and affirmatively seek support.

V. DEFENDANTS PUNISHED BY RURALITY

While the narrative continues of a largely White, prescription drug “epidemic” with a public health response, the reality exposes the roles of poverty, race, continuing tough-on-crime attitudes, and our system of pleas. Drug-induced homicide charges, in particular, elucidate how defendants are punished by their rurality. Prosecutors can bring these drug-induced homicide charges in rural communities by relying on coroner-layperson findings of “homicide” and “overdose” and then using this “scientific evidence” for plea negotiations in the existing plea system. While a medical examiner in an urban or suburban area may have the funding to perform a full toxicology report, coroners in rural areas often do not have that capacity. The courtroom players are captured in rural communities, with a defense attorney often beholden to the judge—and sometimes prosecutors beholden to the court as well. This cycle of pleas, and faulty evidence to reinforce pleas, is particularly harmful against rural people of color. As noted above, rural people of color often live in areas of persistent poverty, with underfunded systems, part-time prosecutors, and court-appointed attorneys captured by the prerogatives of the appointing judge. Drug-induced homicide charges are disproportionately charged

140 NAT’L RESEARCH COUNCIL, supra note 15, at 260.
141 Id. at 247.
142 See Bryan, supra note 1139, at 216 (“A dearth of medical training, methodology, and consistency of approach in investigative methods exists among lay coroners.”). Coroners have requested additional training in their work as well as financial support for addressing the opioid crisis. See NAT’L RESEARCH COUNCIL, supra note 15, at 247 (“Some coroners have suggested establishing a ‘Coroner College.’”).
143 See Beety, supra note 7, at 985.
144 See supra Part II.A.
145 See Haksgaard, supra note 96, at 216 (“Many rural attorneys will work as part-time prosecutors while simultaneously running a private practice. Other rural attorneys will take frequent court appointments to serve as defense counsel (particularly in counties without a full-time public defender) while simultaneously running a private practice.” (citations omitted)).
against people of color where the victim is White, and people of color are more severely sentenced for drug-induced homicide than White defendants.\footnote{Beletsky, supra note 53, at 874.} Although the elements of drug-induced homicide may not have been established if the case went to trial and a full autopsy was performed (with released results), the poverty and resulting shortcuts in rural systems are damning to defendants.

VI. SOLUTIONS PARTICULAR TO DRUG-INDUCED HOMICIDE CHARGES IN RURAL COMMUNITIES

In the midst of an overdose, friends or acquaintances gathered around the person may wait for minutes or hours, not knowing what to do and fearing to call 9-1-1.\footnote{See, e.g., Katie Smith, 2017 Record Year for McHenry County Drug-Induced Homicide Charges, N.W. HERALD (Jan. 13, 2018), http://www.nwherald.com/2018/01/07/2017-record-year-for-mchenry-county-drug-induced-homicide-charges/ase93do [https://perma.cc/B3MT-FEW9] (quoting Drug Policy Alliance senior staff attorney Lindsay LaSalle) (“Critics of drug-induced homicides and similar charges say the law is too frequently used against people best positioned to seek medical help for overdose victims—family, friends, acquaintances and small-time dealers who often sell to finance their own habit . . . .”); see also Amanda D. Latimore & Rachel S. Bergstein, “Caught With a Body Yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law,” 50 INT’L J. DRUG POL’Y 82, 87 (2017).} This tragedy plays out repeatedly because many people who overdose are not using the controlled substance alone.\footnote{See Rowan P. Ogeil et al., Pharmaceutical Opioid Overdose Deaths and the Presence of Witnesses, 55 INT’L J. DRUG POL’Y 8, 10 (2018).} Many overdoses are witnessed,\footnote{See id.} and we fortunately have an antidote to overdoses: naloxone.\footnote{Understanding Naloxone, Harm Reduction Coalition, https://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ [https://perma.cc/3QUL-8ESD].} The individual simply needs time to have the naloxone administered—but that time ticks away as eyewitnesses fail to call for help for fear of being prosecuted themselves.\footnote{Drug Pol’y All., An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane 3 (2017), https://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf [https://perma.cc/6NR8-WRV9] (“The most common reason people cite for not calling 911 in the event of an overdose is fear of police involvement.”).}

A. Extend Good Samaritan Laws

Good Samaritan laws were created to shield eyewitnesses from prosecution for drug-related crimes when they called for help.\footnote{See id.} The laws aim to incentivize
eyewitnesses to call 9-1-1, but these laws do not generally protect eyewitnesses from serious prosecutions such as distribution of an illicit substance or drug-induced homicide.\textsuperscript{153} Good Samaritan laws act as a shield against only low-level charges, such as simple possession.\textsuperscript{154}

For this reason, to stop deaths in the opioid crisis, state legislatures should extend Good Samaritan laws to cover distribution of illicit substances and drug-induced homicide. By truly providing protection for eyewitnesses, less people will die in our overdose crisis.

\textbf{B. Training for Coroners}

Funding is not presently allocated to bring medical examiner systems to all rural counties, although the states that have accomplished this task are commendable. Two-thirds of federal grant funding generally is directed to urban areas instead of rural areas,\textsuperscript{155} and rural counties continue to lose population.\textsuperscript{156} That said, states realistically can commit to better and lengthier training for coroners, particularly on mass overdoses and the opioid crisis in general. This training would improve the reliability of public health statistics and, ideally, also heighten the independence of coroners from local law enforcement and criminal prosecutions. As one example, in Kentucky the medical examiners conduct a yearly training for the coroners and are available as mentors or simply to answer questions as they arise among coroners.\textsuperscript{157} While not without its flaws, this

\textsuperscript{153} See, e.g., \textit{COLO. REV. STAT.} ANN. § 18-1-711 (West 2018) (specifying that immunity will only apply to possession and use of a controlled substance); \textit{720 ILL. COMP. STAT. ANN.} 570/414 (West 2018) (limiting immunity to possession of small amounts of drugs: “less than 3 grams of a substance containing heroin,” for example); \textit{MASS. GEN. LAWS} ANN. ch. 94C, § 34A(d) (West 2018) (“Nothing contained in this section shall prevent anyone from being charged with trafficking, distribution or possession of a controlled substance with intent to distribute.”); \textit{N.M. STAT. ANN.} § 30-31-27.1 (West 2018) (limiting immunity to use or possession of controlled substances); \textit{N.Y. PENAL LAW} § 220.78 (McKinney 2018) (specifying that immunity will not apply to class A-I felonies); \textit{WASHINGTON} REV. CODE ANN. § 69.50.315 (West 2018) (limiting immunity to possession crimes only).


\textsuperscript{156} See \textit{Shrinking Population in More than a Third of Rural U.S. Counties}, \textit{supra} note 98.

\textsuperscript{157} See generally \textit{Office of the State Medical Examiner, KY. JUSTICE & PUB. SAFETY CABINET}, https://justice.ky.gov/Pages/Kentucky-Medical-Examiners-Office.aspx [https://perma.cc/MFR2-9l37] (“Recognized as national leaders in their respective fields, the scientific staff members of the Kentucky Office of the Medical Examiner assist Kentucky coroners and law enforcement agencies in all aspects of death investigation.”).
system does ensure more training for coroners, as well as connect coroners with medical examiners who have substantial scientific training.158

VII. CONCLUSION

The scientific core of a drug-induced homicide charge exposes the everyday dysfunction of rural criminal courts and the lack of engagement with, or individual attention to, the cases presented daily. Drug-induced homicide charges are treated exactly the same as other cases which do not hinge on scientific evidence: in the majority of these cases, the defendant takes a guilty plea.159 In rural communities, prosecutors may meet with defendants to arrange a plea, with no public defender yet assigned.160 In rural communities, part-time prosecutors may be beholden to the town and the judges for continuing their yearly contracts.161 In rural communities, court-appointed defense attorneys, with no oversight, may be most concerned with maintaining a status quo in which the court continues to assign cases to that attorney.162 And in rural communities, scientific evidence may not even be gathered, let alone analyzed by the prosecution or shared with the defense.163 Underlying these cases is a coroner system where an untrained layperson determines the cause of death.164 Until rural criminal justice systems attract and receive more attention, guidance, and funding, these problems will persist.

158 NAT’L RESEARCH COUNCIL, supra note 15, at 248 (“The disconnect between the determination a medical professional may make regarding the cause and manner of death and what the coroner may independently decide and certify as the cause and manner of death remains the weakest link in the process.”).


160 See SIXTH AMENDMENT CTR., supra note 25, at 33.

161 See generally Romero, supra note 75 (stating that cities must sometimes hire prosecutors on a part-time basis and the hiring decision may be made by city officials and local judges).

162 See supra Part III.B.

163 See Beety, supra note 7, at 985.

164 See Robbins, supra note 15, at 931–32.
Carrots, Sticks, and Problem Drug Use: Law Enforcement’s Contribution to the Policy Discourse on Drug Use and the Opioid Crisis

“Why complete drug treatment, if one can’t go to prison?”
- Ohio Common Pleas Judges Association

Taleed El-Sabawi*

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I. INTRODUCTION

Despite the growing support for the idea that problem drug use should be treated like a chronic medical disease,1 some law enforcement interest groups, including trial court judges associations, prosecuting attorneys associations, and police associations ("law enforcement groups" or "criminal justice actors"), continue to argue for the use of the criminal justice system to address the

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*I would like to thank Sandra Tanenbaum for her mentorship, guidance, and unmatched feedback. Special thanks to the Drug Enforcement & Policy Center at The Ohio State University’s Moritz College of Law for providing me with funding and resources. A heartfelt thank you to Leo Beletsky for giving his expert advice and mentorship. Thank you to Doug Berman for his comments on early drafts and his insight on criminal justice reform policy and politics, Alex Kreit for his review of early drafts and willingness to workshop ideas, Micah Berman for his feedback on the many drafts of this Article, and Jennifer D. Oliva for her thoughts on law enforcement groups. Finally, thank you to Charles Perkins for his help with last minute research, Marissa Meredith for her insightful comments on later drafts. Thank you to Emily B. Chatzky for her valued assistance in research and editing later drafts.

nation’s drug crises. The justification for the use of the criminal justice system to oversee the psychological and medical treatment of persons with substance use disorders (SUDs) is based on the belief that persons with SUDs are deviants, who cannot refrain from engaging in sinful behavior. Therefore, punishment, or the threat thereof, is needed to deter the deviants’ immoral conduct and to ensure that the deviants comply with treatment. Law enforcement groups have also argued that incarceration is an effective method to “dry out” someone suffering from a SUD, through a forced detox, thereby encouraging entry into treatment.

The empirical evidence that supports the efficacy of coerced and compulsory treatment is underwhelming, at best, and ineffective, at worst. Furthermore, treatment outcomes for persons with SUDs enrolled in substance abuse treatment without the threat of incarceration are equal to, if not superior than, those under supervision of the criminal justice system. Those entering treatment through means independent of the criminal justice system have the additional benefits of not suffering the stigma that results from a criminal

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3 See generally EDWIN M. SCHUR, CRIMES WITHOUT VICTIMS 3–7 (1965) (for an overview of the historic use of the deviancy narrative and the purported justifications for its use).

4 See generally Rebecca Tiger, Drug Courts and the Logic of Coerced Treatment, 26 SOC. F. 169 (2011).

5 See id. at 174–75; see also Prescription Drug and Heroin Abuse Issues, supra note 2.

6 Dan Werb et al., The Effectiveness of Compulsory Drug Treatment: A Systematic Review, 28 INT’L J. DRUG POL’Y 1, 7–8 (2016).

7 See id.
and do not incur the additional taxpayer dollars spent paying for the requisite law enforcement oversight.⁹

Despite the empirical literature, some law enforcement groups continue to make statements, underscored with assured certainty, that the threat of incarceration is a necessary tool to treat SUDs and to address the nation’s current opioid crisis.¹⁰ For example, in response to a 2018 Ohio Ballot Issue proposing a decrease in criminal penalties for simple possession and reallocating dollars saved to treatment services,¹¹ the Chief Justice of the Supreme Court of Ohio wrote in the Supreme Court’s official position statement,

Drug courts would be impeded by taking jail time off the table. We know, through multiple studies, that drug courts are effective only when they combine the “carrot” of treatment and support with the “stick” of judicial accountability, including incarceration when needed. It is this carrot-and-stick approach that enables judges and drug court teams to use a variety of tools to help people overcome addiction. But Issue 1, while providing a lot of carrots by expanding treatment, takes away the stick. . . . We are talking about Ohio becoming, in effect, unable by its constitution to offer drug court participation and to incentivize that involvement by the “carrot” of not having a felony conviction record. Who would want to participate in a drug court program knowing that they only face probation for possession of fentanyl, cocaine, methamphetamine, K2, heroin, and so forth?¹²

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¹¹ Amendment stated as follows:
If adopted, the amendment would . . . [in part] [m]andate that criminal offenses of obtaining, possessing, or using any drug such as fentanyl, heroin, methamphetamine, cocaine, LSD, and other controlled substances cannot be classified as a felony, but only a misdemeanor. Prohibit jail time as a sentence for obtaining, possessing, or using such drugs until an individual’s third offense within 24 months. Allow an individual convicted of obtaining, possessing, or using any such drug prior to the effective date of the amendment to ask a court to reduce the conviction to a misdemeanor, regardless of whether the individual has completed the sentence. Require any available funding, based on projected savings, to be applied to state-administered rehabilitation programs and crime victim funds. Require a graduated series of responses, such as community service, drug treatment, or jail time, for minor, non-criminal probation violations.
¹² O’Connor, supra note 2.
Ohio’s Chief Justice’s narrative was echoed by statements from the Ohio State Bar Association, the Ohio Prosecuting Attorneys Association, the Ohio Common Pleas Judges Association, the Fraternal Order of Police of Ohio, the Ohio Chief Probation Officers Association, the Ohio Association of Chiefs of Police, and the Buckeye State Sheriffs’ Association.

Stances such as those by these law enforcement groups in Ohio are not unique to state laws and politics; local prosecuting attorneys associations and

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13 President Weaver stated as follows:

We firmly believe that treatment and rehabilitation are the right strategies for curbing Ohio’s opiate crisis and have seen them working in drug courts around the state. However, when you categorically strip our judges of their discretion and take away an important tool—the threat of prison time—you significantly lower the chances that they will get sober, enroll in and complete a drug treatment program.

OSBA Statement, supra note 2.

14 Safe Harbor, supra note 2 (“Research and experience clearly demonstrate that without court intervention, including possible incarceration, addicts are less likely to seek treatment. The amendment will cost some addicts their lives.”).

15 Ohio Common Pleas Judges Association, supra note 2 (“Loved ones of drug dependent individuals will lose their last chance to help their addict get clean in the criminal justice system.”).


17 Veronica M. Perry, OCPOA President stated:

I think we all agree that we have a health epidemic on our hands and treatment is more appropriate than incarceration for individuals who suffer from [substance use disorder]... [however], the measure incorrectly assumes that there is an infrastructure in place to handle the onslaught of people that would enter the court system... This approach not only minimizes a judge’s ability to sanction after repeated offenses and violations, but it seriously hinders a probation officer’s effectiveness in compelling treatment for individuals who may be lacking the motivation to seek help for themselves.


18 OACP named the following five ways in which it would impact Ohioans: (1) undermine treatment efforts; (2) hinder the ability to prosecute drug traffickers; (3) reduce sentences of violent offenders; (4) overburden local governments, and; (5) imply to young individuals that drug abuse and addiction is not serious. Letter from Jeffrey Scott, President, Ohio Ass’n of Chiefs of Police, OACP Issue 1 Opinion (Oct. 10, 2018), https://oacp.org/oacp-issue-1-opinion/ [https://perma.cc/2SND-WND2]. OACP further noted that the proposal would hinder the ways in which drug courts were providing alternative treatment methods to individuals. Id.

19 See Press Release, Buckeye State Sheriffs’ Ass’n, supra note 10 for a statement in which the Buckeye State Sheriffs’ Association emphasized the need for law enforcement to get traffickers off the streets, noting that the proposed amendment would cost law enforcement significant amounts of money, would fuel drug trafficking, and lead to many more deaths in the community.
other law enforcement agencies testifying at congressional hearings on the opioid crisis have similarly argued for the need of the “stick” of incarceration to address the opioid crisis.\textsuperscript{20} Law enforcement groups’ support for the stick is not surprising in light of their historic efforts to support the use of punishment to addressing problem drug use.\textsuperscript{21}

The use of the “carrots-and-sticks” narrative is part of law enforcement groups’ broader commitment to support a criminal justice approach to addressing the nation’s drug problem—an approach defined by the use of the criminal justice system to deter bad behavior through the threat of punishment.\textsuperscript{22} In my previous analysis of congressional hearing testimony preceding the enactment of federal legislation to address the opioid crisis, I found that despite the dominance of the idea that problem drug use is a public health issue, law enforcement groups continued to emphasize the need for the use of the criminal justice system to adequately address the opioid crisis.\textsuperscript{23} This commitment to the use of the criminal justice system has endured despite the international trend shifting away from this approach as a means of addressing problem drug use.\textsuperscript{24} The international community has widely acknowledged that a public health approach incorporates best practices in substance abuse policy.\textsuperscript{25} Although evidence exists to suggest that the criminal justice approach to problem drug use may be transforming, this evolution seems to only be occurring at the margins, a phenomenon that I will discuss infra.

In this Article, I explore how public law enforcement groups\textsuperscript{26} use narratives to define problem drug use as a criminal justice issue in the wake of the opioid crisis. In doing so, I explain the motivations behind law enforcement groups’ continued support for the criminal justice approach, despite the efforts to redefine problem drug use as a health issue. Using theories of interest group behavior, I argue that law enforcement groups’ support of the criminal justice approach is a result of their attempts to protect and further the interests of their members, attorneys, judges, and police personnel who rely heavily on state and

\textsuperscript{20} See, e.g., Prescription Drug and Heroin Abuse Issues, supra note 2.
\textsuperscript{21} See Taleed El-Sabawi, The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis, 11 NE. U.L. REV. 372, 374 (2019).
\textsuperscript{22} See id.
\textsuperscript{23} See generally El-Sabawi, supra note 1; El-Sabawi, supra note 21.
\textsuperscript{25} See generally Policy and Practice Briefings, supra note 24.
\textsuperscript{26} In my analysis of federal congressional hearing testimonies from 2014–2016 on the opioid crisis, most, if not all, law enforcement interest groups participating publicly in the discourse were public, not private, for-profit actors. Similarly, the position statements of law enforcement groups on Ohio’s Issue 1 came from public groups. Because public law enforcement groups have been most active in the discourse, this Article focuses on the contributions that these public agencies have made to the problem definition discourse in the age of the opioid crisis.
federal budget allocations for survival. I will demonstrate that narratives supported by law enforcement groups in the discourse surrounding the opioid crisis position these criminal justice actors as “fixers”\(^{27}\) of the drug problem and, in doing so, encourage the allocation of funding and resources necessary to carry out their duties as problem fixers. I will further show how some law enforcement groups have justified their continued roles as fixers of problem drug use, but have done so on a spectrum, suggesting that at least some law enforcement groups have acknowledged the need to re-envision their perceived role in addressing problem drug use.

In Part II of this Article, I provide a short overview of the relevant literature on pressure group behavior and narrative use in the policy process. In Part III of this Article, I report the findings of my empirical analysis of law enforcement groups’ narratives defining the opioid crisis. Although the findings are based on my analysis of the contemporary discourse, I also provide some historical context to allow the reader to better understand the ways in which narrative use has changed over time. In Part IV of this Article, I apply theories of interest group behavior to explain how law enforcement groups have used criminal justice themed narratives in the discourse on the opioid crisis to further the interests of group members. In Part V, I review the variation between law enforcement narrative use, focusing on the differences in the degree of law enforcement jurisdiction and corresponding funding. I highlight that the acceptance of the health-oriented approach is beginning to occur, but only at the margins. I close with a call for research of proposed explanations for the noted variations in law enforcement groups’ acceptance of a health-oriented approach.

II. BACKGROUND

A. Pressure Group Behavior

In a pluralist majoritarian democracy, such as the United States, actors join together in groups to protect the interests of their constituents.\(^{28}\) These organized interest groups lobby to further the interests of their members at each stage of the legislative process.\(^{29}\) Administrative agencies are also invested in legislative outcomes that will increase or maintain their delegated powers, as well as their operational budgets.\(^{30}\) By engaging in lobbying efforts that include providing legislative testimony or communicating directly with voters in an effort to sway public opinion,\(^ {31}\) both administrative agencies and organized


\(^{28}\) See id. at 20–22.

\(^{29}\) See id. at 19–36.

\(^{30}\) See generally El-Sabawi, supra note 1 for an in-depth discussion of this contention. See also MEIER, supra note 9, at 72–76 (discussing federal drug agency budgets).

interest groups pressure legislators or voters to enact legislative proposals or initiatives that support the interests of its group’s members. When doing so, pressure groups commonly use a rhetorical tool known as the policy narrative.

B. Policy Narratives

Policy narratives, especially those describing the causes of a social problem, are powerful rhetorical tools used by organized interest groups to persuade policy actors to adopt preferred policy proposals. As purveyors of information and expertise, pressure groups are particularly well-situated to influence policy by strategically crafting narratives about what caused the policy problem and who or what is to be blamed. These policy stories classify certain actors as either the “bad guys” or the “fixers” of the problem, create new political alliances, and “either challenge or protect an existing social order.” Like fictional narratives, these policy narratives have elements including characters, a problem, and a solution. The process of crafting these narratives may be conscious or unconscious, and the narrating group can start by choosing either the characters, problem, or desired solution. Narrators have leeway in choosing the elements of their narrative and in choosing the order in which they construct it, but all elements of the narrative must still be believable and credible to the intended audience. Although the elements of most policy narratives are consistent, the order in which the story is crafted differs from narrator to narrator, and the decisions the narrating group makes at each of these decision points affects the alternatives available for the remaining story elements. Consequently, policy narratives can narrow the available alternative policy proposals in ways that limit possible proposals to those that are desirable,

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32 See El-Sabawi, supra note 21, at 374–76.

33 Policy narratives are also referred to generally as narratives or stories. For the purposes of this Article, I will not distinguish between the types of policy narratives, but instead will use the term generally to refer to all types of stories used as forms of communication in the policy making process.

34 See, e.g., El-Sabawi, supra note 1, at 1362, 1367 n.48.

35 Some social narrative scholars also distinguish between stories and narratives. See, e.g., SHAUL R. SHENHAV, ANALYZING SOCIAL NARRATIVES 20–36 (2015). For simplification purposes, I will refer to narratives and stories interchangeably, with the caveat that there is disagreement in the literature as to the differences and similarities of the two constructs.


37 See, e.g., El-Sabawi, supra note 21, at 388–89.

38 See STONE, supra note 27, at 157–82, 224.

39 Id. at 224.

40 See FRANK FISCHER, REFRAMING PUBLIC POLICY: DISCursive POLITICS AND DELIBERATIVE PRACTICES 161–64 (2003); STONE, supra note 27, at 157–82.

41 See El-Sabawi, supra note 21, at 380–85.

42 See FISCHER, supra note 40, at 177–78; see also El-Sabawi, supra note 1, at 1366. See generally SHENHAV, supra note 35.

43 See El-Sabawi, supra note 21, at 380–85; see also STONE, supra note 27, at 206–28 (discussing causal reasoning).
ensuring that the narrating group’s members benefit from the legislative proposals and are protected from the burdens of regulation.44

In the discourse surrounding problem drug use, law enforcement groups have historically employed narratives that positioned the criminal justice system as the best overseer of responses to problem drug use.45 They have done so by defining addiction as a deviant behavior and emphasizing punishment as a deterrence for both drug use and drug sales.46 Although the traditional narrative of deviancy remains a prominent feature of the law enforcement discourse, variations of the deviancy narrative have surfaced as the federal legislative discourse shifts from supporting a criminal justice approach to the opioid crisis to a more health-oriented approach.47

III. LAW ENFORCEMENT GROUPS’ NARRATIVES DEFINING THE OPIOID CRISIS

In my analysis48 of federal congressional hearing testimony from 2014–2016, preceding the enactment of the Comprehensive Addiction and Recovery Act of 2016 (CARA),49 and position statements by law enforcement groups in

44 See generally STONE, supra note 27.
45 See El-Sabawi, supra note 1, at 1362, 1367 n.48, 1406–07.
46 Id.
48 To analyze the congressional hearing testimony, I used both qualitative and quantitative text analysis. I used QDA Miner5 for the qualitative coding and Wordstat7 for the quantitative analysis. I used content analysis methodology to create categories of causal stories and proposed solutions. Once the categories were saturated, meaning causal stories I identified fit into the categories created and no additional categories needed to be created, I identified patterns and broader themes evidenced by the categories.
49 I chose to analyze law enforcement groups’ federal hearing testimony prior to CARA’s enactment because it is a sub-analysis of a much larger project on interest group narratives on the opioid crisis. The corpus, or population, of documents for the parent project were compiled by conducting a search on Thomas Reuters Westlaw for congressional hearing testimony using the search terms “addict!” and “overdose!” and limiting the dates to hearings occurring in January 2014 to June 2016. I chose to limit the analysis to hearings occurring within these dates because it would capture the discourse that preceded CARA, which was passed in June 2016. I restricted the dataset to 2014 because of resource constraints. Future research will be needed to determine whether the findings of this Article are time-limited. The terms “addict!” and “overdose!” were chosen because the purpose of my analysis is to capture the discourse on the social problem commonly referred to as the opioid crisis. The opioid crisis has been characterized by high rates of overdose and an acknowledgment of the problem of addiction. I then excluded testimony, or parts of testimony, that discussed methamphetamine use, synthetic drug use, and marijuana use, as these problems were characterized differently than the opioid crisis, a difference I hope to capture in a future analysis. The results were limited to hearings that occurred from 2014 to 2016. Both written and oral testimony were included. I then supplemented these narratives
Ohio on “Issue 1” of a 2018 ballot initiative, I identified four categories of narratives that attempt to define the social problem of drug use, each of which is outlined separately infra.

A. The Addict as the “Bad Guy”

The traditional narrative that explicitly portrays the addict as a deviant is still supported by some law enforcement groups.\textsuperscript{50} This narrative places the blame on the person who uses illicit substances for fueling the drug trade and for causing the crime that often accompanies black markets.\textsuperscript{51} The individual who uses illicit substances is the “bad guy” in need of punishment, or at least the threat of incarceration, in order to deter his bad behavior.\textsuperscript{52} Emphasis on the drug users’ association with the commission of crimes is often used to justify the need to lock away this deviant in order to improve public safety and protect the public from harm.\textsuperscript{53} Some of these narratives explicitly challenge the idea that addiction is an illness by arguing that the person is not ill but rather a criminal.\textsuperscript{54} In doing so, it supports the idea that addiction should not be used as an excuse for criminal behavior.\textsuperscript{55} The policy proposals accompanying this narrative include increased criminal enforcement and the incarceration of the deviant drug user.\textsuperscript{56} While this narrative was by no means dominant in the law enforcement narratives that I reviewed, it was epitomized by lengthy testimony given by the Prosecuting Attorneys Association of Michigan when testifying in front of Congress on the opioid crisis, excerpts of which follow:

Prosecutors, as indicated above recognize the need to hold persons accountable for the wide variety of crimes they commit while using these drugs. An addiction is not an excuse for criminal behavior. Incarceration is often appropriate. Dealing with a criminal case involves far more than the

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\textsuperscript{50} See sources cited supra note 2.

\textsuperscript{51} Drugs in Native Communities: Hearing Before the S. Comm. on Indian Affairs, 114th Cong. (2015) (statement of Darren Cruzan, Director, Office of Justice Services, Bureau of Indian Affairs), https://www.doi.gov/ocl/hearings/114/dangerousdrugs_033115 [https://perma.cc/A6CA-B7UE] [hereinafter Drugs in Native Communities] (“The use of illicit drugs can lead to impaired behavior that results in violence and other criminal behavior. Drug traffickers often engage in violent crimes to facilitate their operations, while persons with substance use disorders generally engage in property crimes to support their addiction.”).

\textsuperscript{52} Prescription Drug and Heroin Abuse Issues, supra note 2.

\textsuperscript{53} See, e.g., sources cited supra notes 14–19.

\textsuperscript{54} Id.

\textsuperscript{55} In fact, most law enforcement groups that acknowledged the importance of health responses still advocated for increased criminal enforcement alongside the health approach. See, e.g., Press Release, Buckeye State Sheriffs’ Ass’n, supra note 10.

\textsuperscript{56} See, e.g., Prescription Drug and Heroin Abuse Issues, supra note 2.
individual defendant. It also includes public safety, sending a message of deterrence to other offenders and the benefit that punishment also provides to a wrongdoer, including but not limited to drug addicts. However, prosecutors also recognize that if treatment can also be incorporated, the chance of recidivism may well be reduced.

Surprising to some, rehabilitative and treatment providers often also see the merit to the use of criminal prosecution to teach accountability and the threat of incarceration as a real life, practical tool to get addicts to embrace treatment, rehabilitation, etc.

Prosecutors, Defense attorneys and again, treatment providers also see the benefit of periods of incarceration to bring sobriety and a “drying out” period and a clear mind to drug offenders, including prescription and heroin offenders.\footnote{\textit{Id.}}

Using the lens of interest group power politics, the addict-as-a-deviant narrative names the law enforcement lobby as the primary “fixers”\footnote{See \textit{STONE}, supra note 27, at 224.} of problem drug use in the United States, as law enforcement agencies are experts in punishment. As primary fixers, these groups are in a position of power, in part because legislators consult with them when deciding how to address a social problem.\footnote{Taleed El-Sabawi, \textit{What Motivates Legislators to Act: Problem Definition & the Opioid Epidemic, A Case Study}, 15 IND. HEALTH L. REV. 189, 215 (2018).} During such consultations, these fixers are able to guide the discourse to their preferred legislative proposals—those that increase criminal enforcement and criminal penalties.\footnote{\textit{Id.} at 217.} Fixers are considered to have the power to describe the target population and the groups affected by the legislation and, in doing so, can construct their deservingness for policy benefits or burdens.\footnote{See \textit{id.} at 222–25.} Finally, as the primary fixers, they would likely be the recipients of the largest share of federal and state budget allocation to address problem drug use, as those fixing the problem need money to do so.\footnote{\textit{Id.}}

As much as the addict-as-a-deviant narrative may be preferred by law enforcement, due in part to its depiction of law enforcement as the fixers, such a narrative has fallen out of favor with other pressure groups lobbying on the opioid crisis.\footnote{It appears, from my review of congressional hearing testimony preceding the enactment of CARA, the deviancy narrative was not dominant in the discourse amongst law enforcement groups’ testimony. Though common historically, such explicit vilifications of persons using illicit substance were outliers in the federal congressional hearing testimony prior to the enactment of CARA. This finding does not mean that the addict-as-a-deviant narrative is not the dominant discourse within the law enforcement community, but rather, the law enforcement groups that were invited to testify before Congress on the opioid crisis were primarily those that did not tell such a narrative with the same conviction as was done.} These groups have opted for more health-oriented narratives that
utilize health terminology, with some groups explicitly arguing that addiction is a chronic disease of the brain.\textsuperscript{64} If addiction is indeed a chronic disease that changes brain chemistry, and not the result of inert deviance, the disease itself is to blame for addictive behavior.\textsuperscript{65} The addiction-as-a-disease narrative can be interpreted as supporting a causal theory that directly disputes the addict-as-a-deviant narrative.\textsuperscript{66} The increasing popularity of this conflicting narrative may have driven some law enforcement groups to adjust the deviancy narrative or to develop an alternative narrative altogether. Based on my analysis, the three most popular adjusted or alternative narratives include: (1) the carrots-and-sticks, (2) the drug-traffickers-as-the-bad-guys, and (3) law enforcement as active participants in the health approach.

B. Carrots and Sticks

The carrots-and-sticks narrative is a modification of the strict addict-as-a-deviant narrative.\textsuperscript{67} It combines the idea that those with an addiction need help with the idea that they cannot be helped without the threat of punishment.\textsuperscript{68}

The carrots-and-sticks narrative acknowledges that treatment may be effective in addressing problem drug use, but because the addict has a predilection for sinful or pleasurable behavior, punishment must be used as an incentive to correct the bad behavior and ensure compliance with treatment.\textsuperscript{69} This coerced-treatment narrative acknowledges the need for treatment, but argues that due to the drug user’s weak character, treatment adherence will only

\begin{itemize}
  \item Previous, the composition of the law enforcement groups’ testimony does indicate, however, that the public tolerance for the addict-as-a-deviant narrative has decreased. This statement is supported not just by the prominence of health-oriented narratives, but also, in the types of stories the law enforcement groups that were selected to testify were telling. In other words, it may not be that the law enforcement lobby has abandoned the deviancy narrative, but that legislators invited law enforcement groups to testify that supported an alternative narrative. See El-Sabawi, supra note 21, at 396–98.
  \item See El-Sabawi, supra note 21, at 380.
  \item Addiction Science, NAT’L INST ON DRUG ABUSE, https://www.drugabuse.gov/related-topics/addiction-science [https://perma.cc/JJG7-SDT9] (last updated July 2015) (“In reality, drug addiction is a complex disease, and quitting usually takes more than good intentions or a strong will. Drugs change the brain in ways that make quitting hard, even for those who want to.”).
  \item See El-Sabawi, supra note 1, at 1359–60.
  \item Id. at 1388, 1406.
  \item See, e.g., Prescription Drug and Heroin Abuse Issues, supra note 2 (quoting one prosecutor who states they have been more successful in getting defendants into drug treatment after the defendant has served jail time); O’Connor, supra note 2 (arguing “that drug courts are effective only when they combine the ‘carrot’ of treatment and support with the ‘stick’ of judicial accountability, including incarceration when needed”); Ohio Common Pleas Judges Association, supra note 2 (arguing that the threat of prison is what “modif[ies] a dependent defendant’s thinking”); OSBA Statement, supra note 2 (arguing that treatment is less likely and effective without “the threat of prison time”); Safe Harbor, supra note 2 (stating that “addicts are less likely to seek treatment” without the threat of prison).
  \item See sources cited supra note 68.
\end{itemize}
be achieved if the seduction of a high is combatted with the threat of incarceration.70 This narrative is predicated on the idea that the high of drug use acts as a positive reinforcement for the drug-seeking behavior by assuming that no other positive reinforcement will challenge that of the high. Consequently, the only logical response is punishment,71 like incarceration, or the use of negative reinforcement,72 such as releasing prisoners into treatment. The underlying theory is that the carrot does not work without the stick.73

Law enforcement groups that support this narrative argue that as enforcers of punishment, they are in the best position to provide the punishment needed to ensure compliance with drug treatment. For example, Nancy Parr, City of Chesapeake, Virginia, Commonwealth’s Attorney, shared an anecdote during her testimony to demonstrate the effectiveness of carrots-and-sticks.

C.B. was arrested in 2006 and 2007 and, in 2007, was incarcerated for violation of probation on an unauthorized use of a vehicle charge. At that time, she requested and was allowed to enter our Drug Court program. She knew and admitted that she was an addict, she had lost custody of her daughter and she “dried out” in jail. C.B. needed help and the incarceration scared her and “woke her up.” She experienced a couple of setbacks in Drug Court but the immediate sanctions reinforced the concept of consequences for all her actions and choices. She successfully completed and graduated in 2009. She has been clean since then, has regained custody of her daughter, and works full time. C.B. stays in contact with my office and thanks me regularly for “locking her up for 60 days.”74

Specialized courts, called drug courts, offer an institutionalized mechanism for these actors to supervise the process and ensure that persons suffering from problem drug use complete their treatment.75

Setting aside arguments about the merits of the carrots-and-sticks narrative, the carrots-and-sticks narrative allows law enforcement actors to incorporate the popular, “health-oriented”76 solution of treatment, but does so in a way that ensures the use of the criminal justice system to oversee the treatment

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70 Id.
71 Punishment is the addition of a negative stimuli. See generally Alan Baron & Mark Galizio, The Distinction Between Positive and Negative Reinforcement: Use with Care, 29 BEHAV. ANALYST 141 (2006).
72 See generally id.
73 See, e.g., O’Connor, supra note 2 (arguing that drug courts must retain the option to punish addicts in order to be effective).
75 Tiger, supra note 4, at 171–73.
76 Throughout this Article, I use the term “health-oriented” to refer to solutions that are interpreted by some as health solutions and not to effectively claim that a particular type of solution is, indeed, a health solution.
mechanism.\textsuperscript{77} This concession allows for some drug policy funding to be directed into the treatment system, but it also maintains a role for law enforcement groups.\textsuperscript{78} The carrots-and-sticks narrative allows law enforcement to address calls for increasing access to treatment but does so in a way that makes most likely the continued flow of funding dollars into the criminal justice system. Moreover, law enforcement groups maintain their role as enforcers of legislation governing illicit drug possession and as overseers of the treatment process. In sum, while the carrots-and-sticks narrative acknowledges the need for treatment and “tosses a carrot” to the health advocates, it simultaneously allows the law enforcement lobby to retain power and budget allocations.

