

THE CURE FOR AMERICA'S OPIOID CRISIS? END THE WAR ON DRUGS*

CHRISTINE MINHEE** & STEVE CALANDRILLO***

The War on Drugs. What began as a battle waged on morals has created multiple public health crises, and no recent phenomenon illustrates this in more macabre detail than America's opioid disaster. 2017 alone amassed a higher death toll than the totality of American military casualties in the Vietnam, Iraq, and Afghanistan wars combined. With this wave of mortalities came a crash of parens patriae lawsuits filed by states, counties, and cities on the theory that jurisdictions are entitled to recompense for the costs of addiction ostensibly created by Big Pharma. To those attuned to the failures of the Iron Law of Prohibition, this litigious blame game functions merely as a Band-Aid over a deeply infected wound. This Article synthesizes empirical economic impact data to paint a clearer picture of the role that drug prohibition has played in the devastation of American communities, exposes parens patriae litigation as a misguided attempt at retribution rather than deterrence, and calls for the legal and political decriminalization of opiates. We reveal that America's fear of decriminalization has at its root the "chemical hook" fallacy—a hold-over from Reagan-era drug policy that has been debunked by far less wealthy countries like Switzerland and Portugal, whose economies have already benefited from discarding the War on Drugs as an irrational and expensive approach to public health. We argue that the le-

* This Article is dedicated to Bruno Leopold Caterpillar Steenstrup. The authors thank Chryssa Deliganis, Karen Boxx, Tres Gallant, Lauren Sancken, Jonathan Moskow, Anna Deliganis, George Webb, and Irwin Yoon for their helpful thoughts and comments on this Article. We are particularly grateful to Jason Oh, Mary Whisner, and the Marian Gould Gallagher reference librarians for their excellent research assistance, and to the Washington Law School Foundation and the Jeffrey & Susan Brotman Professorship for their generous financial support of this project.

** J.D. Candidate, University of Washington School of Law. B.A., Stanford University, c87@uw.edu, www.linkedin.com/in/christineminhee.

*** Jeffrey & Susan Brotman Professor of Law, University of Washington School of Law, stevecal@uw.edu; J.D., Harvard Law School; B.A., University of California at Berkeley.

gal and political acceptance of addiction as a public health issue—not the view that addiction is a moral failure to scourge—is the only rational, fiscally responsible option left to a country that badly needs both a prophylactic against future waves of heavy opioid casualties and restored faith in its own criminal justice system.

I. INTRODUCTION: DRUG ASSUMPTION RESISTANCE	
EDUCATION (D.A.R.E.).....	549
A. Prohibition Kills.....	549
B. A Brief History of American Opiophilia	554
C. The Iron Law of Prohibition	560
D. Macroeconomic Depression as Unreported Demand	564
II. JUST SAY NO	576
A. Under the War on Drugs' Influence	576
B. Drumming Power from Fear	579
C. The Litigious Blame Game	583
D. Return on Investment from Acceptance	595
III. JUST SAY YES.....	600
A. Ideologically Pure Solutions from Abroad	600
B. The Limitations of Politically Feasible Initiatives	605
C. Skip the Eggs—Kill the Black-Market Golden Goose.....	609
D. Taxation Trumps Prohibition	612
E. Home Brew Decriminalization.....	615
IV. CONCLUSION	622

I. INTRODUCTION: DRUG ASSUMPTION RESISTANCE EDUCATION
(D.A.R.E.)¹

*“Despair may have made certain American communities more vulnerable to the epidemic. Economic and social factors may have contributed to the kindling—but the explosion in the supply of opioids was a flamethrower.”*²

A. Prohibition Kills

America’s opioid crisis is the latest battle in the War on Drugs, with war-like casualties. Like war, our opioid crisis is an entirely manmade, sweeping epidemic of death.³ Major news outlets report that opioid overdoses have claimed more American casualties in one year alone than did the Vietnam, Iraq, and Afghanistan wars combined.⁴ The World Health Organization estimates that 69,000 people die of opioid overdoses

1. Initially founded in 1983 as a partnership between the Los Angeles police department and its public schools, *The History of D.A.R.E.*, D.A.R.E., <https://dare.org/history/> (last visited Oct. 29, 2018), Drug Abuse Resistance Education (D.A.R.E.) is a “police officer-led series of classroom lessons” that attempts to teach kindergarteners through high schoolers “how to resist peer pressure and live productive drug and violence-free lives,” *About D.A.R.E.*, D.A.R.E., <https://dare.org/about> [<https://perma.cc/S9EF-NWHA>] (last visited Oct. 29, 2018). Its ineffectiveness is well documented. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-03-172R, YOUTH ILLICIT DRUG USE PREVENTION: DARE LONG-TERM EVALUATIONS AND FEDERAL EFFORTS TO IDENTIFY EFFECTIVE PROGRAMS 2 (2003) (“All of the evaluations suggested that DARE had no statistically significant long-term effect on preventing youth illicit drug use”). And yet, Attorney General Jeff Sessions has touted the effectiveness of the program. See *Attorney General Jeff Sessions Delivers Remarks at the 30th DARE Training Conference*, U.S. DEP’T OF JUSTICE OFFICE OF PUB. AFFAIRS (Jul. 11, 2017), <https://www.justice.gov/opa/speech/attorney-general-jeff-sessions-delivers-remarks-30th-dare-training-conference> [<https://perma.cc/R7L4-Q3CY>] (“We must have Drug Abuse Resistance Education. DARE is the best remembered anti-drug program. I am proud of your work. It has played a key role in saving thousands of lives and futures.”).

2. Eric Levitz, *Did Americans Turn to Opioids Out of Despair—or Just Because They Were There?*, N.Y. MAG.: INTELLIGENCER (Jan. 16, 2018), <http://nymag.com/daily/intelligencer/2018/01/is-the-opioid-crisis-driven-by-supply-or-demand.html> [<https://perma.cc/5WVA-J4EY>].

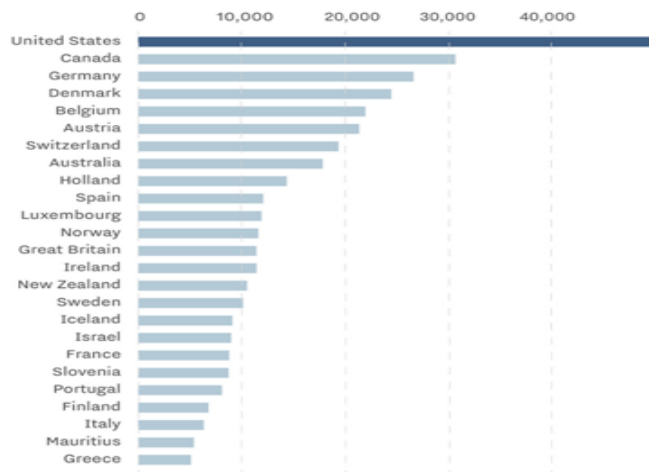
3. See Julie Garner, *The Opioid Boom*, U. WASH. ALUMNI MAG., <https://magazine.washington.edu/feature/the-opioid-boom> [<https://perma.cc/S9JA-5E56>] (last visited Feb. 19, 2019) (quoting UW School of Public Health research professor Gary Franklin, who describes our current opioid crisis as “the worst man-made epidemic in modern medical history”).

4. Anthony Zurcher, *Opioid Addiction and Death Mail-Ordered to your Door*, BBC NEWS (Feb. 22, 2018), <http://www.bbc.com/news/world-us-canada-43146286> [<https://perma.cc/H47F-F9C9>].

globally each year⁵—a sum barely greater than the 63,600 Americans who died from opioid overdoses in 2016 alone.⁶ And since 2000, over 300,000 people⁷—roughly half the population of the state of Vermont⁸—have died from fatal opioid poisoning. Given that “[m]ore Americans die annually from [opioids] than are killed in car accidents or firearm incidents,”⁹ few can deny that the supersized scope of this national tragedy is uniquely American.

Americans consume more opioids than any other country

Standard daily opioid dose for every 1 million people



Source: United Nations International Narcotics Control Board
Credit: Sarah Frostenson

Vox

5. *Information Sheet on Opioid Overdose*, WORLD HEALTH ORG. (Nov. 2014), http://www.who.int/substance_abuse/information-sheet/en [<https://perma.cc/6X78-YS8C>].

6. *Opioid Crisis: Overdose Rates Jump 30% in One Year*, BBC NEWS (Mar. 6, 2018), <http://www.bbc.com/news/world-us-canada-43305340> [<https://perma.cc/M8YY-MRU7>].

7. *The Opioid Crisis*, WHITE HOUSE, <https://www.whitehouse.gov/opioids/> [<https://perma.cc/SK6R-F8JK>] (last visited Aug. 6, 2018).

8. According to the U.S. Census Bureau, Vermont's population in 2017 was 623,657. *Population Estimates, July 1, 2017*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/geo/chart/US/PST045217> [<https://perma.cc/XX8K-L5YF>] (last visited Aug. 6, 2018).

9. Zurcher, *supra* note 4.

Our epidemic is not solely fueled by prescription oversupply, for our country's opioid-related deaths came not in one wave, but three. When listed as a toxicological cause of death, "opioids" include both illegal and legal FDA-approved formulations of the drug. For a diminishing portion of America, the former class is better known. Healthcare providers in one year wrote enough prescriptions to provide each American adult his own bottle of opioids like OxyContin and Vicodin,¹⁰ and incidents of "medicine cabinet" overdoses were reported to have increased for at least a decade after increased prescribing habits began in the mid-1990s.¹¹

Ten years after the peak of prescription opioid popularity came a tidal crash of heroin-related overdoses in 2010,¹² with another wave of deaths linked to synthetic opioids like fentanyl following soon after.¹³ The U.S. Centers for Disease Control and Prevention (CDC) maintains that the strongest risk factor for heroin use is the "[p]ast misuse of prescription opioids," and describes the transition from off-label use of prescription opioids to heroin abuse as mere "part of the progression to addiction."¹⁴ But according to the U.S. Department of Health & Human Services, increases in opioid-related fatalities are now driven by the use of illicitly manufactured fentanyl hybridized with heroin, counterfeit pills, and cocaine.¹⁵

10. *Prescription Opioid Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/prescribing.html> [<https://perma.cc/KA8E-MDRK>] (last updated Aug. 30, 2017).

11. *Understanding the Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/epidemic/index.html> [<https://perma.cc/SKT3-T6F7>] (last updated Dec. 19, 2018).

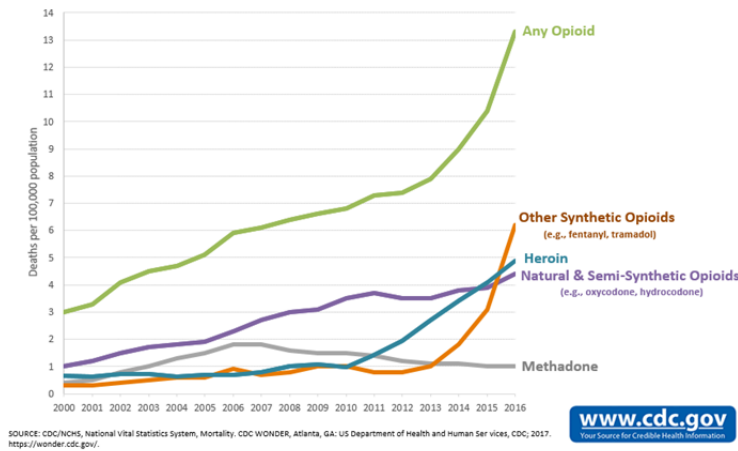
12. *See id.*

13. *See id.*

14. *Heroin Overdose Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/heroin.html> [<https://perma.cc/66E9-J3KH>] (last updated Jan. 26, 2017).

15. *See* William M. Compton et al., *Relationship between Nonmedical Prescription-Opioid Use and Heroin Use*, 374 *NEW ENG. J. MED.* 154, 155 (2016).

Overdose Deaths Involving Opioids, by Type of Opioid, United States, 2000-2016



*No one type of opiate is exclusively to blame for our crisis.*¹⁶

What is worrisome about this trajectory from prescription opioids to fentanyl is the fact that their respective strengths are not linearly related. With their extremely variable potencies,¹⁷ semi-synthetic heroin and synthetic fentanyl pose an exponentially more powerful threat.¹⁸ And as we will illustrate later, the black-market economy virtually ensures their ample supply. The market for synthetic drugs has “never been so complex and widely spread.”¹⁹ This is a terrifying state of popularity for a category of drugs “up to 10,000 times” more potent than morphine,²⁰ for illicit opioids require neither Big Pharma, multi-million-dollar marketing budgets, nor free market availability, to supply their ever-increasing demand.

As Americans rapidly progressed from FDA-approved opioid use to illicit heroin and fentanyl, they also died in larger numbers, but the trajectory of overdose deaths today is de-

16. *Heroin Overdose Data*, *supra* note 14.

17. See U.N. Office on Drugs & Crime, *World Drug Report 2017: Pre-briefing to the Member States* (June 16, 2017), https://www.unodc.org/wdr2017/field/WDR_2017_presentation_launch_version.pdf [<https://perma.cc/W5CA-W8ZF>].

18. See *id.*

19. *Id.*

20. *Id.*

tached from increases in new users of prescription drugs.²¹ “[C]landestinely-manufactured synthetics” like fentanyl now constitute the “primary drivers” of opioid-related overdoses.²² Our executive branch believes that our crisis can be solved by preventing children from stepping onto the slippery slope of opioid use.²³ How does that approach square with the trend of “dramatically” increasing “overdose deaths, addiction treatment admissions, and other adverse public health outcomes associated with [opioid] use . . . since 2002,” despite a simultaneous decline in new, nonmedical opioid users?²⁴ America has experienced such a sudden reversal in health from this crisis that its death toll has nearly surpassed that of the AIDS epidemic, which took the lives of 650,000 Americans between 1981 and 2015.²⁵ “A combination of behavioral change and drug therapy brought the US AIDS epidemic under control.”²⁶ But “public awareness of the enormity of the AIDS crisis was far greater” than that of our opioid crisis today,²⁷ and our epidemic will likely cause millions to “age into Medicare in worse health than the currently elderly,” positioning the middle aged to become a “lost generation” of health with “future[s] . . . less bright than those who preceded them.”²⁸ This cross-

21. *U.S. Drug Overdose Deaths Continue to Rise; Increase Fueled by Synthetic Opioids*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/media/releases/2018/p0329-drug-overdose-deaths.html> [<https://perma.cc/WZY4-7HGR>] (last visited Mar. 29, 2018); see also Andrew Kolodny et al., *The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction*, 36 ANN. REV. PUB. HEALTH 559, 563 (2015).

22. Leo Beletsky & Corey S. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 INT'L J. DRUG POL'Y 156, 157 (2017).

23. Adam K. Raymond, *Trump's Solution to Opioid Crisis: Tell Kids Drugs Are 'No Good'*, N.Y. MAG. (Aug. 9, 2017), <http://nymag.com/daily/intelligencer/2017/08/trumps-solution-to-opioid-crisis-tell-kids-drugs-are-bad.html> [<https://perma.cc/UBN4-G92V>]; see also *Remarks by President Trump on Combatting the Opioid Crisis*, THE WHITE HOUSE (Mar. 19, 2018), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-combatting-opioid-crisis/> [<https://perma.cc/8BW7-V74T>].

24. Kolodny et al., *supra* note 21, at 563.

25. Anne Case & Angus Deaton, *Rising Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 112 PROC. NAT'L ACAD. SCI. U.S. 15,078, 15,081 (2015); see also *Understanding the Epidemic*, *supra* note 11 (noting that more than 630,000 people died from drug overdoses, and more than 350,000 from opioid overdoses, in the United States between 1999 and 2016).

26. Case & Deaton, *supra* note 25, at 15,081.

27. *Id.*

28. *Id.*

generational destruction by opioid addiction is just one reason why our various legal, administrative, and policy approaches should aim to do more than merely prevent new opioid users. In order to do what works, we ought to glean insight from our past battles with these drugs.

B. *A Brief History of American Opiophilia*

Our current epidemic is not America's first bout with fatal opioid overdose poisoning en masse. Large-scale opioid abuse began almost immediately after the Civil War.²⁹ Deaths during this era were epidemiologically traced to the "popularization of hypodermically injected morphine,"³⁰ which triggered thousands of overdoses between the 1870s and the 1920s.³¹ State and federal legislation like the Pure Food and Drug Act of 1906, the Harrison Anti-Narcotic Act of 1914, and the Heroin Act of 1924 were enacted in response.³² And countless newspapers articles published during that era—replete with yellow journalism-tinted titles like *A Beautiful Opium Eater*³³—describe stories that, "aside from some Victorian-era moralizing,"³⁴ feel strikingly familiar to those told on President Trump's CrisisNextDoor.gov.³⁵ The prototypical American anti-heroine heroin tale, then and now, goes something like this: a young American develops an addiction to opiates "at a vulnerable point in her life," finds enabling doctors, and then, inevitably, self-destructs.³⁶

That tale, however, is a normatively prescribed archetype of abuse that inaccurately reflects our history with drug addiction. Often forgotten is America's battle with heroin addiction during the Vietnam War, when 20% of enlisted troops were

29. Clinton Lawson, *America's 150-Year Opioid Epidemic*, N.Y. TIMES (May 19, 2018), <https://www.nytimes.com/2018/05/19/opinion/sunday/opioid-epidemic-history.html> [<https://nyti.ms/2IzHXMe>].

30. *Id.*

31. *Id.*

32. *Id.*

33. *A Beautiful Opium Eater*, CLARENCE & RICHMOND EXAMINER, Mar. 23, 1878, at 4, <https://trove.nla.gov.au/newspaper/article/62080789/5047385> [<https://perma.cc/EJ27-4FY5>].

34. Lawson, *supra* note 29.

35. See *Opioids: The Crisis Next Door*, CRISIS NEXT DOOR, <https://www.crisisnextdoor.gov/> [<https://perma.cc/S2H9-8WNR>].

36. Lawson, *supra* note 28.

addicted to heroin while stationed abroad.³⁷ A ready supply of cheap, illicit heroin—the apparent result of heavy “profiteering” by South Vietnamese government officials³⁸—enabled high rates of use. But demand for analgesic escape was arguably extraordinary for this group as well. The hindsight of modern psychology lends a sense of obviousness to discussions about why heroin addiction flourished amongst U.S. servicemen during this era: “growing disenchantment with the war” and “progressive deterioration in unit morale” are posited to explain the instinct to self-medicate and hedonistically indulge while coping with the existential terror of life-threatening combat.³⁹ But heroin at the time was also considered the “*bete noire* of American drugs”—“the most addictive substance ever produced”—and “a narcotic so powerful” that it was “nearly impossible to escape.”⁴⁰ A “horrified” American public awaited the war’s end, fearing the apocalyptic return of hundreds of thousands of servicemen-turned-junkies.⁴¹ Instead, the Archives of General Psychiatry found that 95% of those 20% of servicemen addicted to heroin did not resume their addictions upon return to American soil.⁴²

Sudden cessation, though seemingly odd, is supported by science. When opioid use is monitored and tapered to avoid side effects of withdrawal, the risk of readdiction can be happily, anticlimactically low.⁴³ Human and animal laboratory studies demonstrate that compulsive self-administration of drugs becomes less likely when subjects are presented with a choice between substance abuse and access to an alternative or

37. M. Duncan Stanton, *Drugs, Vietnam, and the Vietnam Veteran: An Overview*, 3 AM. J. DRUG & ALCOHOL ABUSE 557, 557 (1976).

38. *Id.*

39. *Id.*

40. Alix Spiegel, *What Vietnam Taught Us About Breaking Bad Habits*, NPR (Jan. 2, 2012), <https://www.npr.org/sections/health-shots/2012/01/02/144431794/what-vietnam-taught-us-about-breaking-bad-habits> [<https://perma.cc/6B2J-VVZH>].

41. *Johann Hari: Does Stigmatizing Addiction Perpetuate It?*, NPR: TED RADIO HOUR (Feb. 23, 2018) [hereinafter *Hari*], <https://www.npr.org/templates/transcript/transcript.php?storyId=587908364> [<https://perma.cc/V7RG-S28F>].

42. Stanton, *supra* note 37, at 557.

43. See Kate Nicholson, *What We Lose When We Undertreat Pain*, YOUTUBE (Oct. 17, 2017), <https://www.youtube.com/watch?v=u4vHSLeTe-s> [<https://perma.cc/26PQ-67SJ>].

competing reinforcer like food, money, or entertainment.⁴⁴ When the Vietnam War public then was met with a result not nearly “as severe as originally supposed,” “[m]yths as to the persistence and intractability of physiological narcotic addiction were dispelled.”⁴⁵ For veterans living today, quitting an opioid habit, statistically speaking, beckons suicide and not mere accidental overdose.⁴⁶ How did Vietnam veterans fare any better upon return from war?

The myth of addiction’s intractability does not derive from the medical community, which maintains that opioids are helpful for acute pain and addictive only for a minority of longtime users.⁴⁷ The CDC does not assert a causal relationship between mere prescription opioid use, stating only that “serious risks are *associated* with [opioid] use.”⁴⁸ And yet, addiction is considered a communicable disease—one that defies rational market behaviors.⁴⁹

To be fair, the overarching fear of opioids’ addictive propensity is not entirely misplaced. Many find opioids highly addictive due to their ability to “induce euphoria (positive reinforcement)” and relieve the “dysphoria (negative reinforcement)” triggered by cessation of chronic use.⁵⁰ Chronic use does tempt death, as a person’s first opioid overdose makes a second far more likely.⁵¹ Further justifying opiophobia are recent findings that suggest that continued opioid use may in-

44. See generally Stephen T. Higgins, *The Influence of Alternative Reinforcers on Cocaine Use and Abuse: A Brief Review*, 57 PHARMACOLOGY BIOCHEMISTRY & BEHAV. 419 (1997).

45. Stanton, *supra* note 37, at 557.

46. Nate Morabito, *VA Reps to Discuss Impact of Opioid Reduction on Suicides During Summit*, WJHL, http://www.wjhl.com/news/va-reps-to-discuss-impact-of-opioid-reduction-on-suicides-during-summit_20180123093420242/934066782 [<https://perma.cc/HHT3-UYMM>] (“[O]pioid discontinuation was not associated with overdose mortality but was associated with increased suicide mortality.”)

47. Beletsky & Davis, *supra* note 22, at 157 (citing Deborah Dowell, Tamara M. Haegerich & Roger Chou, *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*, 315 JAMA 1624, 1624–45 (2016)).

48. *Prescription Opioid Data*, *supra* note 10.

49. See, e.g., Ernest Drucker & Victor W. Sidel, *The Communicable Disease Model of Heroin Addiction: A Critique*, 1 AM. J. DRUG ALCOHOL AB. 3 (1974); Patrick H. Hughes, *A Contagious Disease Model for Researching and Intervening in Heroin Epidemics*, 27 ARCH. GEN. PSYCHIAT. 149 (1972).

