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THE "NEW" DRUG WAR

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American policymakers have long waged a costly, punitive, racist, and ineffective drug war that casts certain drug use as immoral and those who engage in it as deviant criminals. The War on Drugs has been defined by a myopic focus on controlling the supply of drugs that are labeled as dangerous and addictive. The decisions as to which drugs fall within these categories have neither been made by health agencies nor based on scientific evidence. Instead, law enforcement agencies have been at the helm of the drug war advocating for and enforcing prohibition.

The drug war has been a failure on all counts. American taxpayers have invested trillions of dollars in the war, yet the United States continues to witness record-setting numbers of drug overdose deaths every year. The drug war has been used as a tool to disenfranchise and incarcerate generations of individuals minoritized as Black. Black Americans are nearly six times more likely to be incarcerated for drug-related offenses than their white counterparts, notwithstanding that substance use rates are comparable across those populations.

The public rhetoric concerning drug use has notably changed in recent years. Many policymakers have replaced the punitive, law-and-order narratives of the Old Drug War with progressive, public-health-oriented language, which suggests that the Old Drug War has ended. We, however, caution against such a conclusion. This paper examines three categories of laws and policies that attend to individuals who use drugs under our country's new, and purportedly public-health-centric, approach: (1) laws that increase surveillance of certain drugs or those who use them; (2) the criminalization and civil punishment of the

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symptoms or behaviors related to drug use; and (3) laws that decrease access to treatment and harm reduction programs.

Our assessment of these policies demonstrates that the War on Drugs is not over. It has merely been retooled, recalibrated, and reframed. The "New" Drug War may be concealed with public-health-promoting rhetoric, but it is largely an insidious re-entrenchment of the country's longstanding, punitive approach to drug use.

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INTRODUCTION

Since the 1800s, American policymakers have waged a racist,[1] costly,[2] and punitive[3] drug war that characterizes some drug use as morally reprehensible behavior and those who engage in it as deviant criminals.[4] The War on Drugs[5] myopically focuses on controlling the supply of drugs deemed dangerous and addictive through prohibition and deterring their sale and possession through arrest and incarceration.[6] American government officials' simplistic justifications for centering drug policy around supply control include their commitment to the notion that people

[1] andré douglas pond cummings & Steven A. Ramirez, Roadmap for Anti-Racism: First Unwind the War on Drugs Now, 96 Tul. L. Rev. 469, 469–70 (2022) ("The War on Drugs (WOD) transmogrified into a war on communities of color early in its history, and its impact has devastated communities of color first and foremost. People of color disproportionately suffer incarceration in the WOD even though people of color use illegal narcotics at substantially lower rates than white Americans." (footnotes omitted)); Paul Butler, Chokehold: Policing Black Men 122 (2017) (noting "that 'the war on drugs' has been selectively waged against African Americans. . . . For drug crimes, African Americans are about 13 percent of people who do the crime, but about 60 percent of people who do the time.").

[2] Juhohn Lee, America Has Spent Over a Trillion Dollars Fighting the War on Drugs. 50 Years Later, Drug Use in the U.S. Is Climbing Again, CNBC (June 17, 2021, 1:15 PM), https://www.cnbc.com/2021/06/17/the-us-has-spent-over-a-trillion-dollars-fighting-war-on-drugs.html [https://perma.cc/9BAL-Y45A].

[3] Nkechi Taifa, Race, Mass Incarceration, and the Disastrous War on Drugs, Brennan Ctr. for Just. (May 10, 2021), https://www.brennancenter.org/our-work/analysis-opinion/race-mass-incarceration-and-disastrous-war-drugs [https://perma.cc/54XD-6FGH] (explaining how increasingly punitive drug "laws flooded the federal system with people convicted of low-level and nonviolent drug offenses"); Michelle Alexander, The New Jim Crow: Mass Incarceration in the Age of Colorblindness 6–11 (rev. ed. 2020) (detailing how the War on Drugs led to mass incarceration).

[4] Taleed El-Sabawi, Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition, 48 U. Mem. L. Rev. 1357, 1390–91 (2018) [hereinafter El-Sabawi, Defining the Opioid Epidemic].

[5] Michael Tonry, Race and the War on Drugs, 1994 U. Chi. Legal F. 25, 25–26 (1994) (defining the War on Drugs as an initiative reinforced by the Reagan and Bush Administrations to reduce drug trade and use by means of education and treatment components with much emphasis on law enforcement).

[6] Taleed El-Sabawi & Jennifer Oliva, The Influence of White Exceptionalism on Drug War Discourse, 94 Temp. L. Rev. 649, 649 (2022); see David T. Courtwright, A Century of American Narcotic Policy, *in* 2 Treating Drug Problems 1, 42 (Dean R. Gerstein & Henrick J. Harwood eds., 1992) ("The sense that illicit drug trafficking and use were out of control led to the present war on drugs."); Mona Lynch, Theorizing the Role of the 'War on Drugs' in US Punishment, 16 Theoretical Criminology 175, 178–79 (2012) (describing specific legislation that criminally punishes both possession and sale of drugs based on "their combined medical value, harmfulness to health, and addictive properties").

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only use drugs because they are available and, once they are no longer available, people will neither initiate nor continue drug use.[7]

Upon superficial examination, limiting access to potentially dangerous drugs sounds like a promising approach to address drug misuse and poisoning problems. A litany of actual evidence, however, suggests that supply control measures steeped in criminal legal theories of deterrence are ineffective at decreasing overdoses and substance use disorders.[8] This is because those tactics fail to address any of the underlying causes of drug demand, facilitate an unpredictable and ever more dangerous drug supply, and often result in the substitution of one drug for another, more potent drug.[9]

Interdiction efforts alone have cost American taxpayers more than a trillion dollars over the last several decades.[10] Federal, state, and local governments spend an estimated 47.9 billion dollars annually on drug enforcement.[11] Despite the substantial funding dedicated to the War on Drugs, American overdose deaths have reached historic levels. According to the Centers for Disease Control and Prevention, the United States

[7] Nat'l Rsch. Council, Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us 139 (Charles F. Manski, John V. Pepper & Carol V. Petrie eds., 2001).

[8] See, e.g., Ojmarrh Mitchell, Ineffectiveness, Financial Waste, and Unfairness: The Legacy of the War on Drugs, 32 J. Crime & Just. 1, 7–10 (2009); Evan Wood et al., Impact of Supply-Side Policies for Control of Illicit Drugs in the Face of the AIDS and Overdose Epidemics: Investigation of a Massive Heroin Seizure, 168 Canadian Med. Ass'n J. 165, 168 (2003).

[9] Leo Beletsky & Corey S. Davis, Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited, 46 Int'l J. Drug Pol'y 156, 156–58 (2017); see also Johanna Catherine Maclean, Justine Mallatt, Christopher J. Ruhm & Kosali Simon, Economic Studies on the Opioid Crisis: A Review 1, 15, 19 (Nat'l Bureau of Econ. Rsch., Working Paper No. 28067, 2021), https://www.nber.org/system/files/working_papers/w28067/w28067.pdf [https://perma.cc/FRN9-D7WB] (explaining that opioid "overdose deaths rose 9.1 percent from March 2019 to March 2020" despite "policy efforts to address the crisis," certain prescription drug monitoring programs "lead[] to increased heroin-related crime," and that other programs addressing OxyContin misuse "spurred development of illicit drug markets"); Meghan Peterson et al., "One Guy Goes to Jail, Two People Are Ready to Take His Spot": Perspectives on Drug-Induced Homicide Laws Among Incarcerated Individuals, 70 Int'l J. Drug Pol'y 47, 52 (2019) (concluding that drug policies were "not . . . effective in mitigating overdose risk and could induce harm" instead).

[10] Christopher J. Coyne & Abigail R. Hall, Four Decades and Counting: The Continued Failure of the War on Drugs, 811 Cato Inst. Pol'y Analysis, Apr. 2017, at 1, 19, https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf [https://perma.cc/LA3Z-VSUU].

[11] Jeffery Miron, The Budgetary Effects of Ending Drug Prohibition, 83 Cato Inst. Tax & Budget Bull., July 23, 2018, https://www.cato.org/tax-budget-bulletin/budgetary-effects-ending-drug-prohibition [https://perma.cc/WN7F-PRPQ].

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suffered a record 107,941 overdose deaths—the highest number of such fatalities ever cataloged in a single calendar year—in 2022.[12]

The War on Drugs is not only costly. It has failed to mitigate both the escalating drug overdose deaths and the myriad poor health outcomes associated with chaotic drug use.[13] The War on Drugs is also racist.[14] In 2016, one of President Nixon's top aides admitted that the War on Drugs was motived by Nixon's desire to subordinate and disenfranchise Black persons and the antiwar left, whom Nixon identified as political enemies.[15] The War on Drugs is, and always has been, fueled by stereotypical myths, racist beliefs, and a desire for political and societal

[12] Merianne R. Spencer, Matthew F. Garnett & Arialdi M. Miniño, Drug Overdose Deaths in the United States, 2002–2022, 491 Nat'l Ctr. Health Stats. Data Brief 1, 1 (Mar. 2024), https://www.cdc.gov/nchs/data/databriefs/db491.pdf [https://perma.cc/5Q7J-4BBR]; Deidre McPhillips, US Drug Overdose Deaths, Fueled by Synthetic Opioids, Hit a New High in 2022, CNN (May 18, 2023, 11:27 AM), https://www.cnn.com/2023/05/18/health/drug-overdose-deaths-2022 [https://perma.cc/34SG-S3S7].

[13] Sessi Kuwabara Blanchard, The Beginner's Guide to Harm Reduction, Healthline (Aug. 30, 2021), https://www.healthline.com/health/substance-use/harm-reduction [https://perma.cc/KEH6-LRH8] (explaining that substance use is experienced on a spectrum that varies from managed to chaotic use and defining chaotic use as "consumption [that] is no longer bound by self-regulation" where "the negative effects on [an individual's] life outweigh the original benefits . . . from consuming drugs").

[14] See, e.g., John Hudak, Biden Should End America's Longest War: The War on Drugs, Brookings Inst. (Sept. 24, 2021), https://www.brookings.edu/articles/biden-should-end-americas-longest-war-the-war-on-drugs/ [https://perma.cc/GCK7-JEAW] ("Despite its dramatic policy failures, the War on Drugs has been wildly successful in one specific area: institutionalizing racism. The drug war was built on a foundation of racism and xenophobia.").

[15] Dan Baum, Legalize It All: How to Win the War on Drugs, Harper's Mag. (Apr. 2016), https://harpers.org/archive/2016/04/legalize-it-all/ [https://perma.cc/W73S-PTNX]. Moreover, the harshness of the criminal penalties associated with a drug's possession have been driven not by the "dangerousness" of the drug so much as the racial characteristics associated with the people who use that substance. Kenneth B. Nunn, Race, Crime and the Pool of Surplus Criminality: Or Why the "War on Drugs" Was a "War on Blacks," 6 J. Gender, Race & Just. 381, 396–98 (2002) (explaining that the dramatic federal sentencing disparity between crack and powder cocaine was unjustified from a physiological perspective because each is simply a different form of the same drug and that, instead, the dramatically more harsh criminal penalties that attended to crack cocaine were based on its use association with Black people (and, concomitantly, that the relatively less harsh criminal penalties that attended to powder cocaine were based on its use association with white people)); Brittany Arsiniega, Teresa Cosby, Spencer Richardson & Kylie Berube, Race and Prohibition Movements, 11 Tenn. J. Race, Gender & Soc. Just. 16, 19 (2021) ("Those drugs associated with minorities have been viewed by governmental majorities (and the public at large) as more harmful or dangerous than those consumed by white people and criminalized accordingly. Examples include crack cocaine versus powder cocaine and consumption of opium by smoking (associated with Chinese immigrants) versus oral consumption (associated with white people)." (footnotes omitted)).

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control of racial minorities and others opposed to failed law and order-driven drug policies.[16]

Evidenced by the framing of the current overdose crisis as a public health issue rather than a criminal legal problem, some argue that the War on Drugs is on the wane.[17] There is no doubt that the rhetoric that drives the drug war has changed in recent years as policymakers have adopted "health-oriented" language to describe what has been popularly characterized as the "opioid overdose crisis."[18] A common refrain from both policymakers and law enforcement has been: "We cannot arrest our way out of this crisis."[19] This change in framing is due, at least in part, to the rampant whitewashing of prescription opioid misuse.[20] Moreover,

[16] See, e.g., Helena Hansen, Jules Netherland & David Herzberg, Whiteout: How Racial Capitalism Changed the Color of Opioids in America 36, 59 (2023) [hereinafter Hansen et al., Whiteout] (explaining that "[i]nherent in the effort of . . . policy makers . . . to distinguish licit from illicit drugs is an unspoken racial symbolism of white biology and Black crime" and "[f]or the last fifty years, . . . policy makers have invested heavily in the association between Black and Brown communities and illicit drug use and have used the threat of drugs to ramp up fears about Black and Brown people and to craft increasingly punitive policies that have been effective tools of racial targeting and control").

[17] Brian Mann, After 50 Years of the War on Drugs, 'What Good Is It Doing for Us?', NPR (June 17, 2021, 5:00 AM), https://www.npr.org/2021/06/17/1006495476/after-50-years-of-the-war-on-drugs-what-good-is-it-doing-for-us [https://perma.cc/79UT-CQ2A] (contending that, in response to the current overdose crisis, "some of the most severe policies implemented during the drug war are being scaled back or scrapped altogether" "[i]n many parts of the U.S.," while admitting that "much of the drug war's architecture remains intact").

[18] Taleed El-Sabawi, The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis, 11 Ne. U. L. Rev. 372, 380, 395 (2019) (finding that a health-oriented approach was used by pressure groups during congressional hearings on the opioid crisis from 2014–2016); see also Max Weiss & Michael Zoorob, Political Frames of Public Health Crises: Discussing the Opioid Epidemic in the US Congress, 281 Soc. Sci. & Med., 2021, at 1, 4–7 (describing the steady rise of overdoses as an "opioid-epidemic" and the responses from the U.S. Congress).

[19] See, e.g., Nabarun Dasgupta, We Can't Arrest Our Way Out of Overdose: The Drug Bust Paradox, 113 Am. J. Pub. Health 708, 708 (2023) (explaining that "[i]n speaking with police about preventing overdose, the officers' common refrain is 'We aren't going to arrest our way out of this'"); Press Release, Dick Durbin, Sen., U.S. Senate, Durbin, Duckworth Announce $1.2 Million for Kane County Diversion Program (Dec. 22, 2021), https://www.durbin.senate.gov/newsroom/press-releases/durbin-duckworth-announce-12-million-for-kane-county-diversion-program [https://perma.cc/ULU7-2EG5] (stating "we can't arrest our way out of" the overdose crisis); Andrea Cipriano, Rural Sheriffs: 'We Can't Arrest Our Way Out of the Opioid Crisis,' Crime Rep. (Jan. 20, 2021), https://thecrimereport.org/2021/01/20/rural-sheriffs-we-cant-arrest-our-way-out-of-the-opioid-crisis/ [https://perma.cc/NXV9-U5Y3].

[20] See generally Julie Netherland & Helena B. Hansen, The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse, 40 Cult. Med. & Psych. 664 (2016) (maintaining that when people who use drugs are

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given that Congress has enacted at least two significant pieces of legislation since 2016 to address the crisis that include provisions that are predominantly health-centric,[21] perhaps the dominant and most visible political response to the "opioid crisis" was a "[w]ar on [d]rugs [t]hat [w]asn't."[22]

We nonetheless caution against any conclusion that the War on Drugs has ended. It has not. It has merely been retooled, recalibrated, and reframed by health-centric rhetoric. New policy proposals aimed at addressing the current overdose crisis may appear more public-health-oriented, and we concede that some are,[23] but an insidious re-entrenchment of the punitive approach to drug use walks in lockstep with those highly publicized public health measures.

Part I of this Article provides an overview of the key features of the Old Drug War with an emphasis on the racism endemic to its purposes. Part II enumerates the extravagant failures of the punitive, supply-side-centric Old Drug War, explaining why its tactics ensure an increasingly dangerous and deadly American drug supply. Part III of this Article deploys three categories of recent laws and policies to demonstrate that the United States persists in waging a punitive and predominantly supply-side War on Drugs cloaked in health-oriented rhetoric.

Part III proceeds in three Sections. Section III.A gives an overview of state laws that provide law enforcement with new data and evidence for criminal prosecution through enhanced controlled substance surveillance.

depicted as white, the policy proposals presented are more likely to be public-health-centered than punitive).

[21] See generally Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, 130 Stat. 695 (prescribing training for first responders, additional addiction treatment for veterans and families, expanding the education and prevention policies, and other methods to fight the opioid crisis); Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018) (expanding Medicaid and Medicare provisions "to address the opioid crisis").

[22] Julie Netherland & Helena Hansen, White Opioids: Pharmaceutical Race and the War on Drugs That Wasn't, 12 Biosocieties 217, 217 (2017).

[23] For example, in 2021, for the first time in history, former Acting Director of the Office of National Drug Control Policy Regina LaBelle included harm reduction (a public health approach to addressing chaotic drug use defined by meeting people where they are and striving to reduce the health harms of drug use) as one of the executive branch's strategic priorities to address overdose deaths. Press Release, Regina LaBelle, Acting Director, White House Office of Nat'l Drug Control Pol'y, Statement from Acting Director Regina LaBelle on Today's CDC Overdose Death Data (Oct. 13, 2021), https://www.whitehouse.gov/ondcp/briefing-room/2021/10/13/statement-from-acting-director-regina-labelle-on-todays-cdc-overdose-death-data-4/ [https://perma.cc/83DB-URSX].

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While policymakers have couched such surveillance as an effort to improve health outcomes, it has motivated a marked decrease in the prescribing of opioid analgesics and, as a result, driven many patients in legitimate medical need of such prescription drugs to the illicit (and more dangerous) market. Increased surveillance has been accompanied by the highly publicized prosecution of prescribers, a chilling effect on providers, and the neglect and abandonment of patients in chronic and intractable pain. Such patients are frequently labeled as drug-seekers and deviants unworthy of treatment in the American health care system. We further detail how the algorithms purportedly used to quantify patient drug use risks are steeped with racial and gender prejudice and discriminate against individuals with disabilities.

Section III.B delineates and analyzes certain criminal and civil punishment enhancements of the New Drug War. It explains that several states have enacted new criminal laws that make it easier to charge persons with drug-induced homicide ("DIH") for overdose deaths and posits that the aggressive enforcement of such laws may lead to an increase in drug-related fatalities and disparately impact individuals minoritized as Black. This Section also points to the federal government's recent use of fentanyl-related product scheduling to enhance the criminal penalties for drug use and distribution. Section III.B concludes by elaborating on the significant civil collateral consequences experienced by individuals who use drugs due to punitive child welfare and drug testing laws and policies.

Section III.C explains how New Drug War policies continue to create obstacles to evidence-based treatment and harm reduction resources for individuals who use drugs. This Section explains that policymakers remain resistant to reducing the numerous and burdensome federal laws and policies that govern access to opioid use disorder ("OUD") medications—the gold-standard treatment for OUD—and contends that those policies exacerbate the country's escalating overdose crisis. This Section further details America's ongoing battles against and opposition to the operation and funding of two specific evidenced-based harm reduction programs that have been proven effective in reducing overdose fatalities and the health and safety harms associated with drug use: syringe services programs and overdose prevention centers.