While this narrative may be commonplace in the discourse on state drug policy issues,\textsuperscript{79} it was not prevalent in the congressional hearing testimony of law enforcement groups on the opioid crisis between 2014 and 2016.\textsuperscript{80} The narrative’s popularity in Ohio’s Issue 1 discourse may have been because of Issue 1’s explicit mandate of the transfer of funds from the criminal justice system to the treatment system as a means for addressing the opioid crisis.\textsuperscript{81} Such a transfer of funds would conceivably be accompanied by a transfer of power from the criminal justice system to the treatment system. The carrots-and-sticks narrative allowed for law enforcement actors to address the call for treatment while maintaining the control and funding that Issue 1 sought to redirect.

C. The Drug Traffickers as the Bad Guys

An alternative narrative that appeared with more frequency at the federal level was the drug-traffickers-as-the-bad-guys narrative.\textsuperscript{82} Similar to the carrots-and-sticks narrative, the drug-traffickers-as-the-bad-guys narrative allows law enforcement to concede the benefits of treatment, while still maintaining their roles as fixers. This narrative characterizes the drug traffickers, instead of the drug users, as the bad guys—or the group to blame for causing the nation’s drug problems.\textsuperscript{83} Within the federal congressional law

\textsuperscript{77} See O’Connor, supra note 2.
\textsuperscript{78} See id.
\textsuperscript{79} See, e.g., supra text accompanying note 12.
\textsuperscript{80} See El-Sabawi, supra note 21, at 380–94.
\textsuperscript{81} Ohio Issue 1, supra note 11; see sources cited supra note 2.
\textsuperscript{83} See, e.g., Community Solutions to Breaking the Cycle of Heroin and Opioid Addiction, supra note 82, at 2 (statement of Tristram J. Coffin, United States Attorney, District of Vermont) (describing a heroin user as a “treasured son” and the heroin dealer as the villain responsible for the heroin user’s death).
enforcement testimony, these drug traffickers were commonly described as doctor dealers,\(^{84}\) organized criminal enterprises,\(^{85}\) or foreign drug cartels\(^{86}\) that capitalize on persons struggling with addiction. By blaming these actors,
narrators indicate that these actors are deserving of punishment—punishment that should be carried out by increased or continued criminal enforcement.87

In a variation of this narrative, some narrators explicitly differentiated between drug traffickers and drug users, describing drug users as victims being preyed upon by greedy drug traffickers.88 For example, Gary Wolske, the Paternal Order of Police Ohio’s President stated, “[W]e must find a way to keep the violent criminals and those selling drugs behind bars, while giving those in the throes of addiction a path to better health.”89 To provide evidence of the benefits of the ongoing enforcement, many of these narratives cited to statistics and examples of cases in which law enforcement agencies intercepted large quantities of drugs or prosecuted particularly nefarious drug dealers.90

The drug-traffickers-as-the-bad-guys narrative was particularly useful to federal law enforcement agencies, regional law enforcement coalitions, and law enforcement agencies in localities that bordered Mexico.91 These law enforcement groups have jurisdiction over persons participating in the importation of illicit drugs, and by portraying foreign drug actors as the villains, they became the important fixers who could disrupt the networks of these villains by intercepting large shipments of illicit substances.92 These narratives established the importance of border security, interdiction, and larger-scale drug busts in addressing the opioid crisis.93 And, they enabled these law enforcement

87 See sources cited infra notes 90–91.

88 Such a distinction is not necessarily supported by empirical evidence, as often those who deal drugs also use them. See, e.g., Kathryn Casteel, A Crackdown on Drug Dealers Is Also a Crackdown on Drug Users, FIVETHIRTYEIGHT (Apr. 5, 2018), https://fivethirtyeight.com/features/a-crackdown-on-drug-dealers-is-also-a-crackdown-on-drug-users/ [https://perma.cc/R3DC-VYEX].

89 Wolske, supra note 16.

90 See, e.g., General Kelly Statement, supra note 86, at 3–7; Heroin Addiction and Drug Trafficking, supra note 84. Historically, to demonstrate the need for continued funding of the criminal justice approach to problem drug use, arrests of high-ranking members of drug cartels or large seizures of illicit drugs, and not the lay drug user or dealer arrest, has been used as a determinative a measure of success. See Joseph F. Spillane, Building a Drug Control Regime, 1919–1930, in FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 25, 25–59 (Jonathon Erlen & Joseph F. Spillane eds., 2004) (discussing the historic use of statistics by law enforcement to establish the need for continued criminal enforcement).


92 See, e.g., sources cited supra note 91.

groups to position themselves, alongside the health actors, as integral to solving the opioid crisis.  

In sum, the focus on the drug-traffickers-as-the-bad-guys and the narrative distinction between the drug dealer and the drug user accomplishes certain political objectives. First, it allows law enforcement groups to maintain the need for the criminal enforcement that they provide. Second, it does so in a way that does not challenge groups that characterize addiction as a disease or a health problem. It obviates the need to directly contradict popular narratives of addiction as a brain disease or a health issue, thereby avoiding a battle of narratives with members of a politically powerful health industry that supports these health narratives. Law enforcement groups could even partner with the health narrative coalition, to address public safety, while health actors increase access to needed substance abuse treatment. Reciprocally, if health-oriented actors find this law enforcement narrative credible and believable, they can support it without sacrificing their narrative. Finally, by recasting the narrative role of the bad guy from the drug user to the drug trafficker, these law enforcement groups avoid seeming out of step with national trends in public opinion, which show an increasing acceptance of the idea that addiction is a brain disease as opposed to a moral failing. By recasting the bad guy and conceding the benefits and need for treatment, these law enforcement narrators could accomplish their policy objectives, while potentially lowering political costs.

D. Law Enforcement Groups as Active Participants in the Health Approach

Some law enforcement groups embraced the definition of problem drug use as a health problem, citing to frustration of the tools of punishment at their disposal and expressing the desire to help members of their community in

94 Drugs in Native Communities, supra note 51.
ways that do not involve incarceration. These narrators often agreed that addiction was a disease and that those suffering SUDs should be diverted away from the criminal justice system and to health actors for treatment. These law enforcement groups commonly argued that they could not “arrest [their] way out of the problem” and encouraged legislators to allocate more money for treatment services. However, rather than espousing a health-oriented approach that appointed health actors as the only fixers, these law enforcement narrators created a role for themselves within the health-oriented approach. For some, this role included the provision of overdose reversal medication to overdose victims. For others, it involved delivering persons suffering from SUDs, not only to emergency rooms, but also to points of entry into the treatment system, where the individual could receive on-demand treatment. Other groups argued that law enforcement officials were best positioned to engage in prevention efforts, specifically in preventing youth drug initiation through education efforts.

suffering from substance use disorders are not our enemies. They are our sons, our daughters, [and] our neighbors. [a]nd, this notion that we are at war with them must be abandoned.”

Id. at 370 (“The fact that law enforcement is recognizing this as a disease that needs to be treated into remission, rather than a crime that requires arrest and incarceration, has had a positive impact in communities throughout America.”).

Frederick Ryan stated:

We, as law enforcement, cannot solve this problem alone—and we must stop telling America that, with just some more resources, we can do so. In fact, a strategy that relies largely on law enforcement and arrest, especially aimed at low-end users, only fuels the epidemic and complicates the chances for long-term recovery.

Id. at 367.

See Jill Westmoreland Rose, Opinion, We Can’t Arrest Our Way out of Growing Opioid and Heroin Epidemic, CHARLOTTE OBSERVER, https://www.charlotteobserver.com/opinion/op-ed/article103032432.html [https://perma.cc/8LNU-SD2A]; see also, e.g., America’s Insatiable Demand for Drugs, supra note 97, at 368 (“Every person with a substance abuse problem that I have talked to has said that arrest and prosecution has never been a deterrent.”).

See, e.g., sources cited supra note 93.


See, e.g., Prescription Drug and Heroin Abuse Issues, supra note 2.
The narratives reviewed in this subsection share two characteristics: they endorse the health approach and recast law enforcement actors as coordinators of care or prevention specialists rather than enforcers of punishment. Despite being most in alignment with the dominant health-oriented narrative, the law-enforcement-as-participants narrative was overshadowed by narratives calling for increased criminal enforcement.105

The lack of popularity of the law-enforcement-as-participants narrative could be attributed to its potential effects on funding allocations. If law enforcement actors become mere participants within the health actor’s approach, as opposed to the architects and enforcers of their own approach, then they need fewer resources than previously needed for enforcement. The shift in responsibility could call for transfers of both power and funding away from the criminal justice system and to the health system to address problem drug use.106

Such a shift, if enacted wholesale, would decrease the number of criminal justice personnel or the resources available to the criminal justice system as a whole. Such an outcome would not be in the best financial interest of law enforcement actors and may explain the narrative’s lack of frequency within the discourse. Notwithstanding its infrequency, this narrative’s mere presence in the discourse is noteworthy because of the degree to which it departs from historic law enforcement approaches to addressing problem drug use.107

IV. THE LAW ENFORCEMENT NARRATIVE CONTINUUM

The narratives reviewed above differ in the degree to which they support the dominant health-oriented approach to the opioid crisis, with some narratives side-stepping the discussion, other narratives challenging the logic behind the health-oriented approach, and others embracing the approach. These narratives also vary in their depiction of persons with SUDs. Some narratives used by law enforcement to define the opioid crisis adhere to the traditional portrayal of the drug user as a deviant,108 some shift the blame to the drug traffickers,109 and others challenge the portrayal of the drug user as a deviant, recasting him instead as a person with an illness.110 Despite these differences, and their social justice implications, each of these narratives implicitly appoint the law enforcement lobby as “fixers” of the drug problem—fixers who are deserving of resource

106 See Ohio Issue 1, supra note 11.
108 See, e.g., Prescription Drug and Heroin Abuse Issues, supra note 2 (“[S]ignificant drug activity creates a generation of addicts who in turn sell drugs, steal property, rob and—as a result of drug altered states, assault and kill—other citizens as part of a vicious cycle.”).
109 See, e.g., sources cited supra notes 89–90.
110 See, e.g., sources cited supra note 93.
allocations to carry out their duties. These narratives define problem drug use in ways that increase the likelihood that law enforcement actors will be allocated a share of the appropriations set aside to address the opioid crisis. These narratives also refute the proposition that law enforcement groups are no longer needed to address drug use—a proposition that threatens the survival of criminal justice institutions by placing in jeopardy drug enforcement funding, which pays for salaries and needed resources.  

The law enforcement narratives defining the opioid crisis could be ranked based on their effects on two primary factors: the degree to which the narrative depicts law enforcement agents as fixers of the problem (“degree of involvement”) and the amount of federal monies that would be needed to fund that particular degree of involvement. The ranking depicted in Figure 1, infra, begins with the narrative that supports the greatest degree of involvement and justifies the greatest degree of funding.  

![Figure 1: Relative Funding as a Function of Proposed Degree of Involvement in Addressing Problem Use](image)

<table>
<thead>
<tr>
<th>Degree of Involvement</th>
<th>Primary Fixers</th>
<th>Overseers of the Fixing</th>
<th>Partial Fixers</th>
<th>Coordinate the Fixing</th>
<th>Not Our Problem to Fix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrative</td>
<td>Incarcerate/punish drug users &amp; traffickers</td>
<td>Treatment only works best with the threat of incarceration</td>
<td>Treatment system may be best for users but punishment is needed for traffickers</td>
<td>Law enforcement can help prevent drug use through education, reverse overdoses, &amp; link users to treatment</td>
<td>--</td>
</tr>
<tr>
<td>Level of Funding Needed</td>
<td>$$$$$</td>
<td>$$$</td>
<td>$$</td>
<td>$</td>
<td>--</td>
</tr>
</tbody>
</table>

The typology of law enforcement narratives depicted in Figure 1 suggests that law enforcement groups envision their roles in addressing problem drug use as evolving—with some law enforcement groups clinging to the idea that they

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112 The level of funding needed is not an estimate of the amount of funding that would actually be needed. It is simply an ordinal ranking of predicted funding levels.
are the primary fixers and others willing to take more secondary roles as active actors within a health-oriented approach. Since budgets are often fixed and resources are scarce, it stands to reason that the greater the role a group has in fixing a problem, the greater allocation of resources they will receive. Based on this logic, groups seeking to further their members’ interests should, hypothetically, prefer narratives that depict their group as the primary fixer of the problem. As applied to problem drug use, this hypothesis would predict that the addict-as-a-deviant narrative would be the narrative most frequently used. However, I found that this narrative has fallen out of favor with law enforcement groups weighing in on the opioid crisis.

I have yet to conduct an empirical analysis of variables that influence this evolution of law enforcement narratives within drug policy, but the following theories may provide scholars with a useful starting point.

It could be electorally costly for legislators to award benefits to groups that are viewed as greedy, or as sacrificing the public’s interest for its members’ financial gain. Therefore, for a narrative to motivate legislators to act, it should demonstrate how the benefits, or funding, awarded will be used to further the public’s best interest. The narrative should also resonate with and be believable to its intended audience of legislators and voting constituents. This suggests that for law enforcement groups to be successful they must consider widely held beliefs when deciding which amongst the available narratives to support. In districts or states where the perceived public opinion supports the explicit characterization of persons with SUDs as deviants, law enforcement groups will be rewarded for using the addict-as-a-deviant narrative—the narrative that awards law enforcement groups the greatest jurisdictional powers (and benefits)—with little political costs.

Alternatively, for law enforcement groups concerned with the political consequences of vilifying overdose victims that are the sons and daughters of their voting constituents, the carrots-and-sticks narrative offers a suitable alternative. The carrots-and-sticks narrative acknowledges that persons with SUDs may be deserving of the opportunity to receive treatment, but also reinforces the need for the criminal justice system to ensure treatment adherence. Like the addict-as-a-deviant narrative, the carrots-and-sticks calls for control, power, and funding dollars to remain within the criminal justice system. Law enforcement groups that support this narrative may find that it addresses the frustration of family members who are unable to force their loved

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113 El-Sabawi, supra note 1, at 1359.
116 El-Sabawi, supra note 1, at 1362–63, 1369, 1380.
117 Id. at 1366.
118 See, e.g., O’Connor, supra note 2.
one into treatment or who are unable to provide the familial support often needed to ensure treatment placement and completion.

Law enforcement groups in districts or states where the idea that addiction-as-a-disease is most accepted, however, may alienate voting constituents with the addict-as-a-deviant narrative or the carrots-and-sticks narrative for the reasons reviewed in the previous section. For these law enforcement groups, narratives that support the health-oriented approach, an approach aligned with the accepted addiction-as-a-disease causal story, may better position the law enforcement group and its elected or appointed leaders as allies to the public. Elected officials of these law enforcement groups may decide that supporting the health-oriented approach has electoral advantages and therefore be willing to take these electoral benefits over the additional funding that would come with a criminal justice approach.

At this point, however, the theories in this section lack empirical or statistical proof. Each of the theories will need to be tested and additional empirical work will need to be conducted to determine the degree to which electoral considerations and shifts in public opinion influence the narratives used by law enforcement groups.

V. CONCLUSION

Like other organized interest groups, law enforcement groups take part in the problem definition discourse, during which they offer narratives that represent a social problem in a manner that best furthers the interest of their group members. For decades, the dominant narrative offered to Congress in support of legislative proposals to address problem drug use depicted the drug user as the deviant in need of punishment at the hands of law enforcement agencies. Given the benefits afforded to law enforcement in accordance with such a narrative, it is no surprise that some law enforcement groups preferred narratives of deviancy when taking part of the discourse on the opioid crisis.

However, the legislative discourse has shifted, with both conservative and liberal legislators shying away from the “fire and brimstone” stories of evil and doom that once dominated the drug policy discourse. Their collective tone has softened. As such, some law enforcement groups’ continued and unwavering commitment to the stories of the past appear antiquated and out of touch with popular opinion. In localities that have been resistant to attempts to de-stigmatize addiction and drug use, such a stance may not cause elected law enforcement officials to be concerned for their re-election. Conversely, these officials may be rewarded, electorally and financially, by constituents that continue to vilify drug users.

Despite the persistence of the addict-as-deviant narrative at the margins, a majority of law enforcement groups that were active in the congressional public discourse have abandoned the express vilification of persons with SUDs.

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119 Supra Part III.
120 See Musto, supra note 107 (providing a general history of federal drug enforcement).
Instead, some have embraced narratives that characterized drug traffickers as the bad guy, while others have gone so far as creating a new role for law enforcement actors within a more health-oriented response framework. This evolution of narratives suggests that the criminal justice groups’ traditional role as the ultimate fixers of problem drug use is being redefined in the policy discourse on the opioid crisis, at least by some law enforcement groups—despite this redefinition requiring law enforcement groups to relinquish some of their power over drug policy. Law enforcement groups willing to accept that such a redefinition is inevitable have re-envisioned their roles strategically so as to ensure that they are still fixers of sort. These groups redefined their own roles in ways that protected their interests—even painted themselves as heroes—as opposed to allowing other groups to relegate them as obsolete or to claim that they are part of the problem. If the definition of problem drug use as a health-oriented issue is durable, then law enforcement groups that refuse to adjust their narratives to account for the shifts in the discourse risk becoming a drug policy anachronism, at best, or, at worst, as the new bad guys of the current drug policy reform narrative.
Kicking the Habit:
The Opioid Crisis, America’s Addiction to Punitive Prohibition, and the Promise of Free Heroin

JOSH BOWERS† & DANIEL ABRAHAMSON‡

There is no single cause of America’s opioid crisis. But unethical physicians and unscrupulous prescription practices undoubtedly have contributed. The federal government has responded predictably: criminally prosecuting doctors who prescribe opioids to the drug dependent. The approach may seem sensible, but it as wrongheaded as our century-old drug war. Indeed, it is part-and-parcel of that misguided struggle. Law enforcement’s recent push for punishment might succeed in limiting opioid prescriptions, but only at the cost of driving drug dependent individuals into more dangerous criminal markets, away from narcotics of reliable quality and toward adulterated street heroin and fentanyl. For individuals addicted to opioids or suffering from chronic pain, a criminal drug war has never been a prescription for improving wellness. Indeed, part of the problem is our very obsession with the pejorative notion of “getting clean.” It is bad enough to conceive of the drug user as “dirty.” It is much worse for a state to monomaniacally pursue an abstinence-based policy model. This dominant model is grounded in the cruel logic of punitive prohibition. It depends not upon healing but upon puritanical blame and shame, isolation and othering, prosecution and penalty. The better model is “harm reduction,” grounded in connection and care, reason and rights, human dignity and worth.

The evidence abounds. International and historical public health efforts have demonstrated, for instance, that one of the best ways to confront epidemic drug use is “addiction maintenance”—that is, establishing medically supervised clinics to provide pharmaceutical-grade narcotics (often free of charge) in amounts calibrated to maintain the social and physical wellbeing of the drug dependent. In this essay, we survey these international and historical efforts. We look to our own sometimes-better, sometimes-worse past. We examine the racist roots of the modern American drug war. We describe contemporary reforms, within and beyond the opioid crisis. We explain how meaningful change is likeliest to occur: from the ground up, as a product of underground experimentalism, initiated by and within the most-affected communities. And we offer our own public health prescription: a set of pragmatic harm reduction responses to punitive prohibition and its inhumane, counterproductive, and often deadly effects.

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‡ Founder, Office of Legal Affairs of the Drug Policy Alliance.
I. INTRODUCTION

In a typical war, strategies change with time. Pragmatic planners abandon goals that prove unattainable or that become undesirable. For a century, this country has fought a criminal war on drugs.1 Some battle lines have changed, of course. The state has diverted manpower—sometimes back and forth—from opium to heroin, to “reefer madness,” to hallucinogens, to powder and crack cocaine, to prescription and nonprescription opioids.2 Likewise, police, prosecutors, and politicians have supplemented conventional weaponry, like the Harrison Narcotics Act, with more powerful hardware, like the Controlled Substances Act and state law corollaries.3 Other battle lines have remained constant. For instance, law enforcement has kept its sights trained throughout on black, brown, and poor neighborhoods.4

More to the point, the goal of the drug war—punitive prohibition—has never shifted. With the exceptions of alcohol, tobacco, and, to a narrow extent, marijuana, recreational drugs are still forbidden, and users are still blamed, shamed, and caged.5 But, less obviously, the state consistently has prohibited much more. It has obstructed and even prosecuted criminally the activists and medical professionals who would help problematic drug users through

2 See id.; infra note 35 and accompanying text (discussing historical and contemporary policy and enforcement approaches); cf. REEFER MADNESS (George A. Hirliman Productions 1936).
4 See infra note 35 and accompanying text.
5 See generally infra note 106 and accompanying text (discussing “blame and shame” as tools of criminal justice).
unconventional but promising means. It has defunded the academics and policy reformers who would endorse or even study innovative approaches to drug use and abuse. And it has undermined localities that would implement alternatives. The objective has never been to foster a healthier, caring collective. The objective is the drug-free society—full stop. Never mind that no society ever has or could achieve that end.

As authors, we might devote this entire essay to unpacking the reasons for the drug war’s single-minded obsession with punitive prohibition. It is enough, however, briefly to flag three principal influences. First, the drug war’s monomaniacal preoccupation with punitive prohibition lies partially in America’s puritanical history and worldview. Second, and to a greater degree, punitive prohibition is rooted in racism. Third, and more subtly, the logic of punitive prohibition follows a distinctly legalistic mindset—a fixation with rules. Punitive prohibition is what happens when public policy is left to conventional lawyers, law enforcers, and central planners to be shaped from the top down. The war on drugs exposes particular drawbacks of law, legal institutions, and the legal turn of mind: all have a tendency toward the infant’s infatuation with clear rules, the sociopath’s obsession with intimidation and strength, and the coward’s aversion to risk and experimentation.

We do not mean, here, to disparage all legal regimes or bureaucratic frameworks. Some have great virtue and value. But they have a tendency to fall prey to blinkered perspectives that not only make for misguided public policy but also complicate course correction. Legal officials and bureaucrats grasp at bright-line answers, preferring wrongheaded simplicity to nuanced solutions.

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6 See, e.g., infra notes 183–88 and accompanying text (discussing activists’ efforts towards, and governmental pushback against, the establishment of needle exchanges to combat the spread of communicable diseases).
7 See, e.g., infra notes 241–43 (discussing impediments to medical cannabis research).
8 See, e.g., infra notes 235–37 and accompanying text (describing the interplay between local officials and state legislators).
10 See supra note 4 and accompanying text.
On this reasoning, punitive prohibition takes on a certain elegance, captured by the directive to “Just Say No.” One might dismiss this drug war missive as no more than an anodyne, state-sponsored public service message. But those three words succinctly describe much more: a century of state-sponsored aggression against its own people, a crusade against science, reason, compassion, public health, equal concern, and respect.

Yet now, in the face of a brutal opioid crisis, there is a modicum of energy for genuine drug policy reform—for a shift from the prevailing “Just Say No” mentality. The shift is welcome, of course. Still, it is hard to get too excited about a newfound enthusiasm that is, in itself, seemingly grounded in racial bias. White America has opened its collective eyes to the evils of the drug war at the very moment that the opioid epidemic has begun to plague rural and predominantly white communities. If Derrick Bell still lived, he might shrug.

We are witnessing a paradigmatic example of his “interest convergence” theory in action, which posits that white America will only see fit to help black America if white Americans are forced to face the same challenges as black Americans. Simply put, there are limits to a polity’s moral imagination when the problem exists over there only.

All the same, we are pragmatic drug policy reformers. And, because real lives hang in the balance, we’ll take what we can get. Any port in a storm, as they say—any opportunity to shift the narrative, however slightly, from “criminal justice menace” to “public health crisis.”

This is not to say that meaningful and effective reform was entirely absent in the decades before the current crisis. There have always been change agents, struggling as best they can, underground and in the shadows. Who were these frontline warriors? Rarely public officials, at least not initially. Nor were they policy wonks or other experts from the professional-thinking classes: they were the community members and movement people—men and women toiling in the trenches. These courageous few have called out the drug war for what it is—a prudish instrument of oppression and a nonsensical and deadly illusion, rooted

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in fear and flawed science. For these street activists (in their capacity as brothers, sisters, parents, partners, friends, neighbors, co-workers, and even users), the war against the drug war has been a war of self-defense—a war waged by foot soldiers fighting for their lives and the lives of others.

In this essay, we intend to do a lot in a little space. In Part II, we recall a time, before our century-long war on drugs, when we did things differently—when we responded to an opioid epidemic not with prohibition but with a compassionate intervention known as addiction maintenance—that is, providing drugs, often free of charge, in amounts calibrated to maintain the wellbeing of dependent persons. In Part III, we explore contemporary—often—grassroots—international efforts to return to an old-style, harm reduction approach. In the process, we explore some of the advantages of addiction maintenance in its modern form. In Part IV, we discuss how, when, and why addiction maintenance works. In Part V, we evaluate what stands in the way of addiction maintenance—namely, the leviathan of a coercive criminal justice system comprised of centralized policymakers who are convinced that they comprehend drug dependency better than treatment providers, medical professionals, and the users themselves. Finally, in Part VI, we survey a host of domestic reform efforts, and we provide a framework for understanding when, how, and to what extent these (often underground) endeavors have beaten back the leviathan.

As these multifaceted reform efforts reveal, addiction maintenance is only one front in a grassroots revolution. Indeed, additional reforms necessarily must precede addiction maintenance, because the practice is appropriate only after the failure of other much needed therapeutic interventions—like medication-

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17 By way of explanation, harm reduction models focus on minimizing the negative social, economic, and physical externalities that flow from human behaviors. In other words, “harm reduction is both a cure and a care-based approach consistent with accepting a duty of care as a compassionate and caring community, and while harm reduction encompasses abstinence as a desirable goal, it recognizes that when abstinence is not possible, it is not ethical to ignore the other available means of reducing human suffering.” Ingrid Van Beek, Harm Reduction—An Ethical Imperative, 104 Addiction 341, 343 (2009) (emphasis omitted) (footnotes omitted). On the other hand, drug prohibition focuses entirely on abstinence—also termed use or prevalence reduction—backed by the cudgel of criminal justice. Robert J. MacCoun, Moral Outrage and Opposition to Harm Reduction, 7 CRIM. L. & PHIL. 83, 84 (2013); Jonathan P. Caulkins & Peter Reuter, Setting Goals for Drug Policy: Harm Reduction or Use Reduction, 92 Addiction 1143, 1145–46 (1997); see also Robert J. MacCoun & Peter Reuter, Assessing Drug Prohibition and Its Alternatives: A Guide for Agnostics, 7 ANN. REV. L. & SOC. SCI. 61, 63 (2011). See generally ROBERT J. MACCOUN & PETER REUTER, DRUG WAR HERESIES: LEARNING FROM OTHER VICES, TIMES, AND PLACES (2001) (analyzing American drug policy in historical context). By way of analogy, imagine two methods for promoting sexual health—providing free condoms or criminalizing contraceptives. Harm reduction describes the first approach; prohibition describes the second. See infra note 216 and accompanying text.
assisted treatment with methadone, buprenorphine, or suboxone, none of which are uniformly available at present. Thus, we conclude with a pragmatic six-point plan, designed to address the current opioid crisis in a manner that abandons the logic of prohibition in favor of activism and—above all—a commitment to the Hippocratic oath to do no harm.

II. EARLY ADDICTION MAINTENANCE EFFORTS

Throughout the nineteenth century, drugs remained mostly unregulated. Users purchased product through mail order catalogues and at local pharmacies. Sears & Roebuck sold syringes with doses of injectable cocaine for a dollar or two. Opiates were packaged into serums with delightfully alliterative names, like “Mrs. Winslow’s Soothing Syrup.” And, critically, this legal market was substantially safer than the modern-day criminal market:

Before the ban, almost all opiate users would buy a mild form of the drug at their corner store for a small price. A few did become addicts, and that meant their lives were depleted, in the same way that an alcoholic’s life is depleted today. . . . But virtually none of them committed crimes to get their drug, or became wildly out of control, or lost their jobs. Then the legal routes to the drug were cut off—and all the problems we associate with drug addiction began: criminality, prostitution, violence.

Medical professionals of the era considered opioid abuse a public health problem. The idea of a criminal drug war would likely have seemed as foreign to them as a modern criminal war on poor diet as a means to fight type 2 diabetes today. To the contrary, doctors regarded persons suffering from drug addiction as patients deserving of treatment. Even for the profoundly dependent, the

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21 Id.
22 HART, supra note 15, at 35.
23 Id. at 226.
medical profession provided a form of palliative care—often termed addiction maintenance—by which cravings were treated by access to the craved substance.\textsuperscript{27}

By the turn of the century, the push for prohibition had begun—conceived of, principally, as a means to control minority communities.\textsuperscript{28} Politicians, pastors, and the press drew specious links between drug abuse and the exploitation of white women.\textsuperscript{29} These early drug warriors pushed for aggressive state responses, playing on vile canards of violent or sexually aggressive African-Americans with cocaine, Mexican-Americans with marijuana, and Chinese-Americans with opium.\textsuperscript{30} African-Americans were singled out for especially harsh treatment. Unsubstantiated claims linked black drug abuse to “many of the horrible crimes committed in the Southern States,” thus providing another convenient excuse for all varieties of Jim Crow persecution and oppression, including continued disenfranchisement.\textsuperscript{31}

\textsuperscript{27} \textit{Hari}, supra note 15, at 34 (quoting Henry Smith Williams) (“[T]he doctor knows just what should be done . . . that he has but to write a few words on the prescription blank that lies at his elbow, and the patient . . . will receive the remedy that would restore him miraculously to a semblance of normality . . . ”); \textit{id.} at 37 (“[Edward Williams] helped to build a free clinic for addicts, and he volunteered his own time there. He wrote his prescriptions for whoever needed them.”). \textit{See generally} \textit{Henry Smith Williams, Drug Addicts Are Human Beings} (1938) (discussing contemporary drug law and policy).

\textsuperscript{28} \textit{See generally} Hamilton Wright, \textit{The International Opium Commission}, 3 AM. J. INT’L L. 828 (1909) (discussing government responses to increased opium use).

\textsuperscript{29} \textit{Hari}, supra note 15, at 17 (describing the racist belief that marijuana made African-American men “forget the appropriate racial barriers—and unleashed their lust for white women”).


\textsuperscript{31} \textit{See}, e.g., \textit{David F. Musto, The American Disease: Origins of Narcotic Control} 7 (3d ed. 1999) (describing “fantasies characterized [by] white fear, not the reality of cocaine’s effects” that “coincided with the peak of lynchings, legal segregation, and voting laws all designed to remove political and social power from [African-Americans]”); \textit{Courtwright}, supra note 25, at 71 (describing the “supercharged racial atmosphere” and
Then, as now, whites used drugs at rates comparable to—and perhaps even higher than—other populations.\(^\text{32}\) Indeed, historian David Courtwright concluded that “southern whites [of the era] had the highest addiction rate[s] of any regional racial group in the country, and perhaps one of the highest in the world.”\(^\text{33}\) But, among more privileged populations, it seems that drug abuse was still considered no worse than an unfortunate—but-tolerable vice.\(^\text{34}\) In other words, attitudes about recreational drugs were shaped by caste and class—by the desire to prevent the “wrong” type from associating with the “right” type. Unsurprisingly, then, the first shots of the drug war were, like most shots since, targeted strikes against poorer and darker communities.\(^\text{35}\)

What did early regulation look like? In 1914, Congress passed the Harrison Narcotics Tax Act, which taxed, but did not wholly prohibit, the production and distribution of cocaine and opioids.\(^\text{36}\) In this way, doctors could still prescribe narcotics, and many continued to do so to treat dependence.\(^\text{37}\) In fact, several municipalities ran public addiction maintenance clinics, including opioid clinics in New York City, Los Angeles, New Orleans, Shreveport, Atlanta, New Haven, Albany, and Jacksonville.\(^\text{38}\) These dispensaries operated aboveground, granting prescriptions to users to ingest hard drugs.\(^\text{39}\) Health officials not only treated users by feeding cravings, but also tracked patients.\(^\text{40}\) Participants were required to register with the state, which minimized the risk of diversion of the drugs into

“exaggerated reactions to isolated but potently symbolic deeds” by the white southern power structure); *Cocaine Sniffers: Use of the Drug Increasing Among Negros in the South*, N.Y. DAILY TRIBUNE, June 21, 1903, at 11.


\(^{33}\) Courtwright, *supra* note 25, at 57.

\(^{34}\) See *HARI*, *supra* note 15, at 35–36.

\(^{35}\) See generally William J. Stuntz, *Race, Class, and Drugs*, 98 COLUM. L. REV. 1795 (1998) (describing the contemporary drug war as a function of class, with race as its correlate).


\(^{38}\) MUSTO, *supra* note 31, at 151; HARI, *supra* note 15, at 37; Courtwright, *supra* note 25, at 59; Weber, *supra* note 24, at 58–59 (”[F]ederal and state health officials and local law enforcement, beginning around 1912, created maintenance clinics in a dozen states that would prescribe medication in an effort to prevent suffering related to addiction and wean individuals from their drug use through the gradual reduction of dosage.” (footnote omitted)).

\(^{39}\) Courtwright, *supra* note 25, at 60 (analyzing the data and observing that the clinics were “designed to supply narcotics to, as well as keep track of, addicts”).

\(^{40}\) Id.
criminal markets and provided potential data to measure success empirically—even though such studies were apparently relatively uncommon at the time.\footnote{See Weber, supra note 24, at 59 ("In Tennessee, persons with addictions were registered and given refillable opiate prescriptions to minimize suffering and reduce illegal drug trafficking.").}

It seems that the efforts were largely successful. If nothing else, they initially enjoyed widespread support from city councils, boards of health, and even local law enforcement.\footnote{MUSTO, supra note 31, at 151, 156–78.} According to the Los Angeles Mayor, the city’s maintenance clinic did “more good . . . in one day than all the prosecutions in one month.”\footnote{HARI, supra note 15, at 37.} But the legal landscape was shifting. Initially, law enforcement focused on the so-called “script doctors” who liberally dispensed opioids to patients.\footnote{Thomas M. Quinn & Gerald T. McLaughlin, The Evolution of Federal Drug Control Legislation, 22 CATH. U. L. REV. 586, 595 (1973) ("[L]aw enforcement officials soon began to move to curtail the medical profession’s freedom to prescribe narcotics in the treatment of addicts.").} Federal prosecutors argued that addiction maintenance failed to qualify under the Harrison Act’s allowance for “good faith” prescriptions “in the course of . . . professional practice.”\footnote{Harrison Act, supra note 36; see also KREIT, supra note 16, at 739–40 (describing cases “in which physicians argued that prescribing narcotics for addiction maintenance—in other words, to keep addicted patients from suffering withdrawal symptoms—was a legitimate medical use”); Jin Fuey Moy v. United States, 254 U.S. 189, 194 (1920).} And the Supreme Court would come largely to credit that claim. First, in \textit{Webb v. United States}, the Court held that a doctor was prohibited from prescribing to “an habitual user” a dose of morphine, where the doctor’s intention was not to “cure . . . the habit” but to keep the patient “comfortable by maintaining his customary use.”\footnote{Webb v. United States, 249 U.S. 96, 99–100 (1919) ("[T]o call such an order for the use of morphine a physician’s prescription would be so plain a perversion of meaning that no discussion of the subject is required.").} Subsequently, in \textit{United States v. Behrman}, the Court decided that violating the Harrison Act did not require intent.\footnote{United States v. Behrman, 258 U.S. 280, 288 (1922).} This ruling, combined with the \textit{Jin Fuey Moy} holding before it, meant that "prescribing drugs for an addict was a crime regardless of the physician’s intent in the matter,"\footnote{RUFUS KING, THE DRUG HANG-UP: AMERICA’S FIFTY-YEAR FOLLY 42 (1st ed. 1972) (emphasis omitted).} and a prescription could not "cater to the appetite . . . of one addicted to the use of the drug."\footnote{Jin Fuey Moy, 254 U.S. at 194 (holding that the physician’s exemption did not include “a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug,” and noting that a “‘prescription’ issued” for addiction maintenance “protects neither the physician who issues it nor the dealer who knowingly accepts and fills it”).} In \textit{Linder v. United States}, however, the Court seemed to endorse a different approach:
[Addicts] are diseased and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith . . . morphine or cocaine for relief of conditions incident to addiction.\footnote{Linder v. United States, 268 U.S. 5, 18 (1925) (“What constitutes bona fide medical practice must be determined upon consideration of evidence and attending circumstances.”).}

But Linder would prove \textit{sui generis}—an exception to the dominant rule, as applied to a case where the doctor had prescribed only a relatively small dose.\footnote{See \textit{id}; LINDESMITH, supra note 19, at 6–7 (discussing early Supreme Court drug cases).} The Harrison Act had set the stage for punitive prohibition.\footnote{See LINDESMITH, supra note 19, at 3–5.} And, with the passage of the Eighteenth Amendment, the logic of prohibition became a constitutional mandate.\footnote{Weber, supra note 24, at 57–59 (discussing the federal government’s ever-more vigorous enforcement of the Harrison Act after alcohol prohibition).} This shifting legal landscape apparently reshaped cultural norms, in turn.\footnote{See generally Symposium, \textit{The Legal Construction of Norms}, 86 VA. L. REV. 1577 (2000).} Enforcement of the Harrison Act “stigmatized medication-assisted treatment as well as the patients who received such care.”\footnote{Weber, supra note 24, at 56.} In short order, the practice of addiction maintenance disappeared.\footnote{See \textit{id} at 58–60 (“The American Medical Association issued a resolution in 1920 opposing ambulatory maintenance clinics and condemning the use of heroin, which sanctioned the further prosecution of physicians who continued to prescribe maintenance medication.” (footnote omitted)).}

By 1925, the last clinic had closed.\footnote{Id. at 60.} With the repeal of the Eighteenth Amendment in 1933,\footnote{Eighteenth Amendment, \textit{ENCYCLOPEDIA BRITANNICA}, https://www.britannica.com/topic/Eighteenth-Amendment [https://perma.cc/YU7R-R8CV].} there was, perhaps, some hope that the state might soften its approach to prohibition \textit{writ large}. To the contrary, federal officials, relieved of alcohol interdiction duties, were free to devote even more time and criminal justice energy to narcotics.\footnote{See HARI, supra note 15, at 40 (discussing Henry Smith Williams’ book “laying out . . . evidence that the entire policy of drug prohibition in America was a gigantic racket” and the “crackdown” was encouraged by organized crime).} Remarkably, there is even some suggestion that law enforcement pivoted hard to controlled substances at the urging of organized crime, which hoped to keep physicians out of the prescription business and thereby to dominate criminal markets for recreational drugs.\footnote{Id. at 40–41 (“Henry Smith Williams urged the public to ask: Why would gangsters pay the cops to enforce the drug laws harder? . . . Drug prohibition put the entire narcotics industry into their hands. Once the clinics were closed, every single addict became a potential customer and cash cow.”).}

In this way, our first federal drug war was an
act of aggression against doctors and patients. The doctor was the principal, the patient was his accessory, and both were made objects and subjects of prohibition and penology.