50. Kolodny et al., *supra* note 21, at 560.

51. *Opioid Crisis: Overdose Rates Jump 30% in One Year*, *supra* note 6.

crease sensitivity to pain.⁵² While “[drug] tolerance is characterized by desensitization of neural pain pathways, . . . opioid-induced hyperalgesia is the result of hypersensitization of those pathways,” a state where “some patients may find themselves taking dangerously high doses while their pain continues to intensify.”⁵³ Rats are found to display an increased sensitivity to pain after being exposed to morphine,⁵⁴ and a Stanford University study involving humans using oral morphine for chronic back aches led researchers to conclude that “opioid tolerance and opioid-induced hyperalgesia might limit the clinical utility of opioids in controlling chronic pain.”⁵⁵ According to one scientist at the New York State Psychiatric Institute, though the rates of opioid-induced hyperalgesia are unknown, this blind spot in the way modern analgesic science understands opioids to work could be a “major factor” in our present-day opioid crisis.⁵⁶

The problem with this fear of addiction’s intractability is that it ultimately stems from the outmoded chemical hook theory—the idea that drugs contain all-consuming, psychologically hijacking “chemical hooks” that capture the unwary, invariably transforming them into raging drug addicts who spiral towards demise.⁵⁷ This theory anthropomorphizes the results of experiments on rats that found that when provided a supply of cocaine or heroin, rats will choose to overdose rather than abstain.⁵⁸ Much like *Reefer Madness* for cannabis,⁵⁹ a 1980s Partnership for a Drug-Free America TV commercial propagandized

52. See Clayton Dalton, *When Opioids Make Pain Worse*, NPR (Mar. 3, 2018, 6:00 AM), <https://www.npr.org/sections/health-shots/2018/03/03/586621236/when-opioids-make-pain-worse> [<https://perma.cc/7CSR-6QWT>].

53. *Id.*

54. Sabih Kayan, L.A. Woods & C.L. Mitchell, *Morphine-Induced Hyperalgesia in Rats Tested on the Hot Plate*, 177 J. PHARMACOL. EXP. THER. 509, 512 (1971).

55. Larry F. Chu, David J. Clark & Martin S. Angst, *Opioid Tolerance and Hyperalgesia in Chronic Pain Patients After One Month of Oral Morphine Therapy: A Preliminary Prospective Study*, 7 J. PAIN 43, 43 (2006).

56. Dalton, *supra* note 52.

57. See, e.g., Hari, *supra* note 41.

58. See, e.g., Adam N. Perry, Christel Westenbroek & Jill B. Becker, *The development of a preference for cocaine over food identifies individual rats with addiction-like behaviors*, PLOS ONE (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3832528/> [<https://perma.cc/P4NB-EG38>].

59. *Reefer Madness*, IMDB, <https://www.imdb.com/title/tt0028346/> [<https://perma.cc/6UNR-6VL6>] (last visited Aug. 8, 2018).

these experiments to reinforce the fear that humans, when faced with the choice between the banality of mere sustenance and drugs, will also opt for the drugs and invariably die.

From the perspective of behavioral psychology, myths of addiction's intractability ultimately derive from "antique notions of demonic possession, divine command, and other supernatural volition," and find expression in modern life when "social factors, societal oppression, emotional distress, external provocation, mental illness, [and] drugs" are used to rebut liability for the negative externalities produced by addictive behaviors.⁶⁰ There are indeed a multitude of biological, genetic, and social factors that contribute to the likelihood of addiction, and many of these factors—subject to intense debates about legal volition and philosophical free will—are within the user's control.⁶¹ The chemical hook theory may very well be our way of garnering support for the public health approach to drugs when we might otherwise fall prey to our normative judgment that public funds ought not be spent on those who need it as a result of what is perceived to be, at least in part, a moral failing. But policies that abide by the belief that addiction can strong-arm the entire superset of factors tending to yield drug addiction are not only "tantamount to a disbelief in free will,"⁶² but also utterly counterintuitive to the goal of addiction recovery. Around 1900, the medical community began using the word "addiction" to refer to the "[u]nconscious processes, genetic determinism, brain mechanisms, [and] chemical forces (e.g., the 'twinkie defense')" associated with the inability to abstain from drug use.⁶³ This medical lexicon facilitated the eventual treatment of addiction as biological destiny,⁶⁴ which, when married with the post-modern insistence "that all human actions are caused by prior events," renders free will in the drug context "entirely an illusion."⁶⁵

From the prohibition propagandist's perspective, the beauty of bloating addiction's power is that it flattens the nuanced,

60. Kathleen D. Vohs & Roy F. Baumeister, *Addiction and Free Will*, 17 *ADDICTION RES. & THEORY* 231, 231 (2009).

61. *See id.* at 233–34.

62. *Id.* at 231.

63. *Id.*; *see also id.* at 233–34.

64. *Id.* at 233.

65. *Id.* at 231 (citations omitted).

complicated, often heartbreaking factors tending humans towards fatal drug addiction, reducing its complexity to logical if-then statements such as: “If you overexpose a society or culture to cheap, plentiful food, you’ll have an obesity epidemic,” and “[i]f you overexpose a culture to opioids, you’re going to have an opioid epidemic.”⁶⁶ Statements like these are co-opted as propaganda to bolster supply-side interdictions. But they also reflect outdated scientific norms, as suggested by a rebuttal study led by Professor Bruce Alexander of Vancouver’s Simon Fraser University.⁶⁷ Alexander, an occupational and environmental epidemiologist, thought that the results of the original rat experiment made perfect sense: When trapped in wire cages with zero healthy reinforcers, rats, like humans in existential despair, will opt to get high and anesthetize in isolation.⁶⁸ To underscore the point, Professor Alexander produced a sequel. In his updated experimental environment, dubbed “Rat Park,” rats were provided a supply of drug-laced water and ample opportunity to eat to their hearts’ content, mate with other rats, and play.⁶⁹ The results? Zero rats died from compulsive opioid or narcotic overdose, while all or most of the lonely rats in bare, non-Rat Park, control cages did.⁷⁰ Alexander’s Rat Park experiment is criticized for “merely replac[ing]” the misconception that drug chemistry dispositively produces addiction with another: “that environment is the most important factor.”⁷¹ But if that is true, and if the chemical

66. Zurcher, *supra* note 4.

67. See generally Bruce K. Alexander et al., *The Effect of Housing and Gender on Morphine Self-Administration in Rats*, 58 *PSYCHOPHARMACOLOGY* 175 (1978); see also German Lopez, *It’s Not Just Opioid Addiction. Alcoholism May Be on the Rise Too.*, *VOX* (Aug. 10, 2017, 1:50 PM), <https://www.vox.com/policy-and-politics/2017/8/10/16124938/study-alcoholism-addiction-epidemic> [<https://perma.cc/7SAV-C92W>] (describing Alexander’s Rat Park study as a “classic experiment”).

68. Bruce K. Alexander, *Addiction: The View from Rat Park*, BRUCE K. ALEXANDER (2010), <http://www.brucekalexander.com/articles-speeches/rat-park/148-addiction-the-view-from-rat-park> [<https://perma.cc/YQ6N-9FPX>].

69. *Id.*

70. Bruce K. Alexander, *Rat Park Versus the New York Times*, BRUCE K. ALEXANDER, <http://www.brucekalexander.com/articles-speeches/rat-park/282-rat-park-versus-the-new-york-times-2> [<https://perma.cc/8EZA-PKQ6>] (last visited Nov. 14, 2018).

71. Katie MacBride, *This 38-Year-Old Study is Still Spreading Bad Ideas About Addiction*, *OUTLINE* (Sept. 5, 2017, 2:55 PM), <https://theoutline.com/post/2205/this-38-year-old-study-is-still-spreading-bad-ideas-about-addiction?zd=1&zi=fszfqmqt> [<https://perma.cc/5QGC-4GPM>].

hook theory is also defunct, how are drugs like OxyContin resulting in more addiction and overdoses than ever before? What makes things so climactic today?

C. *The Iron Law of Prohibition*

One part of the answer rests on the ingenuity of legal supply. Ours is not America's first bout with large-scale opioid addiction, but it is the first in the era of Big Pharma. OxyContin is the brand name of Purdue Pharma's extended-release, FDA-approved formulation of oxycodone, the generic name for the opioid analgesic manufactured in America beginning in the 1930s.⁷² As an extended release formulation, OxyContin provided great hope to the many who suffer from chronic bodily pain.⁷³ However, before OxyContin obtained FDA approval in 1995,⁷⁴ "many physicians were reluctant to prescribe [opioid pain relievers] on a long-term basis for common chronic conditions" due to "concerns about addiction, tolerance, and physiological dependence."⁷⁵ To topple physicians' opiophobia, Purdue developed an idea called "pseudoaddiction," commissioning its "physician-spokespersons" to sell the term to medical communities in order to artificially differentiate and render "clinically unimportant" the "physical dependence" on opioids from drug addiction.⁷⁶ In support of its efforts to "big-pharmasplain" addiction to doctors,⁷⁷ Purdue relied on a single, paragraph-long letter in a medical journal titled *Addiction Rare in Patients Treated with Narcotics*.⁷⁸ This letter anecdotally

72. *Common Myths About OxyContin® (Oxycodone HCl Controlled-Released) Tablets CII*, PURDUE, <http://www.purduepharma.com/news-media/2011/12/common-errors-in-the-media-about-oxycontin-oxycodone-hcl-controlled-release-tablets/> [<https://perma.cc/A6UA-FSJU>] (last visited Nov. 14, 2018).

73. See OXYCONTIN, <https://www.oxycontin.com/> [<https://perma.cc/K2S9-H9ZD>] (last visited Nov. 14, 2018).

74. *Common Myths About OxyContin® (Oxycodone HCl Controlled-Released) Tablets CII*, *supra* note 72.

75. Kolodny et al., *supra* note 21, at 562.

76. *Id.*

77. Cf., e.g., *Mansplain*, ENGLISH OXFORD LIVING DICTIONARIES, <https://en.oxforddictionaries.com/definition/mansplain> [<https://perma.cc/SWB5-RAWJ>] (last visited Jan. 31, 2019).

78. Jane Porter & Hershel Jick, *Addiction Rare in Patients Treated with Narcotics*, 302 NEW ENG. J. MED. 123, 123 (1980); see also *Opioid Crisis: The Letter that Started it All*, BBC NEWS (June 3, 2017), <http://www.bbc.com/news/world-us-canada-40136881> [<https://perma.cc/VP8E-RX3G>].

describes one instance where out of 11,882 hospitalized patients treated with narcotics, “only four patients with no history of addiction became addicted.”⁷⁹ A 0.03% addiction rate—if accurate—is tantalizing evidence against the chemical hook theory. But the paragraph-long study merely describes the addictive effects of weaker narcotics on hospitalized patients, not the effect of extended-life opioids on those who would take them regularly to combat chronic pain.⁸⁰ Citations of the letter spiked into the hundreds in the lead-up to and after Purdue’s introduction of OxyContin.⁸¹ Other letters published at the same time were cited an average of eleven times.⁸² And despite the clinical inapplicability of the study and the dearth of peer review, Purdue offered the letter as conclusive medical proof of pseudoaddiction.⁸³ The study enabled Purdue to market a gateway opioid as chemically unhookable, then push it on an America that has, as we will examine later, been the most un-Rat Park it has been in decades.

The other part of our answer rests in the fundamental economic logic of drug prohibition. The transition from relatively mild, legal opioids to stronger formulations, while shocking to the public, is an entirely foreseeable eventuality under what is called the “Iron Law of Prohibition.”⁸⁴ As a regulatory measure, prohibition imposes “substantial barriers and costs to the illicit drug supply chain”—heightening risk for illicit suppliers, which applies “direct pressure to minimise volume while maximising profit.”⁸⁵ The Iron Law of Prohibition refers to this pressure cooker of supply-demand interplay, which ensures that “[m]ore bulky products become more expensive relative to less bulky ones,” thereby incentivizing dangerous increases in

79. *Id.*

80. *See id.*

81. See Matthew Herper, *Did This 100-Word Letter Help Spark the Opioid Epidemic?*, FORBES (May 31, 2017, 5:00 PM), <https://www.forbes.com/sites/matthewherper/2017/05/31/did-this-100-word-letter-help-spark-the-opioid-epidemic/#6b98d7691057> [https://perma.cc/2M6N-E4LM].

82. *Id.*

83. Marion S. Greene & R. Andrew Chambers, *Pseudoaddiction: Fact or Fiction? An Investigation of the Medical Literature*, 2 CURRENT ADDICT. REP. 310, 310–317 (2015).

84. See Zurcher, *supra* note 4.

85. Beletsky & Davis, *supra* note 22, at 157.

potency.⁸⁶ Take a look at the Iron Law of Prohibition's role during alcohol prohibition between 1920 and 1933, when the production and sale of alcoholic beverages was criminalized, save for industrial or "limited" medical use.⁸⁷ Prior to Prohibition, beer was America's drink of choice.⁸⁸ Faced with the risk of "more voluminous contraband being seized and destroyed,"⁸⁹ black-market constraints caused the cost of products with lower alcohol to increase by over 700%, while the price of spirits rose much more slowly ("Prohibition-era cost increase: 270%").⁹⁰ As a result, Prohibition-era bootleggers transported "less beer and wine,"⁹¹ and transported more "highly-distilled spirits like gin and moonshine."⁹² Put another way, the Iron Law of Prohibition drove illicit suppliers to produce more potent substances over time, which forced consumers to purchase higher doses of illicit alcohol—not because their tastes had changed, but primarily because they ended up being cheaper.

Make no mistake: the Iron Law of Prohibition is not mere black market, price-gouging chicanery. Black-market economics, as applied to the illicit opioid market, routinely produces doses strong enough to kill people. Purchased legally, OxyContin costs \$1.25 for a 10-milligram tablet, and \$6 for an 80-milligram tablet. In the black market, the former's street price ranges from \$5 to \$10, while the latter commands up to \$80.50 a pill.⁹³ By comparison to legal supply, black market heroin is cheap:⁹⁴ at our apex death toll in 2016, heroin's street price was

86. *Id.*

87. *Id.*

88. *Everything You Ever Wanted to Know About Prohibition*, OXFORD U. PRESS: OUPBLOG (Oct. 21, 2011), <https://blog.oup.com/2011/10/prohibition/> [<https://perma.cc/4S53-CCZL>].

89. Beletsky & Davis, *supra* note 22, at 157.

90. *Id.* (citing Jeffrey A. Miron & Jeffrey Zwiebel, Alcohol Consumption During Prohibition 1–13 (Nat'l Bureau of Econ. Research, Working Paper No. 3675, 1991)).

91. Zurcher, *supra* note 4.

92. Beletsky & Davis, *supra* note 22, at 157.

93. *Oxycontin / Oxycodone*, CONNECTICUT CLEARINGHOUSE, <https://www.ctclearinghouse.org/topics/oxycontin-oxycodone> [<https://perma.cc/GJ75-EWX2>] (last visited Mar. 3, 2019); see also *Sky-High Prices for Prescription Opioids Sold on Street*, PARTNERSHIP FOR DRUG-FREE KIDS (June 1, 2011), <https://drugfree.org/learn/drug-and-alcohol-news/sky-high-prices-for-prescription-opioids-sold-on-street> [<https://perma.cc/HP7U-AJ4P>].

94. See Kolodny et al., *supra* note 21, at 560–61.

\$152 per gram.⁹⁵ In one study, 94% of opioid-addicted participants reported switching from prescription opioid pills to heroin because the former were “far more expensive and harder to obtain.”⁹⁶ This is how black-market economics whirlpools supply and demand, and creates a vicious feedback loop that exacerbates itself. As the desire for cheaper drugs increases linearly, the potency of the drugs increases exponentially, and the fear of prohibition-legal doses is then sold for more fear. A lethal dose of fentanyl, for example, is approximately the size of four grains of salt.⁹⁷ So when local law enforcement seizes twenty-four pounds of it—an amount sufficient to “administer lethal doses to [Ohio’s] entire population of 11.6 million”⁹⁸—hyperbolic alarm is conjured merely by framing the danger in simple mathematical proportion.⁹⁹

When black market-generated costs drive much of the demand for lethally potent drugs, “accidental suicide” becomes a predictable negative externality of black-market economics. Perhaps the only satisfying form of justice in this crisis is the poetic full-circling of Dr. Hershel Jick, the physician who wrote the letter Purdue co-opted to scientifically decriminalize opioid use for chronic pain.¹⁰⁰ He “never intended for the article to justify widespread opioid use,” and went so far as to testify at the Senate to say so.¹⁰¹ “I’m essentially mortified that that letter to the editor was used as an excuse to do what these drug companies did,” he states.¹⁰² And we should be mortified, too. For without reexamining our crisis “through the lens of [its] social

95. *Heroin and cocaine prices in Europe and USA*, U.N. OFFICE ON DRUGS & CRIME, https://dataunodc.un.org/drugs/heroin_and_cocaine_prices_in_eu_and_usa [https://perma.cc/FG4J-G9CT] (last visited Nov. 21, 2018).

96. Kolodny et al., *supra* note 21, at 560–561 (quoting Theodore J. Cicero et al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 821–26 (2014)).

97. *Record US Fentanyl Bust ‘Enough to Kill 26 Million People’*, BBC NEWS (May 25, 2018), <https://www.bbc.com/news/world-us-canada-44244688> [https://perma.cc/GXB5-2QSZ].

98. Zurcher, *supra* note 4.

99. See Michelle Chavez, *Fentanyl Bust Nets Enough Drugs to Wipe Out Population of Ohio*, FOX NEWS (Dec. 6, 2017), <http://www.foxnews.com/us/2017/12/06/fentanyl-bust-nets-enough-drugs-to-wipe-out-population-ohio.html> [https://perma.cc/DN8Y-FWSJ].

100. Porter & Jick, *supra* note 78, at 123.

101. *Opioid crisis: The letter that started it all*, *supra* note 78.

102. *Id.*

determinants . . . [such as] unemployment, concentrated disadvantage, isolation, and inadequate access to physical and mental health care,” we will continue to dodge the “multifaceted, structural solutions” designed to “significantly move the needle on the most formidable drug-related public health crisis of our time.”¹⁰³ And as we continue to circumvent holistic analyses of demand, our crisis is free to “mutate[] into something far more deadly.”¹⁰⁴

D. *Macroeconomic Depression as Unreported Demand*

Our crisis is as much a story of underestimated demand as it is one of overexuberant legal and illegal oversupply. Beneath nefarious corporate product marketing and the Iron Law of Prohibition rests an iceberg of undetected demand—one which initially reared its head in doctors’ offices as a “chronic, non-malignant pain.”¹⁰⁵ To monetize the “widespread prevalence and under-treatment” of this pain¹⁰⁶—one found to be “strongly associated with . . . frequent use of ambulatory health care, unfavorable self-appraisal of health status, and psychological impairment”¹⁰⁷—Big Pharma urged physicians to make greater use of opioids.¹⁰⁸ It is this capitalization of demand that births our desire to blame suppliers. But what we lose in our rush to blame supply is a meaningful discussion of the macro-sociological tidal changes constituting the demand for analgesic relief, which as we will explain, yields greater dispositive effect on the scope and scale of our epidemic. In other words, opioid oversupply simply “added fuel to the flames, making the epidemic much worse than it otherwise would have been.”¹⁰⁹

According to the supply-side story, the social blight of our national addiction to opioids sprouted like fungus from an ex-

103. Beletsky & Davis, *supra* note 22, at 158 (citations omitted).

104. *Id.*

105. Ameet Sarpatwari, Michael S. Sinha & Aaron S. Kesselheim, *The Opioid Epidemic: Fixing a Broken Pharmaceutical Market*, 11 HARV. L. & POL’Y REV. 463, 465 (2017).

106. *Id.*

107. *Id.* (omission in original) (quoting Michael Von Korff et al., *Graded Chronic Pain Status: An Epidemiologic Evaluation*, 40 PAIN 279, 289 (1990)).

108. Sarpatwari, Sinha & Kesselheim, *supra* note 105, at 467.

109. Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, 2017 BROOKINGS PAPERS ON ECON. ACTIVITY 397, 399.

cess of pharmaceutical drug supply. This supply-side tale is tidy.¹¹⁰ Framing our opioid crisis as one of oversupply provides the “simplest and most compelling explanations for our exceptional rates of opioid use.”¹¹¹ But opioid addiction is not tidy, and is arguably the ugliest threat to public health in modern-day America. As addictive behaviors become destructive and harmful both to addicts and society at large, we struggle with its ugliness, indulging our libertarian impulse to hold addicts accountable for “shirking their duties” and producing social welfare-deteriorating harms.¹¹² It is this multifaceted, messy causality problem of mass addiction that strengthens the appeal of treating it neatly as an intractable hook. We operationalize as policy the parasitic belief that addicts cannot absolutely control their actions to release ourselves from the politically incorrect task of rationalizing drug addicts’ behaviors.¹¹³ For doing so is what gives us the freedom we need to express our normatively correct desire to treat addicts compassionately, while criminalizing behaviors we subconsciously deem as deserving of moral condemnation.

The danger in circumventing a good-faith analysis of the factors that contribute to opioid demand today, though, is that it also forecloses a valid survey of the market interventions available to reduce it. The chemical hook theory is designed to forever tempt us into circumventing the study of addiction as an expression of demand, and to instead assume that oversupply alone is capable of its production. However, given the scale of our crisis, can we afford to merely hope that the market for illegal heroin and fentanyl will diffuse itself, without looking under the rug and attempting to understand why it might exist in the first place? Given their interplay, heroin and fentanyl’s

110. Cf. Lenny Bernstein & Joel Achenbach, *A Group of Middle-Aged Whites in the U.S. is Dying at a Startling Rate*, WASH. POST (Nov. 2, 2015), https://www.washingtonpost.com/national/health-science/a-group-of-middle-aged-american-whites-is-dying-at-a-startling-rate/2015/11/02/47a63098-8172-11e5-8ba6-cec48b74b2a7_story.html?noredirect=on&utm_term=.4df001bbf3a2 [https://perma.cc/L54-UCUE]. The story is perhaps too tidy, as the overemphasis on supply obfuscates even economists’ analysis of the way our nation got addicted in droves. As one economics professor at Dartmouth expressed his confusion: “I don’t know what’s going on, but the plane has definitely crashed.” *Id.*

111. Levitz, *supra* note 2.

112. Vohs & Baumeister, *supra* note 60, at 232.

113. *See id.* at 231–32.

pharmacological and social differences are worthy of better understanding.