The three categories of "New" Drug War laws and policies that are showcased in Part III of this article—enhanced surveillance, enhanced criminalization and civil punishment, and ongoing obstacles to treatment

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and harm reduction—demonstrate that our "New" Drug War is simply an extension of its predecessor disguised by a public health promotional campaign. Simply stated, the popularity of a predominantly punitive, supply-side, law-enforcement-centric drug policy approach persists despite ample evidence that its core tactics are woefully ineffective. Before diving into a discussion about the very familiar characteristics of our "New" Drug War, we turn first to an overview of the old one, which is provided in the following Part.

I. THE OLD DRUG WAR

"The drug war has been called America's longest war, and appropriately so, given that its antecedents trace back a century or more."[24]

President Richard Nixon is commonly credited with initiating our modern War on Drugs in the 1970s by characterizing drug use as "public enemy number one."[25] In 1994, journalist Dan Baum interviewed John Ehrlichman, who had served as White House Counsel and Assistant to the President for Domestic Affairs in the Nixon Administration.[26] When Baum queried Ehrlichman about the impetus for the drug war, he responded as follows:

> The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. . . . We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.[27]

The racism endemic in America's efforts to control the drug supply through prohibition, however, can be traced back to policy responses to

[24] Erik Luna, Drug War and Peace, 50 U.C. Davis L. Rev. 813, 813 (2016) (footnote omitted).

[25] See, e.g., Jelani Jefferson Exum, Reconstruction Sentencing: Reimagining Drug Sentencing in the Aftermath of the War on Drugs, 58 Am. Crim. L. Rev. 1685, 1686 (2021) (observing that "[t]he War on Drugs officially began in 1971 when President Nixon targeted drug abuse as 'public enemy number one'").

[26] Baum, supra note 15.

[27] Id.

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the country's first opiate epidemic in the 1800s.[28] The first group of Americans who developed opioid use disorder were white, middle-aged, middle- and upper-class women who became addicted to morphine prescribed by their physicians to address an array of physical and mental health issues.[29] These patients tended to ingest their morphine through medicinal tinctures and, subsequent to the invention of the hypodermic syringe, also used the drug intravenously.[30]

Notwithstanding the substantial consumption of morphine by middle-class white women, America's first drug prohibition laws targeted opium smoking, a method of opiate delivery that was associated with immigrant Chinese men and, thus, vilified.[31] San Francisco enacted an ordinance in 1875 that criminalized maintaining or visiting "opium dens," which were primarily operated by Chinese immigrants.[32] Shortly thereafter, and fueled by a virulent anti-Chinese fervor, the United States Congress enacted the Chinese Exclusion Act of 1882, which forbade Chinese laborers from immigrating to the country and Chinese immigrants from naturalizing.[33] Morphine, by contrast, remained licit and marginally

[28] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1388; Jennifer D. Oliva, Dosing Discrimination: Regulating PDMP Risk Scores, 110 Calif. L. Rev. 47, 53–56 (2022) [hereinafter Oliva, Dosing Discrimination].

[29] Caroline Jean Acker, Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control 1 (2002) (pointing out that, in the 1800s, opiate "patients and customers were most typically middle-class, middle-aged women taking morphine to relieve the pain of menstrual cramps or assuage domestic or social anxieties"); see also David T. Courtwright, The Hidden Epidemic: Opiate Addiction and Cocaine Use in the South, 1860–1920, 49 J.S. Hist. 57, 63 (1983) [hereinafter Courtwright, The Hidden Epidemic] (asserting that "postbellum southern whites, as a group, suffered an exceedingly high rate of opiate addiction" and "[o]piates were thus extremely popular as a way of offering temporary relief for a wide variety of ailments; they were in fact used as a virtual panacea").

[30] David T. Courtwright, Dark Paradise: A History of Opiate Addiction in America 46–47 (2001) [hereinafter Courtwright, Dark Paradise]; see also Courtwright, The Hidden Epidemic, supra note 29, at 63 ("If the opiates were popular at mid-century, they were even more so after the 1860s and 1870s, when the spread of hypodermic medication gave doctors a powerful new technique for administering morphine, whose soothing, analgesic effects were almost immediately felt.").

[31] Oliva, Dosing Discrimination, supra note 28, at 55–56; El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1398–99.

[32] See Roseann B. Termini & Rachel Malloy-Good, 50 Years Post-Controlled Substances Act: The War on Drugs Rages on with Opioids at the Forefront, 46 Ohio N.U. L. Rev. 1, 4 (2020) ("Thousands of people on the California coast frequented these [Chinese-operated opium] dens and, by 1875, San Francisco passed an ordinance making it a misdemeanor to have or visit an opioid den.").

[33] Chinese Exclusion Act, Pub. L. No. 47-126, 22 Stat. 58 (1882); see also Angela M. Banks, Respectability & the Quest for Citizenship, 83 Brook. L. Rev. 1, 12 (2017) (summarizing the

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regulated throughout the antebellum era due, at least in part, to successful lobbying by physicians, pharmacists, and early patent drug manufacturers.[34] Indeed, it was conventional during the time to treat the symptoms of opiate use disorder in white women as a medical concern while attributing Chinese men's practice of smoking opium to their purportedly deviant nature.[35]

Black men were similarly cast as deviants for whom drug use delivered superhuman strength and "increased . . . sexual proclivity."[36] In addition, arguments that advanced the criminalization of cocaine use by Black persons often were accompanied by tales of threats to the safety of white women at the hands of othered and subordinated groups.[37] Early iterations of the War on Drugs labeled racialized and marginalized groups who used drugs, such as opium or cocaine, as morally corrupt persons who threatened the well-being of white Americans.[38] As one researcher explains:

> Since the mid-1800[s], media representations of drug users and traffickers in the US have centred on what is perceived as the "dangerous classes" and racial minorities as the "Other." Drug traffickers are constructed as 'outsiders' that threaten the world order of white, middle-class protestant morality. They are depicted as

legislative history of the Chinese Exclusion Act and explaining that federal legislators "argued that Chinese immigrants threatened American society because of their different values, norms, and practices" (footnote omitted)).

[34] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1394, 1397–1400.

[35] Id. at 1397–98.

[36] Id. at 1390–91; see also Courtwright, Dark Paradise, supra note 30, at 95 ("Some authorities charged that blacks, crazed by cocaine, went on superhuman rampages of violence, allegations that have since been denied."); David F. Musto, The American Disease: Origins of Narcotic Control 7 (Oxford Univ. Press 3d ed. 1999) (1973) (explaining that "[w]hite alarm" over Black drug use and the theory that drug use would cause Black men to rape white women was generated by "anticipation of African American rebellion" for segregation, lynchings, and Jim Crow laws).

[37] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1390–91; Douglas Flowe, "Drug-Mad Negroes": African Americans, Drug Use, and the Law in Progressive Era New York City, 20 J. Gilded Age & Progressive Era 503, 505–06 (2021).

[38] See J. Matthew Gorga, "Retribution, Not a Solution": Drug-Induced Homicide in North Carolina, 42 Campbell L. Rev. 161, 165–66 (2020) ("The nation's first drug laws were less about the dangers of the drugs and more about the people associated with them." In fact, "[t]hose advocating for the Harrison Act's passage perpetuated false and racially fueled narratives—black men under the influence of drugs 'murdering whites,' 'degenerate Mexicans smoking marijuana,' and '"Chinamen" seducing white women.'" (quoting Joseph D. McNamara, The American Junkie, Hoover Inst. (Apr. 30, 2004), https://www.hoover.org/research/american-junkie [https://perma.cc/499C-H8UZ])).

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> dangerous, out of control, and a threat to the nation, the family and white women's morality. . . . The white public viewed early drug legislation as a justifiable tool to regulate identified racialised populations.[39]

Such drug-use-deviancy narratives and their resulting policies were magnified by the temperance movement and alcohol prohibition.[40] The temperance movement was a moral crusade that relied heavily on the depiction of intoxication as sinful and morally bereft.[41] Temperance advocates promoted abstinence from alcohol as well as other habit-forming substances.[42] Similar to previous moral panics about drugs, the othering of immigrant working-class populations that frequented saloons during Prohibition provided fodder to the narrative that substance use was a deviant behavior.[43] As author John Hudak recently noted, "the historical foundation of drug policy in the United States was to vilify African Americans, Native Americans, immigrants from Asia and Mexico, and other outgroups, and to turn White America against each."[44]

Temperance proponents advocated for and successfully secured national prohibition of the manufacture, sale, and transportation of alcoholic beverages from 1920–1933 with the ratification of the Eighteenth Amendment and the enactment of its enforcement statute, the Volstead Act.[45] While national alcohol prohibition was ultimately rejected by the repeal of the Eighteenth Amendment, the characterization of non-medical drug use as deviant behavior deserving of punishment outlasted the ban on alcohol and influenced drug law and policy for

[39] Susan Boyd, Media Constructions of Illegal Drugs, Users, and Sellers: A Closer Look at *Traffic*, 13 Int'l J. Drug Pol'y 397, 397 (2002).

[40] See generally Jayesh M. Rathod, Distilling Americans: The Legacy of Prohibition on U.S. Immigration Law, 51 Hous. L. Rev. 781 (2014) (discussing how fears and stereotypes about immigrants ultimately motivated alcohol-related regulation in U.S. immigration law).

[41] W.J. Rorabaugh, Reexamining the Prohibition Amendment, 8 Yale J.L. & Humans. 285, 288 (1996).

[42] David T. Courtwright, A Short History of Drug Policy or Why We Make War on Some Drugs but Not on Others, *in* LSE Ideas: Governing the Global Drug Wars 17, 18–19 (2012).

[43] Andrew Moore, The Arc of Reform?: What the Era of Prohibition May Tell Us About the Future of Immigration Reform, 28 Geo. Immigr. L.J. 521, 525–29 (2014); Molly Banta, What Prohibition Can Teach Us About Immigration Reform, Wilson Q., https://www.wilsonquarterly.com/quarterly/_/what-prohibition-can-teach-us-about-immigration-reform [https://perma.cc/6AVX-ZZTJ] (last visited Apr. 9, 2024).

[44] Hudak, supra note 14.

[45] Wayne Hall, What Are the Policy Lessons of National Alcohol Prohibition in the United States, 1920–1933?, 105 Addiction 1164, 1164–65 (2010).

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generations to come.[46] Historians have convincingly contended that the temperance movement and its attendant policies constitute the nation's first true War on Drugs.[47]

In the early 1900s, Harry Anslinger, the inaugural director of the Federal Bureau of Narcotics, the predecessor agency to the Drug Enforcement Administration ("DEA"), borrowed the rhetoric of the temperance movement and launched a drug war that lasted throughout his thirty-two-year career in the federal bureaucracy.[48] Anslinger had worked at the Prohibition Department, the federal agency tasked with enforcing alcohol prohibition, and, therefore, was intimately familiar with the narratives deployed by temperance advocates.[49] He adopted similar rhetoric to launch a war on cannabis[50]—a drug that was already unpopular in the United States because of its association with Mexican immigrants.[51]

[46] Lisa McGirr, The War on Alcohol: Prohibition and the Rise of the American State, at xxii (2016) ("The government did not retreat from its new role in crime control after the end of the war on alcohol. Its punitive approach to recreational narcotics persisted and expanded in new directions, building on the lessons learned from federal alcohol Prohibition."); Craig Reinarman, The Social Construction of Drug Scares, *in* Constructions of Deviance: Social Power, Context, and Interaction 140, 142–43 (Patricia A. Adler & Peter Adler eds., 5th ed. 2006), https://sociology.ucsc.edu/research/emeriti-publications/reinarman-2006-social-construction-drug-scares.pdf [https://perma.cc/GC2A-M6Q2].

[47] McGirr, supra note 46, at 250–54.

[48] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1373, 1406.

[49] See Jackson Tarricone, Harry J. Anslinger and the Origins of the War on Drugs, Bos. Pol. Rev. (Sept. 4, 2020), https://www.bostonpoliticalreview.org/post/harry-j-anslinger-and-the-origins-of-the-war-on-drugs [https://perma.cc/R9G7-ZS6Y]; see also Michael F. Linden, Seeing Through the Smoke: The Origins of Marijuana Prohibition in the United States 94 (Apr. 2015) (B.A. thesis, Wesleyan University), https://digitalcollections.wesleyan.edu/_flysystem/fedora/2023-03/22885-Original%20File.pdf [https://perma.cc/L4JM-HDNN] (detailing that "Anslinger himself took to the airwaves, making radio broadcasts and speeches to drum up support for" a uniform law that prohibited narcotics and he made "[b]road efforts . . . to attract support from various constituencies—anti-intoxicant messaging to the Women's Christian Temperance Union and legal arguments to lawyers and lawmakers reading legal journals"); id. at 83–84 ("Disconnected from the failures of alcohol prohibition and the abuses of the old Narcotics Division, Anslinger created a remarkably successful career for himself *based on that philosophy* and good initial timing." (emphasis added)).

[50] See Jon Heidt & Johannes Wheeldon, Visions of Cannabis Control 31, 44 (2023).

[51] Robert Solomon, Racism and Its Effect on Cannabis Research, 5 Cannabis & Cannabinoid Rsch. 2, 3 (2020); Michael Weinreb, The Complicated Legacy of Harry Anslinger, Penn Stater Mag., Jan./Feb. 2018, at 32, 36, https://www.case.org/system/files/media/file/Penn%20Stater%20Harry%20Anslinger.pdf [https://perma.cc/R4K4-7WSW] ("Certain forces were in place as Anslinger came into power, and those forces converged around marijuana prohibition. Some of those forces were indubitably driven by racial fears, in particular a fear of Mexicans.").

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Anslinger was motivated by his desire to ensure that the Narcotics Bureau did not suffer the fate of the disbanded Prohibition Bureau.[52] Consequently, he created and sustained moral panic around potentially addictive drugs and was a staunch proponent of the narrative that people who use drugs were deviants who could only be deterred from their sinful behavior through the threat of criminal punishment.[53] In so doing, Anslinger directed a three-decades-long War on Drugs, ensuring that his Narcotics Bureau received adequate funding and accolades for effectiveness; some of this recognition was based on statistics he doctored.[54] He also heavily influenced punitive drug control legislation, which prohibited various potentially addictive substances and harshly criminalized their possession and use.[55]

At Anslinger's behest, persons with drug use disorders were depicted, at best, as a social underclass and, at worst, as psychopaths,[56] for whom institutionalization was the only solution.[57] Anslinger quashed attempts by medical professionals to promote the contention that drug use disorder was a disease[58] and aggressively argued against early efforts to provide

[52] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1406.

[53] Id.; see also Solomon, supra note 51, at 3 (quoting Anslinger as stating "[t]here are 100,000 total marijuana smokers in the US, and most are Negroes, Hispanics, Filipinos, and entertainers. Their Satanic music, jazz and swing, results from marijuana use. This marijuana causes white women to seek sexual relations with Negroes, entertainers, and others." (quoting Laura Smith, How a Racist Hate-Monger Masterminded America's War on Drugs, Timeline (Feb. 28, 2018), https://medium.com/timeline/harry-anslinger-racist-war-on-drugs-prison-industrial-complex-fb5cbc281189 [https://perma.cc/4CZH-LKNH])).

[54] Rebecca Carroll, Under the Influence: Harry Anslinger's Role in Shaping America's Drug Policy, *in* Federal Drug Control: The Evolution of Policy and Practice 61, 65–66 (Jonathon Erlen & Joseph F. Spillane eds., 2004); see El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1373.

[55] Carroll, supra note 54, at 61, 66; El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1407; Molly M. Gill, Correcting Course: Lessons from the 1970 Repeal of Mandatory Minimums, 21 Fed. Sent'g Rep. 55, 56–57 (2008).

[56] The concept that persons with drug use disorders are psychopaths was popularized in the 1930s by Dr. Lawrence Kolb, who oversaw two "federal narcotic farms" operated by the U.S. Public Health Service in Lexington, Kentucky and Fort Worth, Texas. David T. Courtwright, A Century of American Narcotic Policy, *in* 2 Treating Drug Problems 1, 14 (Dean R. Gerstein & Henrick J. Harwood eds., 1992) [hereinafter Courtwright, A Century of American Narcotic Policy].

[57] Id.

[58] Id. The American Bar Association and American Medical Association attempted to push back against the effective criminalization of addiction with their publication Narcotic Drugs: Interim Report of the Joint Committee of the American Bar Association and the American Medical Association on Narcotic Drugs (1958). Id. at 25–26. Those organizations, however,

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medication maintenance to individuals with opiate use disorder.[59] The United States Supreme Court shared Anslinger's view that it was illegal for physicians to prescribe opiates to individuals with opiate use disorder under federal law in 1919.[60] "By 1938, more than 25,000 American doctors had been arraigned on narcotics charges; [and] some 3,000 served time in prison" for prescribing specific drugs to patients.[61]

This War on Drugs ethos was codified into federal legislation that criminalized the possession and sale of certain substances beginning in the early twentieth century.[62] Lawmakers increased the criminal penalties for drug possession and sale over time based on the theory that harsher penalties would deter drug trafficking and use.[63] For example, Congress enacted the Boggs Act of 1951, the first federal law establishing mandatory minimum sentences for drug possession.[64] Shortly thereafter, Congress enacted the Narcotic Control Act of 1956, which mandated imprisonment for all persons convicted of narcotics possession and

proved no match for Anslinger. See El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1409–10.

[59] Courtwright, A Century of American Narcotic Policy, supra note 56, at 14. Medication maintenance involved the prescription of either morphine, cocaine, or heroin and physician oversight of persons with opiate use disorder. Id. at 10–11. Despite efforts to open and maintain narcotics maintenance clinics and, thereby, provide persons who used drugs with an unadulterated safe supply of drugs while working with a doctor to safely taper from the substance, the Bureau of Narcotics arrested doctors prescribing heroin or morphine to persons with use disorder and the doors of local heroin maintenance clinics were soon shuttered. Id.

[60] Webb v. United States, 249 U.S. 96, 99–100 (1919); see also Richard C. Boldt, Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom, 62 S.C. L. Rev. 261, 262–63 (2010) (explaining that the federal government and, ultimately the U.S. Supreme Court, adopted Anslinger's view that doctors should not be permitted to prescribe narcotics to individuals to treat drug use disorders).

[61] Coyne & Hall, supra note 10, at 6.

[62] See, e.g., Harrison Narcotics Tax Act, Pub. L. No. 63-223, 38 Stat. 785 (1914); see also Oliva, Dosing Discrimination, supra note 28, at 56–57 (explaining that the federal government interpreted early twentieth century drug control legislation consistent with the ethos that individuals who use drugs are "bad characters" who should be policed and criminalized instead of treated by physicians (quoting Edwin M. Schur, Narcotic Addiction in Britain and America: The Impact of Public Policy 192 (1968))).

[63] Helen B. Shaffer, Control of Drug Addiction 4 (1956), https://library.cqpress.com/cqresearcher/document.php?id=cqresrre1956090500 [https://perma.cc/8EE2-2RM2] ("In authorizing the stiffer penalties, Congress accepted the advice of federal narcotics officials, who believe that the best way to destroy the illegal market is to put violators in confinement for as long a period as possible.").

[64] Act of Nov. 2, 1951, Pub. L. No. 255, ch. 666, 65 Stat. 767 (repealed 1970).