The government had its reasons, of course, to worry about unscrupulous physicians who indiscriminately dispensed opioids and other narcotics (just as authorities today have good reasons to worry about “pill mills”).61 There is a real concern about the diversion of prescription drugs into criminal markets.62 And the line is fine between treating and creating drug dependency. But criminal law is allergic to such fine distinctions. Thus, the Harrison Act replaced the physician’s armamentarium with the heavy weaponry of the criminal justice system. “The unfortunate consequence of this policy was to drive from the field of drug treatment not only the unethical ‘script doctor’ but the legitimate doctor as well.”63

III. INTERNATIONAL PUBLIC HEALTH EFFORTS

Beyond our borders, a number of cities and countries have, for some time, successfully provided free, uncontaminated, and comparatively safe narcotics to persons addicted to controlled substances. Closest to home, Vancouver has witnessed a grassroots campaign, undertaken by drug users—the Vancouver Area Network of Drug Users (VANDU)—to support and care for each other.64 VANDU initially established an underground supervised injection facility: a sterile medically staffed environment to which recreational users may bring drugs to consume in relative safety.65 And, as VANDU’s successes became apparent, it took its efforts mainstream.66 It pressured the municipality to declare a public health emergency and won the support of the city’s conservative mayor, Philip Owen.67 Thereafter, Vancouver opened Insite, the first licit drug-

61 See Quinn & McLaughlin supra note 44, at 594–95; see also infra notes 140–41 and accompanying text (discussing “pill mills”).
63 Quinn & McLaughlin, supra note 44, at 595.
66 HARI, supra note 15, at 200 (“Suddenly, VANDU was an international news story . . . from the BBC to the New York Times.”).
67 Id. at 200–02.
consumption safe site in North America.\textsuperscript{68} Drug users who brought their drugs to Insite were made safe in three ways: they were insulated from arrest and prosecution, they were given sterile injection equipment and other drug use paraphernalia, and they were supervised by medical professionals prepared to administer naloxone and oxygen as needed to reverse overdoses.\textsuperscript{69}

The results were transformative. To date, Insite claims to have reversed nearly 5000 overdoses without suffering a single overdose death.\textsuperscript{70} More than that, clean needles have kept injectable-drug users from transmitting communicable diseases, like HIV and hepatitis.\textsuperscript{71} And, as drug injectors have moved their habits—and their needles—indoors, quality of life in Vancouver’s formerly derelict Downtown Eastside has improved dramatically.\textsuperscript{72} Many heavy drug users have reduced or even ceased their drug use and have secured stable employment and housing.\textsuperscript{73} These results are in keeping with recent research, which traces addiction primarily to trauma and social isolation and only secondarily to chemical dependence.\textsuperscript{74} The current line is that “the opposite of addiction is connection,” and, by normalizing but still discouraging drug use, these international experiments have served to reconnect dependent drug users with their communities.\textsuperscript{75}

\textsuperscript{68} Id. at 202–03.

\textsuperscript{69} Lopez, \textit{infra} note 76 and accompanying text.

\textsuperscript{70} JoNel Aleccia, \textit{As Seattle Eyes Supervised Drug-Injection Sites, Is Vancouver a Good Model?}, \textsc{Seattle Times}, \url{https://www.seattletimes.com/seattle-news/health/is-vancouver-safe-drug-use-site-a-good-model-for-seattle/} (last updated May 22, 2017, 1:00 PM).


\textsuperscript{72} See Evan Wood et al., \textit{Changes in Public Order After the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users}, 171(7) \textsc{Canadian Med. Ass’n. J.} 731, 733 (2004) (“Our observations suggest that the establishment of the safer injecting facility has resulted in measurable improvements in public order, which in turn may improve the liveability of communities and benefit tourism while reducing community concerns stemming from public drug use and discarded syringes.”). Notably, between 1996 and 2006, life expectancy in the Downtown Eastside rose by several years. Sam Cooper, “I Don’t Want to Die Here”: Residents Buoyed by Stats Showing People in Poorest Area Living Longer, \textsc{Province} (Sept. 7, 2012). Easy access to clean needles would seem to be an obvious factor contributing to increased longevity in the area. \textit{Id.}

\textsuperscript{73} See DRUG POL’Y ALLIANCE, \textit{infra} note 201 (describing Canadian “opiod-maintenance therapy” that has “decreased drug use and crime”).

\textsuperscript{74} HARI, \textit{supra} note 15, at 170–75; \textit{infra} notes 112–13 and accompanying text (discussing the environmental theory of addiction).

But, ultimately, the safe site was not enough to serve effectively the needs of drug-affected Vancouver communities. Thus, the city opened the Providence Crosstown Clinic, which operates on a genuine addiction maintenance model. At Crosstown, staff provide addicts with medical-grade heroin in a supervised setting with care sometimes paid for by Health Canada (the country’s national public healthcare provider). The program reaches the very individuals that criminal legal systems label repeat offenders. Indeed, many participants previously have cycled through Canadian jails and prisons—to no avail. Out of desperation and as a last resort, the city turned to free heroin, making patients out of run-of-the-mill recidivists. At Crosstown—and contrary to the prevailing ideology of punishment—recidivism is no mark of blameworthiness; rather, it is the price of admission. Pharmaceutical-grade heroin is made available to patients for whom all other interventions have failed, such as medication-assisted therapy with methadone, buprenorphine, or suboxone.

The aim is palliative care. First, harm is reduced to the opioid-dependent person by providing clean needles in a clinical setting and drugs of predictable quality, unadulterated by more toxic substances like fentanyl. Second, harm is reduced to the public by minimizing the incentives of drug seekers to commit property and violent crimes to feed drug habits. The operating philosophy is not American-style prohibition and use reduction. To the contrary, there is little expectation that habitual users will even taper in the near future. The idea is to transform the heavy drug user into a functional and socially productive individual who need not spend every waking moment evading law enforcement to furtively score and use illicit substances of unknown purity, potency, and provenance. To that end, the clinic offers additional services, like social

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77 Id.
78 Id. (discussing a Crosstown patient who served time in prison for robberies committed to feed a drug habit).
79 Id.
80 Id. ("These patients are the people for whom other treatments have failed. It’s a last resort. And it works."); cf. Josh Bowers, What If Nothing Works? On Recidivism, Crime Licenses, and Public Health (unpublished manuscript) [on file with Ohio State Law Journal] (reexamining recidivism through a public health lens).
81 Lopez, supra note 76.
82 See generally id.
83 Id.
84 Id.
85 See supra note 17 and accompanying text (comparing harm reduction and use reduction approaches).
86 See generally Lopez, supra note 76 ("But we don’t arbitrarily say, ‘Okay, you’ve been with us for six months. It’s time to reduce your dose.’ There’s a study out of Belgium—they have injectable treatment there—that shows if you just arbitrarily stop people, they will go back to using illicit opioids.").
87 Id.
workers and other health care and treatments, designed to help participants maintain social connections and construct lives of meaning, even as participants remain drug dependent.88

Vancouver’s efforts built upon those of a collection of mainly European countries that also have fashioned innovative harm reduction interventions, including the establishment of addiction maintenance programs. Dating back to the 1980s, the city of Liverpool, England experimented with prescription “heroin reefers”—cigarettes soaked in heroin.89 Although few data were developed or kept, a police study showed that criminal convictions for drug-addicted persons dropped from 6.88 convictions per individual in the eighteen months prior to enrollment, to only 0.44 convictions in the eighteen months thereafter.90

Likewise, Switzerland opened addiction maintenance clinics in the 1990s.91 Today, there are twenty-three of these clinics treating over two thousand heroin dependent persons.92 Predictably, the country has enjoyed a marked decline in communicable diseases, as well as drops in incidences of crimes associated with drug use.93 And the percentage of participants with full-time employment has tripled, while dependence upon welfare has declined dramatically.94 In turn, harm reduction efforts have grown in popularity. In 2008, sixty-eight percent of voters approved a measure to incorporate addiction maintenance into the country’s official health policy.95

Portugal has implemented even more ambitious harm reduction measures, and it has achieved even greater success. By the end of the last century, a staggering (and depressing) one percent of Portugal’s population was hooked on heroin.96 In 2001, the government decriminalized possession and use (but not

88 See Lopez, supra note 76.
89 HARI, supra note 15, at 210.
93 See, e.g., HARI, supra note 15, at 221 (noting drop in HIV infections caused by injection drug use from sixty-eight to five percent); Joanne Csete & Peter J. Grob, Switzerland, HIV and the Power of Pragmatism: Lessons for Drug Policy Development, 23 INT’L J. DRUG POL’Y 82, 84 (2012) (noting drop in hepatitis infections caused by injection drug use from fifty-one to ten percent); Denis Ribeaud, Long-Term Impacts of the Swiss Heroin Prescription Trials on Crime of Treated Heroin Users, 34 J. DRUG ISSUES 163, 173 (noting fifty percent reduction in vehicle thefts among participants).
94 HARI, supra note 15, at 222.
95 KREIT, supra note 16, at 740.
sale) of all drugs and invested heavily in treatment and social services.\textsuperscript{97} A decade later, Portuguese rates of drug use remained relatively high but stable, but rates of hard drug use declined.\textsuperscript{98} And, more to the point, drug-related HIV infections plummeted \textit{over ninety percent} and overdose deaths fell \textit{eighty-five percent}—to the lowest death rate in Western Europe and \textit{one-fiftieth} the rate in the United States.\textsuperscript{99} As Nicholas Kristof remarked: “Portugal may be winning the war on drugs—by ending it.”\textsuperscript{100}

IV. HOW, WHEN, AND WHY ADDICTION MAINTENANCE WORKS

Why have these international efforts proven so successful? For one thing, they are finely targeted to the challenges facing dependent drug users and are designed deliberately to help those users at critical moments. Heroin and other opioids are prescribed only after misguided and coercive penology has failed miserably.\textsuperscript{101} Moreover, addiction maintenance promotes safety: the drugs must be consumed on site—in comfortable but sterile settings with well-equipped medical personnel on hand, thereby minimizing risks of death and the diversion of opioids into criminal markets.\textsuperscript{102} Finally, these efforts are oriented in the right way—against the logic of prohibition.\textsuperscript{103} The operating philosophy, here, is that a criminal war on drugs is destructive.\textsuperscript{104} Isolation and othering produce

\textsuperscript{97}See id.

\textsuperscript{98}HARI, supra note 15, at 249.


\textsuperscript{100}Kristof, supra note 99. Uruguay, Belgium, Germany, Sweden, and the Netherlands have undertaken similar harm reduction reforms with similarly promising results. See, e.g., HARI, supra note 15, at 264–73; Shirley Haasnoot, \textit{Dutch Drug Policy, Pragmatic As Ever}, GUARDIAN (Jan. 3, 2013), https://www.theguardian.com/commentisfree/2013/jan/03/dutch-drug-policy-pragmatic [https://perma.cc/99F4-ZPEH].

\textsuperscript{101}See, e.g., Lopez, supra note 76.

\textsuperscript{102}Id.

\textsuperscript{103}Lopez, supra note 76; see Harry G. Levine & Craig Reinarman, \textit{From Prohibition to Regulation: Lessons from Alcohol Policy to Drug Policy}, 69 MILLBANK Q. 461, 464 (1991).

antisocial behavior. And blame and shame—coins of the criminal justice realm—produce isolation and othering.

Again, the goal of addiction maintenance is harm reduction—a reduction in the harms that flow from criminal drug markets, from infectious diseases, from overdoses, and from criminal enforcement and punishment. And, because addiction maintenance is an intervention of last resort (not unlike “heroic” measures in medicine), it promises to reduce harm most for the most dependent users.

And, even though addiction maintenance is intended only to provide palliative care, there is some evidence that—under the right circumstances—it reduces overall drug use. This would seem counterintuitive, of course. How could it be that free access to opioids might help dependent users get clean? Appreciate, first, the context in which drugs are most often abused. The environmental theory of addiction insists that pharmacology is only secondarily related to dependence. Chemicals have physiological effects to be sure, but plenty of drug users (so-called “chippers”) maintain relative free will to ingest (or not) without becoming dependent. Indeed, the vast majority of persons

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106 Cf. JOEL FEINBERG, DOING AND DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY 98 (1970) (defining punishment as “‘hard treatment’ with a ‘reprobative function’.”).

107 See, e.g., Julia Lowe Behr, Methadone Maintenance Therapy for Opioid Addiction, Clinician Reviews (June 18, 2008), https://www.medge.com/clinicianreviews/article/72298/pain/methadone-maintenance-therapy-opioid-addiction [https://perma.cc/9QST-CM8E] (noting that chippers are “able to regulate their intake so that their drug use does not interfere with other aspects of their life”); Stephen J. Morse, Hooked on Hype: Addiction and
who try even hard drugs manage to avoid dependence. A small subset develop powerful compulsions, but the question of when and whether these compulsions take hold may turn more on an individual’s life circumstances than the chemical composition of the drug.

This is the environmental theory of addiction. Consider the many heroin-dependent American soldiers fighting in Vietnam who readily gave up the substance once they returned home safely. These men self-medicated against the horrors of war but were able to alter their behavior once the context had changed. More to the point, consider a series of animal studies. In an early set of studies, rats were placed alone in cages with food, water, and cocaine drips. In short order, most rats abandoned their food and water and fixated on the cocaine, consuming copious amounts until death. At first blush, the studies seemed to demonstrate the intensity of chemical hooks. But, decades later, social scientists replicated the studies with a clever twist: several rats were housed together in nurturing environments, not in isolation in sterile cages; they were given ample opportunities to interact and socialize. These rats still experimented with the cocaine, but not to excess and less so over time. Like the drug dependent soldiers in Vietnam, the first set of rats were self-medicating against the pain and loneliness. The second set enjoyed meaningful lives. They had less desire or compulsion to fill the void with self-harm.

Now, consider the life of a drug user suffering under punitive prohibition. Hers is an often miserable existence. She hides from a surveillance state—in the shadows and on the margins—devoting her mental and physical energy to unlawful projects in service of her habit. She furtively seeks and finds product of dubious quality, quantity, and safety. She lacks the resources and support to chart a healthier and more productive path. The effect is criminogenic.


114 See Bowers, supra note 113, at 801.
115 See, e.g., HARI, supra note 15, at 171–73 (discussing rat studies that demonstrated how environment shapes dependency and comparing the results to findings on declining drug use among soldiers returning from Vietnam).
116 Id.
117 Id. at 173.
118 Id.
119 Id. at 171–73.
120 Id.
121 HARI, supra note 15, at 171–73.
122 Id.
123 Id. at 172–73.
124 Id.
125 Id. at 172. On this logic, it is easier to understand also how people become addicted even to habits that feature no internal chemical hooks—gambling or pornography, for instance. These habits are likewise driven by context. To be sure, internal brain chemistry impacts the degree to which an individual engages compulsively in even nonchemical habits. But environmental factors, in turn, shape the way in which an individual’s brain chemistry operates.
According to Gabor Maté, a doctor specializing in childhood trauma and addiction:

If I had to design a system that was intended to keep people addicted, I’d design exactly the system that we have right now . . . I’d attack people, and ostracize them . . . the more you stress people, the more they’re going to use. The more you de-stress people, the less they’re going to use. So to create a system where you ostracize and marginalize and criminalize people, and force them to live in poverty with disease, you are basically guaranteeing they will stay at it.\textsuperscript{126}

Doctor Maté has been criticized for overstating the influence of isolation and trauma, while underplaying pharmacological effects.\textsuperscript{127} But the Vancouver and European experiences suggest strongly that the isolation and trauma created by prohibition are causing substantial harm.\textsuperscript{128} When these governments abandoned blame and shame, and focused instead on eliminating barriers to drug acquisition, drug users were better able to focus on self-improvement.\textsuperscript{129} Their ties to family, community, education, and employment were strengthened (or at least left intact).\textsuperscript{130} Thus, for instance, a \textit{Lancet} study found that the majority of participants in Switzerland’s addiction maintenance clinics were able to pivot eventually to methadone or abstinence programs.\textsuperscript{131} Moreover, as Vancouver’s Downtown Eastside discovered, fewer people are likely to become drug dependent in the first instance once a neighborhood’s quality of life improves—that is, once the social environment gets better.\textsuperscript{132}

\textsuperscript{126}Id. at 166. \textit{See generally} id. at 155–67 (discussing Gabor Maté’s work).
\textsuperscript{128}\textit{See}, e.g., Aleccia, \textit{supra} note 70; Faure, \textit{supra} note 92.
\textsuperscript{129}\textit{See}, e.g., Lopez, \textit{supra} note 76.
\textsuperscript{130}\textit{See id.}
\textsuperscript{131}\textit{REUTER}, \textit{supra} note 18, at 3; \textit{see also} \textit{HARI}, \textit{supra} note 15, at 221–22 (discussing how in Switzerland “[t]he number of addicts dying every year fell dramatically” after the clinics opened).
\textsuperscript{132}\textit{See supra} notes 71–73 and accompanying text (describing Vancouver’s harm reduction interventions, improvements in quality of life, and reductions in drug use). This last point sounds in the “broken-windows” theory of policing. \textit{See} Josh Bowers, \textit{Grassroots Plea Bargaining}, 91 MARQ. L. REV. 85, 94 (2007). In practice, that theory has been criticized (and rightly so) for morphing into policies of mandatory arrest and zero-tolerance for public order crimes. \textit{See id.} at 95–96. But, at least in its initial formulation, the theory emphasized flexibility and problem solving—improving quality of life by many means (only one of which was arrest), in an effort to reduce harm and cultivate socially productive norms and conduct. \textit{Id.} at 94 (“In its initial incarnation, proponents of the broken-windows theory . . . believed that the policy worked best by decentralizing police response to public disorder to increase enforcement flexibility and effectiveness. Implementation turned on providing police ample discretion . . . ”) (internal citations omitted). \textit{See generally} George L. Kelling & James Q. Wilson, \textit{Broken Windows}, \textit{ATLANTIC} (Mar. 1982), https://www.the
The conclusion is inescapable. Addiction need not be a terminal condition. And, for the most dependent, the most promising treatment may just be to feed the habit.133 If nothing else, addiction maintenance facilitates the process known as “aging out.”134 Heavy drug abuse and other risk-taking behaviors concentrate in populations of young adult men.135 As the individual matures, he tends to use less.136 (The reader need look no further than the acquaintance who drinks less now than he did in high school or college.) And the more stable a person’s life is, the likelier he is to “age out” more quickly.137 The takeaway is obvious (even if often ignored): sometimes the best approach is patience—to wait out drug dependence, and, in the interim, to minimize the damage done to the individual and his social network.

This is what addiction maintenance programs are designed to achieve. They try to keep the hopeless addict alive, relatively healthy, and socially integrated long enough to navigate, eventually, to the other side of the age divide—to steer clear of the most destructive and deadly byproducts of punitive prohibition.138

V. THE LEVIATHAN

But isn’t the current opioid crisis a product of a prescription market and model? Drug manufacturers pushed opioids on doctors.139 And “pill mills”—the pharmacies and physicians who overprescribed and over-dispensed

atlantic.com/magazine/archive/1982/03/broken-windows/304465/  [https://perma.cc/3PVD-ZRP7].

133 Gavin Bart, Maintenance Medication for Opiate Addiction: The Foundation of Recovery, 31 J. ADDICTIVE DISEASES 207, 207 (2012) (“Results indicate that maintenance medication provides the best opportunity for patients to achieve recovery from opiate addiction.”).


136 See, e.g., Szalavitz, supra note 134.

137 Id.; see, e.g., HARI, supra note 15, at 171–73.

138 HARI, supra note 15, at 212 (“Most addicts will simply stop, whether they are given treatment or not, provided prohibition doesn’t kill them first.”); RICHARD LAWRENCE MILLER, THE CASE FOR LEGALIZING DRUGS 53 (1991) (“Researchers have found chronological age to be a prevalent reason for drug abuse. Abuse is typically a young person’s habit, given up as the individual matures. Most opiate addicts relinquish their drug within 10 years.” (footnote omitted)).

medications—pushed opioids on patients. In short, America already has subscribed to a drug-licensing regime, and it led primarily to lives ruined and families and communities splintered. If prescriptions and addiction maintenance are so promising, what went so wrong?

The short answer is that recent American experience cannot be understood as addiction maintenance. Under addiction maintenance, opioid users who have failed to respond to other kinds of treatment, including methadone maintenance, are admitted into medically supervised clinics and provided pharmaceutical-grade narcotics in amounts calibrated to maintain their social and physical well-being. The American approach is, in fact, the opposite of addiction maintenance. Our prevailing licensing regime permits doctors to prescribe opioids only until patients become dependent.

A recently passed Michigan statute captures the ethos, defining “good faith” practice as “the prescribing or dispensing of a controlled substance in the regular course of professional treatment . . . for a pathology or condition other than that individual’s physical or psychological dependence upon or addiction to a controlled substance.” Once patients get hooked, the American criminal justice takes precedence, displacing “individualized medicine” and patient-centered care with the protocols of mandatory tapering and cessation.

The logic seems simple enough—fewer pills prescribed corresponds with less use by the drug dependent. And, indeed, prescription opioid use has dropped

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140 Pia Malbran, What’s a Pill Mill?, CBS NEWS (May 31, 2007, 6:01 PM), https://www.cbsnews.com/news/whats-a-pill-mill/ (“Pill mill” is a term used primarily by local and state investigators to describe a doctor, clinic or pharmacy that is prescribing or dispensing powerful narcotics inappropriately or for non-medical reasons.).

141 See, e.g., CNN Wire Service, 10 People Died of Overdoses Within 26 Hours in 1 Ohio County, FOX6 NOW (Sept. 30, 2019), https://fox6now.com/2019/09/30/10-people-died-of-overdoses-within-26-hours-in-one-ohio-county/ (“As of about 10 a.m. this morning we have had 10 people die of overdoses in about 26 hours . . . .”).

142 See Lopez, supra note 76.

143 See H. Westley Clark & Karen Lea Sees, Opioids, Chronic Pain, and the Law, 8 J. PAIN & SYMPTOM MGMT. 297, 299 (1993) (“When a physician writes an opioid prescription, care must be taken to determine whether the person is an addict.”).


dramatically in recent years.\textsuperscript{146} Prescriptions peaked in 2012 and have fallen since.\textsuperscript{147} In 2017 alone, they plummeted ten percent, the sharpest decline in a quarter century.\textsuperscript{148} But current enforcement efforts have succeeded only in minimizing prescription drug use and the diversion of prescription drugs into illicit markets.\textsuperscript{149} At the same time, prescription drug users have been redirected into those same markets—markets characterized by crime and death, prosecution and punishment.\textsuperscript{150} Put simply, a downtick in prescription drug availability translates into an uptick in street-level demand for street-manufactured drugs.\textsuperscript{151} Criminal buyers replace patients.\textsuperscript{152} Syringes replace pills.\textsuperscript{153} Laced heroin replaces pharmaceutical-grade opioids.\textsuperscript{154} According to Johann Hari:

If I am an American who has developed an Oxycontin addiction, as soon as my doctor realizes I’m an addict, she has to cut me off. She is allowed to prescribe to treat only my physical pain—not my addiction. . . . That’s when, in desperation, I might hold up a pharmacy with a gun, or go and buy unlabeled pills from street dealers. Most of the problems attributed to prescription drugs in the United States . . . begin here, when the legal, regulated route to the drug is terminated. . . . the prescription drug crisis doesn’t discredit legalization—it shows the need for it.\textsuperscript{155}

\textsuperscript{146}Art Levine, The Government’s Solution to the Opioid Crisis Feels Like a War to Pain Patients, HUFFPOST (July 31, 2018), https://www.huffpost.com/ [https://perma.cc/5WJN-VAC5] (search in search bar for “Art Levine opioid”; then follow “The Government’s Solution” hyperlink); see U.S. Opioid Prescribing Rate Maps, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html [https://perma.cc/C98R-7ZLS].

\textsuperscript{147}U.S. Opioid Prescribing Rate Maps, supra note 146.

\textsuperscript{148}Levine, supra note 146.

\textsuperscript{149}Darius Tahir, Databases Key to Trump’s Crackdown on Opioids, POLITICO (June 29, 2018), https://www.politico.com/story/2018/06/29/databases-key-crackdown-on-opioids-686879 [https://perma.cc/QA45-CNET].

\textsuperscript{150}See id.

\textsuperscript{151}See id.

\textsuperscript{152}Id. ("[T]here’s evidence that thousands of prescription users cut off by fearful doctors are turning to these dangerous street drugs, or being left to suffer. Many addicted patients end up in legal trouble before they are offered help.").

\textsuperscript{153}See Prescription Opioids, NAT’L INST. ON DRUG ABUSE, https://www.drugabuse.gov/publications/drugfacts/prescription-opioids [https://perma.cc/XAA3-24XY] (last updated June 2019) ("In some places, heroin is cheaper and easier to get than prescription opioids, so some people switch to using heroin instead.").


\textsuperscript{155}HARI, supra note 15, at 226.
The data bear out Hari’s claims. Even as opioid prescriptions have plummeted, opioid-linked deaths have skyrocketed. The economics of the street trade produce unreliable doses that fluctuate in quality between exceptionally weak and strong. One dealer may find it profitable to dilute a batch and sell more. Another dealer may cut costs by adding cheap fentanyl—an extremely potent and highly lethal synthetic opioid for which even seasoned opioid users may lack tolerance. More to the point, a given dealer may not even be aware of the purity and potency of their own unlabeled and unregulated product. And comparatively milder prescription drugs, which were so plentiful on pharmacy shelves, are often just too expensive and bulky for street-level sellers to keep in stock.

Recent so-called reform efforts have made the problem only worse. The current war on opioids is, like the first war on drugs, a war on physicians. In the words of former Attorney General Jeff Sessions: “[W]e’re going to target those doctors.” In January 2018, the Drug Enforcement Administration (DEA) initiated a “surge” in efforts to shut down pill mills. The next month, the Justice Department started a task force to go after manufacturers and distributors. According to a press release: “The Department will . . . use all


157 Levine, supra note 146 (describing rise in opioid deaths); Tahir, supra note 149.

158 What Is Heroin, supra note 154.

159 Id. (“[D]rug dealers will add other drugs or non-intoxicating substances to the drug so they can sell more of it at a lesser expense to themselves.”).


161 See What Is Heroin, supra note 154.

162 See HARL, supra note 15, at 231. According to Johann Hari: “On the streets, Oxy is three times more expensive than heroin—way beyond the price range of most addicts. . . . Just as when all legal routes to alcohol were cut off, beer disappeared and whisky won, when all legal routes to opiates are cut off, Oxy disappears, and heroin prevails. This isn’t a law of nature . . . [it’s] drug policy.” Id.

163 See Nedelman, supra note 139.

164 McCoy, supra note 156.

165 Levine, supra note 146 (internal quotations omitted).

criminal and civil tools at its disposal to hold distributors such as pharmacies, pain management clinics, drug testing facilities, and individual physicians accountable for unlawful actions...to prevent diversion and improper prescribing.”

In March, the administration announced plans to cut opioid prescriptions by a third within three years, and the DEA initiated new drug-production quotas, ultimately producing dramatic opioid shortages. In June, Sessions announced charges against 162 individuals for crimes related to prescribing and distributing prescription opioids. And, even before this recent crackdown, the DEA had increased actions against doctors from 88 in 2011 to 479 in 2016.

Nor is the escalation and crackdown unique to federal law enforcement. The Center for Disease Control (CDC) has promulgated its own guidelines for prescribing higher dosages. Initially, the CDC implemented these guidelines as recommendations only, but several states and medical boards have enacted their own statutory and regulatory limits to fit within the CDC guidelines.

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167 Id.
168 See Levine, supra note 146.
169 See Attorney General Jeff Sessions, Attorney General Sessions Delivers Remarks Announcing National Health Care Fraud and Opioid Takedown (June 28, 2018), https://www.justice.gov/opa/speech/attorney-general-sessions-delivers-remarks-announcing-national-health-care-fraud-and [https://perma.cc/Y7VX-5N43] (“In this latest operation, with the help of our fabulous partners at HHS, we have charged another 162 people—including 32 doctors—with the illegal distribution of opioids.”).
170 Nedelman, supra note 139.
Likewise, public and private insurers have imposed their own tapering protocols.\textsuperscript{173} In turn, physicians have changed practices or gotten out of the business altogether. Consider the DEA’s pursuit of Dr. Forest Tennant, a prominent California physician, who faced criminal investigation for atypical prescribing.\textsuperscript{174} Tennant specialized in severe, chronic pain and was world-renowned for palliative care, often at the end of life.\textsuperscript{175} He had evidence-based reasons for prescribing such large quantities of opioids.\textsuperscript{176} Nevertheless, law enforcement successfully pushed Tennant into early retirement, leaving his patients to suffer without effective pain management.\textsuperscript{177}

This is over-deterrence in action—just another example of the manner by which punitive prohibition chills socially valuable conduct at the margins.\textsuperscript{178}
Indeed, in some states, the wait to see a qualified pain management specialist has increased to a year or longer. And it stands to reason that the ethical doctor may be dissuaded most: because they are comparatively risk averse, they may overcorrect to steer well clear of criminal justice. Moreover, they are likelier to be aware of (and comply with) the heightened recordkeeping requirements that law enforcement uses to trawl for targets. At a certain point, it’s just not worth the effort. As one primary care doctor put it: “I will no longer treat chronic pain. Period . . . . There is too much risk involved.”

VI. KICKING THE HABIT

Meaningful domestic drug reform (as modest as it has been) has only ever arisen from the bottom-up and against the grain. Take the example of syringe exchanges. Starting in Europe in the 1980s, activists experimented with exchanges as a response to the deadly epidemic of HIV/AIDS. American reformers took note. But federal and state governments worked actively against initiatives. The Drug Enforcement Administration, for example, had previously promulgated the Model Drug Paraphernalia Act, which provided a template for forty-six states to criminalize the manufacture, possession, or distribution of drug paraphernalia, broadly defined. Moreover, the federal government refused to fund syringe exchanges until they were proven “safe and effective” (and, of course, it refused also to fund research into the question). Indeed, Senator Jesse Helms “equated” any public effort to implement a syringe exchange as government-supported drug abuse. Nevertheless, activists nationally that has reduced the number of doctors willing to prescribe opioids and has left patients already dependent on them in the lurch.

180 See Nedelman, supra note 139.
181 See Tahir, supra note 149.
182 Ehley, supra note 178.
183 See Don C. Des Jarlais, Harm Reduction in the USA: The Research Perspective and an Archive to David Purchase, 14 HARM REDUCTION J. 1, 3 (2017).
184 See id. at 3–4.
185 Scott Burris et al., The Legal Strategies Used in Operating Syringe Exchange Programs in the United States, 86 AM. J. PUB. HEALTH 1161, 1161 (1996) (describing the Model Drug Paraphernalia Act as prohibiting “any equipment, product, or material of any sort, including hypodermic needles and syringes, intended to be used to introduce illicit or controlled substances into the body”).
186 Des Jarlais, supra note 183, at 3; see also 42 U.S.C. § 300ee-5 (1988) (“None of the funds provided under this Act . . . . shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.”).
persisted in doing what they could, typically underground. And, over time, some mainstream stakeholders even began to buy in. Ultimately, a number of municipal and state authorities authorized syringe exchange programs, maneuvering politically and legally to prevent pushback. By 2015, even the federal government had lifted its funding ban—albeit only partially and more than a quarter century too late. Overall, reform efforts proved successful, but only from the outside-in.

Take also the example of medical cannabis. Today, a majority of states have enacted laws permitting at least some form of medical use. But these statutory public health interventions were slow in coming, even though, as early as the 1970s, it already was well established that cannabis could quell cancer patients’ nausea and stimulate their appetites. Indeed, by the early 1990s, patients and advocates had raised awareness that cannabis also could alleviate suffering from other illnesses and afflictions—glaucoma, AIDS-related wasting syndrome, epilepsy, neuropathic pain, and the side effects of ingesting certain drug cocktails.

Nevertheless, the federal government remained intransigent. Even today, the Controlled Substances Act classifies marijuana as a Schedule I drug—a substance purported to have no medical use and a high potential for abuse. Simply put, federal law criminalizes cannabis—almost anytime, anywhere, for anyone. Still, activists found a way to build a grassroots political movement

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190 Id.
195 21 U.S.C. § 812(c)(10) (2018); see also All. for Cannabis Therapeutics v. DEA, 15 F.3d 1131, 1134–35 (D.C. Cir. 1994) (upholding DEA order maintaining Schedule I classification); Kreit & Marcus, supra note 194, at 961.
around medical cannabis, establishing a collection of underground dispensaries.\textsuperscript{197} Municipalities and states began to follow their lead, but, at first, only by citizen-initiated resolutions and referenda.\textsuperscript{198} Policymakers only found the courage to act once the issue of medical cannabis had become obviously expedient.\textsuperscript{199} Until then, the path to meaningful reform was direct democracy and direct action—below and around the apathy and even outright hostility of elected legislators.

To these examples, we could add the drug court movement, which now boasts over two thousand courts currently operating nationwide.\textsuperscript{200} In the interest of full disclosure, we should make clear that the authors are deeply skeptical of the ability of drug courts to provide appropriate treatment and to function effectively as an alternative to incarceration (much less to avoid the collateral harms of the drug war).\textsuperscript{201} More to the point, the drug court model embraces and perpetuates a prohibitionist and coercive paradigm of abstinence that we believe is misguided. The movement operates within criminal justice, retaining the threat of punishment as a backstop for the noncompliant offender.


\textsuperscript{199} Erwin Chemerinsky et al., \textit{Cooperative Federalism and Marijuana Regulation}, 62 UCLA L. REV. 74, 84–86 (2015) (summarizing the spread of state medical marijuana laws); see, \textit{e.g.}, S.B. 119, 2008 Leg., 213th Sess. (N.J. 2009) (justifying medical marijuana legislation in New Jersey based on the growing number of states legalizing medical marijuana). See \textit{generally} Heller, \textit{supra} note 197 (describing the gradual increase in stakeholder support for a medical marijuana ballot initiative).

\textsuperscript{200} Bowers, \textit{supra} note 113, at 784.