Heroin is a black, sticky, semi-synthetic, opioid-based drug that can be injected, smoked, and snorted.¹¹⁴ It became a controlled substance in the early 1970s,¹¹⁵ making its manufacture, distribution, and dispensation illegal.¹¹⁶ But heroin does possess medical value. In other countries, it is sometimes prescribed to the terminally ill as an alternative to morphine, a drug with about half of heroin's potency.¹¹⁷ Rates of non-medical, illegal abuse of heroin remained stable for decades.¹¹⁸ But between 1999 and 2016, heroin-related overdoses increased by a factor of five.¹¹⁹ The CDC attributes this spike to the ubiquity of heroin's use "among men and women, most age groups, and all income levels."¹²⁰ The demographic egalitarianism of this surge is notable, for groups historically unlikely to use the drug—"women, the privately insured, and people with higher incomes"—experienced "[s]ome of the greatest [usage] increases" in recent years.¹²¹ Heroin's newfound ability to capture a historically quotidian, non-criminal demographic of users is likely best illustrated by the cottage industry of so-called opioid cessation products that cater to them. These products tempt addicts into "[i]magin[ing] a life without the irritability, cravings, restlessness, excitability, exhaustion[,] and discomfort associated with the nightmare of addiction and withdrawal symptoms."¹²² For their efforts to snake-oil illusory off-ramps

114. See *Today's Heroin Epidemic*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/heroin.html> [<https://perma.cc/4V9Q-G4JC>] (last updated Aug. 29, 2017).

115. Controlled Substances Act of 1970, Pub. L. No. 91-513, § 202, 84 Stat. 1236, 1249 (codified as amended at 21 U.S.C. § 812 (2012)).

116. *Id.*

117. See Michael Gossop et al., *The Unique Role of Diamorphine in British Medical Practice: A Survey of General Practitioners and Hospital Doctors*, 11 EUROPEAN ADDICTION RES. 76, 76 (2005); Donald R. Jasinski & Kenzie L. Preston, *Comparison of Intravenously Administered Methadone, Morphine and Heroin*, 17 DRUG & ALCOHOL DEPENDENCE 301, 304 (1986).

118. See Beletsky & Davis, *supra* note 22, at 156 (citations omitted).

119. *Opioid Data Analysis and Resources*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/analysis.html> [<https://perma.cc/B3Z5-VRWQ>] (last updated Feb. 9, 2017).

120. *Today's Heroin Epidemic*, *supra* note 114.

121. *Id.*

122. FTC, *FDA Warn Companies about Marketing and Selling Opioid Cessation Products*, FED. TRADE COMM'N (Jan. 24, 2018), <https://www.ftc.gov/news-events/press->

from the complicated condition of drug addiction, several of these products have also ensnared the U.S. Food and Drug Administration's (FDA) and Federal Trade Commission's (FTC) attention.¹²³

Fentanyl, unlike heroin, is a fully synthetic opioid.¹²⁴ It is not only 100 times more potent than natural morphine, but 50 times stronger than heroin,¹²⁵ which makes it medically appropriate only for individuals otherwise facing imminent death. When legally prescribed as a transdermal patch or lozenge,¹²⁶ fentanyl provides end-of-life palliative care,¹²⁷ manages advanced cancer pain,¹²⁸ and addresses "breakthrough pain" unresponsive to the usual suite of prescription opioid pills.¹²⁹ It should come as no surprise that when the opioid black market became "increasingly adulterated with illicitly-manufactured synthetic opioids,"¹³⁰ "deaths attributed to fentanyl analogues spiked by over 72%" in a single year.¹³¹ By 2016, "deaths involving synthetic opioids, mostly fentanyls, had risen 540 percent in just three years."¹³² The artist Prince's death was just one of the 2016 fatalities resulting from fentanyl overdose.¹³³ And these fentanyl-related deaths are expected to increase:

releases/2018/01/ftc-fda-warn-companies-about-marketing-selling-opioid-cessation [https://perma.cc/5PSB-WKPN].

123. *See id.*

124. *Fentanyl*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/opioids/fentanyl.html> [https://perma.cc/6KDV-RETH] (last updated Aug. 29, 2017).

125. *Synthetic Opioid Overdose Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/fentanyl.html> [https://perma.cc/FT2Y-52G7] (last updated Dec. 16, 2016).

126. *Fentanyl*, *supra* note 124.

127. *Synthetic Opioid Overdose Data*, *supra* note 125.

128. *See Fentanyl*, *supra* note 124.

129. *Nine Die in Vancouver in 24 hours from Fentanyl Opioid Overdose*, BBC NEWS (Dec. 17, 2016), <http://www.bbc.com/news/world-us-canada-38351958> [https://perma.cc/W698-N8BU].

130. Beletsky & Davis, *supra* note 22, at 157.

131. *Id.* (citing Rudd et al., *Increases in drug and opioid-involved overdose deaths—United States, 2010–2015*, 65 MORBIDITY & MORTALITY WKLY. RPT. 1445, 1445–52 (2016)).

132. Maya Salam, *The Opioid Epidemic: A Crisis Years in the Making*, N.Y. TIMES (Oct. 26, 2017), <https://www.nytimes.com/2017/10/26/us/opioid-crisis-public-health-emergency.html> [https://nyti.ms/2iATbr].

133. *Prince Death: Powerful Drugs Found in Singer's Home "Were Mislabeled"*, BBC NEWS (Aug. 21, 2016), <http://www.bbc.com/news/world-us-canada-37151146> [https://perma.cc/CEX9-EPUV].

though fentanyl is more easily mixed into the powder heroin sold in Eastern states, distributors are discovering ways to mix synthetic opioids into the black tar heroin sold west of the Mississippi.¹³⁴

The public is accustomed to thinking about prescription opioid, heroin, and fentanyl misuse as a “rural white problem” — an aggrandized craving for hedonistic escape triggered by the economic recession, death of coal mining industries, and ensuing “Appalachian despair.”¹³⁵ Princeton economists Anne Case and Angus Deaton describe it similarly.¹³⁶ They report that American “whites in midlife” are increasingly experiencing greater bodily pain and “greater difficulties with daily living,”¹³⁷ and are also subject to “deaths of despair,”¹³⁸ described to include suicides, fatal drug overdoses, and alcohol-related liver deaths.¹³⁹ To Case and Deaton, increase in suicides and fatal opioid poisoning were “maladaptive attempts to escape physical or psychological pain” caused by worsening macro-national conditions¹⁴⁰ produced by the “collapse of the white working class after its heyday in the early 1970s,” and the “pathologies” produced by “globalization and automation, changes in social customs that have allowed dysfunctional changes in patterns of marriage and childrearing, [and] the decline of unions.”¹⁴¹

134. Josh Katz, *The First Count of Fentanyl Deaths in 2016: Up 540% in Three Years*, N.Y. TIMES (Sept. 2, 2017), <https://www.nytimes.com/interactive/2017/09/02/upshot/fentanyl-drug-overdose-deaths.html> [<https://nyti.ms/2xEFpHB>].

135. *Id.*

136. See generally Case & Deaton, *supra* note 109.

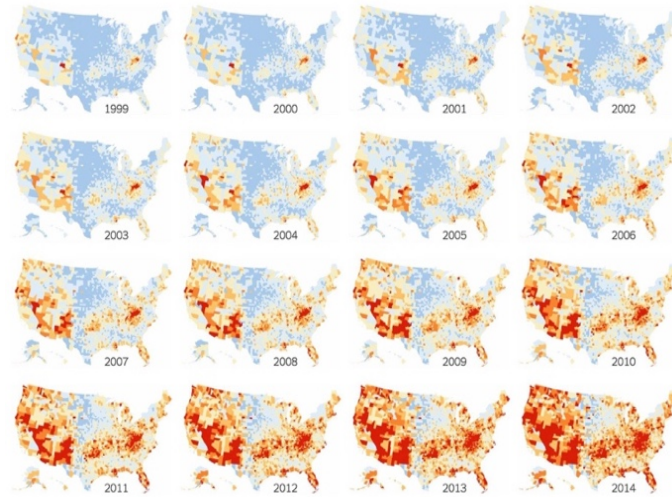
137. Case & Deaton, *supra* note 25, at 15,078.

138. Salam, *supra* note 132.

139. *Id.*

140. Eric Levitz, *The Death Rate for White Middle-Aged Americans is Rising*, CUT (Nov. 15, 2015), <https://www.thecut.com/2015/11/white-americas-mortality-crisis.html> [<https://perma.cc/DC27-8MYA>] (referencing Case & Deaton, *supra* note 25).

141. Case & Deaton, *supra* note 109, at 438–49.



Fatal opioid overdoses “rippled across the United States.”¹⁴²

Indeed, many states with the highest rates of opioid overdose-related deaths are home to the manufacturing and coal mining towns of the American heartland. The Midwest “witnessed opioid overdoses increase 70% from July 2016 through September 2017.”¹⁴³ Fentanyl-related deaths spiked over 55% in Maryland, 77% in Florida, and 109% in Ohio.¹⁴⁴ In 2016, West Virginia experienced 52 fatal overdoses per 100,000 people, with the rates of Ohio (39.1), New Hampshire (39.0), Pennsylvania (37.9), and Kentucky (33.5) following closely behind.¹⁴⁵ The demographics of heroin users entering treatment have also shifted dramatically in the last half century.¹⁴⁶ The mostly white interviewees on President Trump’s CrisisNextDoor.gov are visually representative of this “decidedly rural” crisis,¹⁴⁷ for

142. *Id.*

143. *Opioid Overdoses Treated in Emergency Departments*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/vitalsigns/opioid-overdoses/> [https://perma.cc/4R39-VQ2W].

144. U.S. DRUG ENF’T ADMIN., DEA-DCT-DIR-031-16, (U) NATIONAL HEROIN THREAT ASSESSMENT SUMMARY—UPDATED (2016).

145. *Drug Overdose Death Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/data/statedeaths.html> [https://perma.cc/B45R-NUMJ].

146. T.J. Cicero, H.L. Surratt & S.P. Kurtz, *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 821–826 (2014).

147. Lawson, *supra* note 29.

what was once considered “an inner-city, minority-centered problem” has rapidly transformed into one with greater geographical distribution, with outsized, fatal impact on white Americans residing far outside of “large urban areas.”¹⁴⁸ After 1998, as other rich countries’ mortality rates continued to decline by 2% a year, US white non-Hispanic mortality rose by half a percent a year.¹⁴⁹ This is notable not only because “[n]o other rich country saw a similar turnaround” during this period,¹⁵⁰ but also because the loss of health produced by mass opioid addiction negated “[m]ortality declines from the two biggest killers in middle age—cancer and heart disease.”¹⁵¹ Even tobacco failed to impact U.S. mortality in this way, as “historical patterns of smoking” merely hit “pause” on midlife mortality decreases.¹⁵²

148. Cicero, Surratt & Kurtz, *supra* note 146, at 821, 823.

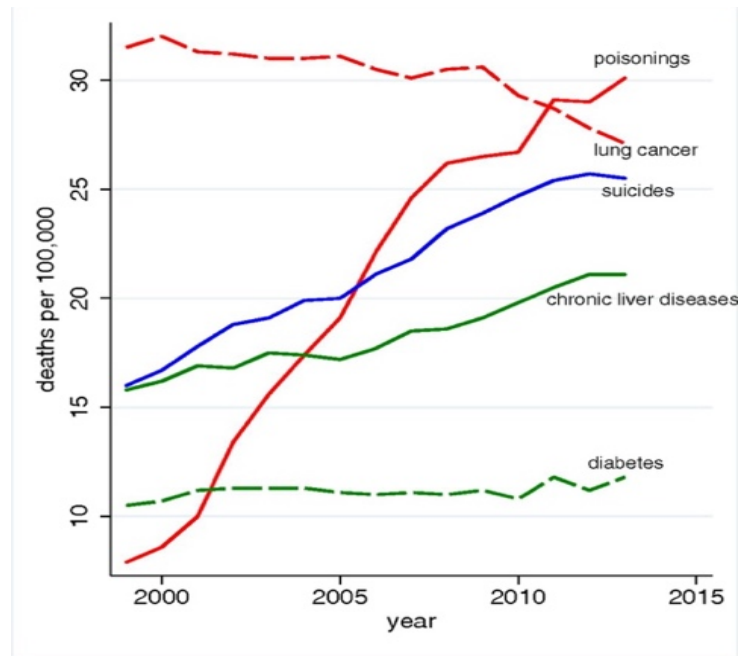
149. Case & Deaton, *supra* note 25, at 15,078.

150. *Id.*

151. Case & Deaton, *supra* note 109, at 398.

152. Case & Deaton, *supra* note 25, at 15,079.

The change in all-cause mortality for white non-Hispanics 45–54 is largely explained by an increasing death rate from external causes, mostly increases in drug and alcohol poisonings and in suicide.¹⁵³



This turnaround in mortality is “historically and geographically unique.”¹⁵⁴ Before our bout with fatal opioid poisoning, and before OxyContin received FDA approval in 1995,¹⁵⁵ the U.S. benefited from a “remarkable long-term decline in mortality rates.”¹⁵⁶ And while “midlife mortality continued to fall in other wealthy countries, and in other racial and ethnic groups in the United States,” deaths of white, non-Hispanics in middle age “increased from 1998 through 2013.”¹⁵⁷ Indeed, from the mid-90s onward, Case and Deaton found “marked differences in mortality by race and education, with mortality among

153. *Id.*

154. *Id.*

155. *Common Myths About OxyContin® (Oxycodone HCl Controlled-Released) Tablets CII*, *supra* note 72.

156. Case & Deaton, *supra* note 25, at 15,078.

157. Case & Deaton, *supra* note 109, at 398.

white non-Hispanics (males and females) *rising* for those without a college degree, and *falling* for those with a college degree.”¹⁵⁸ “In contrast, mortality rates among blacks and Hispanics continued to fall, irrespective of educational attainment.”¹⁵⁹ So, as deaths from cancer and heart disease continued to decline, and as mortality rates in other wealthy countries “continued their premillennial fall at the rates that used to characterize the United States,”¹⁶⁰ America witnessed a “profound uptick in self-reports of chronic pain and mental distress among white middle-aged Americans—particularly those without a college degree.”¹⁶¹ The CDC tells us that our “regional variation in use of prescription opioids” cannot simply be explained by a population’s “underlying health status.”¹⁶² But curious is the fact that worsening individual, *microeconomic* factors—“particularly slowly growing, stagnant, and even declining incomes”—fail to explain why rates of mortality rose specifically for non-college-educated whites.¹⁶³ “Growth in real median earnings has been slow for this group, especially those with only a high school education.”¹⁶⁴ But Case and Deaton find individual, income-based explanations for these reversals in mortality “hard to sustain,”¹⁶⁵ for factors like “lower education, lower incomes[,] and race” typically work against the welfare of American people of color.¹⁶⁶ American people of color saw increases in their lifespans: mortality declines for Hispanic Americans were “indistinguishable from the British” during this period, and rates of “midlife all-cause mortality” for Black Americans dropped as well.¹⁶⁷ When considered against their

158. *Id.* at 397.

159. *Id.*

160. *Id.*

161. Levitz, *supra* note 140.

162. *Prescription Opioids*, CTRS. FOR DISEASE CONTROL & PREVENTION (citing Anne G. Wheaton et al., *Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines—United States, 2012*, 63 MORBIDITY & MORTALITY WKLY. REP. 557, 563–568 (2014)), <https://www.cdc.gov/drugoverdose/opioids/prescribed.html> [<https://perma.cc/EJU8-FS5U>] (last visited Feb. 19, 2019).

163. Case & Deaton, *supra* note 109, at 397.

164. Case & Deaton, *supra* note 25, at 15,081.

165. Case & Deaton, *supra* note 109, at 424.

166. Bernstein & Achenbach, *supra* note 110 (internal quotation marks omitted).

167. Case & Deaton, *supra* note 25, at 15,079.

comparative advantages, the seemingly exclusive effect of our opioid crisis on American whites is, frankly, “shocking.”¹⁶⁸

“An increase in the mortality rate for any large demographic group in an advanced nation has been virtually unheard of in recent decades, with the exception of Russian men after the collapse of the Soviet Union.”¹⁶⁹ Could the death of America’s global economic hegemony constitute the macrosocial tidal change drastic enough to produce such radical effect? America’s industrial productivity was slow in the 1970s, causing income inequality to widen in spectacular fashion among whites. This made many baby-boomers the “first to find, in midlife, that they [would] not be better off than . . . their parents.”¹⁷⁰ The “[d]eclining value of the USD and large outflows of capital” also “threatened the very grounds of U.S. global domination” since the 1970s,¹⁷¹ which could in part explain why increases in suicides and self-reported pain commenced prior to our twenty-first century recession.¹⁷² It is straightforward enough to hypothesize that “wages, marriage rates, job quality, social cohesion, cultural capital, and, perhaps, racial privilege ostensibly dr[ove] an ever-larger number of non-college-educated whites into suicidal” or addictive behaviors.¹⁷³ Far less obvious is the discovery that macrosociological tidal changes in an individual’s environment are more determinative of addiction than individual characteristics.¹⁷⁴

Of course, this historical perspective does not deny that differences in vulnerability are built into each individual’s genes, individual experience, and personal character, but it removes individual differences from the foreground of attention, because societal determinants are so much more powerful. Addiction is much more a social problem than an individual disorder.¹⁷⁵

168. Bernstein & Achenbach, *supra* note 110.

169. *Id.*

170. Case & Deaton, *supra* note 25, at 15,081.

171. Tayyab Mahmud, *Is it Greek or déjà vu all over again? Neoliberalism and Winners and Losers of International Debt Crises*, 42 LOY. U. CHI L.J. 629, 659–60 (2013).

172. Case & Deaton, *supra* note 25, at 15,081.

173. Levitz, *supra* note 140.

174. BRUCE K. ALEXANDER, <http://www.brucekalexander.com/> [<https://perma.cc/A25G-KEYJ>] (last visited Aug. 7, 2018).

175. *Id.*

Global history informs us that “addiction can be rare in a society for many centuries, but can become nearly universal when circumstances change,” like “when a cohesive tribal culture is crushed or an advanced civilisation collapses.”¹⁷⁶

Opioid epidemics may very well be one way in which modern societies grieve the death of majority norms. Russia experienced a similar reversal in mortality after the dissolution of the Soviet Union, where opioid addiction produced massive fatality rates amongst Russian men.¹⁷⁷ Following the collapse of the Soviet Union, “heroin spread very rapidly, attracting most of those users previously injecting homemade solutions drawn from poppy straw, opium, anesthetics and medical drugs.”¹⁷⁸ The “rapid diffusion” of heroin during this era is striking because “the substance was virtually unknown in the former Soviet Union” prior to the collapse.¹⁷⁹

We must also recall our own exceptional bout with mass, fatal opioid poisoning post-Civil War.¹⁸⁰ If mass, mortality-rate-reducing opioid epidemics are historically precipitated by deaths in majority power ideals—such as centralized, federalist states or the institution of human chattel enslavement based on racial class—could it be that our epidemic similarly results from a dip in white dominance in an increasingly diversifying America? As the historian Carol Anderson puts it, “If you’ve always been privileged, equality begins to look like oppression”—a mindset in stark contrast with the “sense of hopefulness, that sense of what America could be, that has been driving black folk for centuries.”¹⁸¹ Terror management theory refers to the practice of “embrac[ing] culturally constructed beliefs,” like American manifest destiny,¹⁸² to “fend off what

176. *Id.*

177. See, e.g., Letizia Paoli, *The Development of an Illegal Market: Drug Consumption and Trade in Post-Soviet Russia*, 42 BRIT. J. CRIMINOLOGY, 21, 21–39 (2002).

178. *Id.* at 25.

179. Letizia Paoli, *The Price of Freedom: Illegal Drug Markets and Policies in Post-Soviet Russia*, 582 ANNALS 167, 167 (2002).

180. Bernstein & Achenbach, *supra* note 110.

181. Susan B. Glasser & Glenn Thrush, *What’s Going on With America’s White People?*, POLITICO (Sept./Oct. 2016), <https://www.politico.com/magazine/story/2016/09/problems-white-people-america-society-class-race-214227> [<https://perma.cc/ZJ8D-KMP3>].

182. Natsu Taylor Saito, *Colonial Presumptions: The War on Terror and the Roots of American Exceptionalism*, 1 GEO. J.L. & MOD. CRIT. RACE PERSP., 67, 92 (2009) (“According to historian Frederick Merk, its ‘postulates were that Anglo-Saxons are

would otherwise be paralysing existential terror.”¹⁸³ It may explain our present-day macrosocial problem with addiction. For if American exceptionalism was the way that “whites with low levels of education” suppressed the very human terror of witnessing their employment opportunities “progressively worsen[],”¹⁸⁴ it is no wonder that so many of them suffer from severe psychological distress, report limitations in daily activities, and are “twice as likely to have limitations in their ability to work.”¹⁸⁵ And if the sheer scale of our crisis is in any way the result of suppressed disappointment at the loss of majority power, Trump’s presidential win would make perfect sense. Trump’s campaign, after all, “put overwhelming emphasis on economic explanations for the demographic’s plight,” both describing the “American carnage” hitting “many white, rural areas” as a “symptom of economic dispossession,”¹⁸⁶ and Trump himself as a solver of “big and intricate problems.”¹⁸⁷ In his remarks accepting the Republican nomination, then-candidate Trump stated that he “joined the political arena so that the powerful can no longer beat up on people who cannot defend themselves.”¹⁸⁸ As he famously proclaimed: “Nobody

endowed as a race with innate superiority, that Protestant Christianity holds the keys to Heaven, that only republican forms of political organization are free, that the future—even the predestined future—can be hurried along by human hands, and that the means of hurrying it, if the end be good, need not be inquired into too closely.” (quoting FREDERICK MERK, *MANIFEST DESTINY AND MISSION IN AMERICAN HISTORY: A REINTERPRETATION* 265 (Greenwood Press 1987) (1963)).

183. Rachel Nuwer, *What if we knew when and how we’d die?*, BBC NEWS (June 18, 2018) (citing Sheldon Solomon, Jeff Greenberg, & Tom Pyszczynski, *A Terror Management Theory of Social Behavior: The Psychological Functions of Self-Esteem and Cultural Worldviews*, 24 *ADVANCES IN EXPERIENTIAL SOCIAL PSYCHOLOGY* 93 (1991)), <http://www.bbc.com/future/story/20180618-what-if-we-knew-when-we-were-going-to-die> [https://perma.cc/2H9B-5S2T].

184. Case & Deaton, *supra* note 25, at 397.

185. Judith Weissman et al., *Disparities in Health Care Utilization and Functional Limitations Among Adults With Serious Psychological Distress*, 68 *PSYCHIATRIC SERVS.* 653, 656 (2017).

186. Levitz, *supra* note 140.

187. Donald Trump, President of the United States, Remarks on the Strategy in Afghanistan and South Asia (Aug. 21, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-strategy-afghanistan-south-asia/> [https://perma.cc/5TXJ-4CUL].

188. Donald Trump, Republican Nomination Acceptance Speech (Jul. 21, 2016), https://assets.donaldjtrump.com/DJT_Acceptance_Speech.pdf [https://perma.cc/LL4Z-P55B].

knows the system better than me, which is why I alone can fix it.”¹⁸⁹

For the “woke,”¹⁹⁰ macroeconomic depression as the foundational cause-in-fact of our crisis makes intuitive sense. The psychosocial, pre-market determinants of demand—primarily, distress over America’s loss of international hegemony for those whose egos have intrinsically, perhaps tribal-narcissistically¹⁹¹ borrowed from their own country’s grandeur¹⁹²—provide lucid reasons to despair. Research suggests that “promoting disbelief in free will produces destructive, antisocial behaviors,”¹⁹³ which suggests that Big Pharma could not have independently produced the entirety of the underlying demand for opioids by oversupplying it, and merely exacerbated our crisis by rampantly overcapitalizing upon it. The problem with this holistic conceptualization of our crisis is that it is not politically fashionable. Habitually inuring Americans to view this crisis as one caused by aggrandized supply, rather than macroeconomically triggered demand for analgesic relief, however, is.