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increased the sentence imposed on a first-time offender from 2–5 years to 2–10 years.[65]

The Narcotic Control Act also authorized the death penalty for certain drug offenses, including a conviction of the sale of heroin to a minor.[66] The death penalty provision was later abandoned, but capital punishment continues to be proposed by federal officials as a solution to the current overdose crisis.[67] In a speech delivered on March 19, 2018, for example, then-President Trump stated the following with regard to individuals who sell opioids: "These are terrible people, and we have to get tough on those people . . . [a]nd that toughness includes the death penalty."[68] In addition, and as discussed in more detail in Part III, policymakers continue to advocate for the imposition of harsh felony sentences akin to those imposed for homicide in response to the current crisis.

President Nixon signed into law Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970,[69] commonly known as the Controlled Substances Act ("CSA"),[70] which consolidated and replaced prior federal legislation that pertained to potentially addictive substances.[71] The CSA created a complex federal drug control scheme that authorized the scheduling of controlled substances[72] and motivated Nixon's 1973 executive order that created the Drug Enforcement

[65] Narcotic Control Act of 1956, Pub. L. No. 728, § 103, 70 Stat. 567 (repealed 1970).

[66] Id. § 107; Doris Marie Provine, Race and Inequality in the War on Drugs, 7 Ann. Rev. L. & Soc. Sci. 41, 43 (2011) (explaining that the Narcotic Control Act made the death penalty available for the sale of heroin to minors).

[67] J. Richard Broughton, The Opioid Crisis and the Federal Death Penalty, 70 S.C. L. Rev. 611, 612, 616–17 (2019).

[68] The White House, Remarks by President Trump on Combatting the Opioid Crisis (Mar. 19, 2018), https://trumpwhitehouse.archives.gov/briefings-statements/remarks-president-trump-combatting-opioid-crisis/ [https://perma.cc/ZL9P-3B96]. It should be noted that there is a widespread consensus that imposition of the death penalty for drug offenses violates the International Covenant on Civil and Political Rights. See, e.g., Patrick Gallahue, Open Soc'y Founds., Drugs and the Death Penalty 3–4 (Oct. 2015), https://www.opensocietyfoundations.org/publications/drugs-and-death-penalty [https://perma.cc/DN6B-Z2XU].

[69] Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (codified as amended in scattered sections of 21 U.S.C.).

[70] Controlled Substances Act, Pub. L. No. 91-513, 84 Stat. 1236, 1242–84 (1970) (codified as amended at 21 U.S.C. §§ 801–971).

[71] See Lisa N. Sacco, Cong. Rsch. Serv., R43749, Drug Enforcement in the United States: History, Policy, and Trends 5 (2014).

[72] 21 U.S.C. §§ 811–12 (providing that all drugs regulated under federal law are scheduled into one of five schedules dependent on their potential for abuse, medicinal value, and safe use under medical supervision).

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Administration.[73] The CSA further institutionalized the punitive nature of the War on Drugs by reinforcing the belief that some drugs, such as cannabis[74] and psilocybin,[75] were extremely dangerous and had no medicinal value, thereby, rendering them illicit in all circumstances.[76]

A common feature of American drug control policy is the characterization of certain drugs as dangerous and medically worthless based on their association with minoritized or racialized groups rather than their chemical properties and scientifically-demonstrable risks and benefits.[77] As a consequence, drugs associated with racialized people are most likely to be prohibited despite their potential for medical use.[78] For

[73] Jason Scott Plume, Cultivating Reform: Richard Nixon's Illicit Substance Control Legacy, Medical Marijuana Social Movement Organizations, and Venue Shopping 1 (Dec. 2012) (Ph.D. dissertation, Syracuse University), https://surface.syr.edu/cgi/viewcontent.cgi?article=1110&context=psc_etd [https://perma.cc/UZS7-NDG7] (explaining that "[i]n order to further his administration's reorganization and uniformity of drug control policies, resources, and personnel [as accomplished by the CSA], Nixon, via Executive Order 11727, directed transformation of an anemic Bureau of Narcotics and Dangerous Drugs (BNDD) into the Drug Enforcement Administration (DEA) . . . "); Exec. Order No. 11,727, 38 Fed. Reg. 18357 (Jul. 6, 1973); Organization, Mission and Functions Manual: Drug Enforcement Administration, U.S. Dep't of Just., https://www.justice.gov/doj/organization-mission-and-functions-manual-drug-enforcement-administration [https://perma.cc/GV4K-GBSP] (last visited Apr. 9, 2024) (explaining that, "[i]n 1973, the Drug Enforcement Administration was created by merging the Bureau of Narcotics and Dangerous Drugs, the Office for Drug Abuse Law Enforcement, the Office of National Narcotics Intelligence, elements of the U.S. Customs Service that worked in drug trafficking intelligence and investigations, and the Narcotics Advance Research Management Team").

[74] 21 U.S.C. § 812(c) sched. I(c)(10) (2018) (characterizing cannabis as "marihuana").

[75] Id. sched. I(c)(15) (2018).

[76] Id. § 812(b)(1) (2018) (stating the criteria for substance to be classified as a Schedule I drug, like cannabis and peyote, is that it "has a high potential for abuse," "no currently accepted medical use in treatment in the United States," and that "[t]here is a lack of accepted safety for use of the drug . . . under medical supervision").

[77] El-Sabawi, Defining the Opioid Epidemic, supra note 4, at 1388–92.

[78] Hansen et al., Whiteout, supra note 16, at 5 (explaining that the whitewashing of the opioid crisis "drew on a century-old system of narcotic segregation in the US, in which some drugs become illegal through association with nonwhite users, and other drugs are legal and are deemed 'medicines' reserved for white and middle-class consumers: in short, a system in which the Whiteness of certain drugs medicalizes them" (footnote omitted)); Cigdem V. Sirin, From Nixon's War on Drugs to Obama's Drug Policies Today: Presidential Progress in Addressing Racial Injustices and Disparities, 18 Race Gender & Class 82, 84 (2011) ("Since the launch of the campaign for the war on drugs, public opinion in the U.S. has been largely shaped by news stories from popular media and reports from law enforcement agencies that depict certain minority groups as being associated with the use, transportation, distribution, and sale of illicit drugs and thus responsible for the country's 'drug problem.'" (citation omitted)); Michael Vitiello, Marijuana Legalization, Racial Disparity, and the Hope for Reform, 23 Lewis & Clark L. Rev. 789, 799–800 (2019); see John P. Hoffmann, Ideology,

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example, the association of cannabis with Mexican immigrants and its characterization as "demon weed" motivated the decision to prohibit the plant and its psychoactive ingredients in the United States.[79] To ensure an ongoing punitive (as opposed to evidence-based public health) approach to drug scheduling, the CSA gives final scheduling authority to a criminal law enforcement agency, the Drug Enforcement Administration,[80] instead of a scientific health agency like, for example, the Food and Drug Administration ("FDA").[81] The CSA also vests the DEA with primary authority to make determinations as to which drugs should be prohibited outright (because they purportedly lack any legitimate medical use),[82] which drugs are dangerous enough to be subject to annual production quotas,[83] and which drugs require prescribers to be subject to additional federal licensure and oversight requirements.[84]

Scholars have argued that President Nixon created the DEA to establish his own police force to prosecute the War on Drugs.[85] On the one hand, Nixon's drug war was simply the continuation of a nearly century-long American drug prohibition campaign. And, much like other drug warriors, Nixon's deployment of the criminal legal system and theories of deterrence to control the supply of drugs was racially motivated.[86] On

Racism and Morality: Investigating the Structural Origins of Drug Prohibition, 18 Free Inquiry Creative Socio. 127, 136–37 (1990) ("Since marijuana and cocaine were seen as the recreational drugs of [Blacks and Mexicans], they were systematically prohibited for what appeared primarily to be moral and safety reasons.").

[79] Vitiello, supra note 78, at 797–800.

[80] 21 U.S.C. §§ 811(a), 812(b). The CSA specifically delegates the authority to add and remove drugs from the federal schedules to the Attorney General. The Attorney General has, in turn, delegated that authority to the DEA by regulation. 28 C.F.R. § 0.100 (2021).

[81] While the FDA is required to weigh in on the determination, the drug scheduling process has historically been co-opted by the DEA. Taleed El-Sabawi, Why the DEA, Not the FDA?: Revisiting the Regulation of Potentially-Addictive Substances, 16 N.Y.U. J.L. & Bus. 317, 338–40 (2020).

[82] 21 U.S.C. § 811(a).

[83] Id. § 826(a).

[84] Id. § 822(a); see also John A. Gilbert & Barbara Rowland, Practicing Medicine in a Drug Enforcement World, *in* 27 Health Law Handbook 391, 394 (Alice G. Gosfield ed., 2015) (explaining that "[f]ailure to comply with [DEA] requirements can result in an administrative action to revoke a health care provider's authority to handle controlled substances").

[85] El-Sabawi, supra note 81, at 339; Fernando Esquivel-Suárez, The Global War on Drugs n.5 (Aug. 23, 2018), https://globalsouthstudies.as.virginia.edu/key-issues/global-war-drugs [https://perma.cc/785V-HNGB] (explaining that the DEA's mission was to "establish a single unified command to combat an all-out global war on the drug menace" (quoting Carmen Boullosa & Mike Wallace, A Narco History: How the United States and Mexico Jointly Created the "Mexican Drug War" 28 (2016))).

[86] Baum, supra note 15.

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the other hand, Nixon's use of the War on Drugs to perpetuate racial violence was more heinous than his drug warrior predecessors because his extravagantly punitive campaign fueled an unprecedented prison industrial complex that continues to devastate Black communities today.[87] Black Americans are approximately six times more likely to be incarcerated for drug-related offenses than their white counterparts, notwithstanding the nearly identical rates of substance use across those populations.[88]

These egregious mass-incarceration-related racial disparities are also attributable to President Reagan's 1980s campaign against crack cocaine, which fueled a slew of harsh—and racially discriminatory—drug statutes that propelled the United States to its current status as the leading mass incarcerator in the world.[89] Those laws included the Anti-Drug Abuse Act of 1986,[90] which famously established a 100:1 quantity sentencing ratio between powder cocaine and crack cocaine[91] despite the fact that crack and powder cocaine are produced from "the same psychoactive alkaloid derived from the leaves of the coca plant"[92] and, thus, pose similar if not

[87] See generally Alexander, supra note 3.

[88] Criminal Justice Fact Sheet, NAACP, https://naacp.org/resources/criminal-justice-fact-sheet [https://perma.cc/Y5CY-6JAL] (last visited Apr. 9, 2024) ("African Americans and whites use drugs at similar rates, but the imprisonment rate of African Americans for drug charges is almost 6 times that of whites."); Racial & Ethnic Bias, N.C. Comm'n on Racial & Ethnic Disparities in the Crim. Just. Sys., https://nccred.org/issues/racial-ethnic-bias/ [https://perma.cc/TF5D-8U2K] (last visited Apr. 9, 2024).

[89] See, e.g., Ashlee Riopka, Equal Protection Falling Through the Crack: A Critique of the Crack-to-Powder Sentencing Disparity, 6 Ala. C.R. & C.L. L. Rev. 121, 122, 123 (2015) (providing that "America currently has the highest incarceration rate in the world" and that the theme that drove the Reagan Administration's antidrug war campaign was "that immoral, mostly nonwhite users and dealers were laying siege to middle-class white America" (quoting Doris Marie Provine, Unequal Under Law: Race in the War on Drugs 106 (2007))); Mark Osler & Mark W. Bennett, A "Holocaust in Slow Motion?": America's Mass Incarceration and the Role of Discretion, 7 DePaul J. for Soc. Just. 117, 124 (2014) (noting that, "[l]argely due to the war on drugs, the United States, with less than 5% of the world's population, has nearly 25% of the world's incarcerated population"); id. at 125 (reporting that "[t]he U.S. incarcerates a higher percentage of its population than any country in the world" and "[p]rison populations have mushroomed through incarceration of increasing numbers of young males, especially young black men, mostly from impoverished urban areas").

[90] Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207.

[91] U.S. Sent'g Comm'n, Special Report to Congress: Cocaine and Federal Sentencing Policy 116 (1995), https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/199502-rtc-cocaine-sentencing-policy/1995-Crack-Report_Full.pdf [https://perma.cc/YFV4-HW9M].

[92] David A. Sklansky, Cocaine, Race, and Equal Protection, 47 Stan. L. Rev. 1283, 1290 (1995).

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equal health risks (putting aside infectious disease risks).[93] This sentencing disparity has been attributed to the mass cultural framing of crack cocaine, a cheaper alternative to powder cocaine, as more likely to be sold, possessed, and used by persons of color and powder cocaine as more likely to be used by white persons.[94]

The Anti-Drug Abuse Act's 100:1 sentencing disparity between crack and powder cocaine possession was reduced to 18:1 in 2010,[95] but even this continued sentencing disparity between crack and powder cocaine ensures disproportionately greater prison terms for Black people and other racialized individuals.[96] As such, these punitive drug control laws demonstrate how the War on Drugs endures despite the inclusion of public health rhetoric in policy discourse and efforts to characterize addiction as a complex health condition rather than a moral failing. This point will be further expounded upon in Part III, which discusses drug-induced homicide laws, their enforcement, and other punitive policies of the New Drug War. We first turn to the Old Drug War's well-chronicled failures, which is the subject of the following Part.

[93] Joseph J. Palamar, Shelby Davies, Danielle C. Ompad, Charles M. Cleland & Michael Weitzman, Powder Cocaine and Crack Use in the United States: An Examination of Risk for Arrest and Socioeconomic Disparities in Use, 149 Drug & Alcohol Dependency 108, 109–10 (2015); U.S. Sent'g Comm'n, 2002 Report to the Congress: Cocaine and Federal Sentencing Policy 16 (2002), https://www.ussc.gov/research/congressional-reports/2002-report-congress-federal-cocaine-sentencing-policy [https://perma.cc/DD72-U9SU] (contending that "[c]rack cocaine and powder cocaine are both powerful stimulants and both forms of cocaine cause identical effects").

[94] Andrew Goulian, Marie Jauffret-Roustide, Sayon Dambélé, Rajvir Singh & Robert E. Fullilove III, A Cultural and Political Difference: Comparing the Racial and Social Framing of Population Crack Cocaine Use Between the United States and France, 19 Harm Reduction J. 1, 2 (2022); Jamie Fellner, Race, Drugs, and Law Enforcement in the United States, 20 Stan. L. & Pol'y Rev. 257, 262 (2009) ("The drug of principal concern was crack cocaine, erroneously believed to be a drug used primarily by black Americans. The use of cocaine, primarily powder cocaine, had increased in the late 1970s and early 1980s, particularly among whites, but powder cocaine use did not provoke the 'orgy of media and political attention' that occurred in the mid-1980s when a cheaper, smokable cocaine in the form of crack appeared." (footnotes omitted) (quoting Craig Reinarman & Harry G. Levine, The Crack Attack Politics and Media in the Crack Scare, *in* Crack in America: Demon Drugs and Social Justice 18, 18 (Craig Reinarman & Harry G. Levine eds., 1997))); id. at 264 (noting that "[c]rack cocaine was perceived as a drug of the Black inner-city urban poor, while powder cocaine, with its higher costs, was a drug of wealthy whites").

[95] Fair Sentencing Act of 2010, Pub. L. No. 111-220, 124 Stat. 2372.

[96] See Riopka, supra note 89, at 121, 125–26, 129–30.

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II. OLD DRUG WAR FAILURES

"[O]ur nation is engaged in a war. It is a war where those who insist on 'staying the course' know their strategy has already failed, and that it will continue to fail; where we—and our fellow citizens—are constant casualties of our nation's disastrous tactics; and where there can be no 'peace with honor'—or even just honor—until we honestly face up to the ineffectiveness and injustice of the manner in which we have pursued the war."[97]

America's perpetual War on Drugs warrants unique demonization because even its so-called "successes" are abysmal failures. The drug war has escalated—and continues to escalate—the arrest of individuals who sell or are in possession of targeted substances and widespread, resource-intensive law enforcement drug seizures.[98] Law enforcement agencies frequently tout drug seizures and other supply-side interdictions as drug war triumphs.[99] These tactics, however, have largely failed to reduce

[97] Ross C. "Rocky" Anderson, Salt Lake City Mayor, We Are All Casualties of Friendly Fire in the War on Drugs, Address Delivered to the Shadow Convention (Aug. 15, 2000), *in* 13 Utah Bar J. 10, 10 (2000) (expanded version).

[98] Pew Charitable Trs., Drug Arrests Stayed High Even as Imprisonment Fell from 2009 to 2019, at 1 (2022), https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf [https://perma.cc/6FTE-6QRV] (explaining that the War on Drugs "led to a 1,216% increase in the state prison population for drug offenses, from 19,000 to 250,000 between 1980 and 2008" and "although prison populations have since declined, the number of people incarcerated for drug offenses remains substantially larger than in 1980—more than 171,000 in 2019—and drug misuse and its harms have continued to grow"); Michelle Keck & Guadalupe Correa-Cabrera, La Política Antidrogas de Estados Unidos y las Estrategias de Control de Oferta: Una Evaluación de su Efectividad y Resultados [U.S. Drug Policy and Supply-Side Strategies: Assessing Effectiveness and Results], 10 Norteamérica 47, 48, 52 (2015) (Mex.) (pointing out that "the size and budgets for [U.S. drug interdiction] agencies . . . have increased considerably" over the last several decades and "[t]oday, the presence of law enforcement on the U.S.-Mexico border is at historic levels").

[99] See, e.g., Press Release, The White House, White House Announces Over $275 Million for Law Enforcement Officials Working to Disrupt Drug Trafficking and Dismantle Illicit Finance Operations (Mar. 16, 2023), https://www.whitehouse.gov/ondcp/briefing-room/2023/03/16/white-house-announces-over-275-million-for-law-enforcement-officials-working-to-disrupt-drug-trafficking-and-dismantle-illicit-finance-operations/ [https://perma.cc/HE92-Y5H6] (publicly proclaiming that, "[i]n 2022, HIDTAs successfully disrupted and dismantled more than 3,000 drug trafficking and money laundering organizations and seized illicit drugs with a wholesale value of more than $22 billion, including more than 13,000 kilograms and more than 44 million dosage units of fentanyl"); Press Release, Dave Yost, Ohio Att'y Gen., Drug Interdiction Task Forces Seize over 64 Million in Narcotics in 2022 (Dec. 29, 2022), https://www.ohioattorneygeneral.gov/Media/News-Releases/December-2022/Drug-Interdiction-Task-Forces-Seize-Over-$64-Milli [https://perma.cc/N9CG-PYP4]; Jozsef Papp, Narcotics Seizure Considered One of Largest in Atlanta Police History, Atlanta J.-Const. (Oct.

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overdose deaths and, worse yet, are associated with the enhanced risk of drug overdose.[100]

Medical providers feared that increased drug interdiction efforts by law enforcement would make the illicit drug supply more deadly and volatile beginning as early as 1955.[101] We now have decades of evidence suggesting that these theories are true.[102] As demonstrated by a recent *American Journal of Public Health* study, fatal overdoses consistently double in neighborhoods approximately one week after a major opioid or stimulant law enforcement interdiction operation in the same geographic area.[103]

There are several well-documented reasons why drug prohibition, criminalization, and interdiction consistently fail to reduce overdose deaths. First, prohibition—and prohibition enforcement—creates and sustains illicit markets that are lucrative and highly profitable. As the New York Academy of Medicine stated in 1955:

> The narcotic laws shut off any legitimate source of drugs for a market with an uncontrollable craving. The stage is set for inflation with profits of such enormity as to strain the imagination. . . . Because of the profit to be made in selling illicit drugs, attempts are made to attract new

12, 2022), https://www.ajc.com/news/crime/narcotics-seizure-considered-one-of-largest-in-atlanta-police-history/OOQNB43VJVCCBOSA3B2KZVY22M/ [https://perma.cc/5T6X-J7NN].