\textsuperscript{201} As both authors have examined elsewhere, court-imposed treatment depends upon a logical and normative flaw: the more typical drug court graduate is the least compulsive user; the genuinely addicted drug user, by comparison, is likelier to fail out and face a draconian termination sentence—a jail or prison sentence longer, perhaps, than even traditional drug penalties. Daniel N. Abrahamson, \textit{The Substance Abuse and Crime Prevention Act of 2000: The Parameters and Promise of Proposition 36}, CAL. CRIM. DEF. PRAC. REP. 535, 536 (2001); Bowers, \textit{supra} note 113, at 789, 792–98; Daniel N. Abrahamson, \textit{Drug Courts are Not the Answer: Guest Commentary}, L.A. DAILY NEWS, https://www.dailynews.com/2015/05/12/drug-courts-are-not-the-answer-guest-commentary/ [https://perma.cc/J4DN-BNAX] (last updated Aug. 28, 2017, 7:03 AM). See \textit{generally} \textit{Drug Courts are Not the Answer: Toward a Health-Centered Approach to Drug Use}, DRUG POLICY ALL. (2011), http://www.drugpolicy.org/drugcourts [https://perma.cc/6TWJ-B6CW] [hereinafter \textit{Drug Courts are Not the Answer}]. For the genuinely addicted offender, court-mandated treatment typically provides only a brief respite from the traditional criminal justice cycle of capture, conviction, and incarceration. See \textit{id}.
participant.\textsuperscript{202} Disappointingly, but perhaps unsurprisingly, many leading drug court advocates have tended, therefore, to publicly oppose more ambitious drug policy reform:\textsuperscript{203} decriminalization of cannabis,\textsuperscript{204} even for medical use;\textsuperscript{205} reduction of felony possession offenses to misdemeanor or noncriminal offenses;\textsuperscript{206} and acceptance of (and reliance upon) medication-assisted treatments.\textsuperscript{207}

But, putting these criticisms aside, the immediate point is only that the drug court movement has followed the familiar path. Its origins can be traced to a small handful of ground-level advocates (in this case, local judges and law enforcement) who could no longer countenance the most egregious excesses of the drug war (\textit{to wit}, lengthy jail and prison sentences for low-level, nonviolent drug offenders).\textsuperscript{208} With no other viable option, these officials began to experiment, first quietly, then vocally, with alternative judicial interventions intended to avoid draconian penalties for chemically dependent persons.\textsuperscript{209}

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\textsuperscript{202} Bowers, \textit{supra} note 113, at 792 ("[S]tudies found that the sentences for failing participants in New York City drug courts were typically two-to-five times longer than the sentences for conventionally adjudicated defendants.").
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\textsuperscript{203} It should be noted, however, that a small but growing minority of drug court treatment programs are not abstinence-only programs, and embrace medication-assisted treatment. Significantly, one of our symposium co-participants, the Honorable Fred Moses, is a drug court judge who runs an innovative (and welcome) medication-assisted treatment program. Spencer Remoquillo, \textit{Judge Touts Success in Vivitrol Drug Court}, CHILlicothe Gazette (Sept. 5, 2015, 12:02 PM, https://www.chillicothegazette.com/story/news/crime/high-in-ohio/2015/09/05/judge-touts-success-vivitrol-drug-court/71719850/ [https://perma.cc/Y54B-66NV]). Of course, the program remains court-mandated, but we welcome its healthy rejection of an abstinence-only approach.
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\textsuperscript{207} See Jeannette Pferr, \textit{Medication-Assisted Treatment: A Solution or a Substitution}, IBH NEWS (Feb. 6, 2018), https://ibhsolutions.com/blog/medication-assisted-treatment/ [https://perma.cc/N6BK-SDNA].
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\textsuperscript{209} Michael C. Dorf & Charles F. Sabel, \textit{Drug Treatment Courts and Emergent Experimentalist Government}, 53 VAND. L. REv. 831, 841–43 (2000) (discussing development of Miami-Dade drug court, which was spearheaded by officials who "actively
Let us return, now, to the subject of this symposium—the opioid epidemic. Until relatively recently, federal and state laws largely stymied persons who use opioids and their peers and family members from preemptively gaining access to naloxone, an opioid antagonist, which reverses overdoses. Naloxone (trade-name Narcan) is called the “Lazarus” drug for good reason: injecting naloxone into a person’s bloodstream revives the sufferer by counteracting respiratory distress. For a long time, however, possession of naloxone was limited principally to emergency medical technicians and emergency room doctors and nurses. Thus, its benefits could reach only those overdose victims who lived long enough to see the inside of an ambulance or hospital.

Technically, some physicians still could prescribe naloxone, but any such efforts were resisted by public officials, law enforcement, and even many within the medical community. In a classic example of retrograde use reduction reasoning, opponents of the Lazarus drug relied upon the specious argument that ready access to naloxone would encourage opioid users (antidote in hand) to use drugs more often and more recklessly.

sought more effective alternatives to incarceration,” and describing subsequent diffusion of this model to other localities).


215 Doleac & Mukherjee, supra note 214, at 1, 36 (“There is a concern, however, that widespread access to the safety net drug can unintentionally increase riskier opioid use and its related problems.”).
anyone who has encountered the inane claim that giving contraceptives to teens induces promiscuity. Here, as there, it is far better to minimize bad outcomes than it is to preach unrealistic abstinence. Naloxone is neither an addictive nor mind-altering chemical compound. It is incapable of recreational abuse. It is, first and foremost, a lifesaver. To withhold it is to endorse the view that the wages of sin are death by overdose.

Enter the street activists—men and women who rejected the illogic and fatalism of prohibitionist thinking. Piggybacking on the highly successful work of a syringe exchange program initiated by the Chicago Recovery Alliance, activists began distributing naloxone to syringe exchange clients and taught them how to administer naloxone to reverse an overdose. Days after distribution of the first naloxone vial, a “save” was recorded. Hundreds, then thousands of saves followed. Other syringe exchanges took note of the Chicago experiment, as did local public health departments.

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218 Id. (“Naxolone has no potential for abuse.”).

219 See id.


221 See id.


other communities began to distribute naloxone; thereafter, municipal and state-level law and policy reform followed.  

Four dynamics describe each of these drug policy reforms. First, until harm reduction interventions are well-established, public officials and law enforcement agents are typically part of the problem, not the solution. In each case, policymakers and professionals either initially opposed pragmatic harm reduction measures or stayed mum, fearing backlash. There are political and market forces at work. The enforcers of the drug war participate in a multibillion-dollar criminal justice industrial complex—just as drug traffickers participate (illicitly and licitly) in multibillion-dollar drug distribution and pharmaceutical industrial complexes. In each of these markets, there is a lot at stake. Criminal justice has its jail and prison cells; its paid prosecutors, judges, and police, probation, and corrections officers. The prescription drug industry has its drug representatives, scientific researchers, public relations professionals, and political lobbyists. Organized drug crime has its guns and safe houses; its gang members, foot soldiers, and street dealers. The pressure is tremendous to keep feeding the drug war machinery. No surprise, then, that institutional elites tend to make such bad insurgents.

Second, and relatedly, public health innovations typically start underground. For years—without any change in local, state, or federal law—sterile syringes were exchanged, medical marijuana was ingested, and naloxone was distributed and injected. If “Just Say No” is the mantra of the drug war, then the ethos of drug reform is Nike’s trademark, “Just Do It.” Grassroots activists have proven willing to risk everything—at first quietly, then

224 Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws, NETWORK FOR PUB. HEALTH L., https://www.networkforphl.org/_asset/qz5pvm/legal-interventions-to-reduce-overdose.pdf [https://perma.cc/4A3G-RFHW] (last updated Dec. 2018) (noting that while “community access to naloxone was historically limited by laws and regulations that pre-date the overdose epidemic,” by July 2017 “all fifty states and the District of Columbia have now modified their laws to increase access to naloxone”).

225 See supra note 214.

226 See id.


228 Keilman, supra note 220.

229 Heller, supra note 197.

230 Keilman, supra note 220.

231 Her Causes, supra note 12 (summarizing history of “Just Say No” campaign).

flagrantly—to defy an immoral system, by purposefully violating draconian drug laws.\textsuperscript{233} For these courageous—and justifiably outraged—advocates, saving lives is worth the gamble. More to the point, it’s often the only available bet against an all-powerful machine. Joseph William Singer once wrote: “What protects us against Nazism is not the belief that reason can prove that it is wrong. What protects us is outrage.”\textsuperscript{234} We don’t mean to equate the American-led war on drugs with fascism (though the two ideologies do share certain features), but rather to posit that sometimes the best way to respond to state-sponsored infliction of harm is to get angry, get hungry, stop talking, and start doing.

Third, if and when \textit{de jure} reform occurs, it often bubbles up from below. Long before legislators find the motivation or courage to enact statutes, city councilors and mayors declare states of emergencies—authorizing, for instance, syringe exchanges to combat HIV/AIDS.\textsuperscript{235} Local police and prosecutors exercise equitable discretion to look the other way when grassroots activists disobey criminal laws against the possession of naloxone.\textsuperscript{236} City officials use local initiatives to push law enforcement to deprioritize the criminal possession of small amounts of marijuana.\textsuperscript{237} And the public pass popular resolutions and referenda.\textsuperscript{238} Eventually, states may follow suit—but only after witnessing what has worked locally.

Fourth, all the while, the federal structure stays largely intact. Its orientation remains prohibition first. At best, federal officials may tolerate local experimentation. But the federal law remains criminal law—the Controlled

\footnotesize{\textsuperscript{233} Dorf & Sabel, supra note 209, at 841–43; Heller, supra note 197; Kirchner, supra note 208.}

\footnotesize{\textsuperscript{234} Joseph William Singer, \textit{The Player and the Cards: Nihilism and Legal Theory}, 94 YALE L.J. 1, 55 (1984).}

\footnotesize{\textsuperscript{235} See Burris, supra note 185, at 1164 (discussing approaches taken by Philadelphia, Cleveland, Los Angeles, and San Francisco).}

\footnotesize{\textsuperscript{236} See \textit{id.} at 1162, 1164 (observing that many early-adopter jurisdictions did not implement syringe exchange programs through legally authorized means but through community “acquiescence” and “negotiation” with law enforcement). See generally Ricky N. Bluthenthal et al., \textit{Impact of Law Enforcement on Syringe Exchange Programs: A Look at Oakland and San Francisco}, 18 MED. ANTHROPOLOGY 61 (1997) (comparing disparities in law enforcement against syringe exchange programs across neighboring municipalities during the 1990s). On equitable discretion, see generally Josh Bowers, supra note 11, at 1655.}


\footnotesize{\textsuperscript{238} Ross & Walker, supra note 237, at 242 tbl.1 and accompanying text; see, e.g., Curtis J. VanderWaal et al., \textit{State Drug Policy Reform Movement: The Use of Ballot Initiatives and Legislation to Promote Diversion to Drug Treatment}, 36 J. DRUG ISSUES 619, 624–26 (2006).}
Substances Act and other punitive statutes like it.\textsuperscript{239} Even today, federal support for syringe exchanges is largely passive\textsuperscript{240}—a marked improvement to be sure, but still nothing close to the full-throated support that this proven intervention deserves. Likewise, the federal government continues to oppose medical cannabis.\textsuperscript{241} And, perhaps more importantly, it continues to stifle medical cannabis research\textsuperscript{242} (thereby keeping technically true the hollow claim that the substance has no \textit{proven} medical benefits).\textsuperscript{243}

It is against this backdrop—and within this framework—that we should consider addiction maintenance. Addiction maintenance is more than a theoretical possibility; it is an historical and international reality.\textsuperscript{244} But, as a domestic practice, it remains far off. How far off is unclear. By nature, subterranean grassroots enterprises are hard to track. It could well be that an American addiction maintenance clinic is operating illegally already—either with a wink and nod from local officials, or completely underground. We hope that there is. The lives of heroin dependent persons rely upon access to pharmaceutical-grade heroin, instead of toxic street-corner junk.

More to the point, a precursor to the addiction maintenance clinic has already begun to find traction—the supervised injection facility, which does not supply drugs but provides a space for relatively safe consumption.\textsuperscript{245} Here, the familiar dynamics are playing out yet again. International experimentation

\begin{itemize}
\item \textsuperscript{239} See, \textit{e.g.}, \textit{The Controlled Substances Act}, U.S. DRUG ENFORCEMENT ADMIN., https://www.dea.gov/controlled-substances-act [https://perma.cc/9D6D-GHV8].
\item \textsuperscript{240} Victoria Knight, \textit{Needle Exchanges Find New Champions Among Republicans}, KAISER HEALTH NEWS (May 9, 2019), https://khn.org/news/needle-exchanges-find-new-champions-among-republicans/ [https://perma.cc/5CYD-K477] (noting the belated and piecemeal but evolving support for syringe exchange programs by Congress and various Republican state legislatures).
\item \textsuperscript{241} Grinspoon, supra note 196.
\item \textsuperscript{243} See Alex Halperin, \textit{Most in US Think Cannabis Has Health Benefits, Despite Lack of Data - Study}, GUARDIAN (July 23, 2018, 5:00 PM), https://www.theguardian.com/society/2018/jul/23/cannabis-health-benefits-american-attitudes-study [https://perma.cc/ZW7A-FSHF] ("According to the US Drug Enforcement Administration, the agency responsible for drug law enforcement, marijuana is a schedule I drug, meaning that it has serious risks and no medical benefits.").
\item \textsuperscript{244} See \textit{DRUG COURTS ARE NOT THE ANSWER}, supra note 201, at 16 ("Drug court adaptations in Canada, Australia, and the United Kingdom have expanded measures of success to include decreased drug use and crime, while broadly allowing opioid-maintenance therapy (such as methadone) and, in some circumstances, tolerating cannabis use.").
\end{itemize}
sparked grassroots curiosity.\textsuperscript{246} Grassroots curiosity fed grassroots activism.\textsuperscript{247} For some time, it has been an open secret that at least one unsanctioned supervised injection facility has operated within the United States.\textsuperscript{248} And activists have lobbied to bring underground safe sites to the surface.\textsuperscript{249} Even the American Medical Association has come aboard, declaring support for the model.\textsuperscript{250} Likewise, the idea has spread to progressive prosecutors and police commissioners.\textsuperscript{251} Just this past year, public health advocates in Philadelphia, with the support of city leaders, formed a nonprofit called Safehouse to open the first aboveground supervised injection facility in the country.\textsuperscript{252} Predictably, state officials have opposed the effort with claims that it cannot be done under federal law (though Pennsylvania’s Governor has signaled he may keep his hands off of the effort).\textsuperscript{253} And federal officials have responded predictably, flexing drug war muscles with obnoxious threats to enforce the so-called crackhouse law against any safe site, should one try to open aboveground.\textsuperscript{254} But where there’s a will, there’s a way—if not in Philadelphia then somewhere else, sometime soon.\textsuperscript{255}

\textsuperscript{246} See id.
\textsuperscript{247} See id.
\textsuperscript{248} See id. (describing an unauthorized safe injection site operating in the United States).
\textsuperscript{253} See id.
\textsuperscript{254} Id.
This is what happened with syringe exchanges and medical cannabis. More to the point, this is what happened in Vancouver. An underground effort by street activists eventually produced a legally authorized supervised injection facility. And that facility, in turn, helped produce an aboveground addiction maintenance clinic—a site where individuals now go to get their fix without needlessly jeopardizing their lives and liberty or, for that matter, public safety and order.

VI. CONCLUSION

Drugs grow organically in our soil. We produce them purposefully in our labs. We take them for pleasure, to alleviate pain, and to feel “normal.” We use them to treat our depression, our hyperactivity, our attention deficit disorders, our sexual dysfunction, and on and on. We take them to forget, and we take them to remember. We use them responsibly, and we abuse them to no good end. Recreational drugs are commonly criticized

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258 Lopez, supra note 76 (discussing Vancouver’s addiction maintenance clinic, Crosstown Clinic); Aleccia, supra note 70 (discussing Vancouver’s supervised injection facility, Insite).


260 Id.


263 Drug Misuse and Addiction, supra note 261.


267 Drug Misuse and Addiction, supra note 261.
for—among other things—producing a false sense of reality. But, as sober-minded citizens, we have lost sight of our own reality. Drugs surround us. The drug-free society is a pipe dream. The goal is not only wrongheaded and hopeless, but also pernicious. To preach drug eradication is to preach drug prohibition. And the logic of prohibition is grounded, necessarily, in the ideology of punishment and acts of state-sponsored violence.

If, instead, we were to acknowledge that drugs are an often (but not always) unfortunate fact of life (just like sugar, red meat, pollution, automobile accidents, and the flu) we might come to regard drug misuse, abuse, dependence, and addiction for what they are—questions of health, not morality; social policy, not penology. The measure of success would not turn on our proximity to a drug-free America. The measure of success would be whether we have minimized drug-related deaths, disease, crime, and suffering; whether we have improved health and welfare; whether we have preserved and expanded autonomy and dignity; whether we have generated and subscribed to sound science directed toward morally appropriate ends; and, most importantly, whether we have cared compassionately for each other as equal members of a social collective.

There is a silver lining to our current moment. The opioid crisis has awoken a previously indifferent (white) America to the evils of its policies. We are hopeful, but not overly so, that this awakening may translate to meaningful changes all the way up to the federal level. But the recent crackdowns against doctors inspire little confidence. We expect that there will be more street-level activism and local initiatives (and also that these steps will prove politically popular). But, ultimately, the moves we make will be too few. The logic of

268 What You Need to Know About Drugs, KIDS HEALTH (Apr. 2018), https://kidshealth.org/en/kids/know-drugs.html [https://perma.cc/SRL9-77VG] (“A drug might—temporarily—make someone who is sad or upset feel better or forget about problems. But this escape only lasts until the drug wears off. Drugs don’t solve problems . . . using drugs often causes other problems on top of the problems the person had in the first place.”).

269 See generally Bell, supra note 14 (describing “interest convergence” and white America).

270 For the reasons discussed in Part V, we are doubtful that federal authorities can or will genuinely reorient away from prohibition, even when it comes to opioids. Still, we are encouraged that the United States Senate—by a remarkable vote of ninety-nine to one—recently passed sweeping legislation that might make it easier for doctors to prescribe suboxone and other forms of medication-assisted treatments for addiction. Coby Itkowitz, Senate Passes Sweeping Opioids Package, WASH. POST (Sept. 17, 2018), https://www.washingtonpost.com/politics/2018/09/17/senate-set-pass-sweeping-opioids-package/?utm_term=.3f9802c2ea72 [https://perma.cc/AMK9-XDU7]. Suboxone is a brand name for buprenorphine. See Michele Brooks, Brooks’ Bill to Curb Suboxone Abuse Passes Senate (June 28, 2019), https://www.senatorbrooks.com/2019/06/28/brooks-bill-to-curb-suboxone-abuse-passes-senate/ [https://perma.cc/WD8W-GCDP]. Again, “interest convergence” has a way of making the seemingly impossible suddenly possible, even if not for entirely admirable reasons. See generally Bell, supra note 14 and accompanying text (discussing “interest convergence” theory of race and politics).
prohibition and the ideology of punishment will continue to predominate. Such is the power of the leviathan—of drug war culture, politics, and dollars. The machinery of penal justice will continue to churn. That’s what machines tend to do. Still, we offer this pragmatic six-point plan for addressing our current opioid crisis (pragmatic, but not ideal, because—though it would reduce opioid-related death and suffering—it would not dismantle the architecture and instruments of punitive prohibition).

911 Amnesty from arrest for all drug offenses for all individuals who contact authorities to report overdoses or persons in need of aid.272

Naloxone available without prescription or cost at pharmacies, fire stations, public libraries, police stations, hospitals, jails and prisons, and supervised injection facilities.273

Pill and Powder Testing available without cost to assess drug purity and to detect the presence of fentanyl and other dangerous compounds, as a means to enable drug users to make informed choices about whether and how to use substances.274

Medication-Assisted Treatment available with prescription but without cost, within and beyond clinical settings, for all individuals who require it, inmates included, without forced detoxification after fixed time periods.275

Supervised Injection Facilities/Drug Consumption Rooms and Syringe Exchanges available without cost and in areas of concentrated injection drug use.276

Physician-Supervised Addiction Maintenance Programs available with prescription but without cost for individuals for whom other forms of medication-assisted therapy have failed.277

The empirical and anecdotal evidence is persuasive that these interventions will save lives, alleviate suffering, and lessen drug-related crime.

The virtue of the criminal law is that it is relatively certain.278 The vice is that (at least when it comes to the drug war) the criminal law is almost certainly wrong. We must acknowledge and abandon our addiction to punishment and broaden our legal horizons to adopt measures proven to reduce the use, misuse, and abuse of drugs in an effort to avoid harms related both to drug use and the drug war. People are dying at record numbers.279 History will judge harshly our inaction.

Legalizing Harm Reduction

AILA HOS*

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I. INTRODUCTION

The opioid use disorder and overdose crisis continues to challenge our agencies, institutions, and the laws underpinning our public health, healthcare, and criminal justice systems.1 Recent data from the Centers for Disease Control and Prevention indicate that the rates of drug overdose have increased in many parts of the country.2 While many overdoses are opioid-related,3 parts of the country have seen increases in the use of methamphetamine and cocaine.4

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Overdose has now surpassed motor vehicle-related deaths as the leading cause of death in many states.\(^5\) Overdose deaths are only one of many tragedies associated with substance use disorder. Substance use disorder is associated with illnesses such as HIV, Hepatitis C, and chronic kidney disease, among others.\(^6\)

In addition to poor health outcomes experienced by individuals with opioid use disorder, the crisis has strained the economy and the criminal justice system.\(^7\) A 2018 report found that the cost of the opioid crisis from 2001 to 2017 exceeded $1 trillion in the form of lost wages, lost productivity, lost tax revenue, as well as government spending on health care, social services, education, and criminal justice.\(^8\) A 2013 study found that over a third of this cost comes in the form of increased health care expenditures.\(^9\) In its civil lawsuit against an opioid manufacturer, the State of New Jersey estimated that its Medicaid vendors, workers’ compensation program, and employee and retiree health plans have spent $290 million in opioid-related costs.\(^10\) Similarly, the City of Tacoma estimated its spending has increased $10 million a year as a result of the opioid crisis.\(^11\)

Children and families are also among the victims of the opioid use disorder crisis.\(^12\) Families are split up when loved ones are in prison for opioid-related overdoses.\(^5\)

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\(^7\) TERRY ET AL., supra note 1, at 9, 18.


\(^12\) See generally Yuki Noguchi, Anguished Families Shoulder the Biggest Burdens of Opioid Addiction, NPR (Apr. 18, 2018), https://www.npr.org/2018/04/18/602826966/
charges, when individuals are seeking treatment, or after an overdose death. Foster care systems are unable to meet the growing demand of placing children in foster care families. Indiana, for example, has seen the number of children in foster care increase by thousands. Many parents with opioid use disorder are imprisoned from drug-related criminal charges, which can have downstream health effects on their children. The Adverse Childhood Experience (ACE) Questionnaire is a tool to assess childhood trauma, such as abuse and neglect. High ACE scores are associated with poor health outcomes, including chronic disease and early death. The questionnaire includes a question on whether the child has had a parent in prison, a trauma for the child which can lead to increased risk of substance use disorder.

The root causes of the opioid use disorder and overdose crisis are complex and necessitate comprehensive changes to our social, health care, and criminal justice systems, which would take significant time to implement. Yet there are interventions that can be implemented to curb overdoses and other poor health


15 Id.


17 See ACE Questionnaire, supra note 16.

18 Id.

19 Id.

20 The Role of Adverse Childhood Experiences in Substance Abuse and Related Behavioral Health Problems, SAMHSA’S CTR. FOR APPLICATION PREVENTION TECHS., https://www.cambridgema.gov/CDD/Projects/Planning/-/media/328D3B716A24449D8504357BD3865949.ashx [https://perma.cc/7KM2-ZBCL].

outcomes associated with substance use immediately. Namely, harm reduction.

Harm reduction refers to public health strategies that seek to minimize the injury and illness associated with substance use, as opposed to eliminating substance use itself. For example, in the context of opioid use, harm reduction strategies can include increased naloxone training and availability to prevent overdose or establishing syringe service programs to allow people who inject drugs to have access to unused syringes, thereby reducing their risk of transmission of HIV, Hepatitis C, and skin infections from the sharing and reuse of needles.

Harm reduction strategies have seen increased prominence in the United States as the opioid overdose crisis unfolded. But implementation has been inconsistent and fragmented in some jurisdictions without adequate policy development to ensure their efficacy. This Article argues that it is long overdue for harm reduction strategies to be legalized with enabling authorities to ensure they are effective in practice.

Part I provides background on harm reduction by describing select harm reduction strategies and the evidence base for them. Part II discusses the status of harm reduction in the United States by describing four harm reduction strategies in more detail. It discusses how the legal frameworks for these strategies could be improved in some jurisdictions. Part III concludes by outlining changes in law that are necessary to legalize harm reduction that would create a path towards legalization of drugs.

23 Id.
27 TERRY ET AL., supra note 1, at 20–21 (explaining how piecemeal implementation has impacted the state of Indiana).
II. UNDERSTANDING HARM REDUCTION

The origins of modern harm reduction in the United States are rooted in the prohibition and criminalization of drugs.28 As drug use went underground to avoid criminal liability, individuals who used drugs and their allies needed to establish methods to utilize these substances safely.29 Particularly following the HIV/AIDS epidemic in the 1980s, harm reduction strategies have been mainstreamed as effective prevention strategies for infectious disease amongst medical and public health communities.30

Researchers have made distinctions regarding the types and justifications for harm reduction strategies.31 A public health model for harm reduction seeks to justify these strategies purely from a disease prevention approach.32 A human rights model for harm reduction justifies these strategies because drug users are deserving of the health care, safety, and freedoms of other members of the public, often denied because of the criminalization of drug use.33

Harm reduction principles have been applied in policies and programs outside of illicit drug use, including tobacco use,34 alcohol use,35 and sexual health education,36 among others. Within these issues, examples include e-cigarettes as a tool to reduce the harm of combustible cigarettes,37 wet shelters and housing as a tool to limit the health harms of homelessness,38 and contraception access and education as a tool to reduce unintended pregnancies.

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30 Id.
31 Id.
32 Id. at 245;
33 Id. at 223.
35 G. Alan Marlatt & Katie Witkiewitz, Harm Reduction Approaches to Alcohol Use: Health Promotion, Prevention, and Treatment, 27 ADDICTIVE BEHAVS. 867, 867 (2002).
37 Notley et al., supra note 34, at 31.
and sexually transmitted infections.\textsuperscript{39} Harm reduction acknowledges that it is impossible to eliminate all health harms and instead seeks to reduce the harms associated with an activity.\textsuperscript{40}

Harm reduction strategies have been studied extensively in the context of drug use, particularly injectable drug use, largely due to the HIV crisis in the 1980s but also due to the current opioid crisis facing the United States.\textsuperscript{41} Examples of selected harm reduction strategies used to respond to the opioid epidemic and their evidence base are outlined below.

A variety of harm reduction strategies are available to fight the opioid crisis. Syringe service programs (SSPs), for example, gained prominence in the 1980s to reduce the spread of HIV among people who inject drugs (PWID).\textsuperscript{42} These programs provide a location where PWID can securely dispose of used syringes and secure unused syringes without cost for future use.\textsuperscript{43} SSPs also often provide other resources and services such as safe injection practices and linkages to treatment.\textsuperscript{44} Importantly, SSPs are often one of the few locations where PWID can come as they are without judgment or stigma.\textsuperscript{45} The evidence base for syringe service programs spans several decades.\textsuperscript{46} Areas with syringe service programs have seen a reduction of bloodborne disease transmission, such as HIV and Hepatitis C.\textsuperscript{47} Amongst PWID, evidence indicates that there is a reduction in the injection-related risk behaviors, such as sharing syringes, and a decrease in the number of times a syringe was reused.\textsuperscript{48} SSPs have also served as a vehicle to link individuals with substance use disorder (SUD) to other services, including initiating treatment.\textsuperscript{49} From a funding standpoint, investments in SSPs are less costly than the alternative of providing healthcare

\begin{thebibliography}{99}
\bibitem{39} Leslie, \textit{supra} note 36, at 53, 55.
\bibitem{40} \textit{Id.} at 53.
\bibitem{41} Des Jarlais, \textit{supra} note 28.
\bibitem{44} \textit{Id.}
\bibitem{45} \textit{TERRY ET AL., supra} note 1, at 29.
\bibitem{46} \textit{See} Wodak & Cooney, \textit{supra} note 26, at 5.
\bibitem{47} \textit{See}, \textit{e.g.}, Hagan et al., \textit{supra} note 26, at 1531.
\bibitem{48} Monita R. Patel et al., \textit{Reduction of Injection-Related Risk Behaviors After Emergency Implementation of a Syringe Services Program During an HIV Outbreak}, 77 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES 373, 373 (2018) (“Sterile syringe access as part of comprehensive HIV prevention is an important tool to control and prevent HIV outbreaks.”).
\bibitem{49} Steffanie A. Strathdee et al., \textit{Needle-Exchange Attendance and Health Care Utilization Promote Entry into Detoxification}, 76 J. URB. HEALTH 448, 448 (1999).
\end{thebibliography}
for HIV and Hepatitis C.\textsuperscript{50} Those opposed to SSPs state that SSPs lead to higher rates of crime and increased drug use;\textsuperscript{51} however, evidence does not indicate that this is the case.\textsuperscript{52} SSPs also create an environment of compassion and care for people who use drugs,\textsuperscript{53} which can lead to better health outcomes.\textsuperscript{54}

The primary reason that friends and family members of individuals experiencing an overdose avoid contacting emergency services is the fear of criminal prosecution for themselves and the person experiencing the overdose.\textsuperscript{55} Overdose immunity protections provide criminal immunity from prosecution for certain crimes to individuals experiencing an overdose or bystanders to the overdose when they contact emergency services.\textsuperscript{56} Overdose immunity laws increase usage of emergency services and prevent overdoses.\textsuperscript{57}

Naloxone and drug testing kits are other tools to reduce overdose and overdose deaths. Naloxone is an overdose reversal drug that can be used to block


\textsuperscript{51}See, e.g., Curtis Hill, Handing Out Syringes to Addicts Is a Perilous Path, CURTIS HILL FOR IND. (Aug. 9, 2019), http://www.curtishillforindiana.com/opinions (scroll to opinion and click “Continue Reading”) [https://perma.cc/R5L5-9H88].

\textsuperscript{52}See generally NAT’L RESEARCH COUNCIL, INST. OF MED., PREVENTING HIV TRANSMISSIONS: THE ROLE OF STERILE NEEDLES AND BLEACH (Jacques Normand et al. eds., 1995) (finding that needle exchange programs do not increase the use of drugs); Melissa A. Marx et al., Trends in Crime and the Introduction of a Needle Exchange Program, 90 AM. J. PUB. HEALTH 1933, 1934 (2000) (refuting that needle exchange programs raise crime rates, with empirical data).

\textsuperscript{53}TERRY ET AL., supra note 1, at 29.

\textsuperscript{54}Kim Sue (@DrKimSue), TWITTER (Feb. 8, 2019), https://twitter.com/DrKimSue/status/1094025140004970497 [https://perma.cc/P2NY-9Z3X].


\textsuperscript{57}Chandler McClellan et al., Opioid-Overdose Laws Association with Opioid Use and Overdose Mortality, 86 ADDICTIVE BEHAVS. 90, 90 (2018) (showing that Good Samaritan laws reduce the amount of opiate overdose deaths).
the effects of opioids. Improved access to naloxone has resulted in thousands of overdose reversals. Drug testing kits can be used to test for the presence of the highly deadly, synthetic opioid, fentanyl in a drug. Test kits allow people who use drugs to avoid tainted supplies and prevent overdose. As outlined in Part II, the laws used to support these harm reduction strategies vary significantly from state to state.

Safe consumption sites, also referred to as overdose prevention sites and supervised injection facilities, are locations where people who use drugs can consume these drugs in a safe location supervised by trained individuals or health care professionals. Safe consumption sites have been found to reduce incidences of overdose deaths and ambulance calls. These facilities reduce public injecting and the disposal of syringes in public spaces. Not a single overdose death has occurred at a safe consumption site.

### III. HARM REDUCTION LAWS IN THE UNITED STATES

Much authority for public health interventions lies with state governments rather than the federal government. States are increasingly passing laws

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59 See McClellan et al., supra note 57, at 90.


66 See Richard A. Goodman et al., The Structure of Law in Public Health Systems and Practice, in LAW IN PUBLIC HEALTH PRACTICE 45, 58–62 (Richard A. Goodman et al. eds., 2d ed. 2007).
supporting harm reduction strategies, including naloxone access, syringe service programs, and overdose immunity laws. Yet, as this section will show, there remain many states that have not utilized these strategies, and there is much variability in the scope of existing state laws.

States that have been the epicenter of the crisis, like West Virginia and Indiana, have seen closures of their syringe exchange programs due to pushback from policymakers and the community. But there has been so much focus on just getting harm reduction programming at all that there is a gap in utilizing legal strategies to support the effective implementation of these strategies. The sections below provide examples regarding the varied implementation of several harm reduction approaches.

A. Syringe Service Programs

Indiana’s syringe service program law provides an example of an inadequate harm reduction law. Following the HIV outbreak in Scott County, Indiana, Indiana passed a temporary measure to allow for syringe exchange programs to operate in the county, which was made permanent and extended to allow for SSPs across the state. The 2015 law allows local governments to create syringe service programs following Hepatitis C and HIV epidemics that occurred because of injection drug use. The law does not allow for the creation


68 See Austin Coleman, Needle Exchange Legality by State, COUNCIL STATE GOV’TS (June 25, 2015), http://knowledgecenter.csg.org/kc/content/needle-exchange-legality-state [https://perma.cc/YPC6-NZWP] (“Sixteen states have passed laws explicitly authorizing needle exchange programs, and there are a number of states with statutes that either decrease barriers to the distribution of clean needles or altogether remove syringes from the list of drug paraphernalia.”). But see Josh Katz, Why a City at the Center of the Opioid Crisis Gave Up a Tool to Fight It, N.Y. TIMES (Apr. 27, 2018), https://www.nytimes.com/interactive/2018/04/27/upshot/charleston-opioid-crisis-needle-exchange.html [https://perma.cc/SU9N-EPKN] (discussing the closure of a “successful” Charleston needle exchange program, “even as dozens of others have opened”).

69 See Good Samaritan Overdose Prevention Laws, supra note 56.

70 See infra Parts IIIA–D.

71 See Katz, supra note 68.


75 Id. § 16-41-7.5-5.
of an SSP in order to prevent an epidemic from occurring, a primary goal of
public health.\(^{76}\)

Programs are only able to operate for two years at a time.\(^{77}\) In order to keep
operating, the SSP must secure renewal from the local government.\(^{78}\) This two-
year operation period has led to SSPs shutting down when unable to secure
political support,\(^{79}\) particularly given the conservative climate within the state.\(^{80}\)
In a state with ninety-two counties,\(^{81}\) only nine counties are operating SSPs.\(^{82}\)

Although Indiana law authorizes the establishment of SSPs, it fails to
provide sufficient legal protections to make them effective. The Indiana Court
of Appeals affirmed the conviction of a man for drug paraphernalia possession
who secured the paraphernalia, a syringe, from an SSP.\(^{83}\) The court said,

Thus, while [the defendant] could not be prosecuted for obtaining hypodermic
needles from a needle exchange or participating in a needle exchange program,
he could be found guilty of possession of paraphernalia if there was evidence
that he intended to use those syringes for unlawful ends.\(^{84}\)

Neither Indiana’s SSP law nor its drug paraphernalia law provide immunity
from drug paraphernalia possession for possessing a syringe from an SSP.\(^{85}\) And, although first-time drug paraphernalia possession is a misdemeanor in the
state,\(^{86}\) the legislature passed a law escalating syringe possession to a felony in
2015.\(^{87}\)

\(^{76}\) Id. (allowing a qualified entity to operate a syringe exchange program only if the
relevant state officials have declared that there is presently an epidemic of Hepatitis C or
HIV); What Is Public Health?, AM. PUB. HEALTH ASS’N, https://www.apha.org/what-is-
public-health [https://perma.cc/X8JK-2TYM].

\(^{77}\) § 16-41-7.5-11.

\(^{78}\) Id.

\(^{79}\) See Leigh Hedger, 2nd Indiana County Ends Needle Exchange, with 1 Official Citing
story/news/2017/10/23/2nd-indiana-county-ends-needle-exchange-one-official-citing-
moral-concerns/787740001 [https://perma.cc/UG6K-KF7B] (describing the closure of
a needle exchange program in Lawrence County after the county prosecutor and state
attorney general made their objections public).

\(^{80}\) See generally Hill, supra note 51.

\(^{81}\) County List, IND. DEP’T CHILD SERVS., https://www.in.gov/dcs/3204.htm
[https://perma.cc/H8SR-SG4Q].

\(^{82}\) Syringe Service Program Providing Counties, IND. ST. DEP’T HEALTH (July 18,
[https://perma.cc/7HCW-JVWE].


\(^{84}\) Id.

\(^{85}\) See IND. CODE ANN. § 16-41-7.5 (West Supp. 2015) (showing that no provision of
the Syringe Exchange Program includes any criminal immunities); IND. CODE ANN. § 35-48-
4-8.3 (West 2012).

\(^{86}\) See § 35-48-4-8.3.