II. JUST SAY NO

“History repeats itself, Marx wrote, ‘first as tragedy and then as farce.’ The continued emphasis on supply-side interventions to suppress non-medical opioid use is both.”¹⁹⁴

A. Under the War on Drugs’ Influence

Experienced policymakers have long heralded the necessity of addressing drug abuse epidemics as public health crises, rather than as failures of criminal enforcement. According to President Obama, “for too long, we have viewed the problem of drug abuse generally in our society through the lens of the

189. *Id.*

190. *Woke*, ENGLISH OXFORD LIVING DICTIONARIES, <https://en.oxforddictionaries.com/definition/woke> [<https://perma.cc/73CT-LBGG>] (last visited Jan. 31, 2019).

191. See, e.g., Jeffrey Kluger, *The Narcissist In All Of Us*, PSYCHOL. TODAY, <https://www.psychologytoday.com/us/articles/201409/the-narcissist-in-all-us> [<https://perma.cc/CT3G-G6XP>] (last updated June 9, 2015).

192. See, e.g., Saito, *supra* note 182, at 92.

193. Vohs & Baumeister, *supra* note 60, at 4.

194. Leo Beletsky & Corey S. Davis, *Today’s Fentanyl Crisis: Prohibition’s Iron Law, Revisited*, 46 INT’L J. DRUG POL’Y 156, 157 (2017).

criminal justice system,” when “the only way that we reduce demand is if we’re . . . thinking about this as a public health problem.”¹⁹⁵ The public health approach is especially appropriate for an overdose crisis that is not solely provoked by the legal, above-ground market for drugs. Opioid prescriptions have declined each year since 2012, and the “force accelerating today’s epidemic is a booming market for potent heroin and fentanyl and its analogs.”¹⁹⁶ But we continue to anchor liability for illegal overdoses to free market, regulated issues like prescription drug diversion—an approach that is at best confusing, and more likely, counterproductive.¹⁹⁷

Inequitable War on Drugs policies, like the well-known disparity between powder and crack cocaine, are also often criticized for operationalizing law enforcement against urban people of color.¹⁹⁸ The opioid epidemic differs for mostly taking the lives of the rural and white.¹⁹⁹ Assuming racial bias, will the races of those dying from fatal overdoses today make the public health approach easier to take? Non-Hispanic whites are far more likely to use prescription opioids than Hispanics.²⁰⁰ And “[w]hile African Americans remain over-represented among those arrested and incarcerated for a drug offense,” white Americans in one year accounted for 83% of the drug overdoses in our country, and represent an even greater percentage of opioid-related deaths overall.²⁰¹ For President Obama at least,

195. Barack Obama, President of the United States, Remarks by the President in Panel Discussion at the National Prescription Drug Abuse and Heroin Summit (Mar. 29, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/03/29/remarks-president-panel-discussion-national-prescription-drug-abuse-and> [<https://perma.cc/J2QZ-5QQW>].

196. Stefan G. Kertesz, *Turning the tide or riptide? The changing opioid epidemic*, 38 SUBSTANCE ABUSE 1, 3–8 (2017).

197. See Don Stemen, *Beyond the War: The Evolving Nature of the U.S. Approach to Drugs*, 11 HARV. L. & POL’Y REV. 375, 414 (2017).

198. See, e.g., Alyssa L. Beaver, *Getting a Fix on Cocaine Sentencing Policy: Reforming the Sentencing Scheme of the Anti-Drug Abuse Act of 1986*, 78 FORDHAM L. REV. 2531 (2010).

199. *Why Is The Opioid Epidemic Overwhelmingly White?*, NPR (Nov. 4, 2017), <https://www.npr.org/2017/11/04/562137082/why-is-the-opioid-epidemic-overwhelmingly-white> [<https://perma.cc/232E-ZM2Y>].

200. STEVEN M. FRENK, KATHRYN S. PORTER & LEONARD J. PAULOSZI, PRESCRIPTION OPIOID ANALGESIC USE AMONG ADULTS: UNITED STATES, 1999–2012, at 3 (Nat’l Ctr. for Health Statistics, Data Brief No. 189, 2015).

201. Rose A. Rudd, et al., *Increases in Drug and Opioid Overdose Deaths – United States, 2000–2014*, 64 MORBIDITY & MORTALITY WKLY. REP. 1378, 1380 (2016) (Fig-

“one of the things that’s changed in this opioid debate is a recognition that this reaches everybody.”²⁰² At the National Prescription Drug Abuse and Heroin Summit in 2016, he stated that “[p]art of what has made it previously difficult to emphasize treatment over the criminal justice system has to do with the fact that the populations affected in the past were . . . stereotypically identified as poor, minority.”²⁰³ The widespread availability of naloxone, for instance—“a non-addictive, life-saving” opioid antagonist capable of reversing an opioid overdose when administered in timely fashion²⁰⁴—is understood to “reflect[] the relatively humane response to the opioid epidemic, which is based largely in the nation’s white, middle-class suburbs and rural areas—a markedly different response from that of previous, urban-based drug epidemics, which prompted a ‘war on drugs’ that led to mass incarceration, particularly of blacks and Hispanics.”²⁰⁵

Regardless of the races involved, the massive scope and shape of our crisis independently beg for the public health approach, for our opioid epidemic is conclusively deadlier than our battle with AIDS. The CDC points out that our overdose deaths in 2016 alone outpaced the HIV/AIDS epidemic’s at its 1995 peak by 50%.²⁰⁶ The responsibility of curbing this epidemic therefore ought not to be triaged to both the criminal justice and public health systems, for doing so would produce con-

ures in Table 1 report a total of 47,055 drug overdose deaths in 2014 and 37,945 drug overdose deaths involving White individuals in 2014; thus, White individuals account for 80.6% of total drug overdose deaths); Rose A. Rudd et al., *Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010-2015*, 65 MORBIDITY AND MORTALITY WKLY. REP 1445, 1448–51 (2016) (Figures in Tables 1 and 2 report total and race-specific numbers of opioid overdose deaths in 2014).

202. Obama, *supra* note 195.

203. *Id.*

204. *Reverse Overdose to Prevent Death*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/prevention/reverse-od.html> [<https://perma.cc/H7R3-TQA7>] (last visited Aug. 9, 2018).

205. Katherine Q. Seelye, *Naloxone Saves Lives, but Is No Cure in Heroin Epidemic*, N.Y. TIMES (July 27, 2016), <https://www.nytimes.com/2016/07/28/us/naloxone-eases-pain-of-heroin-epidemic-but-not-without-consequences.html> [<https://nyti.ms/2aguNCw>].

206. Dan Clark, *The Scourge of Heroin and Opioid Deaths Still Doesn’t Match AIDS at its Worst*, POLITIFACT (July 8, 2016), <https://www.politifact.com/new-york/statements/2016/jul/08/andrew-cuomo/fewer-people-are-dying-heroin-and-opioid-overdoses/>.

flicts between “legitimate approaches for treating pain [and] the punishment for engaging in the illegal use of drugs.”²⁰⁷

The sensibility of taking a public health approach, however, does not on its own secure its execution. The War on Drugs’ lasting institutional effect is likely best illustrated by the unavailability of evidence-based addiction treatment. As the U.S. Surgeon General pointedly observes, “[w]e would never tolerate a situation where only one in [ten] people with cancer or diabetes gets treatment, and yet we do that with substance-abuse disorders.”²⁰⁸

B. *Drumming Power from Fear*

“[C]hronic use of prescription opioid drugs was correlated with support for the Republican candidate in the 2016 US presidential election,”²⁰⁹ so our craving for near-term, War on Drugs strongman solutions to this crisis should not puzzle us in the least. “People who reach for an opioid might also reach for . . . near-term fixes,” says Dr. Nancy Morden from the Dartmouth Institute for Health Policy and Clinical Practice.²¹⁰ “I think that Donald Trump’s campaign was a promise for near-term relief.”²¹¹ Many of us do, after all, participate in a culture that enjoys simple solutions. “Americans are seduced by the idea that drugs can solve most problems and are fast-

207. Stemen, *supra* note 197, at 414.

208. Lenny Bernstein, *Landmark report by Surgeon General calls drug crisis ‘a moral test for America’*, WASH. POST (Nov. 17, 2016), https://www.washingtonpost.com/national/health-science/landmark-report-by-surgeon-general-calls-drug-crisis-a-moral-test-for-america/2016/11/16/4214bf2a-ac49-11e6-977a-1030f822fc35_story.html?utm_term=.62885bf9e77c [https://perma.cc/NE7Z-LRFR] (discussing U.S. DEP’T HEALTH & HUMAN SERVS., *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH* (2016), <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf> [https://perma.cc/V9CB-SCWX]).

209. See James S. Goodwin, Young-Fang Kuo, David Brown, et al., *Association of Chronic Opioid Use With Presidential Voting Patterns in US Counties in 2016*, JAMA NETWORK OPEN (June 22, 2018), <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2685627> [https://perma.cc/RUZ8-DS2J].

210. Paul Chisholm, *Analysis Finds Geographic Overlap In Opioid Use And Trump Support In 2016*, NPR (June 23, 2018), <https://www.npr.org/sections/health-shots/2018/06/23/622692550/analysis-finds-geographic-overlap-in-opioid-use-and-trump-support-in-2016> [https://perma.cc/VER3-H7LR].

211. *Id.*

acting, safe and simple solutions to whatever ails them,”²¹² and this is especially the case when faced with chronic pain with perceivably little individual, immediate causal origin. To address the rising tide of millions who report suffering from chronic pain, Big Pharma marketed painkillers as chemically unhookable, creating a veritable “gateway to heroin by overselling their benefits and underplaying their harms.”²¹³ The Iron Law of Prohibition then funneled moderate users towards more and more lethal drugs, incentivizing a shift in their tastes for the lethal by supplying only drugs with high potency per gram. But in the business of selling simple solutions to big, giant problems, no profit is made unless that problem is not also then rendered as the specific keyhole for which key federal approaches to the War on Drugs can fit. This is how opiophobia is alchemized into expansions of executive control.

The War on Drugs approach fracks considerable political power from fear. “Some argue that by the end of the twentieth century, crime and crime control were central to the exercise of authority in the United States at all levels of government and the control of drugs was central to that authority.”²¹⁴ Take a look at the history of prohibition, with its ability to increase federal power and allocate funds. Resources devoted to alcohol interdiction and law enforcement “reached unprecedented levels” during alcohol prohibition, where the Bureau of Prohibition saw a four-fold budget increase through the 1920s.²¹⁵ In our present-day prohibition against recreational opioid use, the DEA has benefited from “major scale-up in the staffing and funding of federal agents along the US-Mexico Border.”²¹⁶ Even if “[p]rohibition clearly does not work for the vast majority of the world’s citizens,” it does “meet[] the needs of the world’s superpowers, who can resource and engage their military, po-

212. Heather Tick & Jane Ballantyne, Opinion, *Health-care system needs reboot to solve pain and opioid crisis*, SEATTLE TIMES (June 17, 2018), <https://www.seattletimes.com/opinion/health-care-system-needs-reboot-to-solve-pain-and-opioid-crises/> [https://perma.cc/UZ3R-FN3L].

213. *Id.*

214. Stemen, *supra* note 197, at 385 (internal citations and quotations omitted) (citing JONATHAN SIMON, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR 71–72, 262–63 (2009)).

215. Beletsky & Davis, *supra* note 22, at 157 (citation omitted).

216. *Id.* (citation omitted).

lice[,] and criminal justice systems, all justified in the war against the global ‘drug menace.’”²¹⁷

And President Trump, who considers formidable law enforcement to be “absolutely vital to ensuring a drug-free society,”²¹⁸ will likely be the last to discard punitive War on Drugs strategies. The militarized law enforcement approach works particularly well for his administration, given Obama’s strategic passivity within the area of drug enforcement during his presidency. “At the end of 2016, there were 23 percent fewer [federal drug prosecutions] than in 2011,” Trump states, a fact he takes to mean that Obama’s administration simply “looked at this scourge and . . . let it go by.”²¹⁹ Unlike Obama, Trump declares: “we’re not letting it go by.”²²⁰ While some countries pursue the “full decriminalization of narcotics” as a solution, the United States chooses instead to respond with “enhanced law enforcement” to “clamp[] down” on its possession and trade.²²¹ The international community has borne witness to this approach, most recently by our efforts to convince the UN to further criminalize fentanyl.²²² Fentanyl is so potent that dosage mistakes pose Russian-roulette odds of death. But it is its international origins that lubricate American War on Drugs efforts abroad. As President Trump puts it: “In China, you have some pretty big companies sending that garbage and killing our people”—a type of foreign interference he would liken to “a form of warfare.”²²³ Most of the fentanyl shipped to the U.S. does arrive from China, traveling through the U.S. postal sys-

217. Brian Wheeler, *Why not . . . legalise drugs?*, BBC NEWS (Sept. 5, 2013), <https://www.bbc.com/news/uk-politics-23374228> [<https://perma.cc/3BVJ-XM3D>].

218. Donald Trump, President of the United States, Remarks Before a Briefing on the Opioid Crisis (Aug. 8, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-briefing-opioid-crisis/> [<https://perma.cc/PF57-YLJ6>].

219. *Id.*

220. *Id.*

221. *Topic One: Combatting Drug Addiction and Overdoses*, WORLD HEALTH ORGANIZATION 1, 2 (2018), https://static1.squarespace.com/static/533e6b7de4b0d84a3bd7c4be/t/5a387c1bc83025d4900d14f4/1513651232055/WHO_Background_Guide.pdf. [<https://perma.cc/ZNZ9-FAKU>].

222. See Matthew Hall, *US turns to Trump targets — UN, China and Mexico — for help in Opioid Crisis*, GUARDIAN (Jan. 7, 2018), <https://www.theguardian.com/us-news/2018/jan/07/us-> [<https://perma.cc/8JK3-CVBW>].

223. Julie Hirschfield Davis, *Once Dry Discussions, Cabinet Meetings Are Now Part of the Trump Show*, N.Y. TIMES (Aug. 6, 2018), <https://www.nytimes.com/2018/08/16/us/politics/trump-cabinet-meetings.html> [<https://nyti.ms/2My12n6>].

tem in small packages,²²⁴ sometimes mislabeled or with chemical modifications,²²⁵ then “distributed by Internet cryptomarkets and Mexican drug trafficking organizations.”²²⁶ The cryptomarket route of sale poses unique regulatory challenges, as dark web transactions allow purchasers to shop anonymously, then pay for their illicit goods using virtual currencies like Bitcoin.²²⁷ These covert, dark trade routes inspired James A. Walsh, Deputy Assistant Secretary of State for International Narcotics and Law Enforcement Affairs, to warn at the Sixty-First United Nations Commission on Narcotic Drugs (CND) that “[a]nyone with an internet connection and access to international mail can be next. So the world must be vigilant and respond to this new threat.”²²⁸

When our federal officials urge border vigilance as a solution to drug crises, is it mere political rhetoric, or welfare-maximizing policy? As we detail in our next section, Just Say Yes, our major legislative and political efforts cumulatively cut off legal supply of a substance for which there is rabid demand. Could we reasonably have expected anything other than an explosion in illegal supply? “Simply removing access to [opioid analgesics] without replacing this therapy with other pain management modalities and delivering evidence-based opiate substitution treatment could lead to only two outcomes: increases in untreated pain, unmanaged withdrawal or substitution with other, likely more potent, opioids.”²²⁹ Implementing demand-reduction measures, on the other hand—thought to

224. Zurcher, *supra* note 4.

225. See *Tackling Fentanyl: The China Connection: Hearing Before the Subcomm. on Africa, Global Health, Global Human Rights, & Int’l Orgs. Of the H. Comm. on Foreign Affairs*, 115th Cong. 60 (2018) [hereinafter *Tackling Fentanyl*] (statement of Bryce Pardo, Associate Policy Researcher, RAND Corporation) (“It has been reported that Chinese traffickers and chemical exporters will mislabel shipments, modify chemicals, or ship preprecursors that fall outside international controls.”).

226. Beletsky & Davis, *supra* note 22, at 157 (citation omitted).

227. See Nathaniel Popper, *Opioid Dealers Embrace the Dark Web to Send Deadly Drugs by Mail*, N.Y. TIMES (June 10, 2017), <https://www.nytimes.com/2017/06/10/business/dealbook/opioid-dark-web-drug-overdose.html?mtrref=www.nytimes.com> [https://nyti.ms/2s8fNCE].

228. See U.S. *Leading International Progress on Combating the Opioid Crisis at 61st UN Commission on Narcotic Drugs*, DIPNOTE (Mar. 14, 2018), <https://blogs.state.gov/stories/2018/03/14/en/us-leading-international-progress-combating-opioid-crisis-61st-un-commission> [https://perma.cc/38D8-9FZK].

229. Beletsky & Davis, *supra* note 22, at 157.

include a Rat Park-like combination of “improv[ed] access to . . . methadone and buprenorphine,” expanded insurance coverage of treatment, and subsidized treatment costs for those unable to pay—would both reduce “economic incentives for drug dealers” and save lives.²³⁰

The “advent of illicitly manufactured synthetic opioids coming from China” certainly produces uncertainty.²³¹ But what of the significantly “less uncertainty surrounding the impact of medication therapies when it comes to saving lives”?²³² The chemical hook theory foreclosed rational examination of the underlying demand, and the Iron Law of Prohibition worked to ensure that the only accessible doses are those that risk killing people. And yet, at the height of our scourge, what we get is not a commitment to an honest analysis of demand, but a litigious, finger-pointing blame game.

C. *The Litigious Blame Game*

Purdue Pharma and McKesson are frequently in the news.²³³ “Cities as large as Philadelphia and Chicago, as well as hundreds of small towns and cities,” have sued these “Big Pharma” manufacturers and distributors in *parens patriae* lawsuits,²³⁴ which rest on the doctrine that the state, as a sovereign, may prosecute on behalf of its residents.²³⁵ These jurisdictions argue that by knowingly manufacturing inordinate amounts of supply and pumping it into a macroeconomically depressed American heartland, Big Pharma “triggered a public health crisis,”²³⁶ raising insurance rates and imposing an estimated total eco-

230. *Tackling Fentanyl*, *supra* note 225, at 66.

231. *Id.*

232. *Id.*

233. See, e.g., Jared Brown & Kitsap Sun, *Kitsap County files lawsuit against opioid manufacturers and distributors*, KING 5 NEWS (July 25, 2018, 4:32 PM), <https://www.king5.com/article/news/local/kitsap-county-files-lawsuit-against-opioid-manufacturers-and-distributors/281-577475519> [https://perma.cc/CEW7-RFTY].

234. Richard C. Ausness, *The Role of Litigation in the Fight Against Prescription Drug Abuse*, 116 W. VA. L. REV. 1117, 1146 (2014); see also, e.g., *In re Nat'l Prescription Opiate Litig.*, 209 F. Supp. 3d 1375 (J.P.M.L. 2017).

235. *Parens patriae*, BLACK'S LAW DICTIONARY (7th ed. 1999).

236. Andrew M. Harris & Patricia Hurtado, *Opioid Makers Sued for Premium Hikes in First-of-Kind Cases*, BLOOMBERG (May 2, 2018), <https://www.bloomberg.com/news/articles/2018-05-02/opioid-makers-sued-over-rising-premiums-in-first-of-kind-cases> [https://perma.cc/GR6H-YCVH].

conomic burden of \$78.5 billion in 2013 alone.²³⁷ Federal health agencies are forced to respond to this dilemma by scrambling like the little Dutch boy, plugging leaks in the increasingly deteriorating dike of drug crime enforcement with efforts to stem the tide of death.²³⁸

The scope of liabilities is broad, and the instinct to blame *somebody* for our opioid dilemma—whether dealers, doctors, manufacturers, or distributors—is a potent one. The many philosophical bases justifying punishment for social welfare-minimizing offenders tend to go in two directions.²³⁹ The utilitarian view punishes in order to deter future bad acts, while retributive theories seek to punish bad actors “because they deserve to be punished.”²⁴⁰ Corrective justice theory—with its reliance on individual moral rights—falls into the former.²⁴¹ It focuses on achieving justice between parties and holding negligent parties responsible for making injured patients whole,²⁴² which would appear to make it ideal for our crisis of oversupply. But because it prioritizes moral justifications for blame over pragmatic policy goals of compensation,²⁴³ capitalistic America hardly takes to it.

The same cannot be said for retributive justice theory, which ostensibly relies on biblical reasons for blaming Big Pharma for our crisis:

237. Curtis Florence et al., *The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States*, 2013, 54 MED. CARE 901 (2016).

238. *Enhanced State Opioid Overdose Surveillance*, CTRES. FOR DISEASE CONTROL & PREVENTION, <https://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html> [<https://perma.cc/586M-LRBH>] (last visited Aug. 9, 2018) (The CDC, for instance, has invested considerable effort to increasing the “timeliness and comprehensiveness of reporting fatal opioid overdose through the State Unintentional Drug Overdose Reporting System (SUDORS), which captures detailed information on toxicology, death scene investigations, route of administration, and other risk factors that may be associated with a fatal overdose.”).

239. *Punishment—Theories of Punishment*, JRANK, <https://law.jrank.org/pages/9576/Punishment-THEORIES-PUNISHMENT.html> [<https://perma.cc/EAR4-PBUG>] (last visited Feb. 5, 2019).

240. *Id.*

241. See James R. Blaufuss, Note, *A Painful Catch-22: Why Tort Liability for Inadequate Pain Management Will Make for Bad Medicine*, 31 WM. MITCHELL L. REV. 1093, 1114 (2005).

242. *Id.*

243. Hugo A. Bedau & E. Kelly, *Punishment*, in STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., 2017), <https://plato.stanford.edu/entries/punishment> [<https://perma.cc/67XW-8LL9>].

This eye-for-an-eye theory rests upon the premise that crime upsets the peaceful balance of society, and punishment helps to rectify the balance. The major difference between the retributive and utilitarian theories is one of perspective: retributive justice looks backward at the crime itself as the reason for punishment, whereas the utilitarian theory “looks forward by basing punishment on societal benefits.”²⁴⁴

The “acceptability, if not supremacy, of the retributive justification for punishment is reflected in American popular culture,” which glorifies retribution both in entertainment and in political rhetoric.²⁴⁵ And the myriad *parens patriae* suits today certainly do portray addicts and cities ravaged by opioids as the Davids to Big Pharma’s Goliath.