[100] Leo Beletsky & Corey S. Davis, Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited, 46 Int'l J. Drug Pol'y 156, 156–57 (2017); see also Pew Charitable Trusts, supra note 98, at 1 (pointing out that "[d]rug- and alcohol-related mortality rates increased fivefold in prisons and threefold in jails despite the decreases in the number of people in prison for drug offenses").

[101] See, e.g., Subcomm. on Drug Addiction, Comm. on Pub. Health of the N.Y. Acad. of Med., Report on Drug Addiction, 31 Bull. N.Y. Acad. Med. 592, 597, 601 (1955), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1804587/pdf/bullnyacadmed00401-0058.pdf [https://perma.cc/YY75-CQVC].

[102] See, e.g., Nick Werle & Ernesto Zedillo, We Can't Go Cold Turkey: Why Suppressing Drug Markets Endangers Society, 46 J.L. Med. & Ethics 325, 330 (2018) ("Where there is an existing stock of habitual users, no degree of suppression consistent with a democratic society can eradicate supply. Suppressive policies change, rather than eliminate, drug markets, altering the prices paid, the suppliers who profit, and the content of substances ingested."); Abby Alpert, David Powell & Rosalie Liccardo Pacula, Supply-Side Drug Policy in the Presence of Substitutes: Evidence from the Introduction of Abuse-Deterrent Opioids, 10 Am. Econ. J.: Econ. Pol'y 1, 1, 6–7 (2018).

[103] Bradley Ray et al., Spatiotemporal Analysis Exploring the Effect of Law Enforcement Drug Market Disruptions on Overdose, Indianapolis, Indiana, 2020–2021, 113 Am. J. Pub. Health 750, 755 (2023).

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> users. Drug rings constitute big business with all its aggressiveness to increase volume of sales.[104]

Second, and even assuming that American drug policies have been successful at achieving their desired outcomes of intercepting unregulated drugs and arresting individuals who sell those products, there is no evidence such outcomes decrease the demand for drugs or injection drug use.[105] Instead:

> The fear of arrest can induce drug users to become or remain drug injectors (to reduce the amount of drug purchased and thus the frequency with which they have to expose themselves by buying drugs, as well as through stigmatization effects on social integration and self-esteem) and may lead [injection drug users] to inject less safely.[106]

As a 2021 media report succinctly explained,

> [D]rug use in the U.S. is climbing again and more quickly than ever. According to the Substance Abuse and Mental Health Services Administration, the number of illicit drug users rose to 13% of Americans 12 years or older in 2019, nearly reaching its peak from 40 years ago. If the goal of the war on drugs was to decrease drug usage and prevent drug-related deaths, it hasn't made much progress.[107]

Finally, by all pertinent metrics, America's half-century-old punitive drug control strategies have failed to either curb drug-related mortality rates or stymie organized drug trafficking.[108] Instead, drug-related overdose deaths are at an all-time high, and the multibillion-dollar illicit drug market is booming.[109] And, as experts have repeatedly pointed out,

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[104] Subcommittee on Drug Addiction, supra note 101, at 597.

[105] Samuel R. Friedman et al., Drug Arrests and Injection Drug Deterrence, 101 Am. J. Pub. Health 344, 345–47 (2011).

[106] Id. at 344.

[107] Lee, supra note 2.

[108] See Antony Loewenstein, Pills, Powder, and Smoke: Inside the Bloody War on Drugs 304 (2019) ("With nearly half a million deaths every year, an explosion in opium and coca production, a 31 per cent increase in drug use, and increasingly dangerous drugs being consumed without any safeguards, the war on drugs had caused unprecedented upheaval.").

[109] Deidre McPhillips, Overdose Deaths Continue to Rise in the US, Reaching Another Record Level, Provisional Data Shows, CNN (Sept. 13, 2023, 5:40 PM), https://www.cnn.com/2023/09/13/health/overdose-deaths-record-april-2023/index.html [https://perma.cc/EA5S-PKFZ]; Gregory Midgette, Steven Davenport, Jonathan P. Caulkins & Beau Kilmer, RAND Corp., What America's Users Spend on Illegal Drugs, 2006–2016, at xi (Aug. 20, 2019), https://www.rand.org/pubs/research_reports/RR3140.html [https://perma.cc/MN25-FWR3]

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it is vigorously enforced government drug prohibition and not individual drug use that instigates the vast majority of "drug-related" violence.[110] For example, economist Jeffrey A. Miron concluded that "the vast majority of research has found no evidence that drug use overall engenders violence at the individual level," "a key determinant of violence in modern societies is enforcement of drug prohibition," and "societies can both save criminal justice resources and reduce violence by devoting less effort to enforcing prohibition."[111]

The drug war also serves as a macro, upstream social determinant of health insofar as "it exacerbates many of the factors that negatively impact health and wellbeing, disproportionately affecting low-income communities and people of colour who already experience structural challenges including discrimination, disinvestment, and racism."[112] This is because the drug war disrupts or undermines access to, among other things, affordable housing, education, healthcare, public benefits, and family support services.[113] In sum, the Old Drug War can be fairly characterized as expensive, punitive, racist, ineffective, and health-harming. Unfortunately, and as the next Part explains, the New Drug War continues to adopt and expand many of the failed qualities of the Old Drug War, notwithstanding its novel packaging in public-health-promoting rhetoric.

(contending that Americans spent over 150 billion dollars in 2016 on just four illicit substances: cocaine, heroin, marijuana, and methamphetamine).

[110] Erik Luna, Our Vietnam: The Prohibition Apocalypse, 46 DePaul L. Rev. 483, 552 (1997) (providing that "[h]alf of the serious crime in America is a result of drug prohibition (not drug use), and two-thirds of all homicides in major cities are connected to the drug trade (again, not drug use)" (footnote omitted)); see also Shima Baradaran, Drugs and Violence, 88 S. Cal. L. Rev. 227, 290 (2015) ("[D]rug violence is exaggerated and may be attributable to drug law enforcement and prohibition rather than drug use or the nature of the industry.").

[111] Jeffrey A. Miron, Drug Prohibition and Violence, *in* 1 Reforming Criminal Justice 99, 107, 112 (Erik Luna ed., 2017).

[112] Aliza Cohen, Sheila P. Vakharia, Julie Netherland & Kassandra Frederique, How the War on Drugs Impacts Social Determinants of Health Beyond the Criminal Legal System, 54 Annals Med. 2024, 2025 (2022).

[113] Id. at 2026–31.

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III. THE "NEW" DRUG WAR

"The purpose of a system is what it does . . . . There is after all . . . no point in claiming that the purpose of a system is to do what it constantly fails to do."[114]

American policymakers have long relied on War on Drugs rhetoric to justify the creation of a highly intrusive surveillance state. Old Drug War-provoked surveillance tools include, among other things, traditional wiretapping, global positioning service ("GPS") and geolocation tracking, infrared technology, aerial surveillance, and financial transaction monitoring.[115] While such technology theoretically surveils everyone, it is primarily wielded by law enforcement to target subordinated and marginalized groups.[116] "Mass surveillance society subjects us all to its gaze, but not equally so . . . . [I]ts hand is heaviest in communities already disadvantaged by their poverty, race, religion, ethnicity, and immigration status."[117] This is certainly true in the United States, which has systematically deployed wide-ranging surveillance to disparately monitor, arrest, prosecute, and mass incarcerate racialized minorities for low-level, nonviolent drug offenses and, thereby, monetize their bodies and maintain a race-based caste system in the tradition of Jim Crow and slavery.[118]

If the aim of America's privacy-invasive, surveil-and-punish Old Drug War has been to criminalize people experiencing poverty and to maintain

[114] David Benjamin & David Komlos, The Purpose of a System Is What It Does, Not What It Claims to Do, Forbes (Sept. 13, 2021, 6:00 AM), https://www.forbes.com/sites/benjaminkomlos/2021/09/13/the-purpose-of-a-system-is-what-it-does-not-what-it-claims-to-do/?sh=f0ce88d3887a [https://perma.cc/5TM6-2JRG] (quoting British cybernetics theorist Stafford Beer).

[115] Bridge Initiative Team, Factsheet: War on Drugs: Surveillance (July 31, 2023), https://bridge.georgetown.edu/research/factsheet-war-on-drugs-surveillance/ [https://perma.cc/C5QT-5LNF]; Jay Stanley, The War on Drugs and the Surveillance Society, ACLU (June 6, 2011), https://www.aclu.org/blog/smart-justice/sentencing-reform/war-drugs-and-surveillance-society [https://perma.cc/DL69-J8ZF]; Brian Bennett, Police Employ Predator Drone Spy Planes on Home Front, L.A. Times (Dec. 10, 2011, 12:00 AM), https://www.latimes.com/archives/la-xpm-2011-dec-10-la-na-drone-arrest-20111211-story.html [https://perma.cc/L22S-UGM2].

[116] Barton Gellman & Sam Adler-Bell, The Disparate Impact of Surveillance, Century Found. (Dec. 21, 2017), https://tcf.org/content/report/disparate-impact-surveillance/ [https://perma.cc/PP27-4KBN].

[117] Id.

[118] See Bridge Initiative Team, supra note 115; Cohen et al., supra note 112, at 2026–31; Brianna Weiner, Commodifying Captivity: What Society Loses When Private Companies Do the Government's Bidding, 10 Lincoln Mem'l U. L. Rev. 70, 70–71 (2022); Alexander, supra note 3, at 15–16.

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racial subordination, it has been an astounding success. Due to the disparate rates at which the state arrests and convicts persons of color, almost 80% of people in federal prison and nearly 60% of people in state prison for drug offenses are Black or Latino.[119] As one legal scholar puts it, "in modern America, if you were to gaze your eyes on the criminal justice system, you would think that drug use and addiction were largely problems for the urban, poor, African American community."[120]

Given the catastrophic failure of the Old Drug's War punitive, supply-side approaches and the New Drug War's more compassionate, health-oriented language, one might think that the United States is in the process of shifting its efforts and resources from surveillance and hyper-enforcement to proven-effective, evidence-based interventions. Unfortunately, such reasonable thinking would be sorely misguided. Much like the Old Drug War that preceded it, the New Drug War has been co-opted by policymakers and law enforcement as an impetus to develop, fund, and operationalize more expansive and ubiquitous surveillance in the form of artificial-intelligence-powered state prescription drug monitoring programs.[121] In other words, rhetoric aside, the United States has doubled down on fighting the New Drug War with an Old Drug War surveillance-fueled law-and-order crackdown on prescription drugs.

A. Enhanced Surveillance

State prescription drug monitoring programs ("PDMPs") are electronic databases that collect, store, and analyze voluminous information about

[119] Tara O'Neill Hayes, Incarceration and Poverty in the United States, Am. Action F. (June 30, 2020), https://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/ [https://perma.cc/8FUA-AE9B].

[120] Teneille R. Brown, Treating Addiction in the Clinic, Not the Courtroom: Using Neuroscience and Genetics to Abandon the Failed War on Drugs, 54 Ind. L. Rev. 29, 48 (2021) ("It is impossible to speak of the War on Drugs without acknowledging how disproportionately it affected people of color.").

[121] Byungkyu Lee, Wanying Zhao, Kai-Cheng Yang, Yong-Yeol Ahn & Brea L. Perry, Systematic Evaluation of State Policy Interventions Targeting the US Opioid Epidemic, 2007–2018, JAMA Network Open, Feb. 12, 2021, at 1, 2 ("To address the growing opioid epidemic, policy makers have focused largely on controlling the prescription and use of opioid analgesics through the implementation of supply-side drug policies. These include prescription drug monitoring programs (PDMPs), pain clinic laws, and prescription limit laws to reduce inappropriate prescribing behavior."); Oliva, Dosing Discrimination, supra note 28, at 81–85.

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particular classes of prescription drugs.[122] PDMPs were developed as law enforcement and regulatory surveillance tools to deter prescription drug misuse and diversion.[123] During the onset of the current drug overdose crisis in the late 1990s, just a handful of states operated PDMPs.[124] These Old Drug War state databases were passive collection systems that generally limited their surveillance to Schedule II drugs—that is, the controlled substances on the federal schedule that the DEA has deemed as "most susceptible to abuse."[125]

Experts frequently frame the United States' current overdose drug crisis as an intertwined three- or four-wave phenomenon.[126] Under this rubric, the first wave began with an uptick in drug overdose deaths in the late 1990s, which the popular narrative attributed to the increased prescribing of licit opioids.[127] As already explained, policymakers tended to characterize this initial wave—which centered around "innocent," white rural and suburban persons victimized by iatrogenic drug use—as a health problem that demanded access to evidenced-based care and not punishment.[128]

Those policymakers, however, continued to publicly support and fund the Old Drug War's supply-side, surveillance-driven, law-and-order approach. For example, in response to the first wave of our current crisis, Congress began providing significant funding and resources to the U.S.

[122] Pew Charitable Trs., Prescription Drug Monitoring Programs: Evidence-Based Practices to Optimize Prescriber Use 1 (2016), https://www.pewtrusts.org/-/media/assets/2016/12/prescription_drug_monitoring_programs.pdf [https://perma.cc/K7QP-A55T].

[123] See Prescription Drug Monitoring Program Training & Tech. Assistance Ctr., History of Prescription Drug Monitoring Programs (2018), https://www.pdmpassist.org/pdf/PDMP_admin/TAG_History_PDMPs_final_20180314.pdf [https://perma.cc/8MGG-NUY2].

[124] Oliva, Dosing Discrimination, supra note 28, at 74–75.

[125] Id. at 76–77.

[126] Cong. Budget Off., The Opioid Crisis and Recent Federal Policy Responses 1–2 (2022), https://www.cbo.gov/system/files/2022-09/58221-opioid-crisis.pdf [https://perma.cc/2GSD-SD3D] (contending that "[t]he opioid crisis has occurred in overlapping waves"); Daniel Ciccarone, The Rise of Illicit Fentanyls, Stimulants, and the Fourth Wave of the Opioid Overdose Crisis, 34 Current Op. Psychiatry 344, 344–45 (2021); Daniel Ciccarone, The Triple Wave Epidemic: Supply and Demand Drivers of the US Opioid Overdose Crisis, 71 Int'l J. Drug Pol'y 183, 183 (2019).

[127] Ctrs. for Disease Control & Prevention, Understanding the Opioid Overdose Epidemic, https://www.cdc.gov/opioids/basics/epidemic.html [https://perma.cc/A3QM-CLRB] (last visited Apr. 9, 2024) (explaining that "[t]he first wave began with increased prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids (natural and semi-synthetic opioids and methadone) increasing since at least 1999").

[128] Netherland & Hansen, supra note 20, at 664; see also supra text accompanying notes 17–20.

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Department of Justice ("DOJ") through the Harold Rogers Prescription Monitoring Program to incentivize the states to adopt and expand state PDMPs to facilitate law enforcement and regulatory opioid prescribing surveillance.[129] The important takeaway here is that the modern, New Drug War PDMPs were funded by and designed as law enforcement investigatory tools and not for public health surveillance—just like their Old Drug War predecessors. DOJ made this explicit in a 2015 report, in which the agency explained that "the law enforcement community is increasingly focusing more effort on the investigation and prosecution of criminal activities surrounding prescription drugs" and "PDMPs are a valuable tool in successfully conducting these prescription drug diversion investigations and have assisted law enforcement for more than 50 years in pursuing the investigation of issues ranging from doctor-shopper and pill-mill cases to more complex investigations of organized crime rings."[130]

As a result of the federal government's well-funded push for enhanced prescription drug surveillance, the United States witnessed an explosion of state PDMPs during the first decade of the twenty-first century. Twenty-seven states stood up PDMPs between 2000 and 2010, supported by more than 60 million dollars from federal law enforcement.[131] Today,

[129] Bureau of Just. Assistance, U.S. Dep't of Just., Harold Rogers Prescription Drug Monitoring Program (2010), https://web.archive.org/web/20221023220647/https://www.deadiversion.usdoj.gov/mtgs/drug_chemical/2010/rrose.pdf [https://perma.cc/7LN9-4CNA] (explaining that "[s]ince fiscal year 2002, Congress has appropriated funds . . . to support [state PDMPs] through the Harold Rogers Prescription Drug Monitoring Program, which is administered by the [DOJ's] Bureau of Justice Assistance" and that "[t]he program's purpose is to support [states'] efforts to collect and analyze dispensing pharmaceutical controlled substances data . . . [to] enhance the capacity of regulatory and law enforcement agencies and public health officials to prevent and detect the diversion and abuse of pharmaceutical controlled substances, while allowing for legitimate medical use"); Lisa N. Sacco, Johnathan H. Duff & Amanda K. Sarata, Cong. Rsch. Serv., R42593, Prescription Drug Monitoring Programs 2 (2018), https://fas.org/sgp/crs/misc/R42593.pdf [https://perma.cc/8HBZ-X7YW] ("For over a decade, the federal government has provided financial support for state-level PDMPs. In 2002, Congress established the Harold Rogers PDMP grant, administered by the Department of Justice (DOJ), to help law enforcement, regulatory entities, and public health officials analyze data on prescriptions for controlled substances.").

[130] See, e.g., Bureau of Just. Assistance, U.S. Dep't of Just., Justice System Use of Prescription Drug Monitoring Programs 8 (2015) (footnote omitted), https://www.bja.gov/Publications/Global-JusticeSystemUsePDMPs.pdf [https://perma.cc/F586-47AV].

[131] Prescription Drug Monitoring Program Training and Technical Assistance Center, supra note 123; Bureau of Justice Assistance, supra note 129; Leo Beletsky & Jeremiah Goulka, The Opioid Crisis: A Failure of Regulatory Design and Action, 34 Crim. Just., Summer 2019, at 35, 37 ("DEA and DOJ invested ramping up the investment of funding and law enforcement

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all fifty states, as well as the District of Columbia, Guam, the Northern Mariana Islands, and Puerto Rico, have operational electronic prescription drug surveillance programs.[132] The federal government continues to provide substantial financial support to states to enhance and upgrade their prescription drug surveillance. On December 22, 2021, DOJ announced that it was "awarding nearly $29.6 million to fund the Harold Rogers Prescription Drug Monitoring Program . . . [to] enhance[] the capacity of regulatory and law enforcement agencies and public health officials to collect and analyze controlled substance prescription data and other scheduled chemical products through a centralized database administered by an authorized agency."[133]

PDMPs collect vast troves of prescription drug-related data at the point of dispensing.[134] Specifically, state PDMP laws mandate that pharmacists log into the state's PDMP database prior to dispensing any monitored drug and enter a litany of information about the patient, the prescription, the prescriber, and the dispenser.[135] While the specific information captured by PDMPs is heterogenous across jurisdictions, all PDMPs

expertise in state-based prescription drug monitoring programs, 27 of which were established in the first decade of this century."); Sacco et al., supra note 129, at 17.

[132] Prescription Drug Monitoring Program Training & Tech. Assistance Ctr., PDMP Policies and Capabilities: Results for 2021 State Assessment 1 (2021), https://www.pdmpassist.org/pdf/PDMP%20Policies%20and%20Capabilities%202021%20Assessment%20Results_20210921.pdf [https://perma.cc/ME3S-YLZP]; Cameron Gerber, Missouri Legislature Gives Final Approval to Statewide PDMP Bill, Mo. Times (May 11, 2021), https://themissouritimes.com/missouri-legislature-gives-final-approval-to-statewide-pdmp-bill [https://perma.cc/U2UA-WP4C] (observing that "Missouri [was] the only state not to have a statewide PDMP").