\(^{87}\) § 16-42-19-18.
Requirements of an emergency, the two-year duration, the risk of criminal liability, and the actual prosecution of syringe possession limit the efficacy of these programs. Indiana is one of twenty-five states that do not provide criminal immunity for possessing drug paraphernalia for the prevention of bloodborne infections.88

B. Overdose Immunity

Like SSPs, overdose immunity protections are also implemented at the state level and vary substantially across jurisdictions.89 In Indiana, immunity is provided for the arrest and prosecution of drug and paraphernalia possession.90 Unlike a jurisdiction like Nevada, which provides protections for violations of parole and probation,91 Indiana fails to offer any additional protections.92 And Indiana’s protection is only available for the bystander contacting emergency services, not the person experiencing the overdose.93 Yet, as outlined above, bystanders also fear the criminal prosecution of their loved one and thus avoid contacting emergency services.94 Additionally, the bystander can only secure the protection if they administer naloxone,95 thus limiting the protection to those that have access to the drug. In a February 2019 email to a listserv of public defenders in Indiana, one person emailed the group with the subject “calling 911 for overdose” and asked which statute gave the “fake protection.”96

Ohio also provides an instructive example. The state’s overdose immunity law provides immunity from the arrest, charging, and prosecution of drug

88 Syringe Distribution Laws, POL‘Y SURVEILLANCE PROJECT (July 1, 2017), http://lawatlas.org/datasets/syringe-policies-laws-regulating-non-retail-distribution-of-drug-parapherna [https://perma.cc/4V8Y-E2UJ] (examining the question, “[i]f syringes are defined as illegal drug paraphernalia, are there exceptions to the law that would allow for the distribution of syringes to prevent blood-borne diseases?” and finding that twenty-five states, including Indiana, have no such exception for syringe exchange programs).

89 See Good Samaritan Overdose Prevention Laws, supra note 56 (showing that, among the forty-six states with drug overdose Good Samaritan laws, there is variation both in the scope of protections for overdose bystanders and the nature of those protections, e.g., immunities, affirmative defenses, or mitigating factors).

90 IND. CODE ANN. § 16-42-27-2(g)–(h) (West 2019).


92 See Legal Interventions to Increase Access to Naloxone in Indiana Fact Sheet, NETWORK FOR PUB. HEALTH L. 2 (Mar. 2018), https://www.networkforphl.org/_asset/tw9n11/Overdose-Prevention-Fact-Sheet.pdf [https://perma.cc/4RTK-D2YA] [hereinafter Legal Interventions] (stating that the only overdose immunity law for Indiana is contained within its law protecting access to overdose intervention drugs).

93 § 16-42-27-2(g)–(h).

94 See Preventing the Consequences of Opioid Overdose, supra note 55, at 1.

95 § 16-42-27-2(g)–(h).

96 Posting to Public Defender Council Mailing List, defendnet@lists.in.gov (Feb. 8, 2019) [on file with Ohio State Law Journal].
possession. However, the law provides no immunity for drug paraphernalia possession. Many drugs require paraphernalia in order to be consumed and thus the law fails to eliminate the risk of criminal liability, the primary reason for which emergency services are not called during an overdose.

Some jurisdictions have also prosecuted friends and family members of overdose victims for drug-induced homicide if they supplied the drugs that led to the overdose. Overdose immunity laws fail to provide protections to these bystanders against homicide charges.

C. Naloxone and Drug Testing Kits

Naloxone and drug testing kits, such as fentanyl test kits, prevent overdoses and overdose deaths. Yet, in some jurisdictions, they are considered drug paraphernalia, are regularly confiscated by law enforcement, and subject the possessor to criminal liability. Tennessee, for example, makes it illegal:

[For any person to use, or to possess with intent to use, drug paraphernalia to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance or controlled substance analogue in violation of this part.]

In an effort to promote the use of drug testing kits, some jurisdictions have passed laws legalizing their use. For example, a recent bill passed in Colorado
specifies that drug paraphernalia does not include testing equipment to analyze a controlled substance.\textsuperscript{106}

D. Safe Consumption Sites

Safe consumption sites (SCSs), often referred to as “safe injection facilities,” generally serve injectable drug users.\textsuperscript{107} Safe consumption sites provide safe, sterile supplies for drug use.\textsuperscript{108} The staff, often but not always, are healthcare providers that can provide resources and answer questions about safer consumption strategies.\textsuperscript{109} Staff also can provide health care services such as first aid, monitoring for overdoses, and administering overdose intervention drugs.\textsuperscript{110} SCSs may link folks to other social services and health care services.\textsuperscript{111}

These sites are legal in various countries around the world, including Canada and Germany.\textsuperscript{112} As numerous local governments across the country have begun discussing and planning for establishing safe consumption sites in the United States,\textsuperscript{113} the federal government’s position has been that these sites are illegal under federal law.\textsuperscript{114} Specifically, the U.S. Department of Justice

\textsuperscript{106}Colo. S.B. 19-227.

\textsuperscript{107}Supervised Consumption Services, supra note 62.

\textsuperscript{108}Leo Beletsky et al., The Law (and Politics) of Safe Injection Facilities in the United States, 98 AM. J. PUB. HEALTH 231, 231 (2008).

\textsuperscript{109}Id.

\textsuperscript{110}Id.

\textsuperscript{111}Id.

\textsuperscript{112}Supervised Consumption Services, supra note 62.


argues that these sites violate the “crack house statute,” 115 which prohibits the operating of a site where drugs are used. 116 At the state level, a safe consumption site would be unlawful under existing drug and paraphernalia possession laws. 117

The federal government recently sued Safehouse, a Pennsylvania nonprofit that seeks to offer overdose prevention services at a safe consumption site, 118 for declaratory relief stating that the operation of an SCS violates federal law. 119 The suit is pending in the U.S. District Court for the Eastern District of Pennsylvania. 120 In its Answer, Safehouse argues that it is not violating federal law because an SCS is a medical and public health facility, distinguishable from the crack house targeted by federal law. 121

IV. CONCLUSION

Upticks in opioid use disorder and overdose over the past decades are coupled with increased rates of methamphetamine and cocaine use across several communities around the country. 122 Clay Marsh, leaning on research from Anne Case and Angus Deaton, 123 argues that the opioid crisis is a symptom

117 Kreit, supra note 115, at 418 (“The United States Attorneys for the districts of Colorado, Massachusetts, and Vermont have announced that if safe injection sites were established in their states, they would consider bringing criminal charges against facility employees.”).
120 Id.
of a larger crisis.\textsuperscript{124} Really, the crisis’s root causes stem from the social determinants of health—poverty, education, housing.\textsuperscript{125} Policies addressing these social determinants are complex and require significant policy and system change.\textsuperscript{126} In the meantime, harm reduction measures exist that can save lives.\textsuperscript{127}

While there have been significant increases in states’ legislative action supporting harm reduction strategies, many of these laws are narrow in application or fail to close loopholes that undermine the efficacy of these laws. State legislatures need to ensure that when they legislate on these issues, the laws are structured in a way that actually supports these strategies.

I have previously argued that “there are actionable, discrete, evidence-based policy measures” to respond to the opioid overdose crisis that are being undermined by ineffective legislation.\textsuperscript{128} But in fact, harm reduction is not simply undermined but instead has not been legalized in many jurisdictions. Meaningful changes to harm reduction laws must be made in conjunction with social and structural determinants before real improvements to the opioid use disorder and overdose crisis are made.

\textsuperscript{124} See generally Clay Marsh, Opioid Addiction Isn’t the Disease; It’s the Symptom, HUFFPOST (June 16, 2017), https://www.huffpost.com/entry/opioid-addiction-isnt-the-disease-its-the-symptom_b_59441bc3e4b06bb7d272e3b6 [https://perma.cc/X3N3-3TXT] (“The answer to our opioid epidemic, then, is the same as the answer to our increasing health care spending and reduced health and lifespan of our population. . . . We need strong connections to others.”).

\textsuperscript{125} See Dasgupta et al., supra note 21, at 183.

\textsuperscript{126} See id. at 182.

\textsuperscript{127} See supra Parts I, II.

Opioids, Addiction Treatment, and the Long Tail of Eugenics

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I. INTRODUCTION

Our attitude, treatment, and punishment of opioid addiction partly results from the long, intertwined history of eugenics and incarceration. As I have discussed in other work,¹ there is a thread of eugenics-based philosophy undergirding our widespread imprisonment of the poor, disabled, and dependent. The current approach to opioid addiction in the criminal justice and sentencing worlds reflects this bias, hindering our ability to best treat the opioid crisis. Unsurprisingly, the American public has proven receptive to scare stories about “the dangerous classes.”²

As I discuss below, the 21st century tactics to combat the opioid addiction crisis unwittingly track the methods used to address the widespread use of opioids in the late 19th and early 20th centuries, with equally troubling results. Indeed, addiction to pharmaceutical opiates is no recent problem; historically, iatrogenic drug use has been far more extensive than illicit drug use.³ Old errors are being re-enacted as we attempt to solve the problems of opioid-addicted offenders during sentencing, inside correctional facilities, and on release. Accordingly, before we craft workable policies to combat the opioid crisis, we must fully explore and understand the history of iatrogenic opioid addiction, to avoid making the same mistakes.

II. HISTORY OF REGULATING OPIOIDS

The use of opioids in one form or another dates back centuries, but it wasn’t

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³ See David Herzberg, Entitled to Addiction?: Pharmaceuticals, Race, and America’s First Drug War, 91 BULL. HIST. MED. 586, 586 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5679069/ [https://perma.cc/479R-9CFB].
until the last third of the 19th century that opiate addiction was identified as a real problem in the United States. Following the Civil War, a variety of influences combined to bring narcotics addiction out of the shadows to become a matter of local and national concern. This concordance of factors included the increased use of narcotics by doctors, the demographic change regarding who used opiates, and a strong underpinning of eugenics—specifically, the fear that classes, races, and genders would mix, “degrading” pure American stock.

Throughout the 19th century, the majority of opium addicts were women, with some evidence to suggest that these disproportional numbers persisted until the early 20th century. Most opium/morphine addicts were between twenty-five and forty-five years old; it was considered a “vice of middle life.” The users of morphine and opium were largely white and native-born, with a large percentage in the middle or upper classes. By the 1890s, it is estimated that 4.59 of every thousand people in the United States were addicted to opiates. The emergence of “white markets” for sedatives, stimulants, and narcotics, sold overwhelmingly to white, middle class men and women, cemented this problem.

Opium and morphine were common additions to over-the-counter pharmaceuticals, found in such concoctions as Dover’s powder, laudanum, and patent medicines. Prior to 1800, opium was available only in its crude forms such as laudanum, “black drop” extracts, or via prescription. By 1834, opium was the most frequently prescribed drug in the United States. Addiction in the 19th century was principally caused by physician administration of opiates/morphine. Following the introduction and widespread use of the hypodermic needle, which made injection of morphine far easier, morphine use increased dramatically, as injected morphine was one

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7 Id.
8 See id. at 37.
9 Id. at 37, 41.
10 See id. at 9.
11 Herzberg, supra note 3, at 592.
12 COURTWRIGHT, supra note 6, at 35–36.
14 COURTWRIGHT, supra note 6, at 45.
15 See id. at 42.
of the few reliable respite from excruciating pain.\textsuperscript{16} Therapeutically induced, or iatrogenic, addiction was extremely widespread throughout the 19th and early 20th centuries, particularly for those who had chronic medical issues.\textsuperscript{17} Although concerns with morphine’s addictive nature were prevalent by the late 1880s, many doctors continued to prescribe it simply due to inadequate medical education.\textsuperscript{18} Approximately 15% of all prescriptions in 1888’s Boston, for example, were for opiates.\textsuperscript{19}

The other main delivery service for opiate use was through the widespread use of patent medicines.\textsuperscript{20} The active ingredients in most of these patent medicines were alcohol, cocaine, and morphine.\textsuperscript{21} Many of the drug companies selling such patent medicines subtly discouraged the use of a physician, claiming these medicines would allow an individual to diagnose and treat herself.\textsuperscript{22}

Until the 1890s, use of opiates was not a federal offense.\textsuperscript{23} Prior to 1906, any laws concerning opiates were local, imposed either by cities or individual states, and only nine states and territories had laws prohibiting nonprescription opium sales.\textsuperscript{24} In 1874, San Francisco became the first city to criminalize the smoking of opium in opium dens.\textsuperscript{25} It did not ban opium’s sale, import, or use otherwise, however.\textsuperscript{26} San Francisco’s ban on smoking opium resulted directly from openly anti-Chinese sentiment, culminating in fears that opium smoking was yet another way that Chinese immigrants sought to undermine American society.\textsuperscript{27} Thus, hardening attitudes regarding the increasing Chinese immigrant

\begin{footnotesize}
\begin{enumerate}
\item See \textit{Courtwright, supra} note 6, at 48.
\item \textit{Id.} at 49–50.
\item Patent medicines were not really patented, instead protected by trademark and considered “proprietary” remedies, sold by drug manufacturers who aimed their products at the general public. Joseph F. Spillane, \textit{The Road to the Harrison Narcotics Act: Drugs and Their Control, 1875–1918}, in \textit{FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE} 4 (Jonathon Erlen & Joseph F. Spillane eds., 2004).
\item \textit{Id.}
\item \textit{Id.}
\item \textit{Hardaway, supra} note 13, at 88.
\item Audrey Redford & Benjamin Powell, \textit{Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914}, 20 INDEP. REV. 509, 519 (2016).
\item See \textit{id.}
\item See \textit{Hardaway, supra} note 13, at 88. As Hardaway notes, “[t]he first anti-opium crusade in U.S. history was directed against working class Chinese people brought over for cheap labor and no longer needed by 1870.” \textit{Id.} at 89.
\end{enumerate}
\end{footnotesize}
population intertwined with a growing worry about dangerous drugs, ultimately creating a generalized panic about smoking opium in specialized parlors.28

By 1896, twenty-two states and territories, including California, Georgia, New York, Washington, and Massachusetts, outlawed the keeping of an opium den for the purpose of smoking opium, although opiate use was not regulated in other ways.29 These laws were passed in reaction to both Chinese immigrants and non-Chinese Americans who had taken up opium smoking, rapidly labeled as “undesirables,” “unholy persons,” and “persons of the underworlds of prostitution, crime, and filthiness.”30 There was a growing fear, stoked heavily by the media,31 that opium smoking would spread across the races and up the social ladder as the means for doing so became more respectable.32 Most disturbing to the San Francisco police department was the sight of “white women and Chinamen side by side” in opium dens; as the department noted in a plea to the California state legislature, this was “a humiliating sight to anyone with anything left of manhood.”33 Indeed, part of the danger of the opium parlor was its lack of regard for class, racial, or gendered status34—all was blurred in the haze of opium smoke. Morphine and different forms of opiates, on the other hand, were viewed as far less degenerate and destructive. While smoking opium alone was considered dangerous and morally suspect, other opiate uses were seen as standard medical treatment.35 Medicinal use of opium continued to be seen as an acceptable form of behavior, but smoking opium was judged intolerable, and needing to be suppressed with the use of regulation and criminalization.36

In this way, a distinguishing line was drawn between blameless patients lacking volition, forced into opiate addiction through either pain or physician prescription, and the opium smoker, mired in addiction through their own volition (and thus responsible for their narcotic abuse).37 We see a similar classification of opiate users today, with our understanding of users as either patients or criminals,38 licit drug users or illicit pleasure seekers.39

29 Redford & Powell, supra note 24, at 513.
30 Id.
31 HARDAWAY, supra note 13, at 89.
32 See Redford & Powell, supra note 24, at 517.
33 HARDAWAY, supra note 13, at 89.
34 HICKMAN, supra note 5, at 70.
35 See HARDAWAY, supra note 13, at 90.
36 See Gabriel, supra note 28, at 332.
37 HICKMAN, supra note 5, at 67.
38 See Gabriel, supra note 28, at 316.
39 See Herzberg, supra note 3, at 588.
Morphine, the active ingredient in opium, was isolated in 1806, and quickly became the most popular narcotic to treat chronic pain, gaining widespread acceptance as the 19th century progressed. Pure morphine was easily made in large amounts. From the 1850s on, morphine was primarily used to relieve pain and treat various ailments, although its addictive nature was not unknown. As morphine’s addictive aspects became clearer, alternatives were synthesized in hopes of finding a less addictive narcotic. For example, in 1874, Bayer Pharmaceuticals isolated diacetylmorphine in hopes of better treating asthma and bronchitis, creating a new narcotic called heroin. Bayer began commercially producing heroin in 1898, and the use of heroin by both doctors and addicts increased exponentially. Heroin was originally believed to be less addictive than morphine, since addiction to heroin took longer than morphine addiction, because smaller amounts were needed per use. Like laudanum, another opiate derivative, heroin was present in a variety of medicines treating numerous ailments. In 1906, the American Medical Association approved heroin for general use, urging heroin prescription over morphine, because they believed it was less addictive. In fact, pharmaceutical grade heroin was twice as powerful as morphine. Despite widespread use, however, there were no laws regulating the use of morphine, heroin, cocaine, or other drugs, because the use of such opiates was not considered particularly harmful or dangerous. It took until the late 19th century for even physicians and pharmacists, who had gradually become aware of opiates’ addictive nature, to agitate for some sort of regulation and restriction.

41 See Waldrop, supra note 4, at 887–88.
42 Brownstein, supra note 40, at 5391.
43 Redford & Powell, supra note 24, at 518.
44 Waldrop, supra note 4, at 888.
47 See Redford & Powell, supra note 24, at 518–19.
48 See Gordon & Gordon, supra note 45, at 3.
50 See id.
51 Indeed, cocaine was heavily marketed by pharmaceutical companies in the late 19th century, with physicians endorsing such products as “cocaine snuffs” for their stimulant and tonic effects. See Spillane, supra note 20, at 4.
52 See Redford & Powell, supra note 24, at 518.
on the widely available drugs.\textsuperscript{53} The line between legitimate and illegitimate forms of drug consumption was just beginning to be drawn, compounding the problem.\textsuperscript{54}

The federal government only began to truly regulate opioids in the beginning of the 20th century. In 1906, as part of the Pure Food and Drug Act (motivated itself in part by the widespread use of morphine in 19th century patent medicines), the government began requiring the disclosure of morphine levels in over-the-counter drugs.\textsuperscript{55} This disclosure was primarily to provide the upper-middle class, white opiate user with information about the purity and potency of the narcotics present in the medicine, reacting to contemporary fears about “counterfeit, contaminated, diluted, or decomposed drug materials.”\textsuperscript{56}

In 1909, the Smoking Opium Exclusion Act banned the importation, possession and use of “smoking opium,”\textsuperscript{57} but didn’t regulate opium-based medications.\textsuperscript{58} The Opium Exclusion Act was partially motivated by American territorial interests in the Philippines, which had a thriving opium trade, alarming the American missionaries stationed there.\textsuperscript{59} Ironically, the ban on smoking opium led to a much higher domestic use of morphine, heroin, and other far more addictive drugs.\textsuperscript{60}

Further regulation of opium quickly followed. The 1914 Harrison Narcotics Tax Act made any company making, importing, or selling any opiate or coca derivative pay a tax.\textsuperscript{61} It was strongly championed by various temperance movements, who wanted to address “the obvious damage that this ‘sinful, depraved and immoral behavior’ caused among the ‘inferior races.’”\textsuperscript{62}

These xenophobic and blatantly eugenic beliefs were articulated by the combined forces of U.S. missionaries working in Asian countries, other

\textsuperscript{53} See Courtwright, supra note 6, at 52.
\textsuperscript{54} See Gabriel, supra note 28, at 316.
\textsuperscript{57} The ban was due largely to nativist fears and prejudice about Chinese immigrants smoking opium and spreading the habit to Americans. See Trickey, supra note 19, at 3.
\textsuperscript{58} See Redford & Powell, supra note 24, at 521 (noting that smoking opium was banned).
\textsuperscript{59} See Trickey, supra note 19, at 3.
\textsuperscript{60} See Redford & Powell, supra note 24, at 523.
\textsuperscript{61} See Moghe, supra note 46, at 2. The Harrison Drug Act was passed for a number of reasons, including the desire to “confine narcotics traffic to legitimate medical channels;” to “bring drug transactions into the light of day;” to “eliminate drug peddling;” to “provide more information about the narcotics supply chain;” and to create a workable mechanism “through which antinarcotic states could better enforce the importation of drugs into their state” from pro-narcotic states. Redford & Powell, supra note 24, at 524.
American religious groups, and temperance organizations, and persuaded Congress that not only were narcotics sinful, but that their users were also dangerous and depraved. In their view, narcotics needed to be outlawed because “[c]ocaine raised the specter of the wild Negro, opium the devious Chinese, morphine the tramps in the slums.” The opium den posed a particular danger because its existence was just barely out of sight, hidden but easily accessible within the cellars and back alleyways of American cities. Although Chinese immigration was banned in 1882, both Chinese individuals and opium parlors remained as signifiers of foreign menace.

One result of the Harrison Act was its restriction of prescribing narcotics to addicts, thereby eliminating a safe, legal way for them to obtain the drugs (what we now call maintenance). Although pharmacists and physicians could still prescribe opiates, the practice was sharply curtailed, since the law contained enough ambiguities about whether an addict could be prescribed opiates, even for maintenance reasons. Moreover, any physician or pharmacist suspected of prescribing to addicts was either prosecuted or harassed.

Meanwhile, the quest for a nonaddictive pain reliever continued. In 1916, German scientists first synthesized oxycodone, in hopes that it would provide the pain relief of heroin and morphine without their addictive qualities. Oxycodone, of course, is the primary active ingredient inside the highly addictive narcotic OxyContin, promoted by Purdue Pharma as a nonaddictive opioid suitable for long-term use of chronic pain relief.

Further crackdown on the use of narcotics was enabled by the passage of the Narcotic Drugs Import and Export Act of 1922, which prohibited the possession, use, or import of narcotics—largely cocaine and opium—except for medical use. The 1922 Act also established the Federal Narcotics Control Board for enforcement purposes. Heroin was ultimately made illegal in 1924

63 See id.
65 HICKMAN, supra note 5, at 62.
66 Id. at 64.
67 See Redford & Powell, supra note 24, at 526.
68 See COURTWRIGHT, supra note 6, at 2.
69 Id.
70 See Waldrop, supra note 4, at 889.
71 Id.
74 See id.
with the Heroin Act, which prohibited manufacture and importation of the drug, and made possession of heroin illegal, even for medicinal use.\footnote{See Redford & Powell, supra note 24, at 527.}

The 1938 Food, Drug, and Cosmetic Act subsequently required drug manufacturers to safety test their products prior to approval.\footnote{See NAT'L ACAD. SCI., supra note 55, at 359.} However, the opioids already being sold, such as codeine, morphine, and oxycodone, were still legal to prescribe to patients.\footnote{See Waldrop, supra note 4, at 890.} This was in sharp contrast to the federal and state laws prohibiting the use and sale of such “street” narcotics like heroin, cocaine, and marijuana, which were used by the poor and nonwhite.\footnote{See Carl L. Hart, \textit{How the Myth of the “Negro Cocaine Fiend” Helped Shape American Drug Policy}, NATION (Jan. 29, 2014), https://www.thenation.com/article/how-myth-negro-cocaine-fiend-helped-shape-american-drug-policy/ [https://perma.cc/RF4K-V7RZ]. As Hart observes, “Although the Harrison Act did not explicitly prohibit the use of opiates or cocaine, enforcement of the new law quickly became increasingly punitive...” \textit{Id.}} Despite copious evidence to the contrary, opium use was largely ascribed to (and blamed on) Chinese laborers, cocaine to Southern African-Americans, and marijuana to Mexican immigrants and citizens.\footnote{See A Brief History of the Drug War, DRUG POL’Y ALL., http://www.drugpolicy.org/issues/brief-history-drug-war [https://perma.cc/7AJD-RG6E].}

### III. The Changing Face of Opioid Addiction

Motivating these changes in drug criminalization and much stricter regulation was a change in opiate addict type. Beginning in the early 20th century, the public, recognized face of the typical opiate addict—middle class, middle-aged Anglo-Saxon white female—began to transform into the far more threatening poor urban residents, who were often categorized as street criminals.\footnote{COURTWRIGHT, supra note 6, at 1.} These new opiate users were “white,” but of Southern and Eastern European extraction, whose status as members of the white race was deeply questioned during this era of eugenics and fears of immigration.\footnote{Herzberg, supra note 3, at 593.}

Starting in the 1870s, opium dens spread across the nation, operated by Chinese immigrants.\footnote{See Trickey, supra note 19, at 2.} These opium dens, found in most major cities, tended to attract both indentured Chinese immigrant workers and white Americans, especially those who were poor, young and male.\footnote{\textit{Id.}} This seeming change in opiate addict, from unthreatening white woman to fear-inducing delinquent, criminal, or recent immigrant, meant that American views and understanding of addiction transformed. The discourse of addiction used racialized and gendered language that helped inscribe stereotypes of Asians, African-Americans, and
women of all races.84

The reaction to the growing opioid addiction by progressive reformers entirely depended on who the addict was. If the addict was middle class and Anglo-Saxon, their drug dependence was likened to accidental poisoning: “a horrifying tragedy caused by an unregulated market.”85 For these unfortunate souls, the solution was stronger consumer protections, such as correct labeling of medicines, as well as increased professional standards for medical professionals.86

Simultaneously, however, a growing number of medical professionals in the 1920s and 30s began to see addiction as a problem of delinquency and moral rot.87 No longer was addiction viewed as a physical reliance or habituation issue.88 Previously, opiate addicts were viewed with some measure of sympathy, as victims suffering terrible bondage, felled by an unfortunate twist of fate.89 By the early decades of the 20th century, however, illicit opioid addiction began to be characterized as a manifestation of psychopathy or some other form of twisted personality.90 “The average doctor came to think of the average addict as somehow beyond the pale, an unstable and compulsive personality better left to the management of the police or other authorities.”91 As a result, medical professionals began to support mandatory institutionalization of certain types of addicts, and refused to supply opiates to suffering addicts (especially the nonmedical type).92

The increase in regulation and criminalization of opiates gained popularity in part because government regulation was believed to provide a solution to the problem of the autonomous, uncontrolled individual,93 particularly when that individual was neither white nor wealthy. This second kind of narcotics user, who used opiates for pleasure and not medical necessity, was not only seen as psychologically deficient, but also possessing an inborn susceptibility or weakness to addiction from the beginning.94 The nonmedical addict, then, was viewed as inferior, becoming “a profound symbol of deviance to mainstream conventional Americans.”95

This concern about undesirable addicts occurred at a time of rapid industrialization and urbanization, which brought together a mix of people and

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84 See Hickman, supra note 5, at 60.
85 Herzberg, supra note 3, at 594.
86 See id.
87 See Courtwright, supra note 6, at 3.
88 See Gabriel, supra note 28, at 328.
89 See id.
90 Courtwright, supra note 6, at 3.
91 Id.
92 See id.
93 See Gabriel, supra note 28, at 316.
94 See Caroline Jean Acker, Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control 126 (2002); Acker, supra note 49.
95 Acker, supra note 49.
classes in a way that alarmed many middle class and elite Americans. Early 20th century fears about rising numbers of degenerates or feeble-minded individuals led to the belief that positive selective breeding was needed to prevent the hereditary inheritance of certain negative traits. An innate weakness towards addiction was one of them.

Some eugenicists even suspected that opiates were tools used by Asians to overthrow the Anglo-Saxon race. One way to ensure that those individuals with inferior breeding did not mix with proper American stock was to criminalize the substances, such as morphine and heroin, used by these undesirable addicts.

As the number of white, native-born, middle class Americans suffering from opiate addiction began to drop, many nonmedical drug users continued to use these narcotics, simply shifting from legal to illegal substances, such as heroin. As a result, the consensus around addiction transformed into a problem of poor, non-native, inner-city “junkies” using heroin. Medical use of opiates, on the other hand, was deemed under control, and thus far less problematic.

Although strongly promulgated by doctors, drug reformers, and the federal government, this narrative of decreasing iatrogenic users was not entirely correct. “White” medical markets enabled long-term narcotics use for iatrogenic addicts, with only mildly therapeutic reasons. These continuing opiate users, who were white and native-born, tended to live in the Midwest or South, in the suburbs and more rural areas, and obtained their opiates from mostly informal, noncommercial transactions.

Thus, although the standard argument was that the typical face of an opioid addict had changed by the late 1920s and early 1930s, this was not precisely

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96 See id.
98 See id.
99 See EMILY F. MURPHY, THE BLACK CANDLE 188 (1922). Murphy argued, “It is hardly credible that the average Chinese [peddler] has any definite idea in his mind of bringing about the downfall of the white race, his swaying motive being probably that of greed, but in the hands of his superiors, he may become a powerful instrument to this very end.” Id.
100 See Larsson, supra note 97.
101 Herzberg, supra note 3, at 596. As Courtwright further explains, “After 1915 the number of nonmedical addicts continued to increase relative to the total, because of the progressive die-off of medical addicts and the continued recruitment of young users, especially in the slum areas of large cities.” COURTWRIGHT, supra note 6, at 111.
102 Herzberg, supra note 3, at 596.
103 See COURTWRIGHT, supra note 6, at 119.
104 See Herzberg, supra note 3, at 598.
105 See id. at 610.
106 See COURTWRIGHT, supra note 6, at 122.
107 See Herzberg, supra note 3, at 604.
true. Middle and upper class iatrogenic addicts tended to be quite secretive about their use, especially if their narcotics were obtained through the help of a sympathetic physician.\textsuperscript{108} “Good faith” medical practice allowed doctors to prescribe opiates to those in medical need, such as incurable addicts, those approaching the end of life, and temporary relief for the “ordinary addict.”\textsuperscript{109} In other words, doctors continued to enjoy considerable leniency in the prescribing of narcotics, which led to an estimated 35,000 medically supplied addicts nationwide.\textsuperscript{110} Despite this leniency regarding medically enabled opiate access, however, most doctors and citizens believed narcotics addiction had transformed into an urban underworld issue.\textsuperscript{111}

Iatrogenic addicts continued to be supplied by their doctors until at least the 1950s and 60s.\textsuperscript{112} In California, the state AG claimed to have discovered 32,000 licit opiate users, while in Virginia, the majority of addicts obtained their opiates from doctor prescriptions.\textsuperscript{113} Likewise, a federal study of Kentucky in the late 60s found that a large number of addicts were “white, Anglo-Saxon Protestants” from “long-established families,” using physician-provided morphine for long-standing addictions.\textsuperscript{114}

This divided system of treating opiate addicts—turning a blind eye to the many middle class iatrogenic narcotics users who were supplied by their physicians while punishing and criminalizing the urban poor’s illicit use of narcotics—did not end until the 1970s.\textsuperscript{115} Addictive medicines and prescription opiates finally joined heroin and cocaine as controlled substances in the Comprehensive Drug Abuse Prevention and Control Act of 1970.\textsuperscript{116} Use and abuse of opiates was now regulated by the Drug Enforcement Administration (DEA).\textsuperscript{117}

IV. LESSONS FOR TODAY

What can we learn from our nation’s first interaction and bout of addiction with opiates? There are many equivalents to today’s opioid crisis, as well as distinct patterns from which we can learn. First, and most obvious, the sharply rising narcotic and opioid consumption in the late 19th century sparked a major

\textsuperscript{108} COURTWRIGHT, supra note 6, at 123.
\textsuperscript{109} Herzberg, supra note 3, at 599; see also BUREAU OF PROHIBITION, TREASURY DEP’T, REGULATIONS NO. 5 58–59 (1927).
\textsuperscript{110} Herzberg, supra note 3, at 601–02.
\textsuperscript{111} See COURTWRIGHT, supra note 6, at 123.
\textsuperscript{112} See Larsson, supra note 97.
\textsuperscript{113} See Herzberg, supra note 3, at 603.
\textsuperscript{114} JOHN A. O’DONNELL, NAT’L INST. MENTAL HEALTH, NARCOTIC ADDICTS IN KENTUCKY 65 (1969).
\textsuperscript{115} See Herzberg, supra note 3, at 616.
\textsuperscript{117} Herzberg, supra note 3, at 617.
set of concerns and legal and medical reforms, paralleling the crisis today.118

Like today’s opioid crisis, the realization first arose that a large number of people were iatrogenically addicted to opiates, which were prescribed in great amounts to treat chronic, painful conditions.119 Similar to today, when the extent of the addiction was realized, both regulators and physicians sought to severely limit opiate supply and accessibility, lobbying for harsher state and local laws to control narcotics sales and misuse.120 The amount of opiate prescriptions from the late 1890s to the early 1900s dropped precipitously,121 as it has today. And, comparable to the 21st century opiate crisis, a black market in heroin and other drugs quickly arose to serve the desperate, dependent individuals who were now cut off from the opioid supply.122

In addition, the opiate crisis around the turn of the 20th century sparked an unresolved debate about the utility and propriety of long-term maintenance for users, a debate that still currently rages.123 A majority of prisons, jails, and probation/parole programs support an abstinence-based addiction treatment. This dominant abstinence-only model has never recognized medication-assisted treatment (MAT) as an acceptable form of recovery.124

The reality, however, is that treatment for opiate addiction requires long-term management, and it is best managed with help from opioid maintenance programs,125 as politically unpopular as that may be. Medical studies have shown that behavioral interventions alone have very poor outcomes, with more than 80% of patients returning to drug use.126 Psychosocial interventions also lead to death far more frequently than maintenance programs.127 Similarly limited results have been noted with medication-assisted detoxification.128 The harsh physical and psychological effects of withdrawal often require more than

119 See id.
120 See id. at 2096.
121 See id.
122 See id. at 2097.
123 See id.
127 See id. at 209.
128 See id. at 207.
The majority of drug rehabilitation offered in criminal sentencing, however, lies strictly in abstinence regimes, with most parole and probation programs discouraging methadone maintenance and resisting the use of new pharmaceuticals that contain buprenorphine, a partial opioid agonist. Although buprenorphine is a type of opioid, like methadone, and possesses some usual opioid reactions, such as euphoria and respiratory depression, its maximal effects are less than those of full agonists like heroin and methadone, and it carries a lower potential for abuse and addiction.

In September 2002, the DEA increased the classification of buprenorphine from a Schedule V narcotic to a Schedule III narcotic, claiming that the narcotic’s potential abuse “may lead to moderate or low physical dependence or high psychological dependence.” This two-level upwards classification was over the strenuous objection of many physicians and addiction specialists, who argued that it was inconsistent with “the pharmacology and the intended clinical use of the buprenorphine/naloxone sublingual tablets,” which were to help wean addicts from existing opioid abuse. Ironically, about a month later the FDA approved two buprenorphine-based drugs, Suboxone and Subunex, as safe and effective for prescription-based use.

Most detoxification programs in correctional facilities, which treat a high number of addicts, refuse to consider maintenance treatment, whether with methadone or buprenorphine, due to claimed concerns over safety and security. In 2016, only forty jails and prisons across the country offered

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129 Id. at 210.
131 See What Exactly Is Buprenorphine?, supra note 130.
133 Id.
135 See Beth Schwartzapfel, When Going to Jail Means Giving Up the Meds that Saved Your Life, MARSHALL PROJECT (Jan. 29, 2019), https://www.themarshallproject.org/
methadone, and even fewer offered any type of buprenorphine, even to those who were in treatment for opiate addiction.\(^{136}\)

There is a nationwide focus on abstinence in sentencing rehabilitation programs, particularly when prisoners are being paroled or released on probation. This makes treating addicted offenders particularly difficult, given that correctional facilities harbor so many inmates who suffer from drug addiction and dependence.

In Ohio, for example, the state jails function as the state’s largest detox center.\(^{137}\) Most jail detainees do not get any medications to help address their drug withdrawal symptoms, which can be acute.\(^{138}\) Only those who rise above a certain threshold of withdrawal receive any medication, which itself only encompasses anti-nausea drugs, anti-diarrheal medications, and over-the-counter painkillers.\(^{139}\)

Some of the resistance to using either maintenance treatment generally or buprenorphine specifically can be traced to fears that the treatment narcotics will find their way to the street, taking the familiar path from licit to illicit drug. Reports have surfaced that Suboxone pills, a form of buprenorphine combined with naloxone, are being sold on the streets of Cincinnati, Ohio, purchased by those who wish to get intoxicated or to self-medicate.\(^{140}\) For those addicts who are incarcerated, many corrections officials are hesitant to offer maintenance medications due to the combination of cost, bureaucratic difficulty in obtaining and dispensing the narcotics, and the possibility that the drugs could be misused inside correctional facilities.\(^{141}\)

And yet there is a serious danger of going cold turkey for the roughly 30% of inmates who enter correctional facilities addicted to opioids.\(^{142}\) Not only are opioid withdrawal symptoms brutal and extremely painful, but abstinence-based treatment can endanger an offender’s life. Individuals who undergo these abrupt and agonizing withdrawals from heroin and other opioids without an appropriate detoxification process often suffer overdose and death when they are released.


\(^{137}\) See id.

\(^{138}\) See id.

\(^{139}\) Id.