Many argue that doctors ought to have been the protective intermediary between addicts and companies like Purdue. To them, physicians deserve punishment under either theory for acting as “pill-mills,” prescribing opioids for profit rather than to uphold the Hippocratic Oath.²⁴⁶ Physician liability in this crisis appeals to the paternalistic values society ascribes to doctors, and neatly places the burden at the prescriber’s feet to control what use should occur. The entire purpose of the prescription regulation system, after all, rests on the public policy judgment that doctors ought to be vested with the legal responsibility of understanding the benefits and risks of a specific drug to their specific patient.²⁴⁷

Negligent over-prescription by doctors was one of many initial causes-in-fact of this crisis. According to one expert in pharmacology, the success of OxyContin stems “partly [from] the fact that so many doctors wanted to believe in the therapeutic benefits of opioids.”²⁴⁸ While most opioid prescriptions

244. Anna Armistead, Comment, *Epidemics Collide: The Opioid Crisis in Prisons*, 7 WAKE FOREST J.L. & POL’Y SUA SPONTE 49, 69–70 (2017) (internal citations omitted) (quoting *Punishment—Theories of Punishment*, *supra* note 239).

245. Aaron Xavier Fellmeth, *Civil and Criminal Sanctions in the Constitution and Courts*, 94 GEO. L.J. 1, 19 (2005).

246. See Zurcher, *supra* note 4.

247. Judith Edersheim & Theodore Stern, *Liability Associated with Prescribing Medications*, 11 PRIMARY CARE COMPANION J. CLINICAL PSYCHIATRY 115, 115–19 (2009).

248. Patrick Radden Keefe, *The Family that Built an Empire of Pain*, NEW YORKER (Oct. 30, 2017), <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>.

were written in good faith, “some providers prescribed (and sometimes dispensed) large amounts of opioids without regard for the patients’ medical need.”²⁴⁹ “Medication was offered a month’s supply at a time for one-time injuries and chronic pain, often to treat years of working in physically arduous jobs—like those in manufacturing and the coal mines.”²⁵⁰ And as these jobs dried up and more people lost work, companies like Purdue continued to woo physicians with all-expenses-paid trips at resort hotels,²⁵¹ urging them to prescribe twelve-hour, or “Q12h” dosage regimens that were later found to *increase* tolerance, thereby *increasing* demand for drugs stronger than legal OxyContin.²⁵²

This is where the sins of physicians bleed into the sins of Big Pharma. “[T]hrough many fatal overdoses have resulted from opioids other than OxyContin, the crisis was initially precipitated by a shift in the culture of prescribing—a shift carefully engineered by Purdue.”²⁵³ Prior to OxyContin’s release, physicians typically reserved long-term narcotic prescriptions for the terminally ill.²⁵⁴ Purdue thought this market was too small. “A 1995 memo sent to the [Oxycontin] launch team emphasized that the company did ‘not want to niche’ OxyContin just for cancer pain.”²⁵⁵ So, when doctors deviated from Purdue-prescribed OxyContin consumption recommendations, Purdue executives mobilized its sales reps—described in internal budget documents as the company’s “most valuable resource”²⁵⁶—to “refocus” physicians on 12-hour dosing.²⁵⁷ One memorandum, entitled “\$\$\$\$\$\$\$\$\$\$\$\$ It’s Bonus Time in the

249. Beletsky & Davis, *supra* note 22, at 156.

250. Zurcher, *supra* note 4.

251. Harriet Ryan, Lisa Girion & Scott Glover, *You Want a Description of Hell? Oxycontin’s 12-Hour Problem*, L.A. TIMES (May 5, 2018), <http://www.latimes.com/projects/oxycontin-part1/> [<https://perma.cc/7F97-8USY>].

252. *See id.*

253. Keefe, *supra* note 248.

254. *Id.*

255. *Id.*

256. *Id.*

257. Ryan, Girion, & Glover, *supra* note 251 (As one Purdue sales manager wrote to her staff, prescriptions for shorter intervals of OxyContin “needs to be nipped at the bud. NOW!!”).

Neighborhood!", "reminded Tennessee reps that raising dosage strength was the key to a big payday."²⁵⁸

As a result, "doctors wrote 5.4 million [OxyContin] prescriptions in 2014"²⁵⁹—almost all of which were for 12-hour doses.²⁶⁰ Both clinical data and patients report that OxyContin would wear off in less than twelve hours,²⁶¹ creating a veritable sine wave of higher highs and lower lows.²⁶² As a "chemical cousin" of heroin, OxyContin, in between these highs of analgesic coverage, triggered "body aches, nausea, anxiety," and other symptoms of heroin withdrawal in its users.²⁶³ It was entirely foreseeable then that abuse of semi-synthetic opioids would later be identified as the "primary cause of a decade-long increase in overdose deaths in the USA."²⁶⁴ As two doctors would put it, 12-hour dosing intervals of OxyContin creates "the perfect recipe for addiction," which makes Purdue's insistence upon it an "addiction producing machine."²⁶⁵

Purdue likely could not have toppled physician opiophobia without the "many doctors [who] wanted to believe in the therapeutic benefits of opioids."²⁶⁶ It knows this, and victim-blames accordingly.²⁶⁷ In a statement responding to a lawsuit accusing Purdue and other companies producing our opioid epidemic, Purdue "vigorously" denied the allegations, noting that: (1) OxyContin is FDA-approved, (2) its "products account for less than 2 percent total opioid prescriptions," and (3), like the rest of America, it is "troubled by the crisis" and "wants to be part of the solution."²⁶⁸ Purdue is eager to share that it "dis-

258. *Id.*

259. *Id.*

260. *Id.*

261. *Id.*

262. *Id.*

263. *Id.*

264. S. Cunningham & K. Finlay, *Identifying Demand Responses to Illegal Drug Supply Interdictions*, 25 HEALTH ECON. 1268, 1287 (2016) (citation omitted).

265. Ryan, Girion & Glover, *supra* note 251.

266. See Keefe, *supra* note 248.

267. Ryan, Girion, & Glover, *supra* note 251. (In the words of Purdue's senior medical director in 2001, "A lot of [OxyContin users] say, 'Well, I was taking the medicine like my doctor told me to,' and then they start taking them more and more and more I don't see where that's my problem.").

268. Adam Lidgett, *Tribes Hit Pharma Cos. With Suit Over Opioid Crisis*, LAW360 (Mar. 6, 2018), <https://www.law360.com/articles/1018863> [<https://perma.cc/2P6P-RYLV>].

tributed the CDC Guideline for Prescribing Opioids for Chronic Pain, developed three of the first four FDA-approved opioid medications with abuse-deterrent properties,²⁶⁹ and partners with law enforcement to ensure access to naloxone.²⁷⁰ However, addiction does not “simply dissipate with . . . the introduction of ‘abuse deterrent’ formulations,” nor is it addressed by post-hoc, life-saving remedies.²⁷¹ And in the court of public opinion, the naivete of doctors has done little to detract from the detestability of Purdue designing OxyContin for profit, rather than for patient well-being,²⁷² and it holding fast to its “Q12h” dosing campaign to protect its hegemony in the painkiller market.²⁷³

OxyContin’s FDA approval, however, does operate as an affirmative defense against complete responsibility.²⁷⁴ In the words of one former DEA chief of staff, OxyContin’s FDA approval is a “fundamental weakness” in the cases brought against the manufacturer.²⁷⁵ Retributive justice theories do entitle bad actors like Purdue to a number of defenses when they are pilloried to deter future bad acts, in order to “counterbalance the state’s lack of incentive, or conceivably disincentive, to

269. *Id.*; Press Release, *Setting the Record Straight on Our Anti-Diversion Programs*, PURDUE PHARMA (July 11, 2016), <https://www.purduepharma.com/news-media/2016/07/setting-the-record-straight-on-our-anti-diversion-programs/> [https://perma.cc/S949-TGKR].

270. Press Release, Purdue Pharma, National Sheriffs’ Association and Purdue Pharma Announce Additional Funding for Life-Saving Opioid Overdose Initiative (Jun. 26, 2017), <https://www.purduepharma.com/news-media/2017/06/national-sheriffs-association-and-purdue-pharma-announce-additional-funding-for-life-saving-opioid-overdose-initiative/> [https://perma.cc/MW3J-69JN].

271. Beletsky & Davis, *supra* note 22, at 156.

272. Ryan, Girion & Glover, *supra* note 251 (“The company charged wholesalers on average about \$97 for a bottle of the 10-milligram pills, the smallest dosage, while the maximum strength, 80 milligrams, ran more than \$630, according to 2001 sales data the company disclosed in litigation with the state of West Virginia.”).

273. *Id.*

274. *OxyContin Maker Stops Promoting Opioids, Cuts Sales Staff*, REUTERS (Feb. 10, 2018), <https://www.reuters.com/article/usa-opioids-purduepharma/oxycontin-maker-stops-promoting-opioids-cuts-sales-staff-idUSL2N1Q00EU> [https://perma.cc/EB92-VT4X] (“As a company grounded in science,” Purdue writes, “we must balance patient access to FDA-approved medicines, while working collaboratively to solve this public health challenge.”).

275. Nate Raymond, *U.S. state, local government lawsuits over opioids face uphill battle*, REUTERS (June 2, 2017), <https://www.reuters.com/article/us-ohio-opioids-lawsuit-analysis-idUSKBN18T1H4> [https://perma.cc/X9JW-EC89].

verify definitively the actual guilt of the charged party.”²⁷⁶ But allowing federal agency approval to protect opioid makers runs the danger of negating the benefit of deterrence: analysts predict that the FDA’s approval of prescription opioids will cause liabilities to fall short of the “200 billion plus tobacco [master settlement agreement].”²⁷⁷

The desire for retribution, then, is a legally imperfect mode of punishing Big Pharma. It strives not for symmetrical, corrective justice, but mass blame-signaling effect, which means that the inexactness with which litigation seeks to hold Big Pharma stakeholders accountable is a desired feature, rather than a bug. Indeed, the uneven patchwork of litigation is comprised of states that sue using their own attorneys, others using private firms; some capping their attorneys’ compensation fee structures, while others compensate on a sliding scale; and some states choosing to sue only Purdue Pharma, while others add Endo Pharmaceuticals, Johnson & Johnson, Amerisource Bergen, Cardinal Health, and McKesson into the mix.²⁷⁸ Disparate lawsuits do not appeal to the obsessive-compulsive, for the “sprawling nature of the opioid litigation, with hundreds of plaintiffs and a still-expanding roster of defendants, has made it particularly challenging to contain within traditional legal procedures.”²⁷⁹ The breadth of litigants, “from manufacturers and distributors like Purdue Pharma and Cardinal Health and big retail pharmacy chains like Walgreens down to small-town pharmacies and prescribing physicians,”²⁸⁰ also reflects a disharmonious choir of industries who each sing their defenses at

276. Fellmeth, *supra* note 245, at 31.

277. *Fitch Ratings: US Pharma Tobacco—Style MSA Possible, Similar Size Unlikely*, FITCH (Aug. 24, 2018), <https://www.fitchratings.com/site/pr/10042562> [<https://perma.cc/7NWE-GYZ6>].

278. Daniel Fisher, *Latest Wave of State Opioid Lawsuits Shows Diverging Strategies and Lawyer Pay Scales*, FORBES (May 29, 2018), <https://www.forbes.com/sites/legalnewsline/2018/05/29/latest-wave-of-state-opioid-lawsuits-shows-diverging-strategies-and-lawyer-pay-scales/#66c79e776d1d> [<https://perma.cc/H9H4-WU98>].

279. Daniel Fisher, *Judge Sees Litigation As Only An “Aid In Settlement Discussion” For Opioid Lawsuits*, FORBES (May 10, 2018), <https://www.forbes.com/sites/legalnewsline/2018/05/10/judge-sees-litigation-as-only-an-aid-in-settlement-discussions-for-opioid-lawsuits/#3578a9af4b99> [<https://perma.cc/C5FZ-YFAW>].

280. Daniel Fisher, *Judge Orders Trials in Opioid Suits, DEA Records As “Step Toward Defeating the Disease,”* FORBES (Apr. 12, 2018), <https://www.forbes.com/sites/legalnewsline/2018/04/12/opioid-judge-orders-trials-dea-records-as-step-toward-defeating-the-disease/#2105c7667fe5> [<https://perma.cc/PG4S-S33U>].

different keys.²⁸¹ After all, each industry included in suit—drug makers, distributors, and retailers—contributed to our opioid epidemic differently, which inspires defendants to blame each other, and “makes the apportionment of liability even more contentious.”²⁸²

Various still are the flora and fauna of liability claims and defenses that sprout from retributive desire. Both manufacturers and distributors argue against total responsibility for opioid oversupply by ducking behind the medical licensure of the physicians that prescribed them.²⁸³ This view, though morally bankrupt, is a robust defense against public nuisance claims, which require plaintiffs to prove “the defendants had control over the products when it caused the nuisance.”²⁸⁴ The gist of the arguments against opioid manufacturers is that they “knew—or should have known—that their products weren’t safe or effective, yet they advertised their products as safe and effective anyway.”²⁸⁵ The case against opioid distributors, however, requires more nuance to grasp:

Under federal and some state laws, opioid distributors have a legal obligation to stop controlled substances from going to illicit purposes and misuse. The diversion theory argues that these distributors clearly did not do that: As the opioid epidemic spiraled out of control, and as some counties and states had more prescriptions than people, it should have become perfectly clear that something was going wrong—yet, the claim goes, distributors continued to let the drugs proliferate.²⁸⁶

Given that “most . . . overdose deaths are caused by illegal drugs like fentanyl,” plaintiffs seeking distributor liability face the additional burden of proving that “victims were launched on the path to addiction by legally prescribed opioids . . . that

281. See Jan Hoffman, *Can This Judge Solve the Opioid Crisis?*, N.Y. TIMES (Mar. 5, 2018), <https://www.nytimes.com/2018/03/05/health/opioid-crisis-judge-lawsuits.html> [https://nyti.ms/2Fhx7sK].

282. *Id.*

283. Fisher, *supra* note 280.

284. *Id.*

285. German Lopez, *The Growing Number of Lawsuits Against Opioid Companies, Explained*, VOX (updated May 15, 2018), <https://www.vox.com/policy-and-politics/2017/6/7/15724054/opioid-epidemic-lawsuits-purdue-oxycotin> [https://perma.cc/5PFP-DWPB].

286. *Id.*

were illegally diverted with the drug companies' knowledge."²⁸⁷ The desire to blame distributors for enabling diversion is thus criticized for fundamentally misunderstanding how pharmaceutical supply chains are regulated.²⁸⁸ According to John Parker, senior vice president of the Healthcare Distribution Alliance, "[t]hose bringing lawsuits will be better served addressing the root causes, rather than trying to redirect blame through litigation."²⁸⁹

Whether claiming public nuisance, fraud, racketeering, corruption, or violations of state and federal controlled substances laws,²⁹⁰ holding legal suppliers to account can only really recompense costs of legal supply. Both unreported demand and illegal supply, however—not merely legal, pharmaceutical overproduction—work to distinguish our addicts' morbidity from those who got clean when they returned to Vietnam. How much ability do we have, then, to remedy a drug market bifurcated into legal and illegal sources of harm? When the executive and legislative branches are slow to respond to crises, Judge Dan Polster of the Northern District of Ohio is one federal judge who believes that courts must step up to the plate.²⁹¹

Judge Polster has captained a multi-district litigation (MDL) effort to collect the over 1,500 opioid harm-based, *parens patriae* lawsuits clamoring in the federal court system today.²⁹² They are filed by cities, counties, hospitals, and Native American tribes seeking to recover against "central figures in the national opioid tragedy"²⁹³—a motley crew of opioid manufacturers, distributors, and retailers—for the costs associated with what Judge Polster describes as "a man-made plague."²⁹⁴

287. Fisher, *supra* note 280.

288. See, e.g., Lidgett, *supra* note 268.

289. *Id.*

290. Hoffman, *supra* note 281.

291. Abbe R. Gluck, *Can a Judge Solve the Opioid Crisis?*, WALL ST. J. (May 7, 2018, 6:24 PM), <https://www.wsj.com/articles/can-a-judge-solve-the-opioid-crisis-1525731873> [<https://perma.cc/68ML-93P2>].

292. Jan Hoffman, *Opioid Lawsuits Are Headed to Trial. Here's Why the Stakes Are Getting Uglier*, N.Y. TIMES (Jan. 30, 2019), <https://www.nytimes.com/2019/01/30/health/opioid-lawsuits-settlement-trial.html> [<https://nyti.ms/2HE1zTe>].

293. Hoffman, *supra* note 281.

294. Amanda Bronstad, *Opioid Judge Refuses to Dismiss Claims That Drug Companies Caused "Man-Made Plague"*, LAW.COM (Dec. 20, 2018), <https://www.law.com/2018/12/20/opioid-judge-refuses-to-dismiss-claims-that->

The procedural streamlining of MDLs is an attractive feature when the “theories under which parties are suing make for a legal cacophony.”²⁹⁵ Unlike class actions, MDLs allow plaintiffs from different jurisdictions to file their lawsuits separately, group similar cases together before a court, resolve pretrial issues in concert, then remand cases to their home jurisdictions for final adjudication at trial.²⁹⁶ But the “vast majority” of MDLs do settle prior to remand.²⁹⁷ According to Judge Polster, America is not “interested in depositions, and discovery, and trials,” nor “figuring out the answer to interesting legal questions like preemption and learned intermediary, or unravelling complicated conspiracy theories.”²⁹⁸ The goal of this MDL, as stated by him, is rather simple: to “dramatically reduce the number of the pills that are out there.”²⁹⁹

Whether too big to fail or too big to succeed, Judge Polster’s MDL arguably presents “the most daunting legal challenge in the country”³⁰⁰—one even he admits has become “far more” “complex and challenging” than envisioned by his original goal.³⁰¹ And “[c]omplexity” in the litigatory context “favors the defense.”³⁰² As do delays—like those that have already pushed back start dates for the first set of bellwether trials—which are typically better weathered by corporate entities capable of affording “the long game” in litigation, and can also “afford to drag . . . out” settlement negotiations (which typically “drive[s] down” its “final tab”).³⁰³ Indeed: what becomes of economic deterrence when the pharmaceutical industry is able to budgetarily plan for the billions in product liability defense costs,³⁰⁴

drug-companies-caused-man-made-plague/?slreturn=20190105214952
[<https://perma.cc/4LMM-RBF2>].

295. Hoffman, *supra* note 281.

296. Gluck, *supra* note 291.

297. Fisher, *supra* note 280.

298. Eric Heisig, *Here’s why a federal judge presiding over opioid lawsuits thinks settling them is important*, CLEVELAND (Mar. 7, 2018, 5:07 PM), https://www.cleveland.com/courtjustice/index.ssf/2018/01/heres_why_a_federal_judge_pres.html [<https://perma.cc/SP7B-V3BX>].

299. *Id.*

300. *Id.*

301. Hoffman, *supra* note 292.

302. *Id.*

303. *Id.*

304. Sarpatwari, Sinha & Kesselheim, *supra* note 105, at 480 (“Over the past twenty-five years, the industry has paid \$35.7 billion to settle claims of illegal

yet remain “extremely profitable”?³⁰⁵ In 2007, Purdue incurred over \$630 million in fines.³⁰⁶ But it also generated over \$31 billion in OxyContin revenue since the mid-1990s,³⁰⁷ which makes its 2007 penalty just 2% of its gains. Monetary penalties remain a “quite small percentage” of the industry’s global revenue,³⁰⁸ and OxyContin to this day continues to generate billions of dollars per annum,³⁰⁹ which says nothing of pharmaceutical companies’ and distributors’ contention that increased costs of business ultimately fall on patients’ and taxpayers’ shoulders.³¹⁰

There are also few mechanisms to ensure that the money which jurisdictions generate from litigation will reach their intended destinations. This ought to be compelling, given that the results of mass, Big Tobacco litigation by states suggest that grand litigatory compacts achieve very little in terms of victim services.³¹¹ To many, Judge Polster’s MDL mimics Big Tobacco’s 1999 Master Settlement Agreement (MSA), an accord “between the state Attorneys General of 46 states, five U.S. territories, the District of Columbia and the five largest cigarette manufacturers in America concerning the advertising, marketing and promotion of cigarettes.”³¹² The MSA required the Big

marketing, including making false or misleading claims or failing to disclose known risks.”).

305. See Richard Anderson, *Pharmaceutical Industry Gets High on Fat Profits*, BBC NEWS (Nov. 6, 2014), <http://www.bbc.com/news/business-28212223> [<https://perma.cc/BWH9-M5ST>].

306. Ryan, Girion & Glover, *supra* note 251.

307. *Id.*

308. Kevin Outterson, *Punishing Health Care Fraud — Is the GSK Settlement Sufficient?*, 367 NEW ENG. J. MED. 1082, 1083 (2012).

309. Jeff Feeley, *Purdue’s Oxycontin Targeted at Judge’s Opioid Summit*, BLOOMBERG (Feb. 2, 2018, 1:00 AM), <https://www.bloomberg.com/news/articles/2018-02-02/purdue-s-oxycontin-said-to-be-targeted-at-judge-s-opioid-summit> [<https://perma.cc/68ML-93P2>].

310. Geoff Mulvihill & Kyle Potter, *As States Consider Taxing Opioids, Drugmakers Push Back*, U.S. NEWS (Apr. 28, 2018), <https://www.usnews.com/news/us/articles/2018-04-28/as-states-consider-taxing-opioids-drugmakers-push-back> [<https://perma.cc/N69B-ZMC9>].

311. See, e.g., Kip Viscusi, *A Postmortem on the Cigarette Settlement*, 29 CUMB. L. REV. 53 (1999).

312. *Master Settlement Agreement*, PUB. HEALTH LAW CTR., <http://www.publichealthlawcenter.org/topics/tobacco-control/tobacco-control-litigation/master-settlement-agreement> [<https://perma.cc/T3M8-P2TD>] (last visited Aug. 10, 2018).

Tobacco industry to pay states billions of dollars annually.³¹³ The problem with compensating states for their citizens' harms, however, is that it requires states to "keep[] their promise to use a significant portion of their settlement funds—estimated at \$246 billion over the first 25 years—to attack the enormous public health problems caused by tobacco use in the United States".³¹⁴

Despite receiving huge sums from the settlement and collecting billions more in tobacco taxes, the states continue to shortchange tobacco prevention and cessation programs that we know save lives and money. In . . . Fiscal Year 2018, the states will collect \$27.5 billion from the settlement and taxes. But they will spend less than 3 percent of it—\$721.6 million—on programs to prevent kids from smoking and help smokers quit. Meanwhile, tobacco companies spend \$8.9 billion a year—\$1 million dollars every hour—to market their deadly and addictive products. This means tobacco companies spend \$12 to market their products for every \$1 the states spend to reduce tobacco use.³¹⁵

Because retributive consequences are tautologically validated by the desire to punish—and therefore "need be only loosely related to any tangible or even articulable damage actually caused by the defendant"³¹⁶—perhaps they also perfectly justify imperfect means of recompense and economic deterrence like the MSA.