[133] Press Release, U.S. Dep't of Just., Department of Justice Awards More Than $300 Million to Fight Opioid and Stimulant Crisis and to Address Substance Use Disorders (Dec. 22, 2021), https://www.justice.gov/opa/pr/department-justice-awards-more-300-million-fight-opioid-and-stimulant-crisis-and-address [https://perma.cc/H4HT-5XLA]; see also FY 2021 Harold Rogers Prescription Drug Monitoring Program (PDMP), Bureau of Just. Assistance, U.S. Dep't of Just., https://bja.ojp.gov/funding/opportunities/o-bja-2021-49001 [https://perma.cc/4FGF-6TBK] (last visited Apr. 9, 2024) (awarding $24,976,549 to state PDMPs in FY 2021).

[134] Substance Abuse & Mental Health Servs. Admin., Prescription Drug Monitoring Programs: A Guide for Healthcare Providers, 10 In Brief, Winter 2017, 1, 3 (noting that "[p]harmacies must submit required data to their state's PDMP for each prescription they dispense for specified controlled substances").

[135] See, e.g., Educ. Dev. Ctr., Using Prescription Drug Monitoring Program Data to Support Prevention Planning 1, 1–2, 2 n.3, https://pttcnetwork.org/wp-content/uploads/2019/08/pdmp-overview.pdf [https://perma.cc/T8CM-5EGL] (last visited Apr. 9, 2024); Bureau of Justice Assistance, supra note 130, at 5; Sacco et al., supra note 129, at 4 (explaining that "[m]ost states require retail pharmacies and dispensing practitioners . . . to submit data to the PDMP").

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collect "the patient's name, address, age, and gender; the date and place the prescription is filled; the identity of the prescribing physician; the drug prescribed; the drug dosage; and the drug quantity."[136]

Today's PDMPs differ from Old Drug War prescription monitoring databases in at least three notable ways. First, modern PDMPs monitor and surveil a much larger swath of prescription drugs than did their predecessors. Whereas the Old Drug War PDMPs generally limited their surveillance to Schedule II drugs, most New Drug War platforms monitor all controlled substances (Schedule II–V drugs) as well as additional, unscheduled "drugs of concern."[137] Second, New Drug War PDMPs collect, store, and analyze data from more expansive and, frankly, more questionable sources than did their predecessors. Those sources range from patient criminal and trauma histories and medical marijuana dispensing records to DEA Automation of Reports and Consolidated Orders System ("ARCOS") reports[138] and child welfare case information.[139] One can imagine how those criteria disparately impact women and racial minorities. Women are more likely to report and seek medical assistance for sexual abuse and trauma, and it goes without saying that racial minorities—who misuse drugs at virtually identical rates as their white counterparts—are much more likely to have criminal

[136] Jennifer D. Oliva, Prescription-Drug Policing: The Right to Health-Information Privacy Pre- and Post-*Carpenter*, 69 Duke L.J. 775, 780 (2020) (footnote omitted).

[137] Maps and Tables: PDMP Policies and Capabilities, Prescription Drug Monitoring Program Training & Tech. Assistance Ctr., https://www.pdmpassist.org/Policies/Maps/PDMPPolicies [https://perma.cc/WH54-FT6V] (last visited Apr. 9, 2024) (demonstrating that forty-six of the fifty-four PDMPs monitor Schedule II–V drugs (and the additional eight monitor Schedule II–IV drugs) while thirty-two PDMPs monitor unscheduled "drugs of concern"); Substance Abuse and Mental Health Services Administration, supra note 134, at 2 ("Most states track prescriptions for Schedule II–V controlled medications, and some also track unscheduled medications with misuse potential . . . .").

[138] DEA's ARCOS is "an automated, comprehensive drug reporting system which monitors the flow of DEA controlled substances from their point of manufacture through commercial distribution channels to point of sale or distribution at the dispensing/retail level . . . ." Declaration of John J. Martin in Support of the United States of America's Brief Posing Objections to Disclosure of ARCOS Data at 2, In re Nat'l Prescription Opiate Litig., 17-md-2804 (N.D. Ohio June 25, 2018).

[139] Prescription Drug Monitoring Program Training and Technical Assistance Center, supra note 132, at 4 (listing alternate sources of data to include, among other things: ARCOS reports, child welfare case information, criminal court case information, drug court case information, drug-related convictions, lost/stolen prescription drug reports, medical marijuana dispensing information, nonfatal and fatal overdoses, pharmaceutical manufacturer/distributor reports, and registrant disciplinary history and status).

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arrests and convictions.[140] In the United States, criminal records are effective proxies for race from a data science perspective.

Finally, and unlike Old Drug War PDMPs, modern prescription surveillance programs use algorithmic software to mine through the voluminous data that they collect to generate "risk scores" and "red flags."[141] Those scores purport to identify patients at risk of substance use disorder, drug misuse, or diversion.[142] The algorithms also flag providers that the system characterizes as "high-risk," that is, those who the software platform has identified as high-prescribing or high-dispensing outliers.[143] PDMP software platforms then generate "unsolicited reports" concerning flagged patients, prescribers, and dispensers, which they send to law enforcement and state licensing boards.[144]

A PDMP platform's identification of a patient, prescriber, or dispenser as "high-risk" can trigger a cascade of significant consequences. Red flags can, for instance, trigger a federal law enforcement criminal investigation and, thereby, subject practitioners to potential controlled substance registration suspension or revocation, arrest, and even felony prosecution.[145] The mere threat of these potentially career-ending and

[140] John C. Thomas & Jonathan Kopel, Male Victims of Sexual Assault: A Review of the Literature, 13 Behav. Sci., 2023, at 1, 2 (explaining that "[b]etween 10–20% of female sexual assault victims in the United States (US) are believed to have reported the crime, and the number of male victims is likely to be far lower"); Cohen, supra note 112, at 2025 (noting that "Black people—who are 13% of the U.S. population—made up 24% of all drug arrests in 2020, despite the fact that people of all races use and sell drugs at similar rates").

[141] Andrew W. Hunt et al., Characteristics and Red Flag Correlates of Psychiatric Outpatients in a Mandated-Use Prescription Drug Monitoring Program State: A PBRN Card Study, 18 Addictive Disorders & Their Treatment 36, 37 (2019).

[142] Appriss Health, About NarxCare: For Patients and Their Families 1, https://www.floridahealth.gov/statistics-and-data/e-forcse/narxcare-patient-information-sheet.pdf [https://perma.cc/6D6V-Q52V] (last visited Apr. 9, 2024); Prescription Drug Monitoring Program Ctr. of Excellence at Brandeis, Guidance on PDMP Best Practices: Options for Unsolicited Reporting 3–4 (2014), https://www.ojp.gov/pdffiles1/bja/247135.pdf [https://perma.cc/9NJT-ZBQ7].

[143] Prescription Drug Monitoring Program Center of Excellence at Brandeis, supra note 142, at 3–4.

[144] Id. at 3–4, 10–15; Prescription Drug Monitoring Program Training and Technical Assistance Center, supra note 132, at 7; Substance Abuse and Mental Health Services Administration, supra note 134, at 1–2 (explaining that "PDMPs . . . periodically send reports to law enforcement, regulatory, or licensing agencies as part of efforts to control diversion of medication by prescribers, pharmacies, and organized criminals" and "[a] majority of state PDMPs are authorized to send unsolicited reports to providers, licensing boards, or law enforcement agencies when a prescriber's or prescription recipient's activity exceeds thresholds established by the PDMP").

[145] See, e.g., Pharmacy 4 Less, Decision and Order, 86 Fed. Reg. 54550, 54551 (Oct. 1, 2021) (noting a DEA revocation of a pharmacy's certificate of registration for "repeatedly

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liberty-depriving federal investigations, in turn, encourages prescribers to rapid taper, medication discontinue, and abandon legacy opioid patients with complex pain conditions even when such actions are medically unwarranted in order to avoid criminal or regulatory sanction[146]:

> In self-interest, practitioners are incentivized to avoid innovation and the care of patients with unique or complex needs. Instead of comporting with the ethical duties to maximize their patients' well-being, practitioners over-comply with perceived legal norms to avoid any possible legal entanglement at those patients' expense.[147]

The DEA's aggressive surveillance and crackdown on controlled substances also has instigated pharmacies to refuse to either stock or dispense potentially life-saving medications, like buprenorphine, that are used to treat opioid use disorder.[148] In other words, the government's sophisticated hyper-surveillance of controlled substances appears to be exacerbating the current drug overdose crisis by creating barriers to access (1) prescription opioids for individuals with complex, debilitating chronic pain for whom such medications are indicated *and* (2) the gold-

fill[ing] prescriptions in the face of obvious red flags of diversion"); Opioid Takedown: Multiple Medical Professionals Among 60 Charged with Facilitating Illegal Opioid Prescriptions, Fed. Bureau of Investigation (Apr. 17, 2019), https://www.fbi.gov/news/stories/arpo-strike-force-opioid-takedown-041719 [https://perma.cc/8AQT-3ZEV] (announcing "criminal charges against 60 defendants—including 53 doctors, pharmacists, nurse practitioners, and other medical professionals who allegedly gave thousands of opioid prescriptions to addicted patients"); United States v. Gosy, No. 16-cr-00046, 2019 WL 948179, at *1 (W.D.N.Y. Feb. 27, 2019).

[146] One study further notes that PDMPs may reduce opioid prescribing even where such prescribing is indicated and nonproblematic merely due to "hassle costs" they impose, that is, the mandates that providers register with the PDMP and query the database under certain conditions. Abby Alpert, Sarah Dykstra & Mireille Jacobson, Hassle Costs Versus Information: How Do Prescription Drug Monitoring Programs Reduce Opioid Prescribing?, 16 Am. Econ. J.: Econ. Pol'y 87, 88–89 (2024) ("By raising the cost of opioid prescribing, mandates could cause across-the-board reductions in opioid prescribing, even to patients who have an appropriate clinical need for opioids and no recent history of misuse. Additionally, they could lead physicians to substitute to drugs that are not monitored by the PDMP, even if they are less effective.").

[147] Brief of Amici Curiae Professors of Health Law and Policy in Support of Petitioner, at 14, Ruan v. United States, 597 U.S. 450 (2022) (No. 20-1410).

[148] Aneri Pattani, DEA Takes Aggressive Stance Toward Pharmacies Trying to Dispense Addiction Medicine, NPR (Nov. 8, 2021, 2:05 PM), https://www.npr.org/sections/health-shots/2021/11/08/1053579556/dea-suboxone-subutex-pharmacies-addiction [https://perma.cc/P9KV-G9YZ] (explaining that "many pharmacists worry that ordering more buprenorphine will trigger a DEA investigation" and "[p]harmacies are terrified they're going to lose their DEA registration and go out of business").

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standard medication treatments for opioid use disorder.[149] The government's self-manufactured prescription opioid access crisis helps explain why overdose deaths have escalated while prescription drug prescribing has plummeted during the second, third, and fourth waves of the crisis. Those waves have been dominated by highly potent and deadly illicit opioids like heroin and synthetic fentanyl products, and dangerous polysubstance combinations of fentanyl and other drugs, including methamphetamine and cocaine, and not FDA-approved and highly regulated licit prescription opioids.[150]

It was entirely predictable that the government's sophisticated and expensive New Drug War surveillance of prescription opioids would enhance opioid-related mortality[151] because such a result comports with the "Iron Law of Prohibition."[152] Cannabis activist Richard Cowan coined that term in 1986, and it stands for the proposition that "the more intense the law enforcement, the more potent the drugs will become."[153] Fentanyl is 50 to 100 times more powerful than heroin and prescription opioids.[154] The United States witnessed a similar dynamic during alcohol prohibition, where many Americans switched their beverages of choice from beer and cider to hard liquor and high proof spirits.[155] Unfortunately, and notwithstanding its pro-health rhetoric, the New Drug War is simply a technologically upgraded rehash of your grandmother's Old Drug War insofar as government surveillance and its inevitably health-harming outcomes are concerned.

[149] Lee et al., supra note 121, at 9 ("Prescription drug monitoring program access policies . . . were also associated with increases in overdose deaths from synthetic opioids . . . and cocaine.").

[150] Laxmaiah Manchikanti et al., Fourth Wave of Opioid (Illicit Drug) Overdose Deaths and Diminishing Access to Prescription Opioids and Interventional Techniques: Cause and Effect, 25 Pain Physician 97, 98 (2022); Richard A. Jenkins, The Fourth Wave of the US Opioid Epidemic and Its Implications for the Rural US: A Federal Perspective, 152 Preventive Med., 2021, at 1.

[151] Lee et al., supra note 121, at 9.

[152] Sarah Beller, Infographic: The "Iron Law of Prohibition," Filter Mag. (Oct. 3, 2018), https://filtermag.org/infographic-the-iron-law-of-prohibition/ [https://perma.cc/UB6D-N87N].

[153] Richard C. Cowan, How the Narcs Created Crack, Nat'l Rev., Dec. 5, 1986, at 26, 27.

[154] Trevor Burrus, How Drug Prohibition Created the Fentanyl Crisis, Cato Inst. (Dec. 22, 2018), https://www.cato.org/commentary/how-drug-prohibition-created-fentanyl-crisis [https://perma.cc/R7CD-U3WZ].

[155] Id.

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B. Enhanced Criminalization and Civil Punishment

In addition to the deployment of artificial-intelligence-driven technology to enhance the state's surveillance of individuals who use prescription opioids or who are perceived as at risk for substance use disorder, the New Drug War continues to adopt and expand on the Old Drug War's favorite playbook: the use of severe criminal and civil punishment to deter drug use, possession, and distribution. The following Section provides an overview of a trilogy of the New Drug War's law-and-order, punitive tactics, including the widespread adoption or expansion of strict liability drug-induced homicide laws, the up-scheduling of fentanyl-related products to enhance the criminal penalties that attend to their possession, use, and distribution, and the imposition of civil punishments on people who use drugs with an emphasis on the civil penalties that states continue to apply to pregnant people. As this Section explains, the ongoing drug war's expansion of punishment in response to drug use undermines its public health narrative.

1. Drug-Induced Homicide Laws

In 2016, the North Carolina legislature adopted a public health approach to the overdose crisis by enacting robust, evidence-based syringe service program legislation.[156] Just three years later, however, the same legislature passed a different law that made it easier for prosecutors to bring homicide charges against individuals who share or supply drugs that result in an accidental fatal overdose.[157] In other words, in the face of considerable public health opposition, the state quickly retreated to punitive, Old Drug War tactics[158] despite the likelihood that doing so would increase overdose death rates.[159]

North Carolina is not the only state that enacted a new drug-induced homicide ("DIH") law in response to escalating overdose deaths. Nearly

[156] N.C. Gen. Stat. § 90-113.27 (2016).

[157] Id. § 14-18.4 (2019).

[158] Jack Shuler, Overdose and Punishment, New Republic (Sept. 10, 2018), https://newrepublic.com/article/150465/prosecutors-reviving-reagan-era-drug-induced-homicide-laws [https://perma.cc/8A29-J5GG] (observing that "[m]any drug-induced homicide laws date to the 1980s, however, when states and the federal government used them as part of the war on drugs approach to the crack cocaine epidemic").

[159] Matt Shipman, One Way Some Drug Prosecutions May Be Hurting Public Health, N.C. St. U. News (Sept. 1, 2021), https://news.ncsu.edu/2021/09/dih-and-public-health/ [https://perma.cc/H2CN-QTWQ].

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half the states, the federal government, and the District of Columbia currently have a drug-induced homicide (or drug delivery resulting in death) law on the books,[160] and at least ten jurisdictions enacted new or expanded DIH laws between 2012 and 2019.[161] In addition, DIH charges have escalated exponentially in response to the current overdose crisis. "Between 2012 and 2018 alone, the recorded number of DIH prosecutions jumped from 109 to 696," which means that prosecutors increased their reliance on DIH laws by more than 500% in just six years.[162]

Drug-induced homicide laws are classic Old Drug War weapons because they make it easier for the state to charge and convict someone for homicide or manslaughter for simply sharing drugs with another person, including a family member or a friend, who fatally overdoses on those substances.[163] They accomplish this by eliminating or reducing the

[160] Prescription Drug Abuse Pol'y Sys., Drug Induced Homicide Laws, https://pdaps.org/datasets/drug-induced-homicide-1529945480-1549313265-1559075032 [https://perma.cc/8JHV-NRLP] (last visited Apr. 9, 2024) (indicating that 23 states and the federal government have a drug-induced homicide law); Fair & Just Prosecution, Drug-Induced Homicide Prosecutions 2 (July 2022), https://fairandjustprosecution.org/wp-content/uploads/2022/07/FJP-Drug-Induced-Homicide-Brief.pdf [https://perma.cc/L64M-Q8DR] ("Since their introduction in the 1980s, drug-induced homicide laws have spread to 23 states, the District of Columbia, and the federal system.").

[161] Proliferation of New & Expanded Laws Recasting Overdose as Homicide / Murder / Manslaughter (2009–2019), Action Lab, Ctr. for Health Pol'y & L., https://www.healthinjustice.org/drug-induced-homicide [https://perma.cc/5ZTU-5TNB] (last visited Apr. 9, 2024). Data collection stopped in 2019, so there are likely additional laws that were not captured by this table.

[162] Leo Beletsky, Emma Rock & Sunyou Kang, Drug-Induced Panic: Overdose Mortalities and Related Harms Require a Public Health Response, Not More Criminalization and Incarceration, Inquest (Apr. 14, 2022), https://inquest.org/drug-induced-panic/ [https://perma.cc/4RJ2-L46V]; see also Rosa Goldensohn, They Shared Drugs. Someone Died. Does That Make Them Killers?, N.Y. Times (May 25, 2018), https://www.nytimes.com/2018/05/25/us/drug-overdose-prosecution-crime.html [https://perma.cc/Z2Z4-BHRG] (reporting that the newspaper investigation "found more than 1,000 prosecutions or arrests in accidental overdose deaths" in 15 states since 2015).

[163] Goldensohn, supra note 162 ("Using laws devised to go after drug dealers, [prosecutors] are charging friends, partners and siblings. The accused include young people who shared drugs at a party and a son who gave his mother heroin after her pain medication had been cut off. Many are fellow users, themselves struggling with addiction."); Shuler, supra note 158 ("[A]cross the country, as public health officials have struggled to address the opioid and overdose crisis, prosecutors have adopted a decidedly 'tough on crime' approach. Increasingly, this has meant treating overdose deaths as murders and seeking to level harsh penalties against dealers, even small-time drug users . . . who have supplied people with the drugs that killed them.").

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element of criminal intent from the crime.[164] In fact, DIH laws often create strict liability crimes because they do not require the state to prove *any* criminal intent (or mens rea) to return a guilty verdict.[165] As a result, DIH laws relieve prosecutors from their traditional duty to prove that the defendant delivered, sold, or distributed the drug that contributed to the overdose death with the criminal intent to cause that fatality.[166]

Imagine a scenario where Friend *A* procures drugs and then uses or shares those drugs with Friend *B*. Friends *A* and *B* proceed to take precisely the same dose of precisely the same drug but, for any number of reasons, Friend *A* survives while Friend *B* dies. This sort of activity on the part of Friend *A* could never be prosecuted as a homicide under a criminal statute that demands an intentional, knowing, reckless, or even negligent criminal intent because Friend *A* had no such intent.[167] Under a typical DIH statute, however, the state is only required to prove that Friend *A* knew that they had shared a specific substance with Friend *B* to convict Friend *A* of homicide or manslaughter.[168]

The specific purposes of DIH laws are unclear.[169] Certain DIH proponents argue that the enforcement of such laws is necessary to punish people who deal drugs that result in fatal overdoses because otherwise, such individuals are simply "getting away with murder."[170] These

[164] Eric A. Johnson, Understanding General and Specific Intent: Eight Things I Know for Sure, 13 Ohio St. J. Crim. L. 521, 534–35 (2016).