\(^{141}\) See Keilman, *supra* note 130.

from detention, as they have lost their tolerance to the narcotics while incarcerated.\textsuperscript{143} During the first two weeks after correctional facility release, in fact, the risk of dying from overdose is 13 times higher than normal.\textsuperscript{144}

Despite these grim realities, it is currently only Rhode Island that allows its prisoners to all available opioid medication treatments for opioid addiction.\textsuperscript{145} Following this change in treatment options, post-incarceration overdose deaths in Rhode Island plummeted over 60\%, helping reduce the rate of death from overdose statewide by 12\%.\textsuperscript{146} These useful maintenance treatments, however, continue to be shunned by most states and counties, due to fear of misuse, disdain for illicit/criminal addicts, and general disapproval of substituting “one drug (say, heroin) with another (methadone),” especially for those addicts using heroin or other illegal narcotics.\textsuperscript{147}

A few other states have followed Rhode Island’s lead, although in a much less comprehensive way. New York has a methadone clinic at Riker’s Island; Philadelphia has a methadone program for city jails; Vermont and Connecticut run maintenance programs for those offenders who have previously been on methadone or Suboxone; and Massachusetts is currently setting up a system which allows offenders to continue their maintenance treatment.\textsuperscript{148} In addition, the federal government has made a commitment to expanding medication-assisted treatment as a major strategy to help reduce overdose deaths.\textsuperscript{149}

The majority of states, however, stick to abstinence-based programs in their jails, prisons, halfway houses, and drug treatment programs, at most providing addicted offenders Vivitrol, a long-lasting opioid reversal medication, which blocks the effects of opioids but does nothing to treat the withdrawal.\textsuperscript{150} In addition, most state corrections systems only provide Vivitrol upon release from detention, denying even this limited tool to those addicted offenders still

\begin{footnotes}
\item[143] See id.
\item[144] See id.
\item[146] Barnett, supra note 142.
\item[148] See Trickey, supra note 145.
\end{footnotes}
incarcerated.\textsuperscript{151}

It is not difficult to draw a line from most states’ strict abstinence models in criminal justice addiction treatment to our history of discrimination and eugenic philosophy in addressing opioid use. Once the typical user of opioids changed from a white, middle class woman, using legally, to a poor, urban male, often of “the dangerous races,” using illegally, treatment policies transformed accordingly. No longer would either the federal government or the medical establishment look the other way when a long-term addict requested maintenance for their habit; instead, a combination of increasingly harsh drug laws and disdain for narcotic addiction took its place. Our understanding of the stereotypical opioid user has entirely transformed from licit pain sufferer to illicit drug abuser.

In the end, what should be our primary goals in treating opioid abuse, such as “reducing fatal overdoses, medical and social complications, and injection-drug use and related infection” are almost impossible to achieve if we rely only on abstinence-oriented treatment.\textsuperscript{152} Viewing opioid addiction as a moralistic failure in willpower\textsuperscript{153} rather than a disease returns us to the turn of the 20th century, where street “junk” addicts were criminalized but middle-class morphine addicts were quietly permitted.

We must learn from our past mistakes of demonizing opioid addiction, particularly for those criminal offenders who suffer from addiction, and allow these individuals to be treated both humanely and with dignity. Whether an opioid user came to their addiction iatrogenically or through street use, whether at home or imprisoned, there is no call to require them to treat their addictions without the proper maintenance medication. To do so is to implicitly endorse the eugenic philosophy that landed us here in the first place.

V. CONCLUSION

Studying our history of diagnosing and treating opioid abuse can teach us how to avoid the mistakes and pitfalls of the past. Like today, the early 20th century divided opioid addicts into two classes: the licit and the illicit. Although licit users were allowed to quietly continue their maintenance regimes, illicit users were forced to go on the black market to obtain their narcotic, with criminal consequences when they were caught. This artificial division of addict types, reified by gender, class, and race, is replicated in our current criminal justice and sentencing system, with middle class opioid addicts who iatrogenically became addicted to narcotics through over-prescription being

\textsuperscript{152} Courtwright, supra note 118, at 2097.
\textsuperscript{153} See Lopez, supra note 147.
treated far more sympathetically than impoverished heroin addicts, who often turned to street drugs to maintain their habit.

This division is illuminated most dramatically in our treatment of opioid addicts in both sentencing and correctional facilities. Although those with money and resources can enter rehabilitation services that provide long-term maintenance narcotics such as methadone and Suboxone—the gold standard of treating long-term opioid abuse—those who enter the criminal justice system are forced to go through brutal withdrawal from opioids, with no treatment besides abstinence. It is time to require the criminal justice system to provide clinically proven treatment to addicted offenders, and put aside the class, race and gender biases that have once again unwittingly shaped our treatment of our current opioid crisis.
Burn, Sell, or Drive: Forfeiture in the History of Drug Law Enforcement

SARAH BRADY SIFF

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I. INTRODUCTION

Forfeiture is a tactic that has been employed in the enforcement of drug laws in the United States continuously for 150 years. Opium, the original opioid and the first prohibited drug, was the expensive commodity at the center of legal disputes over drug-related forfeitures from the mid-1800s. More or less summary seizure of valuable property from drug offenders, especially of drugs themselves and of vehicles, has consistently yielded revenue for enforcement

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1 The word opioid, though much more recently coined, is interchangeable with opiate, both historically meaning any preparation derived from or containing opium or that produces similar sedating, dulling effects. See Opioid, OXFORD ENGLISH DICTIONARY (3d ed. 2004); Opiate, OXFORD ENGLISH DICTIONARY (3d ed. 2004).

2 Although “[e]veryone knows that the law denies people property rights in illegal drugs and other contraband,” Caleb Nelson, The Constitutionality of Civil Forfeiture, 125 YALE L.J. 2446, 2448 (2016), this article assumes that the forfeiture of such property is worth consideration. Prohibited drugs in particular are extraordinarily valuable by weight, and their
agencies and generated publicity for campaigns of drug prohibition. The U.S. Treasury’s use of forfeiture, originally for tax collection and then for drug and alcohol prohibition, helped fund and expand its enforcement agencies. Local and state governments have also employed statutory forfeiture in drug control with similar results. Prohibitionists and enforcers have long partnered with willing media outlets to showcase dramatic, high-value forfeitures, coverage that appeals to the retributive and moralistic impulses of readers and supports the prohibitive project.

The ethical and moral problems with forfeiture statutes have only fully reached the public sphere over the past twenty-five years or so. Forfeiture has been dubbed “policing for profit,” said to lead to “constitutional kleptocracy” and to amount to “forfeiting our property rights.” These arguments have not fallen upon deaf ears. In February 2019, the Supreme Court unanimously reversed the state of Indiana’s forfeiture of a vehicle seized from a man convicted of selling heroin, incorporating the Excessive Fines Clause of the Eighth Amendment to the states and enabling the defendant to build a defense against the $42,000 forfeiture upon that right. Justice Thomas in 2017 had critically described how civil forfeiture has developed into a tool for law enforcement to collect numerous small payouts from the marginalized and defenseless. He questioned whether the legal status quo on the “broad modern forfeiture practice can be justified by the narrow historical one.”

But the historical practice was not so narrow. Far prior to the statutory forfeiture expansions of the 1970s and 1980s, vast amounts of personal property were confiscated and then destroyed, sold, or pressed into service by government agents in the course of enforcing drug laws. The use of civil status as contraband or nuisance is not innate, but rather shifts according to where and by whom they are owned.

3 See generally Michael A. DiSabatino, Annotation, Evidence Considered in Tracing Currency, Bank Account, or Cash Equivalent to Illegal Drug Trafficking so as to Permit Forfeiture, or Declaration as Contraband, under State Law—Explanation or Lack Thereof, 4 A.L.R. 6th 113 (2005) (reviewing state court forfeiture cases).

4 See, e.g., ‘Lady Day’s’ Car May Be Seized, PITT. COURIER, Nov. 11, 1950, at 1.


8 See Timbs v. Indiana, No. 17-1091, slip op. at 1–2 (U.S. Feb. 20, 2019).


10 Id. at 850.

11 See infra Parts IV, VI.
forfeiture in rem as opposed to criminal forfeiture in personam has merely exacerbated this problem, by routinizing the confiscation of assets in drug cases and expanding the reach of enforcers beyond offenders themselves. Civil and administrative proceedings that deprive people of property even when they are not found guilty have inspired special outrage, but forfeitures as penalties and remedies for crimes are also problematic. The history of this scattered body of drug law, and especially of its enforcement, is not well understood. Even the earliest such laws liberally granted proceeds of forfeitures to enforcement agencies and their personnel. As courts upheld forfeitures and enforcers’ adoption of seized wealth, an entrepreneurial spirit lay hold in drug control. Forfeiture became a solution to the problem of a public that desired a government tough on crime but light on taxation. Aided by a self-interested press, this same public washed its hands of the high human cost of such enforcement, instead eagerly consuming unsympathetic narratives and images that framed forfeiture as just desserts for an immoral caste.

II. FORFEITURE AS REVENUE COLLECTION IN FOUNDING-ERA STATUTES

The historical connection between drug-related forfeiture and revenue generation is clear, for the former originated in federal tax law. The first Congress codified forfeiture in order to enforce collection of import duties and excise taxes on domestic products, which were then the only sources of revenue for a government deep in debt. Perhaps because forfeiture in rem was deeply rooted in England’s methods of revenue collection, the first Congress drew on forfeiture both as a penalty for smuggling and as a means of securing money owed to the United States. Moreover, Congress and the Treasury devised a structure of financial incentives for informers and seizing officers that encouraged zealous enforcement of the revenue laws. Customs collectors were empowered from their creation to board and search any ship and to open and search packages on suspicion of any attempt to defraud the revenue; and could, with a warrant, enter and search private property on land where they suspected smuggled goods were kept. The first customs laws called for forfeiture of ships and vessels only under specific circumstances: for landing merchandise worth more than $400 at night or without the collector’s permission; for fraudulently receiving a drawback for exportation and then delivering the goods to another U.S. port; or for landing dutiable goods anywhere except the designated

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12 See infra Part II.
13 See Nelson Dingley, Jr., The Sources of National Revenue, 168 N. Am. Rev. 297, 298–99 (1899).
14 Nelson, supra note 2, at 2457–60.
15 Id. at 2468.
16 Act of July 31, 1789, ch. 5, §§ 23–24, 1 Stat. 29, 43 (repealed 1790).
17 Id. § 12, 1 Stat. at 39.
18 Id. § 34, 1 Stat. at 46.
ports. Bringing dutiable foreign goods into the country overland meant forfeiture of the goods “together with the carriages, horses, and oxen, that shall be employed in conveying the same.” Procedures were set for advertising and auctioning forfeited merchandise and ships and for dividing proceeds among the U.S. Treasury, the collector himself, other seizing officers, and informers, if any.

The first Congress also laid a contentious internal tax on distilled spirits and set out a system of districts and personnel for enforcing collection. Removing untaxed spirits from a distillery could trigger their forfeiture “together with the cask or casks containing, and the horses or cattle, with the carriages, their harness and tackle, and the vessel or boat with its tackle and apparel employed in removing them.” It authorized the seizure of untaxed liquor “found in the possession of any person,” the possession itself being “presumptive evidence that the [spirits] are liable to forfeiture”; and divided the proceeds of forfeitures between the Treasury and “the person or persons who shall make a seizure, or who shall first discover the matter or thing.” This so-called Whiskey Tax was repealed in 1801, reinstated from 1813 to 1817, then repealed; and no internal federal taxes were again levied until the Civil War.

Although opium in various forms had been available in apothecaries’ shops and among general merchandise since colonial times, its consumption by early Americans apparently was neither robust nor recreational (unlike distilled spirits, which they consumed in large quantities). For the first century of American independence, opium was a valuable, highly concealable commodity that became contraband when smuggled—much like silk, diamonds, and other sumptuary goods. In 1790, opium was subject to an ad valorem import duty of 7.5%, and in 1794, of 12.5%; it was duty-free from 1816 to 1828, when a 15% duty was imposed. In 1832, the opium duty was abolished along with that on many other items as part of a general reduction in the tariff. Congress imposed a specific duty of 75¢ per pound on opium in 1842, modified to 20% ad valorem

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19 Id. § 40, 1 Stat. at 48–49.
20 Id. § 40, 1 Stat. at 49.
21 Id. §§ 36–37, 1 Stat. at 47–48.
22 Act of July 31, 1789, § 38, 1 Stat. at 48.
24 Id. § 19, 1 Stat. at 204.
25 Id. § 28, 1 Stat. at 206.
26 Id. § 44, 1 Stat. at 209.
28 In 1860, “production of whiskey was one of the chief industries of the nation, and the still . . . an almost necessary appendage to every farm.” Frederic C. Howe, Taxation and Taxes in the United States under the Internal Revenue System 1791–1895, at 137 (1896).
29 S. Doc. No. 22–24, at 10 (1832).
30 Act of July 14, 1832, ch. 227, § 3, 4 Stat. 583, 590.
in 1846 and $1 per pound in 1861. Such rates were in line with those on imported liquors and other foreign luxuries, with a view to generating revenue rather than protecting American trade or banning harmful substances. Ship passengers, particularly the Chinese immigrants who arrived to the United States beginning in the mid-19th century and brought along their opium smoking habit, continuously smuggled the compact and expensive article into the country. In 1853, the appraiser at the San Francisco custom house wrote the Secretary of the Treasury that packages of duty-free goods “require as much examination as the dutiable; for in the cheap and free articles we frequently find opium and other valuable articles concealed in tea, sugared pork, or Chinese vegetables.” Yet most smoking opium probably continued to enter the country legally, imported in bulk by early-arriving Chinese merchants who paid the customs duty and then sold their countrymen’s favored brands at retail in small amounts, enough for daily use. The tariff did not yet distinguish between crude opium and the more expensive refined opium for smoking, creating an opportunity for importers to pay a relatively low duty on the priciest brands.

III. ANTI-C HINESE, ANTI-S MUGGLING, AND THE FIRST PROHIBITIVE DRUG TAX

On the West Coast, as the local distaste for Chinese immigrants grew, so did the public scorn for opium smoking. At the same time, the Civil War was greatly increasing the national debt, and Congress in typical fashion sought relief by raising import duties. Yet lawmakers were beginning to recognize the need to balance higher rates of taxation against the resulting incentive to evade. So when, in 1862, a revised tariff separated smoking opium from crude opium and taxed the former at 80% ad valorem (increased to 100% in 1864), the likely intent was to effect a prohibition of this odd foreign habit, and thereby to inconvenience Chinese immigrants. Such result could be had while avoiding

31 S. Doc. No. 54–219, at 112, 125, 142 (1896).
32 See, e.g., id. at 113 (detailing the rates for spirits and other luxury items).
33 See, e.g., Celestial Frauds: Smuggling Opium—Ingenious Expedients, S.F. Chron., Nov. 9, 1869, at 3 (describing various smuggling methods).
36 S. Doc. No. 54–219, at 183, 212.
37 No other article in the tariff of 1862 is subject to an ad valorem rate of 80% or more; neither are any articles except opium taxed at 100% in 1864. Id. at 178–95, 202–18 (1896). The Congressional Record contains no discussion of either increase in the opium duty. However, it does contain debate over Congressman August Sargent of California’s failed attempt to amend the 1862 tariff to discourage Chinese immigration, by raising the duty on cleaned, or milled, rice, the bulk of which imports in the state were consumed, he said, by Chinese immigrants. See Cong. Globe, 37th Cong., 2d Sess. 2938 (1862) (“[The Chinese] are, as a class, characterized by vicious habits; and the State would be very glad to get rid of them altogether. In smoking opium and in intoxicating themselves with other drugs, they
damage to American manufacturers of morphine—needed to treat wounded soldiers—and other therapeutic preparations of opium including patent medicines.

At the end of the Civil War, a Radical Republican Congress enacted the Smuggling Act of 1866 as a way to both pay down the war debt and to flex the United States’ muscles against external threats in an uncertain geopolitical environment.\textsuperscript{38} Thereafter a prohibitive tax on smoking opium desired by one state, California, was bolstered by federal law via extravagant customs enforcement powers. The Smuggling Act’s provisions for searching, seizing, arresting, and using force, along with those established by a concurrent modification of the internal revenue law, set the tone for federal policing of drugs and alcohol for decades to come. The Act gave broader authority to members of an enlarged force of personnel\textsuperscript{39} to board any vessel and to “inspect, search, and examine the same, and any person, trunk, or envelope on board, and to this end, to hail and stop such vessel if under way, and to use all necessary force to compel compliance.”\textsuperscript{40} If it appeared that any goods or merchandise were subject to forfeiture, any member of this force could seize the property and the vessel and could arrest or pursue “any person engaged” in the violation.\textsuperscript{41} Furthermore, enforcers of the new customs law could apprehend and examine “any vehicle, beast, or person on which or whom he or they shall suspect there are goods, wares, or merchandise which are subject to duty or shall have been introduced into the United States in any manner contrary to law” and could “search any trunk or envelope, wherever found, in which [they] may have a reasonable cause to suspect there are goods which were imported contrary to law,” and when finding such goods, should seize them.\textsuperscript{42} Furthermore,

\begin{quote}
Every such vehicle and beast, or either, together with teams or other motive-power used in conveying, drawing, or propelling such vehicle, goods, wares, or merchandise, and all other appurtenances, including trunks, envelopes, covers, and all means of concealment, and all the equipage, trappings, and other
\end{quote}

\begin{itemize}
\item have, by their carelessness, set fire to their own wooden houses, and been the cause of the destruction of many of our towns. . . . In morals and in every other respect they are obnoxious to our people. The women are prostitutes and the men petty thieves. But how can we keep them out?”
\end{itemize}


\textsuperscript{39} Act of July 18, 1866, ch. 201, § 2, 14 Stat. 178, 178 (empowering “any officer of the customs, including inspectors and occasional inspectors, or of a revenue cutter, or authorized agent of the Treasury Department, or other person specially appointed” by customs and naval officials).

\textsuperscript{40} Id.

\textsuperscript{41} Id.

\textsuperscript{42} Id.
appurtenances of such beast, team, or vehicle shall be subject to seizure and forfeiture . . . .\textsuperscript{43}  

The Act provided fines and imprisonment for smuggling activities and for refusal to submit to a search, and penalized any person who “shall receive, conceal, buy, sell, or in any manner facilitate the transportation, concealment, or sale” of goods once imported, and called for the forfeiture of those items.\textsuperscript{44} A defendant’s possession of such items “shall be deemed evidence sufficient to authorize conviction, unless the defendant shall explain the possession to the satisfaction of the jury.”\textsuperscript{45} Proceeds from the forfeiture of seized goods, vessels, and vehicles were to be distributed according to a 1799 law on customs collection.\textsuperscript{46}  

The increased authorization to search and seize people and property, along with increases in the tariff and economic incentives for enforcers, engendered widespread fraud and corruption in short order.\textsuperscript{47} After San Francisco collectors seized a large cargo of openly landed opium for a minor undervaluation, an editorial in one local paper fretted that federal efforts to nurture trade between the western U.S. ports and China risked defeat by a “vicious system of revenue laws, which throws the import trade into the hands of a class of spies and informers, who, for personal profit, pervert the plain intentions of the law.”\textsuperscript{48} Grift was common and did indeed seem to perpetuate the very same frauds on the U.S. revenue that the law had aimed to mitigate. Treasury Special Agent John McLean reported to Congress an 1868 incident during which customs personnel seized a large shipment of smuggled opium, stashed in the ceilings above various state rooms, on a ship from China.\textsuperscript{49} Instead of reporting the haul as a single seizure, they divided it into small ones worth less than $500 each,\textsuperscript{50} which entitled them to divide the proceeds from the opium’s sale without first remitting the unpaid duty to the Treasury.\textsuperscript{51}  

\textsuperscript{43} Id. § 3, 14 Stat. at 178.  
\textsuperscript{44} Id. § 4, 14 Stat. at 179.  
\textsuperscript{45} Act of July 18, 1866, ch. 38, § 4, 14 Stat. 178, 179.  
\textsuperscript{46} Id. § 31, 14 Stat. at 186. By terms of the Act of March 2, 1799, ch. 22, § 91, 1 Stat. 627, 697, after deducting the costs of litigation and sale, remaining funds were split into moieties, or equal parts, and sometimes further divided among enforcement personnel. Under ordinary circumstances, half was paid to the Treasury and half was divided between the collector, naval officer, and surveyor. Id. But if an informer not employed by the government gave information leading to the forfeiture, he was to receive half of the half normally split between the officers, and the officers were to split the remaining quarter; and generous provisions were made for the officers of revenue cutters who made seizures leading to forfeiture. Id.  
\textsuperscript{47} See Cohen, supra note 38, at 382–84 (describing the extent and variety of smuggling and official corruption after 1866, such as the collection of $316,700 in moieties over three years by a single Treasury agent).  
\textsuperscript{48} Editorial, The China Trade—Seizures, DAILY ALTA CAL., Mar. 15, 1867, at 2.  
\textsuperscript{49} S. REP. NO. 41-47, at 108–09 (1870).  
\textsuperscript{50} Id.  
\textsuperscript{51} Act of March 2, 1867, ch. 188, § 1, 14 Stat. 546, 546.
On the West Coast, the new style of tough customs enforcement resulted in continual harassment of passengers arriving from China as federal and local agents sought to make high-value opium seizures. Beginning in 1867, San Francisco newspapers regularly carried advertisements for custom house auctions dominated by numerous lots of seized opium, some in large quantities and some reflecting multiple smaller seizures from individual passengers.52 The rough and invasive searches of Chinese immigrants caught the attention of newspaper reporter Mark Twain, who had spent most of the 1860s in California, growing increasingly outspoken about anti-Chinese prejudice.53 In 1870 he was contributing a column to The Galaxy magazine for which he wrote a series of satirical letters from a fictional Chinese immigrant to a friend at home.54 In one installment, the Chinese traveler describes his arrival at the port of San Francisco, where a small packet of opium becomes a pretext for officials to confiscate all his belongings and arrest his companion:

I stepped ashore jubilant! I wanted to dance, shout, sing, worship the generous Land of the Free and Home of the Brave. But as I walked from the gang-plank a man in a gray uniform* kicked me violently. . . . I was about to take hold of my end of the pole which had mine and Hong-Wo’s basket and things suspended from it, when a third officer hit me with his club to signify that I was to drop it, and then kicked me to signify that he was satisfied with my promptness. Another person came now, and searched all through our basket and bundles, emptying everything out on the dirty wharf. Then this person and another searched us all over. They found a little package of opium sewed into the artificial part of Hong-Wo’s queue, and they took that, and also they made him prisoner and handed him over to an officer, who marched him away. They took his luggage, too, because of his crime, and as our luggage was so mixed together that they could not tell mine from his, they took it all.

*Policeman.55

At this time, the American press was awash in “cheap print” following the rapid proliferation of inexpensive periodicals to a highly literate public that delighted in crime news and salacious reporting.56 California workers, hackles raised toward the cheap Chinese labor force as the gold rush petered out and the economy contracted, could vicariously enjoy the custom agents’ games of cat and mouse by reading the news. Coverage of opium arrests and seizures reflected casual racism mixed with a keen fondness for intrigue and vice.

52 See, e.g., Notice to Claimants, DAILY ALTA CAL., Jan. 3, 1868, at 2.
54 See id. at 457.
55 Id. at 457.
Readers were especially fascinated by Chinese passengers’ methods of opium concealment, as in this 1869 news account of Chinese arrivals to San Francisco:

Almost every conceivable method has been adopted by the smugglers to elude the vigilance of the revenue force. Opium has been brought from China concealed in tea chests, braided in the cues of immigrants, secreted in birds’ nests and hidden in the soles of the elegant Chinese shoe. Elaborately constructed beetles of monstrous size, apparently preserved specimens in natural history, have been discovered to be made almost entirely of opium. Eggs have been broken whose yolks were great compact boluses of the narcotic drug, sufficient to get fifty Celestials as drunk as a poppy seed vessel on the ocean in a typhoon. Cigarettes have been found which contained opium instead of tobacco. Dried fish have been found stuffed with it, and we are not sure that a mummified-looking old Celestial, so dried up that he looked as if he might be a first cousin to the sun and had held a place of trust near King Sol’s person, who was carefully carried in a hack from the China steamer, not long since, was not the solidified extract of the poppy ingeniously constructed into an automaton.  

News accounts often drew on stereotypes and poked fun at the immigrants. For example, after describing how Treasury agents had discovered Chinese passengers disguising wax-covered, egg-shaped brass vessels filled with opium as “pickled eggs,” a writer for the San Francisco Call commented:

These are the kind of eggs with which John settles his coffee, or makes a Mongolian omelet. [sic] What a sleepy hen it must be that lays such an egg! The question arises, will its chicken pipe its note now as usual since the seizure? We are not sure whether it is of the Shanghai stock.  

An 1881 article in the San Francisco Examiner relayed an unnamed customs officer’s ramblings:

The worst smugglers, and the ones that give us the most trouble, are the Chinese. I don’t mean the raw coolies, fresh from Canton, who don’t know the difference between the violation of the revenue laws and the common breaking of one of the commandments, but the old hands who have made two or three voyages. . . . Raw and manufactured silks, pearls, ivory ornaments, Chinese drugs and opium are the principal articles they attempt to smuggle. As for the first-named articles we have no trouble in detecting their presence, as they are bulky and awkward to stow away, except about the person, and we always search them down to their measly, yellow hides. Opium is what troubles us.  

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57 Celestial Frauds, supra note 3, at 3.
58 A Cunning People, SANTA CRUZ SENTINEL, June 4, 1864, at 1.
59 The Dead Smuggler, S.F. EXAMINER, Dec. 1, 1881, at 3.
This article ended with a grisly tale of the officer’s discovery of smuggled opium in the stomach of a corpse brought ashore by two Chinese men who had hacked off its legs and stowed it in a trunk.60

IV. SEIZING THE OPIUM: ENFORCEMENT, CORRUPTION, AND THEIR PRESS

The smoking opium most beloved by the Chinese in California was made by expert “cookers” in Hong Kong from crude opium produced in India.61 Congress targeted smoking opium with prohibitive import duties from 1862; at the hands of California senators and congressmen, often using the language of temperance, duties on smoking opium were pushed ever higher, at one point reaching $12 per pound when the going price was around $7.62 Importers worked around the tariff by allowing their opium to be seized by customs and then buying it at auction for a price well below the duty, an arrangement that benefited local customs officers.63 Employees of the auction house selling seized opium in San Francisco were suspected of colluding with a Chinese “opium ring” to sell at just above the government’s minimum price but later exchange it for slightly more, keeping the difference instead of their commission.64 Due to these and other workaday frauds at ports across the country, Congress passed an Anti-Moiety Act that limited rewards to customs personnel and informers and required the funds to be channeled through the Treasury.65

Before long, enterprising Chinese in San Francisco were preparing their own smoking opium from raw opium, which was subject to a much lower tariff because it was used by pharmaceutical firms to manufacture morphine.66 In 1880, the United States entered into a treaty with China in which each agreed that its own citizens would not be permitted to trade in opium at any port of the other, and the Treasury instructed collectors in San Francisco to seize and forfeit any opium imported by any Chinese national.67 Several wholesalers and bankers soon began importing opium and selling it to Chinese merchants, pocketing a tidy profit.68 Also in 1880, Congress placed an excise tax on the domestic production of smoking opium, and the Treasury issued an onerous booklet of regulations that included registration and specifications for “factories,” which were required to be open to federal inspectors at all times; a $5000 bond to

60 Id.
63 See, e.g., Shady Opium Deals, S.F. CHRON., Nov. 24, 1893, at 10.
64 See T h e O p i u m A u c t i o n s, S.F. CHRON., Nov. 27, 1893, at 8.
66 See Opium Smuggling, S.F. CHRON., July 8, 1887, at 6.
procure a license, which could only be had by American citizens; and affixing stamps to each package after paying $10 per pound in excise.\(^{69}\) Not a single license was issued, and the Treasury collected no taxes.\(^{70}\) Illicit domestic opium refinement, or “cooking” of banned crude opium, was so successful in San Francisco that one of the largest and most sensational seizures made at that port involved American merchants colluding with a customs inspector to smuggle locally made smoking opium out of the city on a boat to Hawaii.\(^{71}\) In the case that unfolded, the owner of the goods intervened to have the seized opium returned on the grounds that he had not in fact been smuggling opium into the country.\(^{72}\) Although evidence presented at the trial tended to prove the petitioner’s version of facts and that customs agents had apparently fabricated parts of their story to help secure the forfeiture, the opium was forfeited because, as the judge wrote, civil cases need not be proven beyond reasonable doubt.\(^{73}\)

Journalists did not ignore the bad behavior at the custom house. Many in California had a nuanced view of the opium problem and looked warily to both Congress and to local governments for solutions. In 1879, discussing a proposed municipal anti-opium ordinance, the editors of the Los Angeles Herald approvingly quoted a contemporary writer in support of their argument that opium dependence should be confronted with medical rather than legal remedies:

> If philanthropy and law have failed to abolish alcoholic drunkenness, law will assuredly fail to abolish opium eating, for law is a gauze barrier against the attack of money, and the druggist who will not sell the most profitable article of his stock because a legislature forbids, is a man above the average of tradespeople. If such a [prohibitive] law were passed, a special policeman would have to be placed in every drug store to watch the druggist, and a detective to watch the policeman—but who should watch the detective? Even detectives will take money, drink whiskey and eat opium.\(^{74}\)

The editors of the San Francisco Chronicle wrote that it was common knowledge that very high duties encouraged smuggling.\(^{75}\) Gone were the days of the smuggler as a romantic figure in European literature, the editors wrote,

> where the low, black lugger is chased by the King’s ship, and the goods are landed at night and concealed in some cave or secret chamber unknown to the

\(^{69}\) U.S. INTERNAL REVENUE, NO. 16, REGULATIONS CONCERNING THE TAX ON OPIUM MANUFACTURED IN THE U.S. FOR SMOKING PURPOSES UNDER THE ACT APPROVED, OCTOBER 1, 1890, at 4–7 (1890).
\(^{70}\) The Sticky Drug, S. F. CALL, Jan. 7, 1893, at 7.
\(^{71}\) See Three Thousand Eight Hundred and Eighty Boxes of Opium v. United States, 23 F. 367, 369, 373 (C.C.D. Cal. 1883).
\(^{72}\) Id. at 376.
\(^{73}\) Id. at 395–96.
\(^{75}\) Opium Smuggling, S.F. CHRON., Jan. 18, 1888, at 4.
revenue officers; but here, where a meek-eyed Mongol hides away a box or package of prepared opium under his coat or in his box, and is ignominiously hauled about and poked here and there until it is found, there is nothing romantic about it. All the romance nowadays consists in catching some Custom house officer dividing the plunder with the smuggler and seeing his attempts to get out of the meshes of the law.\textsuperscript{76}

V. THE STATE’S ELECTIVE ROLE IN PROHIBITING DRUGS AND ALCOHOL

California’s statewide regulation of opium and cocaine sales began early, in 1891, when the legislature passed a Pharmacy Act requiring a pharmacist’s license to “conduct any pharmacy or store for dispensing or compounding medicines,”\textsuperscript{77} commanding pharmacists to record buyers’ names and sale amounts of scheduled drugs, including opium,\textsuperscript{78} and creating a seven-member board of pharmacy charged with issuing licenses and investigating infractions.\textsuperscript{79} In 1907, a state Poison Act prohibited the sale of morphine, codeine, heroin, opium, and cocaine without a prescription;\textsuperscript{80} in 1909, lawmakers added cannabis (as “Indian hemp”) to the schedule of poisonous drugs requiring labeling and record-keeping,\textsuperscript{81} outlawed possession of opiates and cocaine without a prescription,\textsuperscript{82} and forbade doctors to prescribe them to “habitual users.”\textsuperscript{83} Amendments in 1913 made it a crime to possess pipes and other paraphernalia for smoking opium as well as “extracts, tinctures, or other narcotic preparations of hemp, or loco-weed.”\textsuperscript{84} This version also authorized “any peace officer” to seize prohibited opiates, hemp, and paraphernalia, requiring judges to condemn such seizures and deliver them up to the pharmacy board, which could in turn destroy them or dispose of them “either by gift to the medical director of California state prisons or state hospitals or by sale to wholesale druggists, the funds received from such sales to be applied by the board of pharmacy to the carrying out of the provisions of this act or the [Pharmacy Act].”\textsuperscript{85} In an early example of codified “equitable sharing,” fines and forfeited bond money would be divided between the state pharmacy board and the city or county enforcement agency in a 75/25 split.\textsuperscript{86}

The pharmacy board drafted local officers into their raiding parties and seized opium and paraphernalia in the course of arresting Chinese smokers as

\textsuperscript{76} Id.
\textsuperscript{77} Pharmacy Act, ch. 85, § 1, 1891 Cal. Stat. 86, 86.
\textsuperscript{78} Id. § 10, 1891 Cal. Stat. at 89.
\textsuperscript{79} Id. § 6, 1891 Cal. Stat. at 87.
\textsuperscript{80} Poison Act, ch. 102, § 8, 1907 Cal. Stat. 124, 126.
\textsuperscript{82} Id. sec. 4, § 8, 85 Stat. at 424.
\textsuperscript{83} Id. sec. 4, § 8, 85 Stat. at 425.
\textsuperscript{84} Act to Amend the Poison Act, ch. 342, sec. 6, § 8(a), 1913 Cal. Stat. 692, 697.
\textsuperscript{85} Id. sec. 7, § 8(b), 1913 Cal. Stat. at 697–98.
\textsuperscript{86} Id. sec. 4, § 7, 1913 Cal. Stat. at 694.
well as doctors, druggists, and other drug sellers and users. In 1922, the value of a seizure in San Francisco was placed at more than $1500 and described like this:

The confiscated outfit included everything from opium, yen shee and yen pock to pipes, els to scrape the pipes and “gee rags,” which are used in the pipe bowl to prevent air from entering. Little peanut oil lamps with glass guards and trimming scissors were also seized, together with devices used for cooking opium. A delicate pair of scales of ivory and brass was also seized.

In 1923, a state narcotics inspector posed for a newspaper photograph with seized drugs arranged much like a store window product display, under the heading, “Dope From Many Raids Shipped North.” The drugs, reportedly valued at $30,000, had been seized by Los Angeles police during the month of February 1923. The newspaper explained: “After being used as evidence against peddlers and addicts, on whom they were found, the drugs are issued to hospitals and State institutions by the Pharmacy Board.” The article was printed next to an account of a raid by the city’s “hop squad,” under the state inspector’s command, on a Chinatown “opium den,” where the team seized $1700 in “narcotics, together with a number of pipes and other furnishings of the place.” This seizure entailed a pursuit “through devious passages and up a short, narrow stairway, but the fleeing addicts had escaped to the roofs of the adjoining buildings.” To illustrate the story, one of the officers lay on a cot beside a table of paraphernalia, pipe to his lips, to pose as an opium smoker for a photograph.

Even when seized drugs could not be sold for a profit, their public destruction could serve as a deterrent to future crime and satisfy prohibitionists that enforcement was effective. Pharmacy board agents frequently made a public spectacle of destroying seizures by burning piles of collected opium and paraphernalia in the street. As early as 1912, a San Francisco newspaper printed a photograph of a crowd gathered around a pyre under the headline “Old Sam Sing Beholds a Holocaust for His Good.” The bonfire was built from $40,000 in “opium and utensils” and attended by eight pharmacy board

88 Opium Smoking Outfit Worth $1,500 Seized, OAKLAND TRIB., July 31, 1922, at 7.
89 Dope from Many Raids Shipped North, L.A. TIMES, Mar. 13, 1923, at III.
90 Board Gets Seized Drugs, L.A. TIMES, Mar. 13, 1923, at III.
91 Id.
92 Opium Den Raided by Police, L.A. TIMES, Mar. 13, 1923, at III.
93 Id.
94 Id. at III.
95 See, e.g., $25,000 Dope Raid-Seized, Up in Smoke, S.F. EXAMINER, Aug. 7, 1921, at 15.
96 Pharmacy Board Inspectors Burn on Street Opium and Utensils Worth $40,000, S.F. CHRON., May 10, 1912, at 18.
members, including the president, and one inspector, all named by the reporter, who wrote:

Sutherland deluged the pile with kerosene and McKown applied a match. In an instant the flames leaped thirty feet into the air. The costly pipes crackled and curled into strings of charcoal, the opium began to burn and a dense black pungent smoke arose.

Then a strange thing happened. Some wise and charitable gust of wind swirled a great plume of the black smoke toward the window, where Sam Sing sat gazing at the flames like an astounded and grief-stricken mummy.

The dream laden smoke enveloped his old head.97

News items about the burning of drugs commonly appeared in cities, usually noting the value of the destroyed contraband in dollars. “That heavy pall of smoke drifting over Police Headquarters, Manhattan, late this afternoon was caused by a fire fed with $100,000 worth of narcotics, opium pipes and other material seized during the past three months by members of the police narcotic squad,” read one account.98 “The material is fed to the flames gradually, on a clear and breezy day, for it is probable that too much smoke from the burning habit forming drugs might have a tendency to bring pleasant dreams to those who might inhale the flames too deeply.”99 In 1913, a federal judge ordered both the destruction and sale of property seized in Terre Haute, Indiana, from two Chinese men, neither of whom appeared at the hearing.100 Items to be destroyed, according to the local newspaper, included:

five pounds of cooked opium, four pounds of boiled gum opium, seven gallons of opium extract, one bag of gum opium, twenty pounds of gum opium boiled, twenty-five empty powdered opium cans, one quart jug of unknown contents, one two-gallon can, one twenty-five-pound tin can, one twenty-five-pound empty opium can, one two-gallon stone jar, a one-gallon crock and eight cans of different sizes.101

To be sold: “brass and copper kettles, jars, spring scales, dipper, sieve and a gasoline stove.”102

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97 Id.
98 Police Burn $100,000 in Seized Narcotics, STANDARD UNION (BROOKLYN, N.Y.), Jan. 16, 1930, at 2.
99 Id.
100 Orders Opium Destroyed, INDIANAPOLIS STAR, May 17, 1913, at 3.
101 Id.
102 Id.
VI. FORFEITING GUILTY AND INNOCENT VEHICLES

The widespread forfeiture of automobiles for drug infractions began as soon as average Americans could afford to drive them. In 1921, the California legislature amended the Poison Act to enable “any duly authorized peace officer” to seize as evidence any automobile “used by or with the consent or knowledge of the owner thereof, to unlawfully convey, carry or transport any cocaine, morphine, heroin, or opium.” Upon conviction of the driver, a seized car was to pass through the hands of the state board of control, which “shall deliver to the state board of pharmacy such number of said machines as may be needed by the board of pharmacy in enforcing the provisions of this act.”