Perhaps the most persuasive evidence against the wisdom of retribution via MDL derives from the fact that drug warrior-led executive agencies take to it. The Department of Justice, formerly under Jeff Sessions, joined the MDL as a "friend of the court."³¹⁷ It did so to argue "that the federal government" has also "borne substantial costs from the opioid epidemic"³¹⁸—an

313. *Id.*

314. *A State-By-State Look at the 1998 Tobacco Settlement 19 Years Later*, TOBACCO FREE KIDS, <https://www.tobaccofreekids.org/what-we-do/us/statereport> [<https://perma.cc/C3QL-4BVB>] (last updated Dec. 13, 2017).

315. *Id.*

316. Fellmeth, *supra* note 245, at 19–20.

317. *Department of Justice Files Motion in Multi-District Opioid Case*, U.S. DEP'T OF JUSTICE OFFICE OF PUB. AFFAIRS (Apr. 2, 2018), <https://www.justice.gov/opa/pr/department-justice-files-motion-multi-district-opioid-case> [<https://perma.cc/8TB5-2WS7>].

318. *Id.*

argument that ought to be barred as rationally offensive, given the FDA's prior approval of OxyContin, and equitably barred as unfair to the plaintiff-jurisdictions, given that "federal involvement could also undermine a claim made by drugmakers that state and local jurisdictions are not entitled to sue over a federal law at the center of their litigation."³¹⁹ One Yale Law School professor regards the inclusion as President Trump's "desire to show that the federal government is in front in the litigation," or, terrifyingly, to "give the Trump administration more influence over any large award granted in the case."³²⁰

In Judge Polster's view, our crisis cannot be alleviated with "a whole lot of finger-pointing."³²¹ But suing repeatedly does not make America great again either. We Americans will prefer retribution even when it does not economically deter, for litigatory retribution *feels* justified when a single pharmacy in Kermit, West Virginia—with its population of 392—received 9 million hydrocodone pills in just over two years.³²² And it *feels* justified when 845 million milligrams of opioids were shipped to the Cherokee Nation's fourteen counties, effectively supplying "360 pills for each prescription opioid user."³²³ How can we shift our retributive gaze from "supply reduction," and refocus it instead on reducing harm and demand?³²⁴

D. Return on Investment from Acceptance

The U.S. today is experiencing a brief resurgence of 1980s, "Just Say No"-inspired, blanket prohibition approaches to drug interdiction. Channeling the spirit of President Nixon, President Trump describes our opioid overdose crisis as a "national shame," where "[f]ailure is not an option."³²⁵ The executive de-

319. John Fritze, *President Trump threatens to sue opioid makers, says crisis is "warfare,"* USA TODAY (Aug. 16, 2016), <https://www.usatoday.com/story/news/politics/2018/08/16/donald-trump-opioid-makers-could-face-federal-lawsuit/1008957002/> [https://perma.cc/9CDS-BLVC].

320. *Id.*

321. Heisig, *supra* note 298.

322. Eric Eyre, *Drugs firms poured 780M painkillers into WV amid rise of overdose,* GAZETTE-MAIL (Dec. 17, 2016), https://www.wvgazette.com/news/health/drug-firms-poured-m-painkillers-into-wv-amid-rise-of/article_78963590-b050-11e7-8186-f7e8c8a1b804.html [https://perma.cc/DJ95-T2LY].

323. Lopez, *supra* note 285.

324. Beletsky & Davis, *supra* note 22, at 158.

325. *The Opioid Crisis*, *supra* note 7.

sire to eradicate drug addiction entirely, after all, has historically produced catchy political soundbites:³²⁶ Richard Nixon declared drug abuse “America’s public enemy number one”;³²⁷ Ronald Reagan deemed illegal drug use “an especially vicious virus of crime”;³²⁸ and Trump has also concluded that addiction is, categorically, “not our future.”³²⁹

But when it comes to policy, Trump’s take is more akin to Nancy Reagan’s.³³⁰ In 2017, his proposed solution to combat the opioid crisis was the creation of “really tough, really big, really great advertising” designed to convince young Americans to avoid opioids entirely.³³¹ Two years later, he continues to over-emphasize “preventing initiates” through “education” as his primary strategy for “reduc[ing] the size of the drug-using population.”³³² Abstinence-based arguments can sound responsive to an America that is so inundated with opioids that even the mussels in Seattle contain them.³³³ But as support for his approach, he ostensibly relies not on peer-reviewed analyses of evidence-based treatment, but on personal epiphany. “This was an idea that I had,” the President states, “where if we can teach young people not to take drugs, it’s really, really easy not to take them.”³³⁴

326. Rosalind K. Kelley, *Sentenced to Wear the Scarlet Letter: Judicial Innovations in Sentencing — Are They Constitutional?*, 93 DICK. L. REV. 759, 765 (1989).

327. Richard Nixon, President of the United States, Remarks About an Intensified Program for Drug Abuse Prevention and Control (June 17, 1971), <http://www.presidency.ucsb.edu/ws/?pid=3047> [<https://perma.cc/B8DB-9TYU>].

328. Ronald Reagan, President of the United States, Radio Address to the Nation on Federal Drug Policy (Oct. 2, 1982), <http://www.presidency.ucsb.edu/ws/?pid=43085> [<https://perma.cc/F4KT-29PU>].

329. *The Opioid Crisis*, supra note 7.

330. *Just Say No*, HISTORY, <https://www.history.com/topics/just-say-no> [<https://perma.cc/9LEW-52GE>] (last visited Aug. 10, 2018).

331. Julie Hirschfeld Davis, *Trump Declares Opioid Crisis a “Health Emergency” But Requests No Funds*, N.Y. TIMES (Oct. 26, 2017), https://www.nytimes.com/2017/10/26/us/politics/trump-opioid-crisis.html?_r=0 [<https://nyti.ms/2iBk6Uc>].

332. OFFICE OF NAT’L DRUG CTRL. POLICY, EXEC. OFFICE OF THE PRESIDENT, NATIONAL DRUG CONTROL STRATEGY, at iii (2019), <https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf> [<https://perma.cc/2UNZ-PCWK>].

333. Vanessa Romo, *Traces of Opioids Found in Seattle-Area Mussels*, NPR (May 25, 2018), <https://www.npr.org/sections/thetwo-way/2018/05/25/614593382/traces-of-opioids-found-in-seattle-area-mussels> [<https://perma.cc/JX3F-CCVR>].

334. Donald Trump, President of the United States, Remarks on Combatting Drug Demand and the Opioid Crisis (Oct. 26, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-combatting-drug-demand-opioid-crisis/> [<https://perma.cc/ER3H-E4RR>].

When American drug policy implicitly permits the capitalistic oversupply of the legal market for opioids, then stringently criminalizes illicit, non-pharmaceutical uses, blanket prohibition becomes far less reasonable policy, and far more political rhetoric. Total suppression—that is, the “modal programmatic and policy response” with the “singular focus” of eliminating opioid access³³⁵—is a singularly interesting response to our opioid crisis that has multiple, overlapping sources of both legal and illegal supply.³³⁶ In the U.S., “the sale and use of cocaine and heroin is illegal and punishable by prison and sentencing,” while the sale and use of morphine and drugs like OxyContin are legal only when prescribed by a physician.³³⁷ This bifurcated view of addiction ultimately weakens faith in criminalization as an effective policy response: it encourages the criminal justice system to deprioritize rehabilitative approaches to drug interdiction, and to instead view its goals as incapacitation, punishment, and deterrence.³³⁸

Our War on Drugs enforcement efforts also incur “sunk costs in law enforcement, courts, jails, and prisons to apprehend, process, and house large numbers of drug offenders.”³³⁹ These “[e]nforcement and prohibition strategies continue under the assumption that those efforts will increase prices sufficiently to reduce demand,”³⁴⁰ even while the impact of drug criminalization on overall social welfare remains “hotly debated.”³⁴¹ Many believe that drug criminalization creates more negative externalities than it solves,³⁴² and “[p]olicy efforts to increase drug prices through supply-side interventions have had ambiguous results.”³⁴³ Treatment for cocaine dependency, for instance, is significantly more cost-effective as a measure of control than

335. Beletsky & Davis, *supra* note 22, at 156.

336. *See id.* (citation omitted).

337. Methadone is also available at licensed clinics, while its black market sale remains illegal. *See* Donald S. Kenkel & Jody Sindelar, *Economics of Health Behaviors and Addictions: Contemporary Issues and Policy Implications*, OXFORD HANDBOOK OF HEALTH ECONOMICS 1, 9 (Sherry Glied & Peter C. Smith eds., 2011).

338. Kelley, *supra* note 326, at 765.

339. Stemen, *supra* note 197, at 418.

340. Cunningham & Finlay, *supra* note 264, at 1286.

341. Kenkel & Sindelar, *supra* note 337, at 10–11.

342. *Id.*

343. Cunningham & Finlay, *supra* note 264, at 1270.

“domestic enforcement and source country interdictions.”³⁴⁴ And while state governments arrest more people each year for drug crimes than does the federal government,³⁴⁵ the 46.1% of the inmates within the Federal Bureau of Prison incarcerated for drug offenses³⁴⁶ exist as a tantalizing market for the cottage industry of privatized, for-profit prisons,³⁴⁷ which arguably produce entire classes of negative externalities on their own.³⁴⁸

Restricting the supply of drugs as a means of reducing demand has been an “utter failure” in every other macroeconomic sense as well.³⁴⁹ In the case of alcohol prohibition, America ultimately deemed that the “aggregate negative economic, social, and public security consequences of Prohibition could not be justified by dwindling returns in terms of reduced consumption.”³⁵⁰ This was not because Prohibition failed to initially produce “sharp reductions in the volume of alcohol consumed.”³⁵¹ Rather, the myopic focus on reducing consumption ignored the costs of replacing the legal market for lesser-potent dosages of beer with the black market of moonshine. “While the overall volume of alcohol consumption initially decrease[d],” alcohol’s potency during Prohibition rose over 150% relative to pre- and post-Prohibition periods.³⁵² This means that even for a comparatively innocuous substance like alcohol, prohibition had the effect of producing Russian roulette-like circumstances for its consumers. On Christmas Eve 1926, sixty people were hospitalized for alcohol poisoning, and

344. *Id.* (citation omitted).

345. 2014: *Crime in the United States*, FED. BUREAU OF INVESTIGATION (Fall 2015), <https://ucr.fbi.gov/crime-in-the-u.s/2014/crime-in-the-u.s.-2014/persons-arrested/main> [https://perma.cc/UB4M-9MGQ].

346. *Offenses*, FED. BUREAU OF PRISONS, https://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp [https://perma.cc/548V-X7GP] (last updated July 28, 2018).

347. Ari Melber, *Presumed Guilty: How Prisons Profit Off the “War on Drugs,”* MSNBC (July 29, 2014, 5:58 PM), <http://www.msnbc.com/msnbc/presumed-guilty-how-prisons-profit-the> [https://perma.cc/2CAZ-ZJ2T].

348. Farah Mohammed, *The Problem With Privatizing Prisons*, JSTOR: THE DAILEY (May 15, 2017), <https://daily.jstor.org/the-problem-with-privatizing-prisons/> [https://perma.cc/6GCK-RQ29].

349. Bernd Debusmann, *Obama and the Failed War on Drugs*, REUTERS (Apr. 16, 2012), <http://www.reuters.com/article/us-column-debusmann-drugs-idUSBRE83F0ZR20120416> [https://perma.cc/VM7H-PEL8].

350. Beletsky & Davis, *supra* note 22, at 156.

351. *Id.* (citation omitted).

352. *Id.* (citation omitted).

sixteen died from it in New York City *alone*.³⁵³ “Within the next two days, yet another 23 people died in the city from celebrating the season.”³⁵⁴ Because the costs of total alcohol suppression outweighed its benefits, Prohibition was repealed “barely more than a decade after it was enacted.”³⁵⁵

Similarly, the War on Drugs has failed to prove that opioid prohibition—the suppression of both legal and illegal supply—has any lasting effect on eliminating the demand that undergirds it. Purdue Pharma did in fact “successfully contribute[] to and capitalize[] on the medical establishment’s changing view of pain management.”³⁵⁶ But we blame them for their efforts to capitalize upon it, in spite of the fact that the “incentive to sell potent drugs to addicts will always exist” when “our nation’s health care remains a privatized, for-profit industry.”³⁵⁷ As a basic economic principle, “if one supplier of a commodity is prevented from operating, another will quickly emerge to take its place as long as there is a strong incentive to do so.”³⁵⁸ And as we were busy blaming Big Pharma for hyper-commercializing the supply of moderate opioid dosages, demand for an opioid black market grew. After half a century of global drug prohibition, “drugs are cheaper, more available and widely used than ever before.”³⁵⁹ What’s more: this \$300 billion business in drug trade is effectively “gifted” to criminal drug enterprises, who create “vast costs for those least able to bear them,” “undermin[e] public health,” and energize “corruption and conflict,” “destabilising entire regions.”³⁶⁰ Indeed, the illicit drug industry constitutes “between a fifth and a third of the income of transnational organized crime.”³⁶¹ It also enriches “global financial markets who launder the billions in il-

353. *Id.* (citation omitted).

354. Deborah Blum, *The Chemist’s War*, SLATE (Feb. 19, 2010), http://www.slate.com/articles/health_and_science/medical_examiner/2010/02/the_chemists_war.html [<https://perma.cc/G649-EWXH>].

355. Beletsky & Davis, *supra* note 22, at 156.

356. Sarpatwari, Sinha & Kesselheim, *supra* note 105, at 466.

357. Lawson, *supra* note 29.

358. Frank J. Chaloupka, *Curbing the Epidemic: Governments and the Economics of Tobacco Control*, 1 WORLD BANK 1, 45 (1999).

359. Wheeler, *supra* note 217.

360. *Id.*

361. U.N. Office on Drugs & Crime, *supra* note 17.

licit profits.”³⁶² HSBC, for one, was recently fined \$1.9 billion for laundering \$881 million for drug cartels.³⁶³ Given that a third of drug profits “result in illicit financial flows,” drug money also damages economies.³⁶⁴

III. JUST SAY YES

*“At its heart, legalization is . . . a drama reduction program.”*³⁶⁵

A. Ideologically Pure Solutions from Abroad

The scale and severity of our opioid dilemma has exhausted even “historic Republican resistance to [the] public health [approach].”³⁶⁶ First Lady Melania Trump’s “Be Best” initiative—which prioritizes opioid abuse as one of its three pillar focuses—is one example of the way stringent biases against the recognition of drug abuse as a dual-party policy concern have dissolved over time.³⁶⁷ “[W]ide-ranging bipartisan support” for evidence-based solutions is also demonstrated by passage of the SUPPORT for Patients and Communities Act,³⁶⁸ which seeks to “address[] the opioid crisis by reducing access to and the supply of opioids and by expanding access to prevention, treatment, and recovery services.”³⁶⁹ Spearheaded by the Senate health committee’s top Democrat and Republican, Senator Patty Murray (D-WA) and Senator Lamar Alexander (R-TN), H.B. 6 was overwhelmingly approved by Congress in a “rare” show of bipartisan harmony, passing the House 396 votes to 14, and the Senate 98 votes to 1.³⁷⁰ The law contains provisions that re-

362. Wheeler, *supra* note 217.

363. *Id.*

364. *Heroin and cocaine prices in Europe and USA*, *supra* note 95.

365. Hari, *supra* note 41 (internal quotations omitted).

366. Tim Dickinson, *Why America Can’t Quit the Drug War*, ROLLING STONE (Feb. 18, 2017), <http://www.rollingstone.com/politics/news/why-american-cant-quit-the-drug-war-20160505> [<https://perma.cc/8N4V-6WWV>].

367. *Be Best*, WHITE HOUSE, <https://www.whitehouse.gov/bebest/> [<https://perma.cc/G3VK-57AH>] (last visited Nov. 30, 2018).

368. SUPPORT for Patients and Communities Act, Pub. L. No. 115-271 (2018).

369. *President Donald J. Trump Signed H.R. 6 into Law*, WHITE HOUSE (Oct. 24, 2018), <https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-signed-h-r-6-law/> [<https://perma.cc/33SY-KPNF>].

370. Katie Zezima & Seung Min Kim, *Trump signs sweeping opioid bill. Expect to hear about it on the campaign trail*, WASH. POST (Oct. 24, 2018), <https://www.washingtonpost.com/politics/trump-signs-sweeping-opioid-bill->

lax requirements for substance-use disorder telehealth services from specified requirements under Medicare;³⁷¹ requires the National Institutes of Health’s research initiatives to include “cutting-edge research . . . urgently required to respond to a public health threat”;³⁷² and “requires coverage of medication-assisted treatment under Medicaid,” albeit only temporarily.³⁷³ There is even robust support among conservative policymakers to create needle exchange programs and supply police with opioid antagonist drugs like naloxone.³⁷⁴ Hell hath yet to freeze over, but it appears that the end of blanket prohibition—if not nigh—is certainly nearer than it once was.

But are we really ready for what works? States are able to apply for considerable opioid-specific project grants from entities like the Substance Abuse and Mental Health Services Administration (SAMHSA) and the CDC.³⁷⁵ Even with “a lot of money going into the system,” though, it “takes time” for changing political tides to “translate into new infrastructure,”³⁷⁶ which is to say nothing of the varying political willingness across the states to adopt the most progressive, most effective drug reform policies—most of which hail from abroad, where the international community does treat drug addiction in notably different ways.

Portugal, for one, “had one of the worst drug problems in Europe.”³⁷⁷ When the prototypal War on Drugs approach failed to curb the numbers of fatal addiction poisoning, Portugal decided instead to redistribute the funds formerly used to disconnect addicts from society—either via legal criminalization

expect-to-hear-about-it-on-the-campaign-trail/2018/10/24/1328598c-d7a9-11e8-aeb7-ddcad4a0a54e_story.html [https://perma.cc/UB8V-GKBZ].

371. SUPPORT for Patients and Communities Act § 1009.

372. Cong. Research Serv., *Summary: H.R. 6— 115th Congress*, CONGRESS.GOV (June 22, 2018), <https://www.congress.gov/bill/115th-congress/house-bill/6/summary/36> [https://perma.cc/W8ZY-F7PX]; see also SUPPORT for Patients and Communities Act § 7042.

373. Cong. Research Serv., *supra* note 372; see also SUPPORT for Patients and Communities Act § 1006(b).

374. Stemen, *supra* note 197, at 415 (internal citations omitted).

375. Press Release, U.S. Dep’t of Health & Human Servs., HHS Awards Over \$1 Billion to Combat the Opioid Crisis (Sept. 19, 2018), <https://www.hhs.gov/about/news/2018/09/19/hhs-awards-over-1-billion-combat-opioid-crisis.html> [https://perma.cc/HQY2-K34S].

376. Katz, *supra* note 134 (citation omitted).

377. Hari, *supra* note 41.

or stigmatization via restriction in social services—towards efforts to reconnect them, through residential rehabilitation centers, therapy, and loans for small businesses.³⁷⁸ In 2000, 1% of Portugal’s population was addicted to heroin.³⁷⁹ Since these reforms were adopted in 2001, the prevalence of problematic drug use, “particularly intravenous drug use,” experienced a dramatic decline.³⁸⁰

While Portugal’s approach was premised upon an eminently logical proposition—one that asked, “instead of creating harsher conditions for drug users, why not give them a way out?”³⁸¹—Switzerland, as another example, tried a slightly different approach to address its own disastrous rates of heroin addiction.³⁸² According to former Swiss president Ruth Dreifuss, her administration “had to change perspective and introduce the notion of public health [to the problem of drug addiction]. We extended a friendly hand to drug addicts and brought them out of the shadows.”³⁸³ To bring addicts into the light, Swiss authorities implemented large-scale methadone programs, needle exchange sites, and safe or supervised injection facilities (SIFs), “in some cases building on services that had been started quasi-legally in response to open drug use in Swiss cities.”³⁸⁴ Since the inception of Swiss SIFs over fifteen years ago, zero people have died from heroin overdose³⁸⁵—a result often described as “extraordinary.”³⁸⁶

378. *Id.*

379. *Id.*

380. Caitlin Elizabeth Hughes & Alex Stevens, *What Can We Learn From the Portuguese Decriminalization of Illicit Drugs?*, 6 BRITISH J. CRIMINOLOGY 999, 1006 (2010).

381. Chris Branch, *What the U.S. Can Learn from Portugal about Decriminalizing Drugs*, HUFFINGTON POST (Feb. 3, 2015), https://www.huffingtonpost.com/2015/02/03/portugal-drug-decriminalization_n_6606056.html [<https://perma.cc/5VT8-WR9X>].

382. See Hari, *supra* note 41.

383. Stephanie Nebehay, *Swiss Drug Policy Should Serve as Model: Experts*, REUTERS (Oct. 25, 2010), <https://www.reuters.com/article/us-swiss-drugs/swiss-drug-policy-should-serve-as-model-experts-idUSTRE69O3VI20101025> [<https://perma.cc/BP7P-3JDV>].

384. JOANNE CSETE, OPEN SOC’Y FOUNDS., FROM THE MOUNTAINTOPS. WHAT THE WORLD CAN LEARN FROM DRUG POLICY CHANGE IN SWITZERLAND 9 (reissued 2013), <https://www.opensocietyfoundations.org/sites/default/files/from-the-mountaintops-en-20160212.pdf> [<https://perma.cc/DBF9-UHKC>].

385. *Id.*

386. Hari, *supra* note 41.

What these approaches have in common is the *genuine* belief that addiction is a public health problem—one that can be curbed only by acknowledging legal supply, illegal supply, *and* demand. While America’s top executive dubs his country’s struggle with addiction a “national shame,” the United Nation’s top drug and corruption agency would rather describe the opioid crisis as a “growing public health problem,” relapse as “part of the natural history” of “opioid dependence,” and overdose not as something to shame, but an opportunity that “allows people to continue their progress towards recovery,” and “enable[s] them to seek out other life-saving services.”³⁸⁷ SIFs are one such service, with well documented life-saving potential. They operate safely abroad,³⁸⁸ providing intravenous drug users the safety of injecting drugs under the supervision of personnel trained to prevent overdoses.³⁸⁹ Despite the fact that SIFs “significantly reduce the transmission of infectious disease and overdose deaths without increasing drug use or crime rates,” and rid communities of needles and other public drug consumption . . . hazards,³⁹⁰ SIFs in America remain illegal.³⁹¹ “Employees and users of such a site would be exposed to federal criminal charges regardless of any state law or study,”³⁹² for our federal drug policy embraces the view that SIFs both “normalize intravenous use of heroin and fentanyl,” and would rather “undermine[] all of the hard work of treat-

387. U.N. OFFICE ON DRUGS & CRIME & WORLD HEALTH ORG., OPIOID OVERDOSE: PREVENTING AND REDUCING OPIOID OVERDOSE MORTALITY, at 7, U.N. Sales No. V.13-83194 (2013).

388. See Amanda Holpuch, *Secret Supervised Drug Injection Facility Has Been Operating at U.S. Site for Years*, GUARDIAN (Aug. 8, 2017), <https://www.theguardian.com/society/2017/aug/08/secret-supervised-drug-injection-facility-us-opioids-overdoses> [<https://perma.cc/U4BD-TM9R>].