[165] Id. at 535.

[166] In 2014, the United States Supreme Court ruled that federal prosecutors must prove beyond a reasonable doubt that the drug provided by the defendant was the "but-for" cause of the overdose death. Burrage v. United States, 571 U.S. 204 (2014); see also Valena E. Beety, The Overdose/Homicide Epidemic, 34 Ga. St. U. L. Rev. 983, 984–85 (2018). However, state DIH laws may differ from the language of the federal DIH enhancement and, as such, may not require "but-for" causal proof. See, e.g., Phil Dixon, Defending Death by Distribution Cases, N.C. Crim. L. Blog (Jan. 21, 2020), https://nccriminallaw.sog.unc.edu/defending-death-by-distribution-cases/ [https://perma.cc/53KW-XTZG].

[167] Johnson, supra note 164, at 534–35 (Drug-induced homicide statutes "generally require, first, that the defendant deliver one of several specified controlled substances—e.g., heroin, methamphetamine, or cocaine—and, second, that another person die as the result of ingesting the controlled substance. The statutes do not require the government to prove that the defendant was reckless or negligent with respect to the social harm that is the target of the statute. Instead, by way of *mens rea*, they typically require the government only to prove that the defendant knew that he or she was delivering the controlled substance.").

[168] Id.

[169] Goldensohn, supra note 162 (contending that "there is no consensus on [the] purpose" of drug-induced homicide laws).

[170] Why Are Drug Dealers Getting Away with Murder?, Stop Drug Homicide, https://stopdrughomicide.org/ [https://perma.cc/WQL4-5Q2U] (last visited Aug. 25, 2024).

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advocates frame DIH prosecutions as "justice" for persons who die from accidental drug overdoses.[171]

Others point to theories of general and specific deterrence to justify their support of DIH laws.[172] Such theories contend that the imposition of heightened criminal legal sanctions, including harsh punishments and severe penalties, like life sentences, operate to change undesirable social behavior, like drug use, and, thereby, reduce the number of overdose deaths.[173] The efficacy of deterrence theories in drug use and other contexts, however, has been called into question.[174]

Classical deterrence theory posits that punishment must be sufficiently certain, swift, severe, and proportionate to the crime to operate as a deterrent to law breaking.[175] Certainty—that is, "the likelihood or risk of detection and subsequent punishment"[176]—and swiftness, however, are not reliable characteristics of the American criminal legal system.[177] A

[171] Id.; see also Goldensohn, supra note 162 (reporting that, to some, DIH "cases are not meant to achieve public policy goals, but as a balm for grieving families or punishment for a callous act" and quoting the chief prosecutor in Washington County, Minnesota as stating that DIH defendants "owe [him] for that dead kid").

[172] Goldensohn, supra note 162 (explaining that certain DIH law proponents "believe they will reduce the flow of drugs into their communities, deter drug use or help those with addiction 'hit bottom' " and that "many law enforcement officers hope that [DIH] cases [will] act as a deterrent").

[173] See, e.g., Alex R. Piquero, Raymond Paternoster, Greg Pogarsky & Thomas Loughran, Elaborating the Individual Difference Component in Deterrence Theory, 7 Ann. Rev. L. & Soc. Sci. 335, 336–37 (2011); Simon Lenton, Deterrence Theory and the Limitations of Criminal Penalties for Cannabis Use, *in* Preventing Harmful Substance Use 267, 268 (Tim Stockwell, Paul J. Gruenewald, John W. Toumbourou & Wendy Loxley eds., 2005).

[174] Alexis B. Apel & James W. Diller, Prison as Punishment: A Behavior-Analytic Evaluation of Incarceration, 40 Behav. Analyst 243, 245 (2017); Piquero et al., supra note 173, at 336 (providing that "[a] voluminous literature addresses this topic, some of which supports the view that punishment enhances compliance, some that punishment weakens compliance, some that sanctions have no appreciable effect on compliance, and some that sanctions/compliance depend on several moderating factors"); id. at 336–37 (summarizing the studies that called into question whether deterrence was effective in the domestic violence context); Lenton, supra note 173, at 268 ("Despite the prevalence of deterrence theory in academic and popular understandings of the law in society, research and theory in criminology and sociology have called into question deterrence theory and its apparent over-dependence on legal penalties."); see also id. at 269–71 (providing a literature review of studies that undermine the efficacy of deterrence theory with a specific emphasis on cannabis use).

[175] Kelli D. Tomlinson, An Examination of Deterrence Theory: Where Do We Stand?, 80 Fed. Probation J. 33, 33 (2016); Lenton, supra note 173, at 268; see also Piquero et al., supra note 173, at 337 (defining certainty, swiftness, and severity in this context).

[176] Piquero et al., supra note 173, at 337.

[177] Apel & Diller, supra note 174, at 247 ("[A]n offender's probability of incarceration is relatively low. According to analysis of archival data, the probability of being incarcerated for

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recent Pew report shined a spotlight on the failures of deterrence theory and its attendant tough-on-crime drug-related policies.[178] As it explained, "[t]he theory of deterrence would suggest . . . that states with higher rates of drug imprisonment would experience lower rates of drug use among their residents."[179] Yet, the researchers "found no statistically significant relationship between state drug imprisonment rates and three indicators of state drug problems: self-reported drug use, drug overdose deaths, and drug arrests."[180]

Moreover, and as discussed above, sudden shifts in the drug supply often provoke a more unpredictable supply that enhances—rather than mitigates—overdose-related morbidity and mortality.[181] For example, "recent research has suggested that the discontinuation of opioid analgesics for chronic pain increases an individual's risk of experiencing a subsequent overdose and other opioid-related adverse events" and that "prescribed use of opioid analgesics may also reduce . . . overdose [risk], because analgesics can be dosed with much greater precision than illicitly produced opioids, thereby reducing the overdose risk associated with such uncertainty."[182]

Fear of homicide arrest and prosecution also exacerbates overdose fatalities by decreasing the likelihood that a person who provides drugs to, or co-uses drugs with, another will call 911 if their client or partner

homicide is .498. For rape, the probability is .173. For other crimes (e.g., robbery, assault, and motor vehicle theft), the probabilities are even lower (.065, .044, and .01, respectively)." (citations omitted)); see also id. ("Given how unlikely it is that an offender is caught, convicted, and incarcerated, offenders may assume that their criminal behavior will not be consequated."); id. at 248 (noting that "[t]he delay between arrest and sentencing is, on average, almost 9 months").

[178] Pew Charitable Trs., More Imprisonment Does Not Reduce State Drug Problems (Mar. 2018), https://www.pewtrusts.org/-/media/assets/2018/03/pspp_more_imprisonment_does_not_reduce_state_drug_problems.pdf [https://perma.cc/SRH6-Q3SC].

[179] Id. at 5.

[180] Id. at 1.

[181] Werle & Zedillo, supra note 102, at 330–32.

[182] Grant Victor et al., Buprenorphine and Opioid Analgesics: Dispensation and Discontinuity Among Accidental Overdose Fatalities in the Indianapolis Metropolitan Area, 2016–2021, 150 J. Substance Use & Addiction Treatment, 2023, at 1, 2 (citations omitted).

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experiences an overdose.[183] While Good Samaritan laws[184] often protect persons calling emergency services to report an overdose from drug possession and drug paraphernalia prosecutions,[185] most do not protect the caller from being arrested or charged with drug-induced homicide.[186] DIH laws, therefore, undermine the positive, public health impacts of Good Samaritan laws by increasing the likelihood that an overdose will turn deadly.[187]

In other words, DIH laws are not evidence-based, public-health-promoting strategies responsive to increased overdose mortality. Indeed,

[183] Amy Lieberman & Corey Davis, Legal Interventions to Reduce Overdose Mortality: Overdose Good Samaritan Laws, Network for Pub. Health L. (July 17, 2023), https://www.networkforphl.org/resources/legal-interventions-to-reduce-overdose-mortality-overdose-good-samaritan-laws/ [https://perma.cc/Q56B-E3KG] ("Many individuals . . . fear that alerting EMS to an overdose might result in themselves, the person overdosing, or both being arrested or prosecuted for possession of illegal drugs, drug paraphernalia, violation of probation, or other crimes."); Legis. Analysis & Pub. Pol'y Ass'n, Good Samaritan Fatal Overdose Prevention and Drug Induced Homicide: Summary of State Laws 3 (2022), http://legislativeanalysis.org/wp-content/uploads/2022/12/Good-Samaritan-Fatal-Overdose-Prevention-And-Drug-Induced-Homicide-Summary.pdf [https://perma.cc/F4BT-VFF3] (observing that "research indicates that there is often a reluctance among those witnessing an overdose to summon emergency assistance from law enforcement or other first responders out of fear of arrest for drug possession or other charges").

[184] "Good Samaritan laws have endured a historic legacy spanning thousands of years" and require "a general duty to assist" those exposed to "grave physical harm" and other danger. John T. Pardun, Comment, Good Samaritan Laws: A Global Perspective, 20 Loy. L.A. Int'l & Compar. L.J. 591, 591, 593 (1998) (quoting Good Samaritan Statute, Black's Law Dictionary Pocket Edition (1st ed. 1996)). Good Samaritan laws that are specific to drug overdoses offer some legal immunity to certain persons who call 911 following an overdose. Lieberman & Davis, supra note 183; Legislative Analysis and Public Policy Association, supra note 183, at 3.

[185] Legislative Analysis and Public Policy Association, supra note 183, at 5–6; Amanda D. Latimore & Rachel S. Bergstein, "Caught with a Body" Yet Protected by Law? Calling 911 for Opioid Overdose in the Context of the Good Samaritan Law, 50 Int'l J. Drug Pol'y 82, 83 (2017).

[186] Legislative Analysis and Public Policy Association, supra note 183, at 14.

[187] Beletsky et al., supra note 162 (explaining that "[p]ublic health initiatives, such as Good Samaritan Laws, aim to encourage calling for medical help, preventing fatal overdoses. But these policies are rendered useless by enforcement of DIH laws"); see also Latimore & Bergstein, supra note 185, at 87 (finding that bystanders in a Maryland study feared homicide charges even where the state did not have a formal policy of prosecuting drug-induced homicide, undermining existing Good Samaritan laws); Drug Pol'y All., An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane 3 (2017), https://www.hivlawandpolicy.org/sites/default/files/An%20Overdose%20Death%20is%20not%20Murder%2C%20DPA.pdf [https://perma.cc/YZA9-EGGC] (observing that Good Samaritan laws' "public health approach to problematic drug use . . . is rendered useless by enforcement of drug-induced homicide laws").

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recent qualitative work reveals that individuals with close ties to someone charged with DIH were more likely to admit that they would not call 911 when witnessing a drug overdose.[188] As the research team explained, "if the goal of DIH laws is to deter people who use drugs by solidifying perceptions of the certainty, severity, and swiftness of enforcement action, then these prosecutions may, in fact, have measurable deterrent effect—but against potentially life-saving overdose response strategies, not against drug market participation."[189] Another report contends that the arrest of individuals who sell drugs increases overdose death rates in the area that they served because it creates a hole in the market that is quickly filled by a new person with an unfamiliar supply.[190] Research further indicates that the ability to purchase drugs from a known and trusted person is a protective factor against overdose deaths and other drug-use-related harms.[191]

As the evidence makes clear, DIH laws are ineffective at reducing overdose-related morbidity and mortality. Their enforcement also perpetuates American drug policy's longstanding trend of targeting racialized and marginalized individuals for arrest and imprisonment. Media coverage of drug-induced homicide charges suggests that individuals racialized as Black or Asian who are convicted for DIH serve considerably longer sentences than do their white counterparts.[192] Worse yet, prosecutors have disproportionately brought DIH charges in cases where the victim is white and the arrestee is a person of color.[193]

DIH laws also increase stigma and barriers to accessing harm reduction services, medical services, and treatment for substance use disorders by

[188] Jennifer J. Carroll et al., Drug Induced Homicide Laws May Worsen Opioid Related Harms: An Example from Rural North Carolina, 97 Int'l J. Drug Pol'y, 2021, at 1, 4–5.

[189] Id. at 5 (internal citations omitted).

[190] Drug Policy Alliance, supra note 187, at 39; see also Ray et al., supra note 103, at 753–56 (observing results consistent with a "causal relationship between law enforcement drug market disruptions and overdose").

[191] Jennifer J. Carroll, Josiah D. Rich & Traci C. Green, The Protective Effect of Trusted Dealers Against Opioid Overdose in the U.S., 78 Int'l J. Drug Pol'y, 2020, at 1, 7.

[192] Action Lab, Ctr. for Health Pol'y & L., Drug Induced Homicide, https://www.healthinjustice.org/drug-induced-homicide [https://perma.cc/5ZTU-5TNB] (last visited Apr. 9, 2024). Analysis of media mentions of drug-induced homicide charges reveal that Black persons receive median sentences of 10 years, Asian persons receive median sentences of 13.5 years, and white persons receive median sentences of 6 years. Id.

[193] Valena E. Beety, Alex D. Kreit, Anne Boustead, Jeremiah Goulka & Leo Beletsky, Drug-Induced Homicide: Challenges and Strategies in Criminal Defense, 70 S.C. L. Rev. 707, 709 (2019).

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contributing to the criminalization of people who use and sell drugs.[194] The laws exacerbate the "codification of stigma" of drug possession and distribution,[195] which undermines public health efforts to address overdose deaths.[196] This is because stigma and criminalization motivate medical providers to avoid treatment relationships with patients who are associated with illicit-drug-use behavior and disincentivize providers from prescribing medications to treat opioid use disorder, the gold-standard treatment.[197]

2. Fentanyl-Related Product Scheduling

As discussed above, one of the hallmarks of the Nixonian War on Drugs was its delegation of final determinations about a drug's risk-benefit profile to a law enforcement agency—the DEA, whose primary mission is policing—and not to a scientific health agency staffed with pharmacological and toxicological experts.[198] The DEA accomplishes its CSA scheduling function by placing drugs and other substances on one of five controlled substance schedules (Schedules I–V) based on their (1) potential for misuse, (2) medicinal value, and (3) safety.[199] The Schedules escalate in their risk profiles from lower to higher schedules (e.g., V–I) such that Schedule V controlled substances have the lowest risk of misuse,[200] while Schedule I drugs have been deemed to be so high risk that they are illicit and, thus, cannot be lawfully prescribed.[201]

The DEA has historically deployed its scheduling powers to prohibit or further constrain access to a drug that is either unscheduled or placed

[194] Drug Policy Alliance, supra note 187, at 4.

[195] Alexander C. Tsai et al., Stigma as a Fundamental Hindrance to the United States Opioid Overdose Crisis Response, 16 PLoS Med, 2019, at 1, 5 ("Laws criminalizing the possession and distribution of certain substances codify stigma through both normative and instrumental pathways.").

[196] Corey Davis, Traci Green, Lindsay LaSalle & Leo Beletsky, State Approaches to Addressing the Overdose Epidemic: Public Health Focus Needed, 47 J.L. Med. & Ethics 43, 43–44 (2019).

[197] Tsai et al., supra 195, at 4.

[198] DEA Mission Statement, U.S. Drug Enf't Admin., https://www.dea.gov/about/mission [https://perma.cc/L6Z6-WXEF] (last visited Apr. 10, 2024); see supra text accompanying notes 80–81.

[199] 21 U.S.C. § 812(a), (b).

[200] Id. § 812(b)(5).

[201] Id. § 812(b)(1); id. § 829; see also United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 490–93 (2011) (explaining that it is illegal to distribute Schedule I drugs except for limited research purposes and, thus, the CSA makes it illegal to prescribe or administer Schedule I drugs).

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on a lower schedule once the agency targets that drug for enhanced enforcement. Consider, for example, the DEA's scheduling decisions around buprenorphine, a semisynthetic partial opioid agonist, and a gold-standard treatment for opioid use disorder.[202] From 1970 until 1985, the DEA classified buprenorphine as a Schedule II controlled substance.[203] In 1981, the FDA approved buprenorphine as an analgesic (e.g., a pain reliever).[204] In response to that approved indication and the drug's safety profile, the DEA down-scheduled the drug to Schedule V in 1985.[205]

In 2002, however, the FDA approved two sublingual formulations of buprenorphine to treat opioid use disorder.[206] It is important to note that between 1970 and 2002, nothing notable about buprenorphine's toxicological profile had changed. The DEA nonetheless concluded that the FDA's approval of buprenorphine in sublingual form to treat opioid use disorder enhanced the drug's potential for abuse and, therefore, proceeded to up-schedule the drug—in any and all of its formulations—from Schedule V to Schedule III.[207]

The DEA has more recently turned its scheduling attention to fentanyl-related analogues. In its licit form, fentanyl is an FDA-approved, synthetic opioid agonist that is widely used as an analgesic and anesthetic in the

[202] Buprenorphine, Substance Abuse & Mental Health Servs. Admin., https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine [https://perma.cc/X89G-46TW] (last visited Apr. 10, 2024); Joan Stephenson, New Federal Policy Expands Access to Buprenorphine for Treating Opioid Use Disorder, 2 JAMA Health F., 2021, at 1, 1 (noting that the Assistant Secretary for Health & Human Services stated that "[t]he medical evidence is clear: access to medication-assisted treatment, including buprenorphine that can be prescribed in office-based settings, is the gold standard for treating individuals suffering from opioid use disorder").

[203] Jennifer D. Oliva, Policing Opioid Use Disorder in a Pandemic, U. Chi. L. Rev. Online (2020), https://lawreviewblog.uchicago.edu/2020/11/16/covid-oliva/ [https://perma.cc/RW9C-QZT9].

[204] Id.; see also Schedules of Controlled Substances: Rescheduling of Buprenorphine from Schedule V to Schedule III, 67 Fed. Reg. 62354, 62354 (Oct. 7, 2002) (detailing the historical use of buprenorphine as an analgesic following 1981).

[205] Schedules of Controlled Substances: Rescheduling of Buprenorphine from Schedule V to Schedule III, 67 Fed. Reg. at 62354.

[206] Substance Abuse & Mental Health Servs. Admin., Ctr. for Substance Abuse Treatment, Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction, at xv (2004).

[207] 21 C.F.R. § 1308.13(e)(2)(i) (2023).

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United States.[208] It has been long-classified as a Schedule II controlled substance.[209]

According to the Centers for Disease Control and Prevention, however, the current wave of our overdose crisis is driven by highly potent, *illicit* fentanyl products—often in dangerous combination with other drugs like cocaine, methamphetamine, and xylazine.[210] In addition, as the nature of the substances driving overdose deaths has evolved, the demographics of the victims of the overdose crisis have markedly shifted. As recently reported by the Substance Abuse and Mental Health Services Administration ("SAMHSA"), people racialized as Black are disproportionately negatively impacted by fentanyl and polysubstance-driven overdoses:

> Attention to this [opioid] epidemic has focused primarily on White suburban and rural communities. Less attention has focused on Black / African American communities which are similarly experiencing dramatic increases in opioid misuse and overdose deaths. The rate of increase of Black / African American drug overdose deaths between 2015–2016 was 40 percent compared to the overall population increase at 21 percent. This exceeded all other racial and ethnic population groups in the U.S. From 2011–2016, compared to all other populations, Black / African Americans had the highest increase in overdose death rate for opioid deaths involving synthetic opioids like fentanyl and fentanyl analogs.[211]

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[208] Fentanyl, Nat'l Inst. on Drug Abuse, https://nida.nih.gov/research-topics/fentanyl [https://perma.cc/C7HN-LK8Z] (last visited Apr. 10, 2024).