The provision for forfeiture of a vehicle upon conviction for violating the state’s drug laws was similar to that in the new federal law for enforcing national Prohibition. On referendum, California voters had both passed these forfeiture amendments to the poison act and defeated a state alcohol prohibition act. However, the state’s legendary resistance to alcohol prohibition was broken once federal agents began enforcing the Volstead Act. On Election Day in 1922, at least one newspaper printed a report from the head of federal prohibition in California: Enforcement there had netted the United States more than $1.5 million in “seizures, taxes, fines and other penalties” during October alone, while costing only about $22,000 including salaries.

Statistics for the record-setting month, the official said, showed 46 automobile forfeitures, $123,207 in taxes and fines, and 903 arrests. California voters that day passed the Prohibition Enforcement Act, enabling the state to field its own profitable enforcement of the Eighteenth Amendment.

The National Prohibition Act situated federal enforcement in the Treasury, which created a Prohibition Bureau to manage the impossible task of forcing millions of Americans to give up their booze. The Treasury’s long history of collecting excise taxes on alcoholic beverages inclined it toward forfeiture as an enforcement tactic, but Congress had placed some safeguards in Section 26, which provided for vehicle forfeiture.

The loss of a vehicle used to transport

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103 Act to Amend Poison Act, ch. 581, sec. 2 § 8(g), 1921 Cal. Stat. 978, 979.
104 Id.
105 See Act of Oct. 28, 1919, ch. 85, § 26, 41 Stat. 305, 315–16 (allowing for forfeiture of a vehicle “[w]henever intoxicating liquors transported or possessed illegally shall be seized”).
107 Enforcement Is Profitable, SAN BERNARDINO DAILY SUN, Nov. 7, 1922, at 1.
108 Id. The balance of the revenue presumably was derived from some 7,000 gallons of seized liquor, 138,000 gallons of wine, and the forfeiture of property on which 36 moonshine stills had been discovered. Id.
109 Prohibition Enforcement Act, ch. 80, 1921 Cal. Stat. 79.
110 See § 26, 41 Stat. 305, 315–16.
112 § 26, 41 Stat. 305, 316.
or conceal alcohol was a criminal penalty upon conviction rather than a separate civil process, and “innocent owners” such as finance companies holding liens on seized cars were protected from losing their interest. But within a few years, the Bureau began testing a new strategy of bringing forfeiture proceedings under the Internal Revenue Code, which had been used since 1866 for enforcing the liquor tax. U.S. attorneys drew on the internal revenue law to prosecute automobiles in rem for removing, depositing, or concealing untaxed alcohol rather than attempting to adopt the vehicles under the Volstead Act’s newer provisions. The courts, while circumscribing this practice to some extent, never completely barred the Bureau from doing so. The number of cars seized by federal prohibition agents increased each year from 1920 (209 cars) to 1933 (12,222 cars).117

Meanwhile, Congress had banned importation of non-medicinal opium in any form in 1909118 and then in 1914 had passed the so-called Harrison Act, an internal revenue law that required registration with the Treasury and payment of a tax in order to possess, buy, or sell any form of opium or cocaine. Customs already had been enforcing the opium ban, but enforcement of the Harrison Act was uncertain until it was folded into the new Prohibition Bureau. In practical terms this union meant that both drugs and alcohol were policed together by federal agents. But the narcotics division was far less successful with forfeiting automobiles under the Internal Revenue Code; after just a few years, the Eighth Circuit Court of Appeals held that Section 3450 of the Revised Statutes could not be applied to Harrison Act forfeitures. Thereafter the division sought to apply Sections 3061 and 3062 of the Revised Statutes—customs forfeiture provisions dating from the 1866 Smuggling Act—to narcotics forfeitures, reasoning that the vast majority of smoking opium, opium derivatives, and cocaine found in violation of the Harrison Act would necessarily have been imported illegally. In order to avail themselves of the customs laws, the narcotics agents had to turn the cars over to customs collectors

113 See id.
114 Murchison, supra note 111, at 427–28.
115 Id. at 428.
116 Id.
117 BUREAU OF INDUS. ALCOHOL, U.S. TREASURY, STATISTICS CONCERNING INTOXICATING LIQUORS 95 (1933). The numbers for each year from 1921 to 1932 are 706, 1886, 3977, 5214, 6089, 5935, 7137, 6934, 7299, 8633, 8499, and 11,833. Id.
120 See Audrey Redford & Benjamin Powell, Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914, 20 INDEP. R. 509, 511–12 (2016) (noting the difficulty of drug enforcement prior to the adoption of the Harrison Act).
121 United States v. Mangano, 299 F. 492, 496 (8th Cir. 1924).
122 See Memorandum from R.C. Valentine, Head of Law Division, Bureau of Narcotics, to Mr. Anslinger, Comm’r, Bureau of Narcotics 1, 9–10 (July 21, 1932) (on file with National Archives & Records Administration, RG 170, Subject Files, Box 47) [hereinafter National Archives].
to be forfeited; moreover the customs statute did not work exactly like the internal revenue statute, requiring an uncomfortable period of adjustment.\textsuperscript{123} For example, while the language of the Harrison Act made possession of the newly illicit substances without a doctor’s prescription presumptive evidence of guilt, that language applied only to a criminal proceeding.\textsuperscript{124} The crucial element in forfeiture proceedings under the customs laws, on the other hand, was establishing probable cause for the initial seizure.\textsuperscript{125} Narcotics agents had to convince judges that they knew a suspect’s car contained narcotics \textit{imported} contrary to law, or that the suspect knew them to be illegally sourced.\textsuperscript{126} Other enforcement matters also arose. According to the language of the customs law, the contraband would have to be found inside the car at the time of the search, and the seizure would have to be made on the spot.\textsuperscript{127}

Yet seizures of drugs, alcohol, and cars continued apace, with federal agents from all corners of the Treasury setting the tone with a brusque and merciless style of enforcement. The press did not report on prohibition raids in order to inspire outrage over hidden motives or strongarm tactics. Rather, they aimed at readers’ retributive and moralistic impulses in a distinct genre of tales about dangerous rascals who got their comeuppance. In a brief on the 1922 seizure by Memphis police of “narcotic drugs, imported whisky [sic] and automobiles valued at almost $35,000,” the reporter, though failing to list the names of those detained, provided this bit of local color: “In one house raided, where two stills were located, the walls of the room used for distilling purposes, were covered with framed Biblical passages.”\textsuperscript{128} Reading these un-bylined stories a century later, other striking elements are the overreliance of reporters on law-enforcement sources and the lack of curiosity about suspicious assertions. This introduction to a 1921 news report captures the breathlessness of media coverage of cooperative raids that often captured drugs, alcohol, and property—and could result in death:

Eighteen Federal agents in a raid at 5 o’clock yesterday morning seized narcotics and liquor said to be worth $1,000,000, shot at least five Greek sailors, blackjacked about twenty more, made 327 prisoners, and seized a 15,000-ton ship, the King Alexander, anchored alongside Pier 22, at the foot of Atlantic Avenue, Brooklyn.\textsuperscript{129}

The article grows wilder from there, relating how customs officers, excluded from the raid due to suspicions of collusion with the smugglers, fired on the

\textsuperscript{123} See id.
\textsuperscript{124} Harrison Narcotics Tax Act, ch. 1, § 2, 63 Stat. at 786.
\textsuperscript{126} Id.
\textsuperscript{127} See id.
\textsuperscript{128} Liquor, Automobiles and Drugs Seized, ATLANTA CONST., Mar. 23, 1922, at 18.
\textsuperscript{129} 5 Shot in $1,000,000 Drug Raid, 1 Missing; Greek Liner Seized, N.Y. TIMES, Sept. 10, 1921, at 1 (numbers as in original).
narcotics agents from the shore; how the alleged ringleader of the smugglers disappeared overboard with $34,000 cash; how customs and narcotics agents quarreled over custody of the captured drugs afterward; how narcotics agent and squad commander Frank J. Fitzpatrick had committed suicide one hour after the raid, in the washroom of the ferry house, by shooting himself in the heart; and how the raid had commenced after a narcotics agent had arranged to purchase some of the drugs, but then not having enough cash, used money “composed of $1000 bills said to have been formed by cutting Os out from ten-dollar bills and pasting two of them after each $10 on genuine ten-dollar bills.”

While deaths were only occasionally reported, the undercover drug purchase was a staple element of raid accounts. In a San Francisco item published in 1922: “Federal narcotics agents, posing as ‘drug dealers,’ yesterday seized 598 bottles of cocaine, with a market value of more than $5000, together with two valuable automobiles, and arrested four persons on charges of violating the Harrison narcotics act.” In 1927, the Washington Post reported that federal narcotics agents had seized eleven cars registered to a single owner, August Scontrino, after he reportedly agreed to sell $62,500 worth of morphine to undercover agents. This seemed to justify a sweeping seizure of the man’s property:

Scontrino carried an automatic. A search of the house revealed four more automatics and 25,000 rounds of ammunition. Five touring cars, the license plates of which revealed that they were the property of Scontrino, were found in the block. Six other automobiles were found listed under the same name. Officers said the fleet of automobiles was used in transporting narcotics throughout the South.

Two San Diego police officers joined a state narcotics agent on an undercover operation in 1930. They bought forty-five dollars’ worth of heroin from a woman using marked bills; followed her home, where they searched her house and found more heroin; and confiscated her car, where they said the drug sale had taken place.

The Treasury embraced inter-agency cooperation in a series of large-scale raids. In 1926, according to the Associated Press, “forces of secret service men, narcotic inspectors and prohibition agents cooperated” in Miami-area raids netting thirty-five arrests and the confiscation of eight automobiles, one truck, and two boats as well as 9600 quarts of liquor. The windfall in automobiles

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130 Id.
131 In 1934, a federal agent reportedly shot a suspect during an undercover drug buy. See Five Seized in Dope Net, L.A. TIMES, June 3, 1934, at 22.
132 Agents Seize $5,000 in Drugs and Nab Four, S.F. CHRON., Jan. 19, 1922, at 2.
133 3 Men and 11 Autos Seized in Drug Raid, WASH. POST, Mar. 18, 1927, at 3.
134 Id.
136 Id.
137 Arrest 39 in Big Florida Rum Raids, BOS. GLOBE, July 18, 1926, at 2.
and contraband was also shared across departments, particularly for law enforcement purposes; this snapshot of vehicle seizures, auctions, and adoptions by Treasury bureaus was offered in support of allowing the Department of Labor to receive forfeited cars “for use in the enforcement of the immigration laws”:

Under the act of March 3, 1925, vessels or vehicles summarily forfeited to the United States may be used for customs or prohibition enforcement and forfeitures by decree of court, upon application to the Secretary of the Treasury, may be delivered to the Treasury Department for the same purpose, in lieu of being sold under existing law.

During the fiscal year 1927, 1,293 automobiles were seized by customs patrols, of which 215 were retained for customs use, 185 were transferred to the Bureau of Prohibition, and 454 were sold at public auction. The balance of these seizures were either returned or being held as a result of litigation. Those sold at auction brought in proceeds of $46,760.

The Bureau of Prohibition used 541 confiscated automobiles during the same fiscal year in the enforcement of the national prohibition act and the so-called Harrison Narcotic Act. The seizures totaled 7,137 automobiles and the net proceeds from those sold were $105,093.65.138

One result, perhaps, of the practice of prosecuting liquor law violators under the revenue laws was that enforcement did not stop once Prohibition ended. The Alcohol Tax Unit continued to seize thousands of cars yearly; customs enforcement work, too, continued apace.139 One broad post-repeal enforcement effort involved the Alcohol Tax Unit, the Bureau of Narcotics, and customs across multiple cities, as the New York Times reported: “Hurling the full strength of an enforcement army of nearly 12,000 men against law violators, the Treasury delivered a crushing blow today to counterfeit, illicit distilling, narcotic and smuggling rings in one of the most spectacular drives of its kind ever staged.”140 The agents had arrested 1909 people over the course of a single day and were still arresting more.141 “Property valued at hundreds of thousands of dollars was seized. This included automobiles, boats, illicit stills, distilled spirits, narcotics and jewelry.”142 Customs alone had seized property worth $1.5 million, according to the reporter,143 “There were many unusual seizures, including horses and other live stock [sic], grain, flour, potatoes, beans, wool, hides, . . . fish, and, in Montana, a stump puller.”144 The Alcohol Tax Unit

138 H.R. REP. NO. 7O-1O81, at 1 (1928).
140 Id.
141 Id.
142 Id.
143 Id.
144 Id.
seized “851 stills, 37,450 gallons of spirits and 110 automobiles.”145 As another writer framed the 1935 cooperative enforcement:

From land, sea and air, combined forces of the Coast Guard, Secret Service, Internal Revenue, Intelligence Unit, Customs Bureau and Alcohol Tax Unit struck at every part of the underworld over which the Treasury has jurisdiction.

After 72 hours of almost unceasing warfare without precedent in American police annals, bootleggers, drug dealers and counterfeiters everywhere could count these among their losses:

Nearly $2,500,000 tossed into the lap of Uncle Sam in the form of fines and seizures; 44,662 gallons of liquor taken out of illicit circulation; more than $1,000,000 in bogus bills and the paraphernalia for making that many more destroyed; the wreckage of an illegal rum-making industry capable of producing 219,866 gallons a day.146

Some instances of federal drug enforcement ending in automobile forfeiture now appear aimed at particular people and particular cars. In the Territory of Hawaii in 1937, federal narcotics agents arrested 32-year-old Beatrice Adams, along with nine other women, after raiding their Honolulu apartment building.147 Apprehended July 13, Adams was charged with possession, transportation, and concealment of narcotics, posted bond on July 14,148 and was indicted by a grand jury for possession of 155 grains (about a third of an ounce) of opium on August 26.149 On September 4, her dead body was found at the foot of a cliff and subsequently identified at the morgue by narcotics officers.150 The more credulous and sensational of the competing major Honolulu dailies reported that Adams’ fear of being busted for “white slavery” had led her to jump to her death.151 “Persecution in the form of ostracism from her former underworld associates may have been the dominating factor in the suicide of the woman, according to opinions expressed in federal law enforcement circles today,” read the account.152 “Since the raid on the Rose Rooms by narcotics officers several weeks ago, she had been harassed by other women of the underworld who blamed her for putting them ‘on the spot,’ a federal officer

145 U.S. Arrests 2,000 in Surprise Raids on Nation’s Gangs, supra note 139, at 1.
147 Eleven Taken in Two Raids Held in Jail, HONOLULU ADVERTISER, July 14, 1937, at 1; Holt Indicted by U.S. Jury, HONOLULU ADVERTISER, Aug. 28, 1937, at 1. Beatrice Adams was also known as Zola Knight. Id.
149 Holt Indicted by U.S. Jury, supra note 147, at 1.
151 Id.
152 Id.
said.” More likely, Adams had been targeted by narcotics agents because of her local popularity as a night club performer under the stage name Zola Knight. What had not been reported was the government’s seizure of Adams’s 1937 Packard convertible, a libel against which was filed the day of her indictment. Although the criminal drug charge was dismissed after she died, the civil suit went forward, with the government asking the court to turn over her car for use by the head of the narcotics division in Honolulu. Both the finance company holding a lien on the car and Adams’s brother, who had also been arrested by narcotics agents, contested the forfeiture (although her brother did not appear in person, having agreed to leave the island as part of a plea bargain for a suspended prison sentence). The claimants protested the U.S. attorney’s presenting as evidence a note Adams was supposed to have written confessing that she had used the car to transport the opium; but the judge allowed it, so the U.S. attorney asked for a directed judgment on whether the agents had probable cause to seize the car. The answer was yes. Perhaps flustered by this turn of events, both claimants’ lawyers failed to discharge the burden of proof thus laid upon them to establish the dead woman’s innocence and thereby that of her late-model convertible. A jury found for the United States.

In 1950, a Pittsburgh newspaper reported that jazz singer Billie Holiday’s “snazzy $5,000 Lincoln” had been seized in San Francisco. “The royal blue, specially built sedan, topped by a cream-colored leatherette top, was impounded” after her chauffeur was arrested for drug possession. A follow-

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153 Id.
154 The initial newspaper report listed Beatrice Adams as one among ten women arrested, but as Zola Knight she occupied the lead and the headline of subsequent coverage, even before her death. Id. Her brother, James Byron Adams, arrested and charged with drug possession on the same day, had recently performed in a community theater production of *The Criminal Code*, a Martin Flavin play set in a prison that explored cruelty in the American justice system. Edna B. Lawson, *Players Offer Smashing Hit in “Criminal Code,”* *Honolulu Advertiser*, May 21, 1937, at 3 (noting “Byron Adams is horrifying as the drug sodden Runch”). The play was popular; it had run on Broadway and its second Hollywood film adaptation was then in production. Mildred Martin, *Gripping Prison Drama Revived as “Penitentiary,”* *Philadelphia Inquirer*, Feb. 7, 1938, at 9. Flavin’s wife died by falling from a cliff outside their home near Santa Cruz, California, two months after Beatrice Adams died. *Mrs. Flavin’s Body Found on Beach at Point Lobos, Oakland Tribune*, Jan. 6, 1938, at 20.


158 See Stainback Letter, supra note 155, at 1–3.

159 Id.
160 Id.
161 Id.
162 ‘Lady Day’s’ Car May Be Seized, supra note 4, at 1.

163 Id.
up piece in the same paper six months later read, “Billie Holiday’s $5,500, royal blue Lincoln sedan—which makes Gov. Earl Warren’s Cadillac look very mediocre—has been officially awarded to the state of California.”164 The chauffeur had been sent to the state prison at San Quentin.165

VII. ROUTINIZING AND BUREAUCRATIZING AUTOMOBILE FORFEITURES

In 1952, political columnist Peter Edson described automobile forfeiture as a “standard government practice . . . few people know about,” poking fun at a federal administrator who “was driven up to the White House the other day in a snazzy blue Cadillac.”166 When some reporters asked the official about the car, the man explained that “the government—and the taxpayers—didn’t buy this car for him. It was seized by the Treasury’s Bureau of Narcotics agents from some big dope peddler.”167 Edson, in extensive syndication based on his ability to put government jargon into plain language, explained, “[w]henever an automobile is seized in the arrest of anyone for violation of federal law, the car is held in custody of the U.S. marshal until a court issues an order for its disposition. The seizing agency has a right to requisition the car if it wants it.”168

Indeed, Treasury forfeiture of cars was routine to the point that bureaucrats included it in their budgets and sometimes eyed its expansion as a source of additional revenue.169 Frederick Evans, a finance officer for the Bureau of Internal Revenue, told Congress in 1951 that he anticipated replacing 100 cars in the department’s aging fleet of 1,380 with late-model forfeitures over the coming year.170 Senator Harley Kilgore wanted to know more about the Treasury’s request to purchase new cars; Evans replied that the Bureau “has been endeavoring to meet its needs by seizing cars and having them forfeited to the Government for official use,” but that the cars it seized increasingly were too old and worn to adopt.171 Dwight Avis of the Alcohol Tax Unit helped explain:

As Mr. Evans has indicated, while our seizures of automobiles are rapidly reaching the prewar level of approximately 2,000 a year, yet a great part of those cars are what you might call junk.

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164 Billie Holiday Loses Auto, PITZ. COURIER, Apr. 7, 1951, at 5.
165 Id.
167 Id.
168 Id.
170 Id.
171 Id.
In other words, the cars are old. They have over 40,000 and 50,000 and 60,000 miles on them when we seize them, and some of them much more. Many of them are 1937, 1938, 1939, and 1940 models.

Senator Kilgore. It is not like the prohibition days when you used to pick up Cadillacs, is it?

Mr. Avis. It is not like before the war, Senator. An automobile costs so much money today. We have some difficulty in acquiring cars. The courts are much more apt to return the car to the finance company, where there is a lien of, say, $1200 or $1500 on it. That complicates our problem.

Senator Kilgore. You also have this long-time credit proposition, which you did not have before, and cars used to be liquidated in 12 months or so. Now they have a longer period of time to liquidate.

Mr. Avis. That is true, sir.

Senator Kilgore. The bootlegger buys on the longest possible time.

Mr. Avis. Yes.172

In 1955, Chester MacPhee, collector of customs at San Francisco, told a congressional committee that his area’s thirty-eight enforcement personnel should be tripled, but that the expense of new hires could be mitigated through enforcement.173 “A substantial portion of the cost . . . would be returned to the taxpayer as the results of fines and penalties from increased seizures, in addition to payments of duties on merchandise now brought in without such payments due to lack of proper coverage,” MacPhee said.174 “In addition, the war on narcotics would be intensified.”175 He explained that his thirty-eight agents made ten to twenty automobile seizures each year of cars brought in by boat and driven off the dock with smuggled alcohol or tobacco inside.176 Recently, for example, the discovery of a late-model car with $150 worth of liquor in the trunk fetched $600 in fines, he said, and:

In addition to that, of course, they forfeit the vehicle. That vehicle comes into the custody of the Government. It is used by the General Services Administration or the Treasury Department in another assignment or that [car] might very well be sold by the United States marshal and that money turned into [sic] the Treasury Department. . . . If we had adequate personnel to do this

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172 Id. at 103–04.
174 Id.
175 Id.
176 Id.
job there is one instance where we might double or triple that thing, where the revenue would come into the country for the personnel we use.177

Also, MacPhee said, his agents routinely caught and fined cigarette smugglers, then gave the seized contraband away to veterans’ hospitals.178

State and local drug warriors were also busily forfeiting cars in the 1950s. In October 1952, according to a newspaper report, 283 cars were seized and forfeited in southern California while 73 others were “impounded on suspicion but later released.”179 After running through fifteen forfeiture claims in a single day and finding for the state in each case, Los Angeles Superior Judge Frank G. Swain explained that “‘one pill, or a cigarette butt in an ash receiver can be evidence to send the responsible driver or car owner to jail, and to impound the car for forfeiture proceedings.’”180 Hiding narcotics in a car, the reporter added, is “simply an invitation for a search.”181 Judge Swain explained the court’s understanding of the statute’s intent:

We believe the law which provides for forfeiture of cars used in illegal narcotics traffic is a deterrent to such traffic . . . . Persons involved know the penalty is losing the car. I’ve heard more than one person say, “I can do six months standing on my head, but I hate to lose my car.”182

A far cry, in its implementation, from depriving large-scale drug traffickers of the instruments and profits of their crimes, such forfeiture harmed ordinary people. In 1956, Wadie Shaheen, a resident of a working-class neighborhood in southern Los Angeles, wrote a letter to his councilman about his 19-year-old son, Bob.183 Arrested in possession of marijuana, Bob had spent a month in the San Diego County Jail and then had been transferred to a youth work camp after his conviction.184 The events, Wadie wrote, were “an unfortunate blow to his Mother and myself who have raised four children in a decent and upright manner as decent citizens”; moreover, it was the first time any of their children had run afoul of the law.185 But, Wadie wrote, the Shaheens took consolation in knowing not only that Bob had learned his lesson but that they themselves had gained an education on “such a very bad condition that is sweeping our Country.”186 The only remaining problem was that the state had impounded the family car, a 1955

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177 Id. at 853.
178 Id.
180 Id.
181 Id.
182 Id.
184 Id.
185 Id.
186 Id.
Mercury that Bob had been driving when he was arrested, on which the Shaheens still owed $2400. He wrote:

[W]e feel that our boy is paying his penalty and we hope that the State can consider our side of the story as we are ordinary working people and can ill afford to lose the car and the equity we have in it. Our son has co-operated with the Authorities in every way and we are looking forward to the time when he will be back out of this predicament and we can help him rehabilitate himself and get back to a normal life and we also need the car to carry on his and our working conditions. We feel we have suffered enough and hope the Court will be kind enough to help us retain our car.

The Shaheens’ hope would prove vain, even though the councilman, Don Allen, wrote a sincere personal plea to California Attorney General Edmund “Pat” Brown, Sr., asking him to release the car to the family. “I am sure the law is made on the basis of justice and equity,” Allen wrote, but, “It seems rather cruel…. I know the family’s condition and they just cannot afford to go ahead and pay the balance of $2400 on that car and then not to have its use. They are just not that kind of people.” Moreover, Allen wrote, the father “went all out to see that the boy cooperated 100% with your people…. The boy, through the counsel of his father, also has shown his willingness to aid and assist the law, after seeing the enormity of the situation.” In a memo to Brown about the councilman’s letter, Assistant Attorney General Frank Mackin also referred to cooperation; Mackin had arranged for Bob to meet with two state narcotics agents, but Bob “had no helpful information to give them” and the agents were “definitely opposed, naturally, to returning the car” because it had been used to transport seven pounds of cannabis, presumably to sell, from Tijuana, Mexico. “We are filing on and forfeiting cars all the time where a few [marijuana] cigarettes are found in the car—sometimes hardship cases on the parents,” Mackin wrote. In turn responding to Allen, Attorney General Brown wrote, “I think you should know that the law intends that innocent persons should sometimes suffer, as they probably do in this case. This is done because narcotics are such a horrible thing.”

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187 Id.
188 Id.
190 Id.
191 Id.
193 Id.
That pretty much everyone in 1950s California agreed about the horrible nature of drug trafficking and addiction could hardly be overstated. Rarely does public opinion coalesce so completely around stamping out a perceived social ill through whatever measures can be taken at a reasonable cost to taxpayers. But this exchange of letters reveals how expensive assets were also used as leverage to turn drug defendants into informants. The effort to extract information from Bob Shaheen through his father, who stood to owe $22,000 in today’s dollars on the seized car unless the narcotics agents could be satisfied, was viewed by bureaucrats as justified by the state’s wartime footing.

In May 1958, Attorney General Brown’s office wrote to the state director of finance to ask permission for the Bureau of Narcotic Enforcement to use forfeited cars instead of state-issued cars “for stake-outs, as meeting places with dealers, addicts and underworld characters, and for the tailing and pursuing of other automobiles.” In addition to their drab appearance, the state’s standard four-door sedans manufactured by Ford, Chevrolet, or Plymouth “have often been driven so many miles that proper tailing and pursuit [of suspects] is impossible.” The unremarkable cars had ruined good cases repeatedly: “Dope peddlers are, of course, very conscious that they might be dealing with law enforcement agents in their transactions,” a member of Brown’s staff wrote. “Undercover agents tell of cases where peddler drivers of cars in which they are riding recognize a car following them as having the general appearance of a State car. This, of course, ends all negotiations for a narcotic purchase.”

Given that the “fine police art” of tailing suspects required cars both powerful and nimble, the letter suggested that the Bureau

obtain its cars exclusively from forfeited vehicles which have been seized because of narcotic violations . . . . Selection would be made of flashy convertibles, hardtops and such other cars which are of the type generally used in the narcotic traffic, and which, in the opinion of the Bureau, would not be suspected. They would also be chosen for their get-away and power qualities so that they may cope with situations so frequently found in narcotics law enforcement.

VIII. CONCLUSION

Histories of drug policy offer convincing arguments that prohibition does not achieve the purported goal of curbing recreational drug use; rather, it serves

\[195\] Calculation of Inflation for $2400 from 1956 to 2018, INFLATION CALCULATOR, https://westegg.com/inflation/ [https://perma.cc/M2XH-X7EN] (enter amount of money and years in fields; then submit).

\[196\] Letter from Norman Elkington, Chief Assistant, Attorney Gen., to John M. Pierce, Dir. of Fin. 1–2 (May 20, 1958) (on file with Brown Papers, Carton 98, Folder 1).

\[197\] Id. at 1.

\[198\] Id.

\[199\] Id.

\[200\] Id. at 2.
other hidden agendas. Yet each generation seems to convince itself and its lawmakers that the current moment is an unprecedented crisis of drug abuse. The detriments of opioids, while quite real, have always been misunderstood and exaggerated; and the supposed urgency of confronting “the drug evil” has frequently provided a consensual pretext for unconstitutional policing and disproportionate penalties. Property rights are not the only rights affected by drug-related forfeitures, which violate the spirit of equal protection by exacting extraordinary penalties on some that cannot be had on others guilty of the same crime and by encouraging the arrest and prosecution of some offenders but not others. Used writ small for highly discretionary leverage over drug-involved citizens and writ large to increase enforcement capacity, forfeiture adds up to the great detriment of personal liberty. This problem, with its extensive history, manifests from day to day in interactions with city police and sheriff’s deputies. Americans have waited supportively for the improvements in public health and safety long promised by drug warriors. But if drug-related asset forfeitures have failed to secure them, and if instead such forfeitures primarily generate revenue for police forces and bolster public support for continued prohibition, then maybe forfeiture should be re-relegated to tax law.

Certainly forfeiture’s use to collect taxes is firmly situated in the nation’s legal past, but the tax-as-prohibition arrangement has been rejected as unconstitutional. The problems with modern forfeiture have more to do with longstanding cultures of drug law enforcement—with the corruption and meanness of spirit that seem to spring from the daily grind of the drug wars. It would be better if the entire motivation for forfeiture was financial. But it is not; and neither is the penalty purely financial for those who experience it. Forfeitures are also pursued in order to inflict humiliation on offenders, to win leverage by placing family or friends in jeopardy, to offer the public misleading proof of effective enforcement, and so on. In today’s drug wars, the arbitrary peril of possible forfeiture of an automobile or of real estate is certainly analogous in nature to “tough” sentencing. While hearing the arguments in

201 See generally KATHLEEN J. FRYDL, THE DRUG WARS IN AMERICA, 1940–1973 (2013) (to closely monitor inner cities and to project state power abroad); SUZANNA REISS, WE SELL DRUGS: THE ALCHEMY OF U.S. EMPIRE (2014) (to amass advantageous wartime arsenals of prohibited drugs); Matthew D. Lassiter, Pushers, Victims, and the Lost Innocence of White Suburbia: California’s War on Narcotics During the 1950s, 41 J. Urb. Hist. 787 (2015) (to construct a white suburban utopia contrasting with a dark, urban drug menace). Cf. LISA MCGIRR, THE WAR ON ALCOHOL (2016) (arguing that alcohol prohibition was an unprecedented state-building project largely ambivalent about consumption per se and suggesting that narcotics control has similar bases).

202 This term often appears in historical sources to describe social problems related to recreational drug use, dependence, and the black market. In addition to its current meaning, the opposite of good, an obsolete sense of “evil” referred to complex negative consequences arising from law, policy, or custom. See The Drug Evil and the Drug Law, 14 Bos. Med. & Surgical J. 394, 394–95 (1919).

203 Leary v. United States, 395 U.S. 6, 12 (1969), remanded to 431 F.2d 85 (5th Cir. 1970), aff’d, 544 F.2d 1266 (5th Cir. 1977), reh’g denied, 548 F.2d 355 (5th Cir. 1977).
Timbs v. Indiana, the Justices, laboring to compare the possible prison sentence for Tyson Timbs’ heroin-sale conviction to his Land Rover forfeiture in light of the Eighth Amendment, noted the difficulty of quantifying excessiveness in punishing his crime.204 Justice Alito asked how low “the ceiling of permissible term of imprisonment would have to go in order to justify a holding that a fine of $42,000 is a violation of the Eighth Amendment”; what, he asked, was the equation between dollars in a fine and time in a prison sentence?205

When Indiana’s Solicitor General insisted that the Court must grapple with the history of civil forfeiture,206 he meant that legal precedents supporting the broad deployment of forfeiture by police should be honored. But in drug crimes, a whole set of nonlegal implications arises, including the diminished social status of drug users and truisms about the risks of drug involvement. Chief Justice Roberts himself remarked that Timbs’ car was “an instrumentality of the crime,” that he had used it to transport drugs to the place he sold them.207 “Normally, I mean, you’re carrying the—the drugs in your car, I think it’s pretty well established your—your car can be forfeited.”208 But exactly why is this concept well established? Legal precedent reveals little about why enforcers feel entitled to profit from drug control, or why juries and judges find drug defendants unsympathetic. The whole history of drug prohibition, especially the troublesome cultures of enforcement it fosters, should be part of the conversation as lower courts begin to apply Timbs to the pressing question of disproportional punishments. Ideally the courts would employ similar considerations to pare back prison sentences for drug offenders as well.

205 Id. at 22.
206 Id. at 52–56.
207 Id. at 27.
208 Id.
The Opioid Crisis and the Drug War at a Crossroads

ALEX KREIT*

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I. INTRODUCTION

John Boehner, the Republican former Speaker of the House of Representatives, and Ed Rendell, the former Chair of the Democratic National Committee and Governor of Pennsylvania, have something unusual in common: Each has publicly announced that he is part of an ongoing conspiracy to violate federal drug laws. It feels more than a little strange to write that. But it is true. In April 2018, Boehner joined the advisory board of Acreage Holdings, which bills itself as having “the most diverse portfolio of any company in the American cannabis industry, with cultivation, processing and dispensing operations across 14 states with plans to expand.” Even more daringly, in October 2018, Ed Rendell incorporated a nonprofit organization called Safehouse in order to open the first safe injection site in the United States; a safe injection site is a place where people can self-administer drugs in a controlled environment under medical supervision.

That two prominent established political figures would so openly flout federal drug laws is indicative of a broader shift in thinking about the status of

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the war on drugs. For decades, the drug war enjoyed nearly universal support from elected officials across the political spectrum and being seen as “soft” on drugs or crime was considered to be “one of the surest career-killers in American politics.” Recently, however, voicing opposition to the drug war has become fashionable. Politicians who have called the drug war a failure include conservatives like former New Jersey Governor Chris Christie and Kentucky Senator Rand Paul and progressives like New Jersey Senator Cory Booker and California Governor Gavin Newsom. Similarly, both of President Barack Obama’s “drug czars” said they thought it was time to end the war on drugs in favor of a different strategy.

In an article published three years ago in this journal, I argued that these developments were signs of an emerging political consensus against the war on drugs. Since then, the effort to end the drug war has continued to gain momentum in some quarters. But there has also been a backlash as the Trump administration has sought to revive the drug war. Former Attorney General Jeff Sessions, whose harsh views on drugs are well-known, rescinded Obama-era Department of Justice policies that had limited the use of mandatory minimum penalties in lower-level drug cases. Former Deputy Attorney General Rod Rosenstein lamented the fact that federal drug prosecutions and sentences both decreased during the Obama administration and pledged to “work[] to reverse those trends.”

With some leaders calling for an end to the drug war and others proposing to double down on it, U.S. drug policy appears to be at a crossroads. There is perhaps no better example of this dynamic than our response to the opioid epidemic, the topic of this symposium. On the one hand, policymakers have implemented a number of modest harm reduction-oriented policies, including some that would have been unthinkable at the height of the war on drugs. Forty states and the District of Columbia have passed “Good Samaritan” laws, which give people who call 911 to report a drug overdose immunity from prosecution.

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4 JIM WEBB, A TIME TO FIGHT: RECLAIMING A FAIR AND JUST AMERICA 216 (2008); see also Alex Kreit, Drug Trace, 77 OHIO ST. L.J. 1323, 1323 (2016).
5 See Kreit, supra note 4, at 1325–26 (discussing opposition to the drug war among well-known elected officials).
6 Id. at 1324.
7 Id. at 1325.
8 Sheldon Whitehouse, Foreword, 11 HARV. L. & POL’Y REV. 359, 373 (2017) (noting that before he became Attorney General, “Sessions spent years as one of the most vocal obstacles to criminal justice reform in Congress”).
for specified crimes like drug possession. Approximately thirty different cities and counties have established Law Enforcement Assisted Diversion (LEAD) programs, which send some drug arrestees to treatment without criminal charges ever being filed. With some support from the federal government, states have also enacted a range of laws to expand access to the anti-overdose drug naloxone. On the other hand, since 2011 at least thirteen states have enacted new drug war-style mandatory minimum penalties for opioid offenses. As already noted, the federal government has resumed seeking mandatory minimum penalties against lower-level drug offenders as part of what the Trump administration has referred to as a “war” on opioids. Trump has even proposed the death penalty for “drug dealers” and disturbingly praised Rodrigo Duterte, President of the Philippines, for carrying out a drug war in which there have been thousands of extrajudicial killings of suspected drug sellers and users.