389. Lenny Bernstein, *White House Opioid Commission Calls for Wide-Ranging Changes to Anti-Drug Policies*, WASH. POST (Nov. 1, 2017), https://www.washingtonpost.com/news/to-your-health/wp/2017/11/01/white-house-opioid-commission-calls-for-wide-ranging-changes-to-anti-drug-policies/?noredirect=on&utm_term=.71313874da20 [<https://perma.cc/BAU8-DC5B>].

390. Megan McLemore, *How the Justice Department Can Help Solve the Opioid Crisis*, NATION (Dec. 18, 2017), <https://www.thenation.com/article/how-the-justice-department-can-help-solve-the-opioid-crisis/> [<https://perma.cc/3Q5J-JXQP>].

391. Press Release, U.S. Dep’t of Justice, Statement from U.S. Attorney Andrew Lelling Regarding Proposed Injection Sites (July 19, 2018), <https://www.justice.gov/usao-ma/pr/statement-us-attorney-andrew-elling-regarding-proposed-injection-sites> [<https://perma.cc/49AA-S6X9>].

392. *Id.*

ment providers and law enforcement across the Commonwealth.”³⁹³

Wide-ranging legislative support for norm-challenging health interventions may reflect a culturally decriminalized mindset unavailable to a capitalistic America that chooses to privatize healthcare. The unmonetizable good of social cohesion, for instance, was one way post-Soviet Union Russia weathered the storm of macro-socioeconomic despair.³⁹⁴ The start of mass privatization programs in Russia was heavily correlated with a steep uptick in suicides and instances of fatal poisoning for all groups, save one: those connected to their local community in some way.³⁹⁵ In fact, each “1% increase in the percentage of population who were members of at least one social organization” had the effect of decreasing the statistical association between privatisation and mortality by 0–27%.³⁹⁶ And when more than 45% of a population was a member of at least one social organisation, “privatisation was no longer significantly associated with increased mortality rates.”³⁹⁷ These social organizations had the effect of mitigating the effect of the macro-social changes Russia was undergoing at the time, as “the effect of privatisation was reduced if social capital was high.”³⁹⁸ Case and Deaton assert that a lack of the same social capital—weakening social cohesion, and declining institutional support for “marriage, childrearing, and religion”—trigger “deaths of despair” in middle-aged white Americans.³⁹⁹ Together, these findings suggests that human Rat Park, if ever constructed, ought to include programs that foster the feelings of social cohesion and connectedness, in order to allow individuals to weather cognitively dissonant, meta social changes in their environment.⁴⁰⁰ For if the real determining factor of addiction rests not in a particular substance, but in the uncon-

393. *Id.*

394. David Stuckler, Lawrence King, and Martin McKee, *Mass Privatisation and the Post-Communist Mortality Crisis: A Cross-National Analysis*, LANCET (Jan. 15, 2009), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)60005-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60005-2/fulltext) [<https://perma.cc/H7AQ-ZK6S>].

395. *Id.*

396. *Id.*

397. *Id.*

398. *Id.*

399. Case & Deaton, *supra* note 109, at 398–99.

400. See, e.g., Hari, *supra* note 41.

scious suspicion we harbor about the insubstantiality of our own lives, the uncivil,⁴⁰¹ un-Rat Park state of America today may be the most powerful factor determining the scale and scope of our crisis.

B. The Limitations of Politically Feasible Initiatives

Despite the fact that our political climate is ripe for some type of change, we cannot create Rat Park-like conditions for everybody. So in lieu of total, cultural decriminalization of drug use, perhaps our next-best, politically feasible, American Rat Park alternative ought to provide drug users with “comprehensive and integrated treatment, counselling, and clean needles and syringes.”⁴⁰² Here in America, there is urgent need for “[b]road scale-up in access to high-quality, low cost drug treatment and other physical and mental health services.”⁴⁰³ We have made good progress in recognizing that a focus on “overdose fatality prevention and education, including expanding access to naloxone is critical, especially following periods of forced abstinence or other times of special vulnerability.”⁴⁰⁴ And we have also made headway in pushing medication-assisted treatment (MAT), “a combination of psychosocial therapy and U.S. Food and Drug Administration-approved medication”⁴⁰⁵ considered the “most effective remedy for opioid addiction, bar none.”⁴⁰⁶

Under MAT, addicts are provided with methadone and buprenorphine—less powerful opioids that satiate most addicts’

401. German Lopez, *Police Shootings and Brutality in the U.S.: 9 Things You Should Know*, VOX (May 6, 2017), <https://www.vox.com/cards/police-brutality-shootings-us/us-police-racism> [https://perma.cc/EP58-U7MM].

402. Gunilla Backman et al., *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047, 2049 (2008); see also Richard Horton, *What does a National Health Service mean in the 21st Century?*, 371 LANCET 2213, 2213–18 (2008).

403. Beletsky & Davis, *supra* note 22, at 158.

404. *Id.*

405. *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, PEW CHARITABLE TRUSTS (Nov. 22, 2016) [hereinafter *MAT Improves Outcomes*], <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder> [https://perma.cc/U79J-YNKK].

406. Eric Levitz, *Why the Opioid Crisis Could Shatter Trump’s Coalition*, DAILY INTELLIGENCER (Oct. 26, 2017), <http://nymag.com/daily/intelligencer/2017/10/the-opioid-crisis-is-an-emergency-for-american-conservatism.html> [https://perma.cc/7MFJ-XETN].

cravings, and arrest their withdrawal symptoms, without inducing opioids' debilitating, euphoric high. Decades of research, the World Health Organization, CDC, and National Institute on Drug Abuse have all demonstrated MAT's efficacy. Some studies suggest that the treatment reduces mortality among drug addicts by more than 50%.⁴⁰⁷

MAT is also extremely effective for helping addicted inmates successfully reenter society.⁴⁰⁸ A 2001 Rikers Island study found that inmates who received MAT during their sentences were less likely to commit new crimes and more likely to pursue treatment upon release,⁴⁰⁹ results that were echoed by a companion 2014 study involving Australian prison inmates.⁴¹⁰ But even though President Trump's own commission on opioid addiction advocates for inmates' increased access to addiction medication,⁴¹¹ barriers to MAT availability in jails stems from typical factors, like "inadequate funding for treatment programs and a lack of qualified providers who can deliver these therapies."⁴¹² Our criminal justice system indubitably maintains a "punitive approach to addiction," which takes MAT out of the list of treatment options for most jails.⁴¹³ Indeed, "[m]any who work in corrections believe, incorrectly, that treatments like methadone, itself an opioid, allow inmates to get high and simply replace one addiction with another. And many officials say they have neither the money nor the mandate to provide the medications."⁴¹⁴

407. *Id.*

408. Salam, *supra* note 132.

409. Vincent Tomasino et al., *The Key Extended Entry Program (KEEP): A Methadone Treatment Program for Opiate-Dependent Inmates*, 68 MOUNT SINAI J. MED. 14, 20 (2001).

410. Louisa Degenhardt et al., *The Impact of Opioid Substitution Therapy on Mortality Post-Release from Prison: Retrospective Data Linkage Study*, 109 ADDICTION 1306, 1311 (2014).

411. PRESIDENT'S COMM'N ON COMBATING DRUG ADDICTION & THE OPIOID CRISIS, FINAL REPORT 119 (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf [<https://perma.cc/7P8N-DD3E>].

412. *MAT Improves Outcomes*, *supra* note 405.

413. Timothy Williams, *Opioid Users Are Filling Jails. Why Don't Jails Treat Them?*, N.Y. TIMES (Aug. 4, 2017), <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html?mtrref=www.nytimes.com> [<https://nyti.ms/2uqbyQd>].

414. *Id.*

Treatment of inmates aside, when the non-incarcerated American addict seeks professional help, the chances of her encountering an empirically validated program are slim.⁴¹⁵ The slowness with which empirically validated, efficacious treatment programs are disseminated into American community treatment centers is well known.⁴¹⁶ MAT, despite the fact that it significantly reduces overdose fatalities and is “more effective than either behavioral interventions or medication alone,”⁴¹⁷ is only available in 10% of American drug-treatment facilities.⁴¹⁸ And even naloxone, which is “extremely effective at preventing opioid overdoses from turning fatal,” is often least accessible to those who need it.⁴¹⁹ The U.S. Surgeon General recommends “[e]xpanding the awareness and availability of this medication” to “health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose” as the most effective way to reduce overdose deaths.⁴²⁰ And yet, the Affordable Care Act (ACA) and Comprehensive Addiction and Recovery Act (CARA) did “little to assure that naloxone distribution is well-targeted.”⁴²¹ Cities like Baltimore would have to spend \$46.5 million dollars to equip each of its residents with a two-dose kit—a sum of money greater than the Baltimore health department’s annual budget.⁴²² In spite of the fact that government-use authorities are routinely employed to circumvent patent restrictions in the military

415. Kenneth M. Carpenter, *Psychosocial Treatments for Substance Use Disorders: Guiding Principles for Promoting Behavioral Change*, PRIMARY PSYCHIATRY (Feb. 1, 2006), <http://primarypsychiatry.com/psychosocial-treatments-for-substance-use-disorders-guiding-principles-for-promoting-behavioral-change/> [https://perma.cc/J6PZ-RXA6].

416. *Id.*

417. *MAT Improves Outcomes*, *supra* note 405.

418. Levitz, *supra* note 406.

419. Beletsky & Davis, *supra* note 22, at 158 (citation omitted).

420. *Surgeon General’s Advisory on Naloxone and Opioid Overdose*, U.S. DEP’T OF HEALTH & HUMAN SERVS. (2018), <https://www.surgeongeneral.gov/priorities/opioid-overdose-prevention/naloxone-advisory.html> [https://perma.cc/T9FB-MKQ2].

421. Beletsky & Davis, *supra* note 22, at 159.

422. Robert Weissman & Leana Wen, Opinion, *One Easy, Cost-Free Thing Trump can do to Ease the Opioid Crisis*, WASH. POST (June 11, 2018), https://www.washingtonpost.com/opinions/one-easy-cost-free-thing-trump-can-do-to-ease-the-opioid-crisis/2018/06/11/16165efa-69a9-11e8-9e38-24e693b38637_story.html. [https://perma.cc/69ZF-MQ6U].

realm,⁴²³ the municipal public health officials who petition Trump's "opioid czar" Kellyanne Conway to use existing federal patent law to circumvent Big Pharma markups and secure cheaper stockpiles of naloxone are met with silence.⁴²⁴

By stymying affordable access, America's capitalistic reality relegates the widespread adoption of evidence-based solutions to pie-in-the-sky fantasies. When it comes to drug addiction interventions, we historically do not spend money on evidence-based solutions,⁴²⁵ despite the fact that every \$1 invested in evidence-based treatment yields up to \$6 in saved "costs for health, security and welfare."⁴²⁶ The problem of access is highlighted in states with the political will to reach high-water marks in progressive programming, yet struggle to spread baseline services across the board. Take Washington, where the University of Washington School of Medicine Harborview Medical Center's "innovative" addiction program "treat[s] patients with heroin addiction the same way it would treat those suffering from a chronic disease, such as diabetes," while "myriad" barriers ensure that "[l]ess than half of those who would benefit from methadone or buprenorphine are able to access them" in the state.⁴²⁷ "Efforts to undermine or repeal the ACA and short-sighted budgetary austerity measures" also threaten to "further undermine access to evidence-based treatment and prevention"⁴²⁸—an embarrassing state of public health affairs for a world leader, when the global human rights community broadly considers affordable access to be a "critical" component of public health—one "critical for functioning health systems."⁴²⁹ Without "serious, sustained efforts to ad-

423. See Robert S. Pasley & John TeSelle, *Patent Rights and Technical Information in the Military Assistance Program*, 29 LAW AND CONTEMPORARY PROBLEMS 566 (1964). For a proposal to use these powers in the context of hepatitis C, see Amy Kapczynski and Aaron S. Kesselheim, "Government Patent Use": A Legal Approach to Reducing Drug Spending, 35 HEALTH AFF. 791 (2016).

424. Weissman & Wen, *supra* note 422.

425. Beletsky & Davis, *supra* note 22, at 159 (citation omitted).

426. UNITED NATIONS OFFICE ON DRUGS & CRIME, UNODC-WHO JOINT PROGRAMME ON DRUG DEPENDENCE TREATMENT AND CARE, U.N. Sales No. V.09-80987 (2009).

427. Garner, *supra* note 3 (citation omitted).

428. Beletsky & Davis, *supra* note 22, at 159.

429. *Innovation Access and Use*, WORLD HEALTH ORG., <https://www.who.int/medicines/access/en/> [<https://perma.cc/6H7M-5956>] (last visited Mar. 3, 2019).

dress the direct and root causes non-medical opioid use, intensive supply suppression efforts that brought us fentanyl will continue to push the market towards deadlier alternatives.”⁴³⁰

C. *Skip the Eggs—Kill the Black-Market Golden Goose*

This is because the subterranean, extrajudicial black market for drugs is the ultimate negative externality of drug prohibition—one that prohibition, as a particularly “stringent” breed of regulation, has failed to control.⁴³¹ The regulatory issues that plague the pharmaceutical market generally—“[w]eak patenting standards and ineffectual policing of both anticompetitive actions and fraudulent marketing”⁴³²—played an important role in launching and prolonging the opioid epidemic,⁴³³ which would make prohibition seem like the best way to reduce the negative externalities of legal addiction. What is particularly crazy about this crisis, however, is that the growth of the black market for illicit opioids was preemptively accepted as a cost of stringently regulating legal supply:

[The] iatrogenic risk to the health of people who use [opioids] was not just foreseeable, but in some cases directly foreseen by policymakers. One of the most shocking articulations of this came from Pennsylvania’s former Physician General, who recently remarked, “We knew that [drug user transition to the black market] was going to be an issue, that we were going to push addicts in a direction that was going to be more deadly. But . . . you have to start somewhere.”⁴³⁴

Statements like these reflect the erroneous view that the ultimate negative externality of prohibition-as-regulation is an increase in illicit use—social blight—when it is in fact the black market’s tendency to skyrocket the risks of opioid use disorder into lethal stratospheres.

Regulation also fails to control supply when the regulated market captures only the iceberg tip of demand. Take regulation in the methamphetamine (“meth”) context. Regulatory supply interdictions of its precursor drugs used in manufacture were at best only temporarily effective at reducing its black-

430. Beletsky & Davis, *supra* note 22, at 158.

431. Kenkel & Sindelar, *supra* note 337, at 214–15.

432. Sarpatwari, Sinha, & Kesselheim, *supra* note 105, at 484.

433. *Id.* at 464.

434. Beletsky & Davis, *supra* note 22, at 157 (alterations in original).

market consumption, as producers eventually optimized their processes to rely on unregulated materials.⁴³⁵ Unlike meth, opioids require “sophisticated production facilities,” and do possess legitimate medical use.⁴³⁶ Regulatory shortcomings in the legal opioid context not only hinder access to lower-cost, medically appropriate generics,⁴³⁷ but also has the ironic effect of simultaneously “spur[ring] overutilization” of brand-name OxyContin while reducing access to life-saving naloxone.⁴³⁸ And the dearth of regulatory efforts controlling the “contents, quality, and dosage in black market opioid products” is what inevitably trailblazed the path from casual Percocet user to black market heroin overdoser.⁴³⁹ Thus, in the opioid context, it at best “remains to be seen if interdictions are cost effective in the long-run,” or if regulation may be implemented in a way that protects social welfare from reduced access to “legitimate medicines.”⁴⁴⁰

Although regulation is unable to reduce drug demand, it caters to our desire for decisive action over holistic solutions that reduce overall societal harm. Criminalizing addiction is “inimical to both public health scientific and ethical norms,”⁴⁴¹ and has the tendency to both crowd out evidence-based treatments and encourage prohibition as a sole intervention.⁴⁴² It is problematic not only for its counterproductivity, but also because “[e]very dollar spent on enforcement is a dollar not spent on treatment, harm reduction, or prevention.”⁴⁴³ And like the chemical hook theory, which allows us to flatten the complexity of drug addiction into a two-dimensional failure of Victorian restraint, opioid prohibition allows us to circumvent the task of analyzing drug addiction as an expression of rational demand, and opioid addicts as rational consumers.

Unlike the way we consider addictions to recreationally legal substances, we assume that addiction to heroin could not be

435. See Cunningham & Finlay, *supra* note 264, at 1269.

436. *Id.* at 1287.

437. See Sarpatwari, Sinha, & Kesselheim, *supra* note 105, at 484.

438. *Id.* at 477.

439. Beletsky & Davis, *supra* note 22 (citation omitted).

440. Cunningham & Finlay, *supra* note 264, at 1287.

441. Beletsky & Davis, *supra* note 22, at 156.

442. *Id.*

443. *Id.*

the product of rational choice. “Modern economic theory holds that consumers are usually the best judges of how to spend their money on goods and services,” and this “principle of consumer sovereignty” rests on two assumptions: “first, that the consumer makes rational and informed choices after weighing the costs and benefits of purchases, and, second, that the consumer incurs all costs of the choice.”⁴⁴⁴ We accept that cigarette smokers smoke because the benefits of doing so outweigh the costs.⁴⁴⁵ The former is understood to include “pleasure and satisfaction, enhanced self-image, stress control and, for the addicted smoker, the avoidance of nicotine withdrawal,” while the latter based on “money spent on tobacco products, damage to health, and nicotine addiction.”⁴⁴⁶ And indeed, though tobacco’s addictive qualities would seem to except it from basic laws of economics—such as the principle that when the “price of a commodity rises, the quantity demanded of that product will fall”⁴⁴⁷—a “growing volume of research now shows that . . . smokers’ demand for tobacco, while inelastic, is nevertheless strongly affected by its price.”⁴⁴⁸

In contrast, when we observe people beginning their addictive trajectories with OxyContin and ending with fatal dosages of fentanyl, we assume that the “simple answer”—that people “derive enough utility from the consumption of the substances that they willingly accept the health consequences”—is very unlikely to apply.⁴⁴⁹ But we assume so while neglecting the reality that “reduced consumer ability to exercise preferences” catalyzes “ability of black market traffickers to get the ‘biggest bang for their buck,’”⁴⁵⁰ incentivizing the mass availability of fatality-inducing moonshine and fentanyl over the comparatively moderate beer and poppy tea. By stymying the availability of moderate, pharmaceutical opioids and criminalizing non-FDA approved supply, all opioid suppliers—legal and not—

444. Chaloupka, *supra* note 358, at 3.

445. *Id.*

446. *Id.*

447. *Id.* at 38–39.

448. *Id.* at 39.

449. Kenkel & Sindelar, *supra* note 341, at 3.

450. Beletsky & Davis, *supra* note 22, at 156.

operate under higher “legal risk,” and drug users are “less able to act on informed choices.”⁴⁵¹

Opioid addiction “challenge[s] the standard neoclassic assumption that consumers make rational, utility-maximizing choices.”⁴⁵² But it does so because regulation, in the form of prohibition, obfuscates the rational cost-benefit analyses of drug addiction by utterly foreclosing rational choice in the market.

D. Taxation Trumps Prohibition

Regardless of which market interventions America ought to use in lieu of its blanket, War on Drugs approach, we cannot assume that opioid addicts will not respond to free market interventions when the costs of their addiction are necessarily muffled by black market pricing. After all, “[m]ost economic studies suggest that addictive substances are consumed on the inelastic portion of demand,”⁴⁵³ and products for which there is inelastic demand, like cigarettes, are prime candidates for “sin” taxing.⁴⁵⁴ Sin taxing—a regulatory measure once used to express moral judgment—now receives wide support as a public health intervention.⁴⁵⁵ And sin taxes on products for which there is inelastic demand are a consistently “effective source of revenue generation.”⁴⁵⁶ “Even though an increase in the tobacco tax may cause some smokers to stop smoking, the overall result of the tax increase” produces net profits.⁴⁵⁷

Unlike prohibition and criminalization, sin taxes have proven themselves to be highly effective in reducing demand.⁴⁵⁸ In the tobacco context, “[e]vidence from countries of all income levels shows that price increases on cigarettes are highly effective in . . . induc[ing] some smokers to quit and prevent[ing] other individuals from starting.”⁴⁵⁹ Like tobacco, demand for

451. *Id.*

452. Kenkel & Sindelar, *supra* note 337, at 3.

453. Cunningham & Finlay, *supra* note 264, at 1275.

454. See Andrew J. Haile, *Sin Taxes: When the State Becomes the Sinner*, 82 TEMP. L. REV. 1041, 1045–46 (2009).

455. See Kenkel & Sindelar, *supra* note 337, at 207.

456. See Haile, *supra* note 454, at 1045.

457. *Id.* at 1046.

458. See Chaloupka, *supra* note 358, at 6.

459. *Id.*

heroin is inelastic, which makes it a prime candidate for “sin” taxation.⁴⁶⁰

The fear of a free, taxed market for even the most innocuous doses of opioids, however, is strong. Many imagine that it would entail a “heroin aisle” at one’s local CVS,⁴⁶¹ and critics opine that a free market for opioids would have the effect of “increasing addiction, normalising use among kids, and relegating its sale to profit-hungry corporations or governments with every incentive to increase addiction to advance their bottom line.”⁴⁶² But because sin taxing tobacco did reduce consumption and increase revenue in places like Canada, the United Kingdom, and South Africa,⁴⁶³ the U.S. would be remiss if it did not explore the ways a free market opioid tax might lance the boil that is our epic national demand for immediate analgesic relief.

Taxes on opioids will inevitably be difficult to calculate, even with the “standard neoclassical economic criteria for determining the optimal tax on a substance” dictating that “taxes should be levied to reflect the marginal negative externalities.”⁴⁶⁴ And empirically estimating those negative externalities would be a challenge, given the difficulty in determining the “full and appropriate range of factors” to include as costs.⁴⁶⁵ A “1% increase in white meth use,” for example, is correlated with a “1.5% increase in white foster care admissions”⁴⁶⁶—a result that is predictable in hindsight, yet arguably unforeseeable in the *Palsgraf* sense.⁴⁶⁷ However, the Master Settlement Agreement that

460. See Cunningham & Finlay, *supra* note 264, at 1275 (citation omitted).

461. See Hari, *supra* note 41.

462. Wheeler, *supra* note 217.

463. See Chaloupka, *supra* note 358, at 39.

464. Kenkel & Sindelar, *supra* note 337, at 213.

465. *Id.*

466. Cunningham & Finlay, *supra* note 264, at 765.

467. See *Palsgraf v. Long Island R. Co.*, 162 N.E. 99 (N.Y. 1928). *Palsgraf* is the seminal 1L year tort law staple, a case in which an employee at a railway station helped push a passenger onto a train car as it was beginning to depart the station. In doing so, the employee dislodged the passenger’s package, which unbeknownst to the employee, contained fireworks. When the package hit the ground, the fireworks inside exploded. The reverberations from the explosions then knocked down some scales across the railway station platform. Mrs. *Palsgraf* happened to be standing next to those scales and was seriously injured. *Id.* at 99. Upon suing to recompense her suffering, the court laid down the general principle of “proximate causation”—the notion that unless it was reasonably foreseea-

“ended” the era of Big Tobacco resulted in a “tax-like hike” in cigarette prices, in addition to “new restrictions on cigarette advertising and other tobacco industry practices.”⁴⁶⁸ Could similar provisions be included in agreements resulting from Judge Polster’s MDL, provided that the parties settle?