[209] 21 U.S.C. § 812(c).

[210] Mbabazi Kariisa, Julie O'Donnell, Sagar Kumar, Christine L. Mattson & Bruce A. Goldberger, Illicitly Manufactured Fentanyl-Involved Overdose Deaths with Detected Xylazine—United States, January 2019–June 2022, 72 Morbidity & Mortality Wkly. Rep. 701, 721 (June 30, 2023) ("In 2022, provisional data indicated that more than two thirds (68%) of the reported 107,081 drug overdose deaths in the United States involved synthetic opioids other than methadone, principally illicitly manufactured fentanyls . . . ."); Deidre McPhillips, Opioids Mixed with Cocaine or Psychostimulants Are Driving More Overdose Deaths, CDC Data Show, CNN (July 19, 2023, 7:24 AM), https://www.cnn.com/2023/07/19/health/overdose-deaths-cocaine-meth-opioids-cdc-report/index.html [https://perma.cc/FDH2-LPSH].

[211] Substance Abuse & Mental Health Servs. Admin., The Opioid Crisis and the Black / African American Population: An Urgent Issue 3 (2020), https://store.samhsa.gov/sites/default/files/pep20-05-02-001.pdf [https://perma.cc/SCL3-H6UR] (footnotes omitted); see also Bridget M. Kuehn, Black Individuals Are Hardest Hit by Drug Overdose Death Increases, 328 JAMA 702, 702–03 (2022) ("Fueled largely by illicit fentanyl or fentanyl analogues, the relative overdose death rate increased by 44% among Black people and by 39% among

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In 2018, the DEA issued a temporary scheduling order, which made it unlawful to possess, use, sell, or distribute all unscheduled "fentanyl-related substances," including "those that have not yet been introduced by traffickers into the U.S. market" by placing those substances on Schedule I and, thereby, deeming them illicit.[212] Notwithstanding the fact that the DEA's temporary Schedule I classification of fentanyl-related drug products has failed to reduce the rate of fentanyl-related overdose fatalities for over half a decade, Congress has joined the fray with the support of the Biden Administration. On May 25, 2023, the House of Representatives passed the HALT Fentanyl Act, which would make the DEA's temporary scheduling order permanent, on a 289-133 vote with the support of 74 Democrats.[213]

In other words, Congress's bipartisan response to the fentanyl/polysubstance overdose crisis, which has disproportionately negatively impacted individuals racialized as Black, is a classic War on Drugs approach: severely criminalizing the individuals who use, possess, or sell the target substance.[214] If the past is any guide, we can expect at

American Indian and Alaska Native individuals—the largest increases of the population groups studied. In comparison, the data showed a 22% relative rate increase among White people.").

[212] Schedules of Controlled Substances: Temporary Placement of Fentanyl-Related Substances in Schedule I, 83 Fed. Reg. 5188, 5188–92 (Feb. 6, 2018).

[213] Jordan Rubin, Biden Is Backing the Latest Failed Chapter in the Fentanyl-Related Drug War, MSNBC (June 4, 2023, 7:04 AM), https://www.msnbc.com/deadline-white-house/deadline-legal-blog/halt-fentanyl-act-biden-rcna87524 [https://perma.cc/C9DT-NY3Y]; Karoun Demirjian, House Passes Bill to Make Penalties Permanent for Fentanyl-Related Drugs, N.Y. Times (May 25, 2023), https://www.nytimes.com/2023/05/25/us/politics/fentanyl-bill-house.html [https://perma.cc/BM3N-3BMZ]. As this Article goes to print, the Act continues to await action in the Senate. See H.R. 467—HALT Fentanyl Act, Congress.gov, https://www.congress.gov/bill/118th-congress/house-bill/467/all-actions [https://perma.cc/25FF-LBHN] (last visited Aug. 5, 2024).

[214] See, e.g., Open Soc'y Founds., Why We Need Drug Policy Reform, https://www.opensocietyfoundations.org/explainers/why-we-need-drug-policy-reform [https://perma.cc/YT66-3CYE] (last updated June 2021) (noting that "poorly designed drug policies, the criminalization of people who use drugs . . . and other low-level actors, and harsh enforcement measures have fueled social marginalization, health crises, and mass incarceration"); Jason Tan de Bibiana et al., Vera Inst., Changing Course in the Overdose Crisis: Moving from Punishment to Harm Reduction and Health 1 (Feb. 2020), https://www.vera.org/downloads/publications/changing-course-in-the-overdose-crisis.pdf [https://perma.cc/G2W8-R7ZD] (opining that "relying on criminalizing drug use and enforcement-led approaches does not work" and "it is now firmly established that the long-running 'war on drugs' in the United States has not only failed to reduce illicit drug use and associated crime but has also contributed mightily to mass incarceration and exacerbated racial disparities within the criminal justice system, with a particularly devastating impact on Black communities").

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least three outcomes from this punitive drug war approach: (1) an intense yet racially disparate enforcement of drug laws that carry severe criminal penalties,[215] (2) an unstable, constantly fluctuating, ever more dangerous underground drug market,[216] and (3) an increase in overdose-related morbidity and mortality.[217]

3. Civil Punishment

Regardless of the popular public health rhetoric concerning substance use disorders in the mainstream discourse, there has been little abatement of the dramatic civil collateral consequences that attend to individuals who use drugs, have a drug use disorder, or have a drug arrest or conviction. In 2021, for example, the Biden Administration ignored a request to reconsider its enforcement of the federal law that denies public housing benefits to individuals who use cannabis and the family members with whom they reside.[218] That draconian statute requires landlords to deny housing to—and terminate the tenancies of—eligible households if any individual in the household uses cannabis.[219] Because cannabis is an illicit substance under federal law, the federal prohibition on access to affordable housing applies even where an individual household member's cannabis use is pursuant to a legitimate medical need accompanied by a bona fide medical prescription or otherwise entirely in compliance with state law.[220]

[215] See, e.g., Taifa, supra note 3.

[216] See, e.g., Vanila M. Singh, Thom Browne & Joshua Montgomery, The Emerging Role of Toxic Adulterants in Street Drugs in the US Illicit Opioid Crisis, 135 Pub. Health Reps. 6, 7 (2020) (explaining that the current illicit drug market is in flux, complex, adulterated, toxic, and more health harming).

[217] See, e.g., Tan de Bibiana et al., supra note 214, at 5–8.

[218] Andrea Steel & Lila Greiner, No Roof for Your Reefer! Medical Cannabis Tenants Need Patient Protections in Federally Assisted Housing, Am. Bar Ass'n (May 11, 2022), https://www.americanbar.org/groups/tort_trial_insurance_practice/publications/tortsource/2022/spring/no-roof-your-reefer-medical-cannabis-tenants/ [https://perma.cc/CF3B-D8XD]; Ally Schweitzer, Norton Asks Biden Administration to Allow Marijuana Use in Public Housing, DCist (May 27, 2021, 9:08 AM), https://dcist.com/story/21/05/27/norton-asks-biden-administration-to-allow-marijuana-use-in-public-housing/ [https://perma.cc/9MBY-LVCR].

[219] 42 U.S.C. § 13662(a)(1).

[220] Id.; see also Benjamin T. Metcalf, Memorandum from U.S. Dep't of Hous. & Urban Dev. to Pub. Hous. Dirs. and Landlords on Use of Marijuana in Multifamily Assisted Properties (Dec. 29, 2014), https://www.hud.gov/sites/documents/USEOFMARIJINMFASSISTPROPTY.PDF [https://perma.cc/MT6L-59RE] (clarifying that federal law requires owners to deny admission to affordable housing for any individual who uses medical marijuana).

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Civil law also continues to create significant obstacles to evidence-based substance use disorder treatment for individuals who are pregnant or postpartum.[221] It is uncontroversial that opioid agonist pharmacotherapy is the recommended treatment for pregnant individuals with opioid use disorder.[222] Such medication therapy is, in fact, preferable to medically supervised withdrawal because withdrawal is associated with high relapse rates, which lead to worse health and pregnancy-related outcomes.[223] People who are pregnant and seek evidence-based medication treatment, however, are often subject to harsh criminal and civil penalties.[224]

Prosecutors have a long history of deploying a panoply of criminal laws, including fetal harm statutes, to attack prenatal substance use and other pregnancy behaviors they view as fetal threats.[225] "These laws disproportionately impact racial and ethnic minorities and people who are

[221] See, e.g., Substance Abuse & Mental Health Servs. Admin., Evidence-Based, Whole-Person Care for Pregnant People Who Have Opioid Use Disorder 2 (May 2023), https://store.samhsa.gov/sites/default/files/pep23-02-01-002.pdf [https://perma.cc/53WX-YNAD] ("Effective medications exist to treat OUD during pregnancy, but rates of treatment remain low. Only 50 to 60 percent of pregnant people who have OUD take any medication for the treatment of the condition" and "barriers include a legal system that may penalize pregnant people who disclose their substance use to their provider when seeking help and the potential for child welfare system involvement, including removing a child from the home, if substance use or related treatment is identified during pregnancy.").

[222] See, e.g., Lynn M. Madden et al., Pregnant Women and Opioid Use Disorder: Examining the Legal Landscape for Controlling Women's Reproductive Health, 48 Am. J.L. & Med. 209, 210 (2022) ("According to the World Health Organization ('WHO'), the National Academy of Medicine ('NAM'), and the American College of Obstetricians and Gynecologists ('ACOG'), medication for OUD ('MOUD') with methadone or buprenorphine is the gold standard of treatment for OUD, including for pregnant women."); Jennifer J. Carroll, Taleed El-Sabawi & Bayla Ostrach, The Harms of Punishing Substance Use During Pregnancy, 98 Int'l J. Drug Pol'y, 2021, at 1, 3 (providing that "medications for opioid use disorder (MOUD), such as naltrexone for non-pregnant persons and methadone buprenorphine for pregnant and non-pregnant persons, are considered the gold standard of care for opioid use disorder (OUD) and are the only form of treatment found to reduce overdose risk at the population level").

[223] Kelley A. Saia et al., Caring for Pregnant Women with Opioid Use Disorder in the USA: Expanding and Improving Treatment, 5 Current Obstetrics Gynecology Reps. 257, 258 (2016) ("Opioid withdrawal (detoxification) in pregnancy is complex and has both risks associated with withdrawal and of relapse for the mother and the fetus. Current practice recommendations are to avoid opioid withdrawal (detoxification) as the benefits of opioid agonist treatment (OAT) for the mother and the fetus exceed the risks.").

[224] Madden et al., supra note 222, at 215–18; Carroll et al., supra note 222, at 3.

[225] Valena E. Beety & Jennifer D. Oliva, Policing Pregnancy "Crimes", 98 N.Y.U. L. Rev. Online 29, 35–51 (2023), https://www.nyulawreview.org/online-features/policing-pregnancy-crimes/ [https://perma.cc/JDE4-7HEP]; Cynthia Dailard & Elizabeth Nash, Guttmacher Rep. on Pub. Pol'y, State Responses to Substance Abuse Among Pregnant Women 3 (Dec. 2000).

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poor, who simultaneously lack access to prenatal healthcare and substance use treatment."[226] More than 1,700 people were arrested or detained between 1973 and 2020 on charges where being pregnant was a necessary element of the purported crime.[227] The Supreme Courts of Alabama and South Carolina have upheld convictions ruling that substance use during pregnancy constitutes criminal child abuse.[228] Prosecutions of pregnant people for drug use during pregnancy are likely to increase in the wake of the United States Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization*,[229] which overruled *Roe v. Wade* and its progeny[230] and, thereby, stripped pregnant people of their federal constitutional right to abortion health care.[231]

Meanwhile, numerous jurisdictions have expanded their civil child-welfare requirements to include prenatal substance use as child neglect so that in utero drug exposure can provide grounds for terminating parental rights without additional evidence of child abuse or neglect.[232] In addition, some states authorize the civil commitment (such as forced admission to an inpatient treatment program) of pregnant individuals who use drugs under the guise of protecting the fetus.[233] Nearly half of the states require health care professionals to report suspected prenatal drug exposure, which can later be used as evidence in child-welfare proceedings.[234] It should also be noted that, to remain eligible for federal

[226] Madden et al., supra note 222, at 211.

[227] Beety & Oliva, supra note 225, at 30.

[228] See State v. McKnight, 576 S.E.2d 168, 171–72 (S.C. 2003) (affirming McKnight's homicide by child abuse conviction on the theory that her use of cocaine while pregnant caused her stillbirth); Ex parte Ankrom, 152 So. 3d 397, 401–02 (Ala. 2013) (affirming Ankron's conviction for endangerment due to her post-delivery positive drug test for cocaine).

[229] 142 S. Ct. 2228, 2242 (2022).

[230] Roe v. Wade, 410 U.S. 113, 164–66 (1973); see also Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878–79 (1992) (plurality opinion) (upholding the constitutional right to abortion and creating the undue burden standard).

[231] Beety & Oliva, supra note 225, at 30 (explaining that *Dobbs* "gives [the] states the green light . . . to fervently police the gestational behavior of pregnant persons" and predicting that "[s]tates that choose to severely restrict or criminalize abortion are likely to enhance their policing of pregnant peoples' bodies and criminalization of pregnancy conduct and outcomes"); Katrina Kimport, Abortion After *Dobbs*: Defendants, Denials, and Delays, Sci. Advances, Sept. 2022, at 1, https://www.science.org/doi/10.1126/sciadv.ade5327 [https://perma.cc/C4R3-46KJ] (arguing that, "[f]ollowing *Dobbs*, we can expect a dramatic increase in the surveillance and criminalization of activities during pregnancy and inequality in how that happens").

[232] Dailard & Nash, supra note 225, at 3–5.

[233] Id. at 4.

[234] Madden et al., supra note 222, at 215–16.

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child abuse prevention funds, federal law mandates that states require their health care providers to report to child protective services whenever they provide care for an infant affected by illicit substance use.[235]

Several states have placed a priority on making drug treatment more readily available to pregnant women, which is bolstered by federal funds that require pregnant women to receive priority access to programs.[236] Unfortunately, these so-called "family friendly" programs often place extravagant and onerous burdens on mothers by, among other things, subjecting them to extensive drug testing requirements and other mandates and prohibiting them from contacting their other children.[237] In addition, and quite ironically, although such "family friendly" programs purportedly exist to protect children, they largely serve to supervise, detain, and surveil mothers with substance use disorders.[238] Fathers who struggle with drug use, on the other hand, are rarely subject to such compulsory conditions in exchange for evidence-based treatment simply because they are parents.

C. Ongoing Obstacles to Treatment and Harm Reduction

Our current drug policy approaches continue to mimic and extend Old Drug War tactics insofar as they remain resistant to expanded access to

[235] Id. at 216; see also Margaret Sturtevant, Shifting Mandated Reporting Laws from Family Surveillance to Assistance, Reg. Rev. (Dec. 14, 2021), https://www.theregreview.org/2021/12/14/sturtevant-shifting-reporting-surveillance-to-assistance/ [https://perma.cc/9JCT-Q9NB] ("Under the federal Child Abuse Prevention and Treatment Act (CAPTA), all states are required to have a mandated reporting law in order to receive federal funding for child abuse and neglect prevention and response."); Cong. Rsch. Serv., R40899, The Child Abuse Prevention and Treatment Act (CAPTA): Background, Programs, and Funding 4–5 (Nov. 4, 2009), https://www.everycrsreport.com/files/20091104_R40899_52b107ff31f0e25899fbe35212a7435e09a9a385.pdf [https://perma.cc/9JCT-Q9NB] (noting CAPTA requires state grant program recipients to have procedures for addressing referrals of known or suspected child abuse and noting most states require professionals to report suspected child abuse or neglect).

[236] Madden et al., supra note 222, at 219 (providing that "[t]wenty-eight states have created or funded drug treatment programs specifically targeted to pregnant individuals; twenty-three states and the District of Columbia provide pregnant women with priority access to state-funded drug treatment programs; and ten states prohibit publicly funded drug treatment programs from discriminating against pregnant women").

[237] Pamela Appea, For Parents with Substance Use Disorder, Advocates Call for Resource and Support Instead of Family Separation, Prism (July 12, 2022), https://prismreports.org/2022/07/12/parents-substance-use-disorder-support-not-separation/ [https://perma.cc/SB6Z-PE29]; Aukje Lamonica & Miriam Boeri, Stories of Loss: Separation of Children and Mothers Who Use Opioids, 15 J. Ethnographic & Qualitative Rsch. 63, 64–65 (2020).

[238] See, e.g., Rebecca Stone, Pregnant Women and Substance Use: Fear, Stigma, and Barriers to Care, Health & Just., Feb. 2015, at 3, 8–13.

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evidence-based treatment and proven-effective harm reduction strategies. This is evidenced by the country's ongoing low rates of access to gold-standard substance use disorder treatment, the shuttering or attempted shuttering of syringe service programs, and the refusal to approve or fund the operation of safe consumption spaces. Each of these New Drug War phenomena is discussed, in turn, in the following Subsection.

1. Access to Opioid Use Disorder Treatment

The United States has long had an abysmal track record of ensuring adequate access to methadone and buprenorphine, the gold-standard, evidence-based medication treatments for opioid use disorder ("OUD").[239] Due to these barriers, only one in five adults with OUD in the United States receives treatment that includes an efficacious OUD therapeutic.[240] In addition, the access problems that attend to OUD medications are inequitable across patient populations and treatment settings.[241] As detailed above, it is much more difficult for pregnant people to access medication treatment for OUD than other patient populations.[242]

Disparities in access to medication treatment also exist across racial and ethnic lines. Black Americans, for example, are far less likely to be prescribed buprenorphine for OUD than their white counterparts.[243] A study that analyzed 13.4 million buprenorphine prescriptions issued between 2012 and 2015 found that white people received 12.7 million—or 95%—of those prescriptions, while only 363,000 were provided to

[239] See supra note 202 and accompanying text.

[240] Nat'l Inst. on Drug Abuse, Only 1 in 5 U.S. Adults with Opioid Use Disorder Received Medications to Treat It in 2021 (Aug. 7, 2023), https://nida.nih.gov/news-events/news-releases/2023/08/only-1-in-5-us-adults-with-opioid-use-disorder-received-medications-to-treat-it-in-2021 [https://perma.cc/S423-YMY5].

[241] Nat'l Acads. of Scis., Eng'g & Med., Medications for Opioid Use Disorder Save Lives 63–101 (Alan I. Leshner & Michelle Mancher eds., 2019).

[242] Stephen W. Patrick et al., Association of Pregnancy and Insurance Status with Treatment Access for Opioid Use Disorder, JAMA Network Open, Aug. 14, 2020, at 1, 4–6 (conducting a secret shopper study that revealed that actors who identified as pregnant people were far less likely to access OUD treatment than their non-pregnant counterparts).

[243] Andis Robeznieks, Black Patients Less Likely to Get Treatment for Opioid-Use Disorder, Am. Med. Ass'n (Nov. 4, 2019), https://www.ama-assn.org/delivering-care/opioids/black-patients-less-likely-get-treatment-opioid-use-disorder [https://perma.cc/V3L8-RPLZ].