This Article considers the state of the war on drugs through the lens of the opioid crisis. I focus on two responses to the opioid epidemic—the pursuit of safe injection sites and the increase in drug-induced homicide prosecutions—that exemplify two divergent approaches: ending the drug war or doubling down on it. The Article proceeds in four parts. Parts I and II describe current efforts to establish safe injection sites and the recent surge in drug-induced homicide prosecutions, respectively, and situate both in the context of the war on drugs. In Part III, I argue that these two examples help to shed light on why turning enthusiasm for ending the drug war into concrete reform has been so challenging. In both cases, drug war supporters have been able to use long-dormant laws that were passed at the height of the drug war to frustrate reform efforts. Ending the drug war requires significant legislative change; reviving can be easily done with drug war-era laws that are already in place. Part IV concludes.

14 See Andrew M. Parker et al., State Responses to the Opioid Crisis, 46 J.L. MED. & ETHICS 367, 373 (2018).
15 How We Will Win the War on Opioids, WHITE HOUSE (Mar. 1, 2018), https://www.whitehouse.gov/articles/will-win-war-opioids/ [https://perma.cc/3KKT-NLPX].
II. SAFE INJECTION SITES

Second to state cannabis legalization laws, there is perhaps no better example of the political shift away from the war on drugs than efforts to establish safe injection sites in response to the opioid crisis.\(^\text{17}\) Safe injection sites are grounded in the principle of harm reduction.\(^\text{18}\) Harm reduction policies are not primarily concerned with reducing drug use.\(^\text{19}\) Instead, the strategy is to reduce the negative consequences associated with drug use.\(^\text{20}\) Consistent with this approach, safe injection sites (also sometimes called supervised injection facilities or safe consumption rooms, among other terms)\(^\text{21}\) aim “to reduce morbidity and mortality by providing a safe environment for more hygienic use . . . [and] to reduce drug use in public and improve public amenity in areas surrounding urban drug markets.”\(^\text{22}\) They do this by providing a space for people to use drugs they have purchased elsewhere in a safe environment, with clean syringes, and with medical professionals on hand.\(^\text{23}\) Many safe injection sites also provide other services to clients, including counseling, educational programming about communicable disease prevention, and referrals to health and social services programs.\(^\text{24}\)

Safe injection sites have been operating in other countries for decades. The first sanctioned facility opened in 1986 in Berne, Switzerland.\(^\text{25}\) Today, there are approximately 100 supervised injection sites in ten different countries, including Canada.\(^\text{26}\) Although there is some disagreement about the overall strength of the empirical evidence in support of safe injection sites, the studies to date have been overwhelmingly positive. A 2014 systemic review of the literature on safe injection sites examined seventy-five studies and concluded that injection sites “have largely fulfilled their initial objectives without enhancing drug use or drug trafficking.”\(^\text{27}\) Specifically, the literature review

\(^{17}\) This Part draws heavily from my discussion of safe injection sites in Alex Kreit, Safe Injection Sites and the Federal “Crack House” Statute, 60 B.C. L. REV. 415, 420–28 (2019).

\(^{18}\) Id. at 420.

\(^{19}\) Id.

\(^{20}\) Id.

\(^{21}\) Alex H. Kral & Peter J. Davidson, Addressing the Nation’s Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S., 53 AM. J. PREVENTATIVE MED. 919, 919 (2017).


\(^{23}\) Kral & Davidson, supra note 21, at 919 (providing an overview of safe injection sites).

\(^{24}\) Kreit, supra note 17, at 422 n.42.

\(^{25}\) EUR. MONITORING CTR. FOR DRUGS AND DRUG ADDICTION, supra note 22, at 2.

\(^{26}\) Kral & Davidson, supra note 21, at 919.

found that the evidence suggests safe injection sites improve public health outcomes for drug users by reducing overdose deaths and increasing access to health care while also improving public safety outcomes for the community by reducing public drug use and the prevalence of dropped syringes in public places. Further, the literature review found no evidence that safe injection sites increase drug use, which is the primary argument made by safe injection site opponents. These results should not be terribly surprising, particularly with respect to reductions in overdose deaths. The opioid-receptor antagonist drug naloxone is very effective at reversing overdoses if it is administered relatively soon after the onset of symptoms. And, of course, medical professionals are able to respond much more quickly to an overdose that occurs at a safe injection site than to one that occurs elsewhere.

Despite the evidence in support of safe injection sites, they were long considered to be political nonstarters in the United States because they were seen as incompatible with the war on drugs. The war on drugs has been organized around the principle of use reduction in general and an idealized vision of a “drug free society” in particular. The drug war’s concern with “the consumption of the prohibited substance rather than any secondary consequences that might ensue” is in tension with harm reduction measures like safe injection sites. And at the height of the drug war, opposition to harm reduction proposals went beyond a difference of opinion about balancing public policy goals. The war on drugs was framed as a life and death struggle in which, as President Reagan’s Attorney General Edwin Meese put it, “there are no neutrals.” Regardless of the costs and benefits, safe injection sites and similar measures were considered to be unacceptable simply because they were a form of surrender.

28 Id. at 65. A 2018 review of the evidence by the RAND Corporation likewise found existing studies to be encouraging but struck a more cautious tone than the 2014 literature review. See BEAU KILMER ET AL., CONSIDERING HEROIN-ASSISTED TREATMENT AND SUPERVISED DRUG CONSUMPTION SITES IN THE UNITED STATES, RAND CORP. vi–xiii (2018), https://www.rand.org/content/dam/rand/pubs/research_reports/RR2600/RR2693/RAND_RR2693.pdf [https://perma.cc/LX3F-X3P5]. The RAND report found studies show that drug consumption that occurs at a safe injection site is less harmful, with a reduced risk of disease transmission. Id. at xi. But, the authors cautioned, that “[o]verall, the scientific evidence about the effectiveness of [supervised consumption sites] is limited in quality and the number of locations evaluated.” Id. at x.

29id.


31 Kreit, supra note 4, at 1336.


seen as possible enemies in the war on drugs; President George H.W. Bush famously described the enemy as “[e]veryone who uses drugs. Everyone who sells drugs. And everyone who looks the other way.”35

For decades, the drug war enjoyed nearly universal support among politicians. In this environment, safe injection sites were unable to gain traction even in politically progressive cities like San Francisco. In 2007, for example, drug policy reform advocates held a symposium on Vancouver’s safe injection site that was co-sponsored by San Francisco’s health department in an attempt to get the issue on the local political agenda.36 The conference was promoted as an event to help city officials “figure out whether this is a way to reduce the harms and improve the health of our community.”37 As might have been expected, federal officials came out strongly against the idea. In response to the conference, an Office of National Drug Control Policy representative described safe injection sites as “a form of giving up” and said it was “disconcerting” that San Francisco would even consider them.38 But opposition at the time was not limited to the federal government. Even then-San Francisco Mayor Gavin Newsom, known for taking bold political stances on other progressive issues like marriage equality and marijuana legalization, declined to back the effort to study safe injection sites.39 As a result, the initiative “just kind of crashed and burned,” according to one of its backers.40

A little over ten years later, the picture is decidedly different. “There are at least thirteen efforts underway in U.S. cities and states to start an official

Facilities, LAGUNA TREATMENT HOSP., https://lagunatreatment.com/supervised-injection-facilities/ [https://perma.cc/L5N3-F4X2] (last updated Sept. 20, 2019); see also Jonathan P. Caulkins & Peter Reuter, Dealing More Effectively and Humanely with Illegal Drugs, 46 CRIME & JUST. 95, 117 (2017), (“In the United States ‘harm reduction’ became a toxic term, seen within law enforcement circles as a Trojan horse for legalization. . .”).

35 BAUM, supra note 33, at 289 (quoting President George H.W. Bush). In this vein, former drug czar William J. Bennett once described state ballot measures to decrease penalties for marijuana possession as “the drug legalization movement’s advance on [the] home fronts” of those states. William J. Bennett, Don’t Put Up with Pot, Ohio, CIN. POST, Nov. 2, 2002, at A14.


37 Id.

38 Id.

39 See C.W. Nevius, Support for Supervised Injection is Growing, SFGATE (Oct. 15, 2007), https://www.sfgate.com/bayarea/article/C-W-Nevius-Support-for-supervised-drug-2518428.php [https://perma.cc/PC67-XQGG] (“As asked for a comment from Mayor Gavin Newsom, spokesman Nathan Ballard said, ‘The mayor is not inclined to support this approach, which quite frankly may end up creating more problems than it addresses.”’).

supervised injection site.” In four cities—New York, Philadelphia, San Francisco, and Seattle—officials have formally announced plans to open a safe injection site. Among this group, San Francisco and Philadelphia have arguably gone furthest. In February 2018, San Francisco’s Department of Public Health revealed that the city hoped to open two facilities in July 2018. Although officials backed away from that plan, in late August 2018, they opened a nonoperational prototype safe injection site and Mayor London Breed has consistently reiterated her intent to open a functioning injection site in the near future. Efforts in Philadelphia have advanced even further. In January 2018, Philadelphia outlined a plan to find a nonprofit organization to open a safe injection site in the city. For months, it seemed like the initiative was going nowhere. But, as noted in the introduction to this Article, former Pennsylvania Governor and Philadelphia Mayor Ed Rendell incorporated a nonprofit called Safehouse in October 2018 to open and operate the planned safe injection site. Safehouse began to work toward its goal until it was sued by the United States Attorney for the Eastern District of Pennsylvania in February 2019.48


47 Allyn, supra note 3.

48 Bobby Allyn, U.S. Prosecutors Sue to Stop Nation’s First Supervised Injection Site for Opioids, NPR (Feb. 6, 2019), https://www.npr.org/sections/health-shots/2019/
As a result of federal opposition, which is discussed more below in Part III, efforts to open a facility have not yet moved past the planning stage. But the fact that safe injection sites are receiving serious consideration from so many state and local lawmakers says a great deal about the state of the war on drugs. In just over a decade, safe injection sites have gone from being politically off-limits, even in San Francisco, to a mainstream policy issue in a number of cities and states. Indeed, if not for federal opposition, safe injection sites would almost certainly be operating in one or more cities already. No doubt, the severity of the opioid crisis is what has prompted state and local lawmakers to consider safe injection sites. In addition, media coverage of the opioid epidemic that has tended to focus on “the white prescription opioid cum heroin user” has surely contributed to the way politicians have responded to the opioid crisis. But the fact that this particular policy option is generating so much interest is also a testament to the changed politics of the war on drugs. In previous drug epidemics—from the crack epidemic in the 1980s to the methamphetamine epidemic in the 2000s—lawmakers almost uniformly responded with reactionary and punitive proposals. Over the past decade, the calls from politicians of all stripes to end to the drug war have changed the tenor of the discussion. This has created the political space for policy proposals like safe injection sites to be evaluated and debated on their merits, rather than being dismissed out-of-hand on ideological grounds.

III. DRUG-INDUCED HOMICIDE PROSECUTIONS

Although the opioid epidemic has seen U.S. policymakers embrace harm reduction-oriented policies in a way that would have been unthinkable a decade ago, there have also been signs of a backlash. At the federal level, the Trump administration’s interest in reviving the drug war has received a good deal of attention. But even before Trump took office, the war on drugs continued to
march along, if only due to inertia. By and large, drug laws and enforcement budgets have not changed very much since the height of the war on drugs.\textsuperscript{52} Drug possession arrest rates have remained relatively steady, and sentences for drug trafficking offenses are still quite severe.\textsuperscript{53} This is a reflection of the fact that rhetoric in favor of ending the drug war has not yet translated into significant legislative reform; most changes have occurred at the margins of drug policy, not its foundation.\textsuperscript{54} The result is that “use of the criminal justice system continues to dominate local, state, and federal responses to increasing rates of opioid use and overdose.”\textsuperscript{55}

Indeed, in some respects, the war on drugs has intensified. The rise in drug-induced homicide prosecutions provides an example. Under drug-induced homicide statutes, drug distribution that results in death is punished as a homicide offense. Twenty states and the federal Controlled Substances Act (CSA) have a drug-induced homicide law.\textsuperscript{56} Although the particulars of these laws vary, they generally make defendants strictly liable when death results from the distribution of a controlled substance.\textsuperscript{57} Most were passed at the height of the war on drugs, in the 1980s and 1990s.\textsuperscript{58} The federal law, for example,

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\textsuperscript{52} Kreit, \textit{supra} note 4, at 1324–25.


\textsuperscript{54} See generally \textit{First Step Act, supra} note 53 (summarizing legal changes pursuant to the First Step Act).


\textsuperscript{56} See \textit{id.} at 56–60 (summarizing existing drug-induced homicide statutes).

\textsuperscript{57} \textit{id.}

\textsuperscript{58} \textit{id.}
was passed in 1986 and provides for a twenty year mandatory minimum sentence “if death or serious bodily injury results from the use of”\(^{59}\) an illegally distributed drug. Although most of these laws have been on the books for decades, they were not frequently employed until recently.\(^{60}\) This has changed over the past few years as more police and prosecutors have come to see them as a tool for responding to the opioid crisis. Some police and prosecutors have adopted policies of treating every overdose death as a homicide scene.\(^{61}\) The DEA has worked to encourage this approach by offering trainings to patrol officers on investigating overdose death cases.\(^{62}\) Drug-induced homicide prosecutions have skyrocketed as a result. Although no database tracks these prosecutions, two recent studies based on news articles both concluded that there has been a dramatic increase in drug-induced homicide prosecutions over the past decade, with one of the studies finding a 300% spike between 2011 and 2016.\(^{63}\)

To appreciate why this trend suggests a revival of the war on drugs, it is important to understand the broad reach of drug-induced homicide laws. First, drug-induced homicide laws are strict liability offenses that, many courts have held, also dispense with traditional proximate cause requirements.\(^{64}\) Because the government does not need to show that a defendant was reckless or even criminally negligent, the laws are not limited to sellers who are particularly culpable, such as a seller who distributes a substance claiming it to be cocaine while knowing that it is laced with fentanyl.\(^{65}\) With respect to causation,


\(^{60}\) *Drug Policy All.*, *supra* note 55, at 11 (“Though many drug-induced homicide laws have sat idly on the books since their enactment decades ago, prosecutors are now reinvigorating them with a rash of drug-induced homicide charges in the wake of increasing overdose deaths.”).


\(^{62}\) Fenton, *supra* note 61 (reporting that more than 1000 patrol officers had been trained by the DEA as of mid-2017).

\(^{63}\) *Drug Policy All.*, *supra* note 55, at 2, 11–14; *see also* Leo Beletsky, *America’s Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, 2019 UTAH L. REV. 833, 873 (finding “a sharp upward trend” in drug-induced homicide prosecutions beginning in 2009 that indicates a “spike in prosecutions”).

\(^{64}\) *Drug Policy All.*, *supra* note 55, at 9–10.

although the Supreme Court has held that the federal drug-induced homicide statute incorporates a but-for causation requirement, it left the question of whether the offense requires proof of proximate cause unresolved. Most circuit courts have held that the law does not include a foreseeability requirement, however. These courts have reasoned that the statute’s language is plain and “unambiguous and that giving effect to its plain meaning prohibits us from superimposing upon the statute a foreseeability or proximate cause requirement.”

Although there are relatively few published opinions addressing whether the intervening cause doctrine—which holds that “the causal link between [a defendant’s] conduct and the victim’s death is severed when the victim exercised his own free will”—applies to drug-induced death cases, the little case law on the question suggests it does not. In its absence, drug-induced homicide statutes might apply even where death resulted because a person took an unusually large amount of the drug or mixed the drug with other substances. One federal district court judge went so far as to write that “[s]uicide through heroin overdose meets the statute’s terms.”

Second, and perhaps even more significant, drug-induced homicide laws do not apply only to drug sellers but also to people who share drugs with friends or family members. This is because some state laws and the federal Controlled Substances Act criminalize drug distribution, not drug sale. Courts have consistently held that “the social sharing of a small quantity of drugs, without consideration, constitutes the distribution of drugs.”

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67 Id. at 887 (noting that while the Court had also granted review on the question of foreseeability, “[w]e find it necessary to decide only” the question of actual causation).
69 United States v. McIntosh, 236 F.3d 968, 972 (8th Cir. 2001), aff’d, 332 F.3d 550 (8th Cir. 2003).
71 See United States v. Rodriguez, 279 F.3d 947, 951 n.5 (11th Cir. 2002).
72 Zanuccoli v. United States, 459 F. Supp. 2d 109, 112 (D. Mass. 2006) (emphasis added). But see Rodriguez, 279 F.3d at 951 n.5, 952 (citation omitted) (observing that some circuits “have not addressed whether there is an intervening cause exception” to the federal drug-induced homicide statute and declining to decide the issue in light of the disposition of the case).
74 United States v. Wallace, 532 F.3d 126, 128–29 (2d Cir. 2008) (citations omitted) (collecting cases). This rule is limited somewhat by the so-called “joint-user” defense, which has been recognized by a number of courts. This doctrine provides that when “two individuals simultaneously and jointly acquire possession of a drug for their own use, intending only to share it together, their only crime is personal drug abuse—simple joint possession, without any intent to distribute the drug further.” Swiderski, 548 F.2d at 450. The legal basis for this rule is that users who jointly acquire drugs to use with each other are in either constructive (or actual) possession of the drugs from the time of the purchase. Id. Because a person cannot distribute an item to someone who already possesses it, joint
principle of drug laws dramatically expands the reach of drug-induced homicide statutes, which typically apply to any drug trafficking offense that results in death, including distribution.

Of course, prosecutors could use their discretion to only charge sellers with drug-induced homicide. Although some prosecutors presumably do just that, others have decided to apply drug-induced homicide laws as aggressively as possible. Indeed, the limited data available suggests that users who shared drugs with friends or family members make up a shockingly high percentage of drug-induced homicide defendants. In his recent study of drug-induced homicide prosecutions, Leo Beletsky found that half of the drug-induced homicide defendants in his data set “were not, in fact, ‘dealers’ in the traditional sense, but friends and partners to the deceased.” Similarly, journalists who reviewed drug-induced homicide prosecutions in Wisconsin in 2017 reported that nearly 90% of the 100 cases they reviewed involved “either low-level street dealers or friends and relatives of the person who overdosed.” Not infrequently, spouses find themselves the target of these prosecutions. Consider one representative case. Jennifer Marie Johnson was convicted of third-degree murder under Minnesota’s drug-induced homicide law after her husband overdosed in March 2013. Johnson had shared some of her prescribed liquid methadone with her husband, at his request, “to help him fall asleep. He then took more without asking her permission. When [her husband] started to have difficulty breathing, Jennifer yelled to her daughter to call 911, and tried to revive him while they waited for help.” Johnson’s husband died and Johnson was sentenced to six years in prison.

Even when drug-induced homicide laws are applied to drug sellers, they rarely ensnare higher-level operators. Because each link in the distribution chain makes it more difficult to prove even but-for causation, the typical drug-induced homicide investigation begins and ends with the person who distributed drugs to the end-user. This is almost never a high- or even mid-level drug trafficker but, instead, a street level seller who deals in relatively small quantities of drugs. These kinds of low-level sellers are exceedingly unlikely to have any control over whether the drugs are cut with fentanyl or other dangerous

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75 **Drug Policy All.**, *supra* note 55, at 14.
76 Beletsky, *supra* note 63, at 873–74.
78 **Drug Policy All.**, *supra* note 55, at 28.
79 *Id.*
80 *Id.*
81 *Id.* at 42.
82 *Id.*
adulterants. 83 Not infrequently, they are users themselves, selling drugs in order to get money to pay for their own supply. 84 Thus, although some drug-induced homicide laws purport to be targeted at “entrepreneurial drug dealers who traffic in large amounts of illegal drugs for profit,” rather than users who sell to support their habit, 85 the practical reality of drug markets in combination with the broad reach of the laws means that very few drug-induced homicide defendants fall into that category. Instead, most drug sellers who are prosecuted for drug-induced homicide are no different than any other low-level drug seller. 86

The surge in prosecuting friends, family members, and low-level sellers for homicide offenses as a result of an overdose embodies the drug war philosophy. A core feature of the drug war has been the widespread application of unforgiving criminal penalties that bear no relationship to blameworthiness or efficacy. 87 War connotes an existential threat and so, in the war on drugs, drug crimes came to be thought of as offenses “of the highest order,” 88 despite the fact that drug exchanges are consensual transactions. Lengthy and far-reaching mandatory minimum drug penalties were “viewed as a statement that society would no longer tolerate the illegal drug epidemic.” 89 In order to “send a message,” punishment was “pegged at a level that the legislature considers appropriate for a highly culpable participant . . . [and] just punishment for lesser roles is inevitably precluded.” 90

Like the archetypical drug war policy of mandatory minimum penalties, drug-induced homicide statutes can impose severe punishments on low-level sellers and even on users who share drugs with friends or family members. This is because, in most states, legislators did not narrowly craft drug-induced homicide statutes to focus on their purported targets of higher-level drug traffickers or traffickers who knowingly sell drugs with dangerous adulterants. 91 Instead, just as with mandatory minimum penalties based on drug type and quantity, lawmakers appear to have entrusted the reach of the laws to

83 Id. at 17.
84 DRUG POLICY ALL., supra note 55, at 41 (discussing studies suggesting that a large percentage of people convicted of drug trafficking offenses also use drugs and observing that “[i]t is widely understood among experts who study drug markets that many sellers are suffering from a substance use disorder and are selling to support their own drug use”).
85 Shuler, supra note 77 (quoting Vermont’s legislative findings).
86 DRUG POLICY ALL., supra note 55, at 42.
87 See Kreit, supra note 4, at 1337–38.
91 See DRUG POLICY ALL., supra note 55, at 9, 59, 65, 67 n.49 (discussing the strict liability mens rea imposed in drug-induced homicide statutes).
prosecutorial discretion. And, as with the application of mandatory minimum penalties based on drug type and quantity, prosecutions all too often target the low-hanging fruit. Unless one subscribes to the view that— in the words of one prosecutor—"[e]ven if you’re an addict, once you cross that line and give it or sell it to someone, you become a dealer," it is hard to escape the conclusion that the aggressive use of drug-induced homicide statutes divorces punishments from blameworthiness.

Drug-induced homicide prosecutions are perhaps even harder to justify on utilitarian grounds. Like other drug war-era policies, they are meant to send a message for its own sake. In contrast to safe injection sites, there is no empirical evidence whatsoever demonstrating that drug-induced homicide prosecutions achieve their stated goals. Nor is there much reason to think these prosecutions will reduce drug trafficking in general or trafficking in drugs cut with dangerous adulterants in particular. If prosecutions were limited to sellers who knew they were selling adulterated drugs or to higher-level participants responsible for deciding what to cut the drugs with, they might incentivize sellers to take greater care to protect the health of their buyers. But, as discussed above, most cases involve low-level sellers and users who share with one another—groups that have little or no control over what is in their product. Tellingly, even some of the prosecutors who pursue these cases have said they do not believe they have any deterrent effect, let alone an effect sufficient to justify the cost of prosecuting the cases and imprisoning the defendants who are convicted. Worse, there is some reason to think that drug-induced homicide prosecutions might contribute to the overdose death problem by deterring people from calling 911 to report an overdose. Despite all of this, as with most

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92 See Schulhofer, supra note 90, at 202 (noting that mandatory minimum drug penalties “in effect delegate to prosecutors the power to decide whether the statute is really a mandate to impose a minimum sentence or instead is only a source of discretion”).
93 See DRUG POLICY ALL., supra note 55, at 42.
95 Shuler, supra note 77 (quoting a prosecutor who said, following a drug-induced homicide conviction, that the case “sent a strong message that cavalier use of drugs in our community isn’t going to be tolerated”).
96 See Beletsky, supra note 63, at 875–77 (arguing that drug-induced homicide prosecutions are unlikely to have a deterrent effect on drug sales in general or especially risky drug sales in particular); see also DRUG POLICY ALL., supra note 55, at 39.
98 DRUG POLICY ALL., supra note 55, at 40 (arguing that “rather than reduce fatalities, drug-induced homicide laws only result in additional overdose deaths due to people failing to summon medical help for overdoses out of fear of prosecution”).
drug war policies, drug-induced homicide prosecutions are pursued because they further a zero-tolerance ideology.\textsuperscript{99} There is no need to show that the policy is likely to produce tangible benefits or even to study the question. Regardless of the costs and benefits, the policy is considered to be worthwhile because it is a “tough” response to drugs.

IV. THE DRUG WAR AT A CROSSROADS

Efforts to establish safe injection sites and the increase in drug-induced homicide prosecutions represent two competing visions for how to respond to the opioid epidemic. They also help to provide some insight into one of the reasons why ending the war on drugs is much more easily said than done: the availability of rarely used but broadly written drug war-era laws. So long as they remain on the books, these long-dormant drug war-era statutes can quickly be put into action at any time. Because of this dynamic, prosecutors have been able to double down on the war on drugs by aggressively charging and prosecuting drug-induced homicide cases, and the Department of Justice (“DOJ”) has been able to single-handedly stymie local efforts to establish safe injection sites. In both cases, broadly written laws passed in the 1980s that were dormant or near dead—the “zombie laws” of the drug war\textsuperscript{100}—are being employed in ways their drafters likely did not intend in order to breathe new life into the drug war.\textsuperscript{101}

Federal opposition to safe injection sites provides an especially striking example of the scope of drug war-era laws and their potential to prevent reform today. Four cities have announced plans to open safe injection sites but none have done so due at least in part to threats of federal prosecution.\textsuperscript{102} In Philadelphia, the United States Attorney for the Eastern District of Pennsylvania preemptively sued the nonprofit Safehouse to block a safe injection site from opening.\textsuperscript{103} Although the DOJ has not taken a formal position on safe injection sites, the United States Attorney for the Eastern District of Pennsylvania’s position does not appear to be an outlier. In an August 2018 \textit{New York Times} editorial, then-Deputy Attorney General Rod Rosenstein pledged to take “swift and aggressive action” against any city or state that opens a safe injection site.\textsuperscript{104} What is especially striking about Rosenstein’s threats and the lawsuit against Safehouse is the legal basis for the federal government’s opposition to safe injection sites. Safe injection sites do not manufacture, distribute, or possess

\textsuperscript{99} Shuler, supra note 77 (citation omitted).
\textsuperscript{100} I thank Eve Hanan for suggesting this phrase.
\textsuperscript{102} See Kreit, supra note 42 and accompanying text.
\textsuperscript{103} Allyn, supra note 48.
\textsuperscript{104} Rosenstein, supra note 10.
illegal drugs and it is unlikely site operators could be considered accomplices to drug possession. One might naturally wonder, then, why it is that federal prosecutors have proclaimed safe injection sites to be illegal. After all, federal law does not make it a crime to provide health services to people who use illegal drugs.

The argument that safe injection sites violate federal law is grounded in a rarely used statute passed at the height of the war on drugs, the so-called federal “crack house” law. That law makes it a crime to “manage or control any place, whether permanently or temporarily, either as an owner, lessee, agent, employee, occupant, or mortgagee, and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance.” Formally titled “[m]aintaining drug-involved premises,” the law is often referred to as the crack house statute because it was passed in response to concerns about “so-called ‘crack-houses’[] where ‘crack’, [sic] cocaine and other drugs are manufactured and used.” It was passed near the height of the drug war and during the moral panic surrounding crack cocaine, as part of the Anti-Drug Abuse Act of 1986.

The legislative history of the law makes clear that it was written with crack houses in mind. Both “the short title and the Congressional Record synopsis refer to manufacturing and crack houses.” The Senate summarized the new law as one “that ‘outlaws operation of houses or buildings, so-called ‘crack houses’[] where ‘crack’, [sic] cocaine and other drugs are manufactured and

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105 Assuming *arguendo* that a safe injection facility facilitates the possession of a controlled substance, accomplice liability attaches only to those who act “with the intent of facilitating the offense’s commission.” Rosemond v. United States, 572 U.S. 65, 71 (2014). Safe injection site operators do not intend to help people possess drugs or to encourage drug use; their purpose is to provide medical services to injection drug users. *See* Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 St. Louis U. L.J. 1089, 1100, 1133 (2009) (“An [sic] SIF is providing a space for use of controlled substances not for its own sake or for profit, but in order to promote drug treatment, prevent disease, and avoid overdose mortality.”).


108 *Id.*


111 United States v. Sturmoski, 971 F.2d 452, 462 (10th Cir. 1992) (discussing the legislative history of the crack house statute).

112 United States v. Tamez, 941 F.2d 770, 773 (9th Cir. 1991).
Since drug manufacturing and possession were already federal crimes, the crack house statute seemed designed more to meet a political need than to fill a real gap in the law. Not surprisingly then, crack house statute prosecutions are exceedingly rare. In 2017, maintaining a drug-involved premises was the primary offense of conviction for just 24 of the 19,750 drug offenses that received federal sentences. Despite this, the text of the law can apply to individuals with only a tenuous connection to drugs. Courts have consistently held that the statute “only requires that a defendant has the purpose of maintaining property where drug use takes place, and not that the defendant intends the drug use to occur.“As a result, “a `defendant may be liable if he manages or controls a building that others use for an illicit purpose, and he either knows of the illegal activity or remains deliberately ignorant of it. Based on this interpretation, it seems likely that courts would find that the crack house statute applies to safe injection site operators since they would have knowledge their clients were coming to the facility for the purpose of using drugs. To be sure, the legal status of safe injection sites has not yet been tested in court; Safehouse is vigorously fighting the DOJ’s lawsuit against them. And, as I have argued elsewhere, there may be a legal avenue for cities or states to open government-run safe injection sites without federal interference. Whichever side prevails in the looming conflict over the legal status of safe injection sites, however, it is striking that a drug war-era law that was passed in response to concerns about so-called crack houses might, years later, block cities from establishing safe injection sites. Congress certainly was not thinking about safe injection sites when it passed the crack house statute. But, like many laws enacted at the height of the war on drugs, the crack house statute’s text sweeps much more broadly than the problem to which it was addressed.

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113 Sturmoski, 971 F.2d at 462 (quoting 132 CONG. REC. S13,780 (daily ed. Sept. 26, 1986)).


115 U.S. SENTENCING COMM’N, supra note 101, at S-41 tbl.17, S-104 tbl.33.

116 United States v. Tebeau, 713 F.3d 955, 960 (8th Cir. 2013).

117 Id. at 961 (quoting 8th Cir. Model Crim. Jury Instr. § 6.21.856B).

118 See Kreit, supra note 17, at 432-34 (analyzing application of the crack house statute to safe injection site operators based on the prevailing interpretation of the statute’s mens rea provisions).


120 See Kreit, supra note 17, at 442–62 (arguing that the Controlled Substances Act’s immunity provision might apply to shield a state- or local-government-run safe injection site from federal interference).

121 See United States v. Sturmoski, 971 F.2d 452, 462 (10th Cir. 1992) (discussing the legislative history of the crack house statute).

so, more than three decades later, the DOJ may be able to employ the law against safe injection site operators. If the strategy succeeds, federal prosecutors will have blocked safe injection sites without Congress ever considering whether or not safe injection sites are good policy or whether this is an issue that should be decided at the national or the local level.

The rise in drug-induced homicide prosecutions paints a similar picture about the competing efforts to end or to reinvigorate the war on drugs. Like the crack house statute, most drug-induced homicide laws were passed at the height of the drug war. In fact, the federal drug-induced homicide provision was part of the same bill as the crack house statute, the Anti-Drug Abuse Act of 1986. The federal drug-induced homicide provision was motivated by outcry over the cocaine overdose death of star college basketball player Len Bias. A number of states followed Congress’s lead and most legislators appeared to see these laws as targeted at “drug dealers” in general and higher-level drug dealers specifically.

Although some lawmakers may have imagined the laws would also be employed against low-level sellers, there is reason to think many would not have realized that friends and spouses who share drugs with one another could be subject to drug-induced homicide charges. It is exceedingly rare for people to be prosecuted for drug distribution based on social sharing because these kinds of exchanges are well hidden from the police. The odds of being caught for sharing drugs with someone else in your home or even in public are quite low. As a result, at the time the federal drug-induced death statute was passed, a number of federal circuit courts had not yet resolved the question of “whether the social sharing of a small quantity of drugs, without consideration, constitutes the distribution of drugs within the meaning of” the CSA. Until recently, drug-induced homicide prosecutions were also relatively rare. But, as discussed above, they have exploded over the past few years, mostly because some police and prosecutors have decided to investigate every overdose as a homicide. Because drug users often share with one another (as anyone who has been offered a beer at a friend’s house can attest), a sizeable


124 Id. (“[I]n 1986 . . . Congress enacted the Anti-Drug Abuse Act, 100 Stat. 3207, which redefined the [CSA] offense categories, increased the maximum penalties and set minimum penalties for many offenders, including the ‘death results’ enhancement at issue here.” (citations omitted)).

125 Beletsky, supra note 63, at 869–70 (discussing Len Bias’s death and passage of the federal drug-induced homicide-provision). Indeed, drug-induced homicide statutes are sometimes referred to as by shorthand “Len Bias laws.” Goldensohn, supra note 97.

126 Goldensohn, supra note 97 (“The Len Bias laws were supposed to go after drug dealers—greed-soaked mutants,’ Howell Heflin of Alabama called them on the Senate floor.”).

127 United States v. Wallace, 532 F.3d 126, 128–29 (2d Cir. 2008) (collecting cases, only one of which was decided prior to 1986).

128 See discussion supra Part III.
number of drug-induced deaths result from the “distribution” of drugs between friends and spouses. Outside of drug-induced homicide cases, police typically expend no investigative resources targeting friends who share illegal drugs with each other. But these kinds of exchanges have increasingly been the focus of drug-induced homicide enforcement. Conduct that has never been of particular concern to law enforcement (the social sharing of drugs) is now leading to homicide charges because of the expansive application of rarely used drug war-era laws. In this way, prosecutors have been able to single-handedly breathe new life into the war on drugs, even as many lawmakers have expressed interest in moving toward a public health approach to drug policy.

The rise in drug-induced homicide prosecutions also undermines more recent, public health-oriented legislation. While drug-induced homicide laws may not directly block reform, they work at cross-purposes with the Good Samaritan laws that have been passed in forty states. Lawmakers have embraced Good Samaritan laws in response to increasing evidence that “[t]he most common reason people cite for not calling 911 [in response to an overdose] is fear of police involvement.” In order to encourage people to call 911, Good Samaritan laws give limited immunity (most often, immunity from prosecution for simple drug possession) to people who call 911 to report an overdose death. But by increasingly targeting friends and family members for drug-induced homicide charges, prosecutors are frustrating these laws by deterring people from calling for help in response to an overdose “for fear of prosecution for manslaughter or murder.”

Much like the DOJ’s expansive application of a dormant drug war-era law has blocked safe injection sites, the expansive application of drug-induced homicide laws allows prosecutors to single-handedly set back current day reform efforts.

V. CONCLUSION

The past decade has seen a great deal of enthusiasm for establishing a new, public health-oriented approach to drug policy. Barack Obama’s first drug czar, Gil Kerlikowske, said upon taking office that it was time to retire the drug war strategy. This change in rhetoric has coincided with some reforms on the state and local level, through the establishment of programs like Law Enforcement Assisted Diversion (LEAD) and Good Samaritan laws. It has also led lawmakers

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129 See Beletsky, supra note 63, at 873–74 (citations omitted) (discussing charges against friends and family members).
131 DRUG POLICY ALL., supra note 55, at 40.
132 Id.
133 Id. (discussing Good Samaritan laws).
134 Id.
in some states to repeal some mandatory minimum drug penalties. Similarly, under Attorney General Eric Holder, the Department of Justice placed modest limits on the use of federal mandatory minimum drug penalties. But achieving significant and lasting reform will require some very heavy lifting. At the federal level, Congress will need to dramatically revise federal drug laws, beginning with mandatory minimum penalties; a Department of Justice charging policy or modest legislative reform is insufficient.\textsuperscript{136} In the states, programs like LEAD will need to be turned into lasting changes to state law, perhaps with a view toward even bolder reforms along the lines of Portugal’s decriminalized civil drug court system.

Even as efforts to end the drug war have continued to gain momentum, there have been growing calls to revive it. This leaves the country in a pivotal moment for drug policy, particularly in the context of the opioid epidemic. It is possible to imagine a near future in which safe injection sites are operating in multiple cities, Congress has finally enacted meaningful mandatory minimum reforms, and one or more states are eyeing decriminalizing drug possession. It is also easy to imagine a future in which reform efforts have stalled, the federal government has beaten back safe injection sites, and Congress has enacted a new set of harsh mandatory minimum drug penalties. Or perhaps the next decade of drug policy may include components of each approach. We may see a reduction in the criminalization of drug possession and an increase in enforcement against drug “sellers” (a group that, of course, also includes many users). Or drug policy may become much more decentralized, with some states and localities continuing to wage war and others turning to harm reduction measures. Whatever the future holds, the battle over safe injection sites and the recent increase in drug-induced homicide prosecutions shows that drug war supporters currently have the structural upper hand. The height of the drug war saw lawmakers pass a dizzying array of broadly worded and increasingly severe criminal statutes. Some of these laws were never widely used. But as long as they remain in effect, prosecutors can bring these moribund laws back to life to frustrate the efforts of those who hope to see an end to the war on drugs.