A heavily taxed, free market for opioids ought to attract President Trump, who is prone to moral absolutism in his criticism of foreign importers of crime,⁴⁶⁹ and believes that the “best way to prevent drug addiction and overdose” is to tell young people that drugs are “[n]o good, really bad for you in every way.”⁴⁷⁰ For one, even when drugs are smuggled at a high rate, taxes still manage to reduce consumption for them while yielding high revenues.⁴⁷¹ And sin taxes are known to have the “greatest [impact] on young people, who are more responsive to price rises than older people.”⁴⁷² Since any drug fatality-reduction strategy designed to deter children will yield delayed results, policymakers “concerned with health gains in the medium term” must also adopt “broader measures” that help existing addicts reduce their consumption.⁴⁷³

Taxation fits the bill here, too. Even under conservative assumptions, sin taxes on tobacco had the effect of reducing “the number of ex-smokers who return to cigarettes” and “consumption among continuing smokers,” in addition to “deter[ring] others from taking up smoking in the first place.”⁴⁷⁴ And evidence suggests that sin taxes on drugs are a particularly effective deterrent for long-time users, as “a real and permanent price increase will have approximately twice as great an impact on demand in the long run as in the short run.”⁴⁷⁵

ble to the employee that his actions would result in harm, no action in tort could lie. *Id.* at 101.

468. Kenkel & Sindelar, *supra* note 337, at 207; *see also* Viscusi, *supra* note 311, at 53.

469. Donald Trump, President of the United States, Remarks at a California Sanctuary State Roundtable (May 16, 2018), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-california-sanctuary-state-roundtable> [<https://perma.cc/E5DF-PTY5>].

470. Raymond, *supra* note 23.

471. *See* Chaloupka, *supra* note 358, at 14.

472. *Id.* at 38.

473. *Id.* at 10.

474. *Id.* at 6.

475. *Id.* at 41.

Taxation generally, unlike prohibition, does lack a bold moral condemnation signaling feature—a serious deficiency in user experience given America’s particular affinity for retributive punishment.⁴⁷⁶ But there are legislative bills proposed in almost half of our states that suggest taxing prescription painkillers, and they garner bipartisan support under the promise that such fees will “funnel millions of dollars toward treatment and prevention programs.”⁴⁷⁷ Could the taxation of illicit opioids also yield the similar effect of bringing black market economics out into the sunlight, and disinfecting the Iron Law of Prohibition’s tendency to funnel the unwary towards overdose and death?

E. Home Brew Decriminalization

Thanks to state sovereignty, the end to ineffective, blanket drug prohibition may be near. The Achilles heel of federal War on Drugs initiatives may be that they require state allegiance to enforce. And local governments are those that feel the financial pinch of blanket prohibition most, given that states are responsible for the majority of drug arrests in America.⁴⁷⁸

How many times can state and municipal codes reclassify drug offenses and mandate probation in lieu of jail for simple possession charges before the exceptions to blanket criminalization become the rule?

Safe injection sites may not be endorsed by President Trump’s Opioid and Drug Abuse Commission,⁴⁷⁹ and the Department of Justice has yet to support pilot programs that would enable “local officials to help remove legal barriers” or “increase[e] awareness of the evidence-based public-safety arguments in their favor.”⁴⁸⁰ But powerful medical entities like the U.S. Surgeon General and American Medical Association support safe injection programs.⁴⁸¹ And underground safe injection facilities for Americans who would otherwise “inject[]

476. See Fellmeth, *supra* note 245, at 19.

477. Mulvihill & Potter, *supra* note 310.

478. In one year, the DEA arrested 30,035 people drug offenses, while state and local law enforcement arrested over 1.5 million. *Crime in the United States*, *supra* note 344.

479. See Bernstein, *supra* note 389.

480. McLemore, *supra* note 390.

481. Holpuch, *supra* note 388.

in a public restroom, street, park or parking lot” have already saved lives.⁴⁸² Hope springs from the fact that “defiant” cities like Seattle, San Francisco, New York City, Philadelphia, and Baltimore have publicly announced plans to open SIFs, despite the federal government threatening “criminal prosecution” and “confrontation” akin to those that occurred over sanctuary cities.⁴⁸³

The complete decriminalization of certain drugs may not be far behind as well. Some have proposed that California serve as a testbed for Portugal’s two-pronged decriminalization approach, which pairs “drug dissuasion panels” with harm-reducing public health initiatives.⁴⁸⁴ Portugal, exhausted by the costs of drug criminalization, pursued a strategy grounded in “principles of harm reduction, prevention, and reintegration of the drug user into society.”⁴⁸⁵ California, “with its history of trailblazing marijuana laws,” is considered “well poised” to serve as the American petri dish for this model.⁴⁸⁶

By following Portugal’s lead by decriminalizing possession for all illicit substances, [California] may reap significant rewards. To name a few, the state may see 40% fewer drug arrests, a drop in prevalence rates for drug use, and over \$2 million in Medicaid savings. Overall, . . . California’s budget may see rewards of over \$480 million in the first few years after decriminalization.⁴⁸⁷

If California were to decriminalize drugs entirely, its statutes would brazenly challenge the War on Drugs.⁴⁸⁸ And states’

482. *Id.*

483. Lenny Bernstein & Katie Zezima, *Cities defiant after Justice Department’s threat on “supervised injection sites,”* WASH. POST (Sept. 4, 2018), https://www.washingtonpost.com/national/health-science/cities-defiant-after-justice-departments-threat-on-supervised-injection-sites/2018/09/04/fcf798d6-b056-11e8-a20b-5f4f84429666_story.html?utm_term=.20832b411772 [https://perma.cc/TFA3-RYRX].

484. Mallory Whitelaw, *A Path to Peace in the U.S. Drug War: Why California Should Implement the Portuguese Model for Drug Decriminalization*, 40 LOY. L.A. INT’L & COMP. L. REV. 81 (2017).

485. Kellen Russoniello, Note, *The Devil (and Drugs) in the Details: Portugal’s Focus on Public Health as a Model for Decriminalization of Drugs in Mexico*, 12 YALE J. HEALTH POL’Y L. & ETHICS 371, 384 (2012).

486. *Id.*

487. *Id.*

488. *Id.*

rights-driven collisions into federal initiatives can be a good, galvanizing thing for the creation of sound drug policy.

The state-level shifts in drug policies that are occurring today do indicate “clear public and . . . policymaker support to move beyond the War on Drugs,”⁴⁸⁹ as is best evidenced by the sheer quantum of senators, governors, mayors, and Democratic presidential candidates in support of the federal legalization of marijuana, including Senators Cory Booker, Kirsten Gillibrand, Kamala Harris, and Bernie Sanders.⁴⁹⁰ For many, decriminalization and legalization efforts have always smacked of good policy. Novel in our current epidemic is that supporting the federal legalization of a Schedule I drug also constitutes “good politics.”⁴⁹¹ To imagine why, one only needs to imagine what the televised debates of Democratic presidential candidates in 2020 might look like. According to one Colorado cannabis advocate, “If a moderator just asks, ‘Do you support descheduling marijuana[?]’ and a candidate says ‘no,’ that’s a viral ad right there.”⁴⁹² As political costs of supporting War on Drugs policies continue to rise, one questions the motives of politicians whose “thinking . . . on the issue has evolved” only very recently.⁴⁹³ However, when candidates for the highest political office in our nation are able to publicly assert that broad legalization proposals, like the Marijuana Justice Act, “must be about restorative justice,”⁴⁹⁴ the task of splitting ideological hairs begins to feel like an ungrateful exercise.

489. Stemen, *supra* note 197, at 417.

490. Dan Merica, *Potential Democratic 2020 contenders are rushing to back marijuana legalization*, CNN (Apr. 20, 2018), <https://www.cnn.com/2018/04/20/politics/democrats-marijuana-legalization/index.html> [<https://perma.cc/23H3-C8RY>].

491. Daniella Diaz, *Harris says she’ll back Booker’s legislation to legalize marijuana*, CNN (May 10, 2018 4:59 PM), <https://www.cnn.com/2018/05/10/politics/kamala-harris-cory-booker-legalizing-marijuana/index.html> [[https://perma.cc/Z9P\]-7UU6](https://perma.cc/Z9P]-7UU6)] (citation omitted).

492. *Id.*

493. Press Release, Senator Chuck Schumer, Senator Chuck Schumer Announces Support for Decriminalizing Marijuana at Federal Level, Plans to Introduce New Legislation in U.S. Senate (Apr. 20, 2018), <https://www.schumer.senate.gov/newsroom/press-releases/schumer-announces-support-for-decriminalizing-marijuana-at-federal-level-plans-to-introduce-new-legislation-in-us-senate> [<https://perma.cc/965G-X6S4>].

494. *Cory Booker Reintroduces Weed Legislation Called the Marijuana Justice Act*, NOW THIS NEWS (Mar. 1, 2019), <https://nowthisnews.com/videos/weed/cory-booker-reintroduces-the-marijuana-justice-act> [<https://perma.cc/B2H9-3QMY>].

Eradicating prohibition as America's default approach to drug addiction will require incredible legislative effort, though. Already in place are laws denying those convicted of felony drug charges federal aid,⁴⁹⁵ access to public housing,⁴⁹⁶ and food stamps,⁴⁹⁷ and the right to vote in most states,⁴⁹⁸ which is to say nothing of the War on Drugs sentencing practices that are thirty years in the making—precedent that requires extreme political will to change.⁴⁹⁹ As rates of state incarceration continue to rise, policymakers and corrections administrators, faced with “growing fiscal constraints and social scrutiny,” will continue “evaluat[ing] the cost-effectiveness and efficacy of incarceration as a response to drugs.”⁵⁰⁰ Deferred prosecution and local drug courts are the results of cost-benefit analyses like these.⁵⁰¹ California, Colorado, Delaware, Idaho, Iowa, Maine, Massachusetts, Mississippi, New York, Oregon, Pennsylvania, and South Carolina have all decided to charge many of their simple drug possession crimes as misdemeanors.⁵⁰² An Oregon bill reclassifies—from felony to misdemeanor—the

495. Higher Education Amendments of 1998, 20 U.S.C. § 1091(r) (2012) (stating that a conviction of any offense under any federal or state law involving the possession or sale of a controlled substance makes an individual ineligible for any federal grant, loan, or work assistance).

496. The Quality Housing and Work Responsibility Act of 1998, 42 U.S.C. § 13662 (2012) (supporting a public housing authority's right to exclude applicants with a history of controlled substance use and to exercise their discretion to determine which applicants were possible risks to the safety of the community); Cranston-Gonzalez National Affordable Housing Act of 1990, Pub. L. No. 101-625, § 501, 104 Stat. 4079, 4180–81 (imposing a mandatory three-year ban on the readmission of tenants evicted for drug-related criminal activity); Housing Opportunity Program Extension Act of 1996, 42 U.S.C. § 1437d(l), (q) (2012 & Supp. I 2013) (strengthening eviction rules and allowing housing authorities access to housing applicants' criminal records).

497. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 814(3), 110 Stat. 2105, 2313–14 (since repealed) (establishing that a state or federal felony drug conviction makes an individual ineligible for federal welfare benefits).

498. See *Felon Voting Rights*, NAT'L CONF. OF STATE LEGISLATURES (Apr. 30, 2017), <http://www.ncsl.org/research/elections-and-campaigns/felon-voting-rights.aspx>. [<https://perma.cc/JVB8-YP75>].

499. Stemen, *supra* note 197, at 418.

500. *Id.* at 403.

501. *Id.* at 411–12.

502. Review of Those States' Laws Which Provide Misdemeanor Penalties for Simple Possession of Drugs Other Than Marijuana (Unpublished draft, Alaska Judicial Council), <http://www.ajc.state.ak.us/acjc/drugs/misdechrt.pdf> [<https://perma.cc/XCW4-U729>] (last visited Aug. 10, 2018).

possession of heroin, cocaine, and other drugs.⁵⁰³ Oregon, as one lawmaker put it, “can’t continue on the path of building more prisons when often the underlying root cause of the crime is substance use.”⁵⁰⁴

Two Washington counties’ approaches to the crime of simple drug possession illustrate the power of piecemeal exceptions from federal War on Drugs policies. As of February 2018, King County and Snohomish County—two out of Washington States’ three largest counties⁵⁰⁵—no longer charge possession crimes involving less than two grams of drugs.⁵⁰⁶ The reasons? Expense, and futility.⁵⁰⁷ Snohomish County Prosecutor Mark Roe believes that the “prosecutorial response to minor possession” has failed to curb drug use, and merely distracted city attorneys from prosecuting crimes that cause greater harm to communities.⁵⁰⁸ The county now prosecutes possession crimes involving small amounts of drugs only if a defendant’s underlying addiction serves as a nexus to criminal behaviors of “higher importance,” such as DUIs, assaults, and burglaries.⁵⁰⁹

These counties realize what the federal government does not: that “dutifully charging” minor drug possession crimes is, in practice, indistinguishable from the unconstitutional practice of criminalizing drug abusers “essentially for being addicts in the first place.”⁵¹⁰ Prosecutorial discretion is just one way local jurisdictions operationalize their individual distaste for the costs of blanket prohibition without waiting for the repeal of federal

503. Nicole Lewis, *Oregon Bill Decriminalizes Possession of Heroin, Cocaine and Other Drugs*, WASH. POST (July 11, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/07/11/oregon-legislature-passes-bill-decriminalizing-heroin-cocaine-meth-possession-hoping-to-curb-mass-incarceration/?noredirect=on&utm_term=.1887c402b266 [https://perma.cc/8EFT-MLF5].

504. *Id.*

505. *Washington Counties by Population*, CUBIT, https://www.washington-demographics.com/counties_by_population [https://perma.cc/R85J-NHUS] (last visited Aug. 10, 2018).

506. *See Snohomish Co. to Stop Prosecuting Small-Time Drug Users*, KING 5 NEWS (Feb. 27, 2018, 4:43 PM), <https://www.king5.com/article/news/local/snohomish-co-to-stop-prosecuting-small-time-drug-users/281-523887181> [https://perma.cc/VV52-WT9X].

507. *See id.*

508. *Id.*

509. *Id.*

510. *Id.*; *see also* *Robinson v. California*, 370 U.S. 660 (1962) (holding that statutes criminalizing addiction to the use of narcotics violate the Fourteenth Amendment’s bar against cruel and unusual punishment).

drug initiatives. And this is a powerful idea, for encouraging “experimental drug law reform” at the state level will yield the dual benefit of helping less progressive states, and the federal government, observe how “smarter, more effective” approaches to drug addiction may alleviate the costs they incur upon jurisdictions nationwide.⁵¹¹ It is one thing for the public to disbelieve in War on Drugs programming and quite another for municipalities to employ cost efficiency principles to effectively engender their own species of drug decriminalization.

This is how executive War on Drugs priorities find their greatest threat from nonbelieving local jurisdictions. The type of political will sufficiently potent to upturn federally programmed norms has typically brewed first at the local level, then has gradually made its way into national policy either via the legislature, the judiciary, or by civilly disobedient local government policies.⁵¹² We have witnessed this occur with cannabis, where Colorado’s and Washington’s decriminalization efforts have challenged federal War on Drugs objectives since 2012.⁵¹³ Lay the heat map of states that have suffered the most fatal opioid poisonings⁵¹⁴ over the map of states that have decriminalized cannabis,⁵¹⁵ and one observes that they are nearly mutually exclusive. This is not mere coincidence. According to one JAMA Internal Medicine study, “states with medical marijuana laws between 1999 and 2010 saw, on average, about 25 percent fewer opiate overdose deaths” than did states without them.⁵¹⁶ And for their flagrant acts of civil diso-

511. Whitelaw, *supra* note 484, at 113.

512. See Lawson, *supra* note 29.

513. See Scott Johnston, *Five Years In: The Effects of Legalization in Colorado and Washington State*, LIFT NEWS (Nov. 13, 2017), <https://news.lift.co/five-years-effects-legalization-colorado-washington-state/> [<https://perma.cc/VX9W-83E7>].

514. See FRANK, PORTER & PAULOZZI, *supra* note 200.

515. See *State Marijuana Laws in 2018 Map*, GOVERNING, <http://www.governing.com/gov-data/state-marijuana-laws-map-medical-recreational.html> [<https://perma.cc/9YBR-LUAN>] (last visited Aug. 10, 2018).

516. Christopher Ingraham, *Attorney General Sessions Wants to Know the Science on Marijuana and Opioids. Here It Is*, WASH. POST (Feb. 28, 2017), https://www.washingtonpost.com/news/wonk/wp/2017/02/28/attorney-general-sessions-wants-to-know-the-science-on-marijuana-and-opioids-here-it-is/?noredirect=on&utm_term=.76cfd9f61998 [<https://perma.cc/P66C-X2EL>] (referencing Marcus A. Bachhuber, Brendan Saloner, Chinazo O. Cunningham, et al., *Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999-2010*, 174 JAMA INTERN MED. 1668 (2014)).

bedience, Washington and Colorado were not visited upon by the Department of Justice,⁵¹⁷ but handsomely rewarded. Washington has generated \$220 million in cannabis taxes, Colorado \$129 million, and neither state noted any worrisome increases in crime and substance abuse.⁵¹⁸ The legal marijuana market is expected to reach \$23 billion in annual revenue by 2020⁵¹⁹—an unsurprising figure when the federal legalization of marijuana may not be far behind.⁵²⁰ The Marijuana Justice Act, if enacted, would limit funding for states if the Bureau of Justice Assistance determines that the state “has a disproportionate arrest rate or a disproportionate incarceration rate for marijuana offenses,”⁵²¹ direct federal courts to “expunge conviction[s] for a marijuana use or possession offense,”⁵²² and “establish a grant program to reinvest in communities most affected by the war on drugs.”⁵²³

The United States of Drug Criminalization has produced an economy where states are able to, quite literally, legalize one drug to compensate for the economic, health, and social costs of criminalizing another.⁵²⁴ When states’ cost-benefit analyses have already begun to carve out exceptions to the War on Drugs—and as restorative justice principles continue to seep into our national drug policies, via federal legislation, no less—for how long will our federal government insist on its survival?

517. Press Release, U.S. Dep’t of Justice, Justice Department Issues Memo on Marijuana Enforcement (Jan. 4, 2018), <https://www.justice.gov/opa/pr/justice-department-issues-memo-marijuana-enforcement> [<https://perma.cc/W7MK-K38D>].

518. Christopher Ingraham, *Here’s How Legal Pot Changed Colorado and Washington*, WASH. POST (Oct. 13, 2006), https://www.washingtonpost.com/news/wonk/wp/2016/10/13/heres-how-legal-pot-changed-colorado-and-washington/?utm_term=.e053611ba487 [<https://perma.cc/5DSX-HNYG>].

519. Trevor Hughes, *Legal Marijuana Sales Forecast to Hit \$ 23 Billion in Four Years*, USA TODAY (Mar. 20, 2016), <http://www.usatoday.com/story/money/business/2016/03/20/legal-marijuana-sales-forecast-hit-23b-4-years/82046018/> [<https://perma.cc/W34E-RC7S>].

520. See Marijuana Justice Act of 2019, S. 597, 116th Cong. (2019).

521. *Id.* § 3(b).

522. *Id.* § 3(c).

523. *Id.* § 4.

524. David DiSalvo, *How Cash from Marijuana Legalization Can Help Kill the Opioid Epidemic*, FORBES (May 31, 2017), <https://www.forbes.com/sites/daviddisalvo/2017/05/31/how-cash-from-legal-pot-sales-can-help-kill-the-opioid-epidemic/#2e290c1b5135> [<https://perma.cc/5BKD-UR9H>].

IV. CONCLUSION

Legal and illegal opioids have killed off more Americans than war. And as Americans rapidly progressed from FDA-approved opioid use to illicit heroin and fentanyl, the trajectory of overdose deaths far exceeded increases in new prescription drug users.

But as we search for solutions to our crisis, we forget to refer to our own history with addiction and assume that the chemical hook theory applies in every case. We prefer promises of immediate relief over the task of remembering that the myth of addiction's intractability is what allows the Iron Law of Prohibition to generate lethally potent doses, then deliver them to a depressed America that has been the most "un-Rat Park" it has been in decades. We do so to give ourselves the space to both judge and express compassion towards the drug-addicted. But our ambivalence elects leaders who help us further ignore what global addiction history has to say about our own: that our America is the worst it has been in a while, and that our epidemic is one undergirded by rational demand.

Experienced policymakers herald the necessity of treating drug abuse with evidence-based solutions, but we ignore their pleas for evidenced-based treatment and access, even when the mostly rural and white fatalities of our crisis would suggest greater political amenability to the public health approach. We reject holistic conceptualizations of our crisis because it better serves those in power to drum power from the fear of addiction. We reject them also because our capitalistic reality and cultural appreciation for retribution persuades us to believe that blame-gaming Big Pharma is what will help America feel great again, even when supply-side interdictions have done little to decrease demand, and have failed to economically deter those who oversupply. And by bifurcating the issues of legal versus illegal supply, we implicitly permitted Big Pharma's overcapitalization on demand while exhausting our criminal justice system, dealing fatal blows to our faith in the effectiveness of drug criminalization as sound public policy.

We watch countries like Portugal and Switzerland benefit from discarding ineffective War on Drugs policies, and hope that our patchwork of politically facile initiatives will yield the same effect. And we invest hope in futile directions because we

misunderstand the greatest negative externality of our epidemic to be the golden eggs of death, when it is actually the golden goose of the black-market drugs economy. We abide in the power of prohibition, even as it flattens the complexity of drug addiction into a two-dimensional failure of Victorian restraint, because it allows us to circumvent analysis of drug addiction as an expression of rational demand. But if we were to understand our demand for analgesic relief better, and had faith that addicts, like us, are rational consumers, we could sin tax their behaviors, which would also deter children from stepping onto the slippery slope of addiction and disincentivize long-term users.

In the end, it may be the cash-strapped states that homebrew the strongest challenges to the War on Drugs, for the Achilles heel of federal prohibition initiatives is that they require local jurisdictions to enforce. So, we should mimic the counties that have effectively engendered their own species of decriminalization as a way of financing the costs incurred by the drug criminalization generally. We should support states like California, who are best situated to attempt heroin decriminalization and to profit from it, much like recreational cannabis has yielded hundreds of millions of dollars in profits for other civilly disobedient jurisdictions. And we should take the advice of our U.S. Surgeon General and American Medical Association to erect safe injection sites, increase access to naloxone and medication-assisted treatment, and continue passing bipartisan proposals like the SUPPORT for Patients and Communities Act. For without reexamining our battle with opioids as a story of demand *and* supply, we will continue to fail ourselves, and the War on Drugs will win again.