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minoritized patients.[244] Racialized and minoritized people have reduced access to evidence-based OUD treatment and, as a result, experience lower treatment completion rates and worse OUD-related health outcomes instigated by implicit bias and compounding socioeconomic factors, including higher rates of homelessness and unemployment.[245]

The effectiveness of methadone and buprenorphine in treating OUD is uncontroversial. As the National Academies of Sciences, Engineering, and Medicine explained in a 2019 report:

> Large systematic reviews and randomized controlled trials have demonstrated that treatment with either methadone or buprenorphine is associated with an array of positive outcomes, including fewer fatal overdose deaths, better treatment retention rates, lower rates of other opioid use, decreased mortality, less injection drug use, reduced transmission of HIV infections, improved social functioning, decreased engagement in criminal activity, and lower rates of neonatal abstinence syndrome. Expanding access to these medications reduces the number of deaths due to opioid overdose.[246]

Numerous factors, including stigma, lack of availability of a qualified provider, mistrust of medical professionals, lack of transportation, and lack of insurance or ability to afford treatment, contribute to the low rate of access to evidence-based treatment for individuals with OUD.[247]

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[244] Pooja A. Lagisetty, Ryan Ross, Amy Bohnert, Michael Clay & Donovan T. Maust, Buprenorphine Treatment Divide by Race/Ethnicity and Payment, 76 JAMA Psychiatry 979, 979 (2019).

[245] Brendan Saloner & Benjamin Lê Cook, Blacks and Hispanics Are Less Likely Than Whites to Complete Addiction Treatment, Largely Due to Socioeconomic Factors, 32 Health Affs. 135, 138 (2013).

[246] National Academies of Sciences, Engineering, and Medicine, supra note 241, at 18 (citations omitted); see also, e.g., Hilary Smith Connery, Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions, 23 Harv. Rev. Psychiatry 63, 63 (2015) (noting that "[e]ffective treatment of OUD has been identified as a national priority to reduce the rates and societal costs of individual disability associated with OUD, the infectious disease burden associated with intravenous opioid use (especially hepatitis C [HCV] and HIV transmission), and escalating rates of accidental opioid overdose deaths and pediatric opioid ingestions").

[247] See, e.g., National Academies of Sciences, Engineering, and Medicine, supra note 241, at 109–27; Amanda M. Bunting, Carrie B. Oser, Michele Staton, Katherine S. Eddens & Hannah Knudsen, Clinician Identified Barriers to Treatment for Individuals in Appalachia with Opioid Use Disorder Following Release from Prison: A Social Ecological Approach, 13 Addiction Sci. & Clinical Prac., 2018, at 1, 3–8; see also Haiden A. Huskamp, Lauren E. Riedel, Colleen L. Barry & Alisa B. Busch, Coverage of Medications that Treat Opioid Use Disorder and Opioids for Pain Management in Marketplace Plans, 2017, 56 Med. Care 505,

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Additional obstacles to quality OUD treatment stem from the federal government's longstanding policy of segregating OUD treatment from the traditional American health care delivery system[248] and imposing numerous, burdensome legal and regulatory qualifications on both OUD providers and their patients.[249] "In the United States, medications for treating OUD are typically delivered through high-threshold, low-tolerance models that require patients to comply with a number of strict requirements, such as frequent urine testing and weekly counseling sessions, in order to receive treatment."[250] Indeed, and in an effort designed virtually exclusively to prevent drug diversion at the expense of drug access, long-standing federal law required most opioid treatment

506 (2018) ("Insurance coverage limits may be one important barrier to broader use of OUD medications. Previous research has documented that many state Medicaid programs and large private health plans place restrictions on coverage of OUD medications."); Alene Kennedy-Hendricks et al., Primary Care Physicians' Perspectives on the Prescription Opioid Epidemic, 165 Drug & Alcohol Dependence 61, 68 (2016) (finding, among other things, that "larger proportions of physicians in our survey expressed negative attitudes toward people with prescription OUD than has the general public"); Colleen L. Barry, Emma Elizabeth McGinty, Bernice Pescosolido & Howard H. Goldman, Stigma, Discrimination, Treatment Effectiveness, and Policy: Public Views About Drug Addiction and Mental Illness, 65 Psychiatric Servs. 1269, 1270–71 (2014) (concluding that "the American public holds significantly more negative attitudes toward persons with drug addiction than toward those with mental illness, and these attitudes translate into lower support for policies to improve equity in insurance coverage or to increase government funding in support of better treatment rates and housing and job support options" and "addiction is often viewed as a moral shortcoming . . . , and the illegality of drug use reinforces this perspective").

[248] Alexander Y. Walley, Danielle Farrar, Debbie M. Cheng, Daniel P. Alford & Jeffery H. Samet, Are Opioid Dependence and Methadone Maintenance Treatment (MMT) Documented in the Medical Record? A Patient Safety Issue, 24 J. Gen. Internal Med. 1007, 1007 (2009) (explaining that methadone treatment for OUD in the United States is "restricted to federal- and state-regulated clinics" and that such clinics "are in locations that are separate from general medical care").

[249] Oliva, supra note 203, at 94–95 (explaining that the Controlled Substances Act "regulates [methadone and buprenorphine] more stringently when they are used to treat OUD than it does all other similarly scheduled drugs, including, in the case of buprenorphine, other opioids that the CSA schedule deemed to have a higher potential for abuse"); id. at 95–97 (enumerating the numerous burdensome federal rules that attend to OTPs and their patients); id. at 98–99 (enumerating the burdensome federal rules that attended to buprenorphine providers prior to recent reforms); National Academies of Sciences, Engineering, and Medicine, supra note 241, at 92 (observing that "[t]he Narcotic Addict Treatment Act of 1974 requires that methadone be administered to patients only through federally certified and regulated opioid treatment programs (OTPs), commonly referred to as methadone clinics" (footnote omitted)); id. at 92, 94–96 (listing several of the numerous burdensome federal requirements that attend to OTPs and buprenorphine providers).

[250] National Academies of Sciences, Engineering, and Medicine, supra note 241, at 96.

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program ("OTP") patients to travel to the clinic *on a daily basis* to be administered oral methadone under staff supervision.[251]

The COVID-19 pandemic and its social distancing requirements prompted a slew of federal waivers of the stringent requirements that had applied to methadone and buprenorphine treatment for OUD for half a century, including a relaxation of the rules that apply to take-home supplies of the drugs and their prescription via telehealth.[252] For example, on March 16, 2020, SAMHSA issued guidance that allowed OTPs to administer a twenty-eight-day take-home supply of OUD medication to "stable" OTP patients and a fourteen-day take-home supply to "less stable" patients.[253] Three days later, SAMHSA exempted OTPs from the requirement to perform an in-person physical examination to initiate buprenorphine treatment but did not extend that exemption to methadone initiation.[254] The agency also explained that current methadone and buprenorphine patients were permitted to receive OUD treatment via telehealth from either an OTP or an authorized buprenorphine prescriber for the duration of the public health emergency.[255]

Research indicates that these reforms increased access to medication treatment for OUD and improved the health outcomes associated with OUD.[256] As a result, medical experts called for the federal government to

[251] 42 C.F.R. § 8.12(i) (2022).

[252] See, e.g., Joanne Spetz et al., Changes in US Clinician Waivers to Prescribe Buprenorphine Management for Opioid Use Disorder During the COVID-19 Pandemic and After Relaxation of Training Requirements, JAMA Network Open, May 12, 2022, at 1.

[253] Substance Abuse and Mental Health Servs. Admin., Opioid Treatment Program (OTP) Guidance (Mar. 16, 2020), https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf [https://perma.cc/R4UN-GP7Z].

[254] Substance Abuse and Mental Health Servs. Admin., FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency (Apr. 21, 2020), https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf [https://perma.cc/MH9Y-N8FM] (expressly acknowledging that, "[f]or new OTP patients that are treated with methadone, the requirements of an in-person medical evaluation will remain in force").

[255] Id.

[256] Increased Use of Telehealth Services and Medications for Opioid Use Disorder During the COVID-19 Pandemic Associated with Reduced Risk for Fatal Overdose, Nat'l Insts. of Health (Mar. 29, 2023), https://www.nih.gov/news-events/news-releases/increased-use-telehealth-services-medications-opioid-use-disorder-during-covid-19-pandemic-associated-reduced-risk-fatal-overdose [https://perma.cc/5BGK-UYLE]; Ruth Hailu, Ateev Mehrotra, Haiden A. Huskamp, Alisa B. Busch & Michael L. Barnett, Telemedicine Use and Quality of Opioid Use Disorder Treatment in the US During the COVID-19 Pandemic, JAMA Network Open, Jan. 24, 2023, at 1, 1 (concluding "that clinical outcomes were similar among patients who were treated by clinicians with high and low telemedicine use during the COVID-19

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permanently adopt the access-to-medication reforms it put in place during the pandemic.[257] Nora Volkow, the director of the National Institute on Drug Abuse ("NIDA") argued that, "[i]f we now remove the flexibilities with telehealth, we will make the [opioid use disorder] problem even worse . . . . Patients will just go untreated."[258]

Consistent with its routine refusal to accede to the scientific and medical evidence that pertains to controlled substances,[259] the DEA took the opposite tack. As drug policy expert Corey Davis described, "[t]here's this tension between the federal agencies where you've got SAMHSA [, NIDA,] and the [Office of National Drug Control Policy] saying medications for opioid-use disorder are good . . . . And then you've got the DEA, which it's just in its DNA to try and control controlled substances."[260] On March 1, 2023, the DEA issued two proposed rules designed to roll back, at least in part, certain of the relaxed telehealth and take-home supply rules applicable to OUD medications that were in force during the pandemic.[261]

pandemic, suggesting that telemedicine is a comparable alternative to in-person OUD care"); Christopher M. Jones et al., Receipt of Telehealth Services, Receipt and Retention of Medications for Opioid Use Disorder, and Medically Treated Overdose Among Medicare Beneficiaries Before and During the COVID-19 Pandemic, 79 JAMA Psychiatry 981, 988 (2022) (finding that "beneficiaries who received OUD-related telehealth services had lower odds of experiencing medically treated overdose, and among the subset of beneficiaries receiving [medication treatment for OUD], those receiving OUD-related telehealth services had elevated odds for improved [medication treatment for OUD] retention").

[257] See, e.g., Erik Wicklund, How Will the End of the PHE Affect Telehealth and Digital Health?, healthleaders (Feb. 9, 2023), https://www.healthleadersmedia.com/technology/how-will-end-phe-affect-telehealth-and-digital-health [https://perma.cc/5A9R-YZQG]; Krista Mahr & Ben Leonard, 'Untreated': Patients with Opioid Addiction Could Soon Lose Access to Virtual Care, Politico (June 20, 2022, 8:41 PM), https://www.politico.com/news/2022/06/20/opioid-addiction-telehealth-00040568 [https://perma.cc/34R3-MXGQ].

[258] Mahr & Leonard, supra note 257.

[259] David Downs, The Science Behind the DEA's Long War on Marijuana, Sci. Am. (Apr. 19, 2016), https://www.scientificamerican.com/article/the-science-behind-the-dea-s-long-war-on-marijuana/ [https://perma.cc/T5V3-V2X6] (describing the DEA's placement of cannabis—a plant whose active ingredients have proven therapeutic value and "no obtainable lethal overdose threshold" in humans—on Schedule I as a "determination [that] has come to be insulated by a byzantine, Kafkaesque bureaucratic process now impervious to the opinion of the majority of U.S. doctors—and to a vast body of scientific knowledge").

[260] Mahr & Leonard, supra note 257.

[261] Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation, 88 Fed. Reg. 12875 (Mar. 1, 2023); Expansion of Induction of Buprenorphine via Telemedicine Encounter, 88 Fed. Reg. 12890 (Mar. 1, 2023).

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In addition to being entirely devoid of evidentiary support, the DEA proposals were met with fierce hostility.[262] The agency received 38,369 comments from patients, patient advocates, health care providers, and professional health organizations, many of which were fiercely opposed to the DEA's attempt to restrict access to OUD medications and other controlled substances that are prescribed to treat a panoply of complex, chronic conditions.[263] In the face of this intense resistance, the DEA temporarily relented on May 10, 2023, and agreed to extend the relaxed pandemic rules applicable to controlled substance prescribing until November 11, 2023.[264] The agency subsequently agreed to extend the relaxed rules until December 2024.[265] It appears that the Old Drug War agency remains committed to returning to its law-and-order tactics that severely restrict access to the medications that treat OUD as soon as possible.

2. Syringe Services Programs

Unfortunately, attempts to roll back policies that increase access to OUD treatment are not the only New Drug War attacks on proven-effective harm reduction approaches to drug use. Amid our ongoing, unprecedented overdose crisis, state and local policymakers have also taken aim at a different harm reduction strategy designed to improve drug

[262] DEA Rulemaking Docket: Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation (DEA407), Regulations.gov, https://www.regulations.gov/docket/DEA-2023-0029 [https://perma.cc/LW4R-4W3J] (last visited June 24, 2024).

[263] Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications, 88 Fed. Reg. 30037, 30037 (May 10, 2023); see also, e.g., Katie Adams, Providers Mostly Agree with the AMA's Views on Controlled Substance Prescribing Via Telemedicine, MedCityNews (Apr. 9, 2023), https://medcitynews.com/2023/04/providers-mostly-agree-with-the-amas-views-on-controlled-substance-prescribing-via-telemedicine/ [https://perma.cc/47EU-YF3H] (describing the physician response to the AMA's comments on the DEA's proposed rules for OUD treatment via telemedicine); Terri D'Arrigo, APA Responds to DEA's Proposed Rules Regarding Telehealth, Buprenorphine, Psychiatric News (Apr. 3, 2023), https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2023.05.5.47 [https://perma.cc/WQ5Z-F8N7] (describing the American Psychiatric Association's response to proposed rules that would extend flexibilities in OUD treatment enacted as part of the COVID-19 public health emergency).

[264] Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications, 88 Fed. Reg. at 30037.

[265] U.S. Drug Enf't Admin., DEA and HHS Extend Telemedicine Flexibilities Through 2024 (Oct. 6, 2023), https://www.dea.gov/documents/2023/2023-10/2023-10-06/dea-and-hhs-extend-telemedicine-flexibilities-through-2024 [https://perma.cc/9FLE-N35Z].

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use-related morbidity and mortality: syringe services programs ("SSPs").[266] SSPs "are community-based prevention programs that provide a range of social, medical, and mental health services—often including, but not limited to, the provision of sterile syringes, screening and treatment for infectious diseases and substance use disorders, and naloxone distribution—for individuals who inject drugs."[267] These programs have been studied for decades, and rigorous research demonstrates that SSPs are safe, cost-effective, and public-health-promoting.[268]

SSPs, for example, are associated with a fifty-percent reduction in the spread of infectious diseases, including HIV and hepatitis C.[269] The services provided by these programs significantly decrease needle sharing by individuals who inject drugs and protect both the public and first responders by promoting safe needle disposal.[270] In addition, individuals who engage with SSPs are five times more likely to voluntarily participate in drug treatment programs and three times more likely to quit using drugs than individuals who lack access to such services.[271]

SSPs are also excellent public health investments. Given the extravagant cost of treating HIV and other infectious diseases, a recent

[266] Sessi Kuwabara Blanchard, US Syringe Exchanges Are Still Under Attack (Part 1), TalkingDrugs (July 6, 2021), https://www.talkingdrugs.org/us-syringe-exchanges-are-still-under-attack-part-1/ [https://perma.cc/4FT9-GEAP] (explaining that "syringe access is facing a wave of revamped aggression. From rural counties to capital cities, regional US governments are limiting, shuttering, and even outright banning SSPs.").

[267] Jennifer D. Oliva, Taleed El-Sabawi, Sonia L. Canzater & Shelly R. Weizman, Defending Syringe Services Programs, Health Affs. Forefront (Aug. 23, 2021), https://www.healthaffairs.org/content/forefront/defending-syringe-services-programs [https://perma.cc/R2D4-WRKX].

[268] Safety and Effectiveness of Syringe Services Programs, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/syringe-services-programs/php/safety-effectiveness.html [https://perma.cc/V9ST-JVVQ] (last visited June 24, 2024) ("Nearly 30 years of research has shown that comprehensive SSPs are safe, effective, and cost-saving, do not increase illegal drug use or crime, and play an important role in reducing the transmission of viral hepatitis, HIV and other infections.").

[269] See Jerome M. Adams, Making the Case for Syringe Services Programs, 135 Pub. Health Rep., at 10S, 11S (2020); Esther J. Aspinall et al., Are Needle and Syringe Programmes Associated with a Reduction in HIV Transmission Among People Who Inject Drugs: A Systematic Review and Meta-Analysis, 43 Int'l J. Epidemiology 235, 245–46 (2014) (conducting a systematic review of literature on the effectiveness of needle-sharing programs on reducing HIV transmission and finding support for conclusions as to its effectiveness).

[270] Jonathan H. Mermin, Syringe Services Programs: Technical Package, Ctrs. for Disease Control & Prevention (Dec. 21, 2020), https://www.hiv.gov/blog/syringe-services-programs-technical-package [https://perma.cc/FTK9-X6HD].

[271] Centers for Disease Control and Prevention, supra note 268.

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study determined that an SSP with an annual budget of $500,000 would be cost-effective if the program prevented just three new HIV infections a year.[272] Another study concluded that areas with SSPs saved $363,821 annually per 100 individuals with injection drug use disorder due to hepatitis C avoidance.[273]

"Despite the evidence demonstrating their effectiveness, SSPs have been limited in number, scale, and scope in the U.S. due to persistent legal, policy, political, social, and funding barriers."[274] Federal law has long undermined the operation and expansion of SSPs by expressly prohibiting the use of federal funds to support their work due to concerns that such support would signal approval of drug use, encourage increased drug use, and undermine the government's punitive, law-and-order approach to drug control.[275] In 2016, Congress passed a consolidated appropriations bill that permitted the Department of Health and Human Services ("HHS") to provide funds to SSPs to support certain services under certain circumstances.[276] Federal law, however, continues to

[272] Don C. Des Jarlais, Jonathan Feelemyer, Courtney McKnight, Kelly Knudtson & Sara N. Glick, Is Your Syringe Services Program Cost-Saving to Society? A Methodological Case Study, Harm Reduction J., Dec. 2021, at 1, 4 ("Given the high cost of treating HIV infections and the modest budgets of SSPs, it is extremely likely at any SSP functioning very well in an area in which HIV transmission is under control (HIV incidence of 1/100 PWID per year) will be preventing a sufficient number of new HIV infections to be cost saving to society.").

[273] Stephen C. Ijioma, Vasco M. Pontinha, David A. Holdford & Norman V. Carroll, Cost-Effectiveness of Syringe Services Programs, Medications for Opioid Use Disorder, and Combination Programs in Hepatitis C Harm Reduction Among Opioid Injection Drug Users: A Public Payer Perspective Using a Decision Tree, 27 J. Managed Care & Specialty Pharmacy 137, 142 (2021).

[274] Christopher M. Jones, Syringe Services Programs: An Examination of Legal, Policy, and Funding Barriers in the Midst of the Evolving Opioid Crisis in the U.S., 70 Int'l J. Drug Pol'y 22, 22 (2019).

[275] Id. at 23 (noting that "in 1988, Congress prohibited the use of federal funds to support SSPs due to concerns this would signal government endorsement of drug use, increase use and injection, and contradict law enforcement efforts").

[276] Syringe Services Programs (SSPs) Determination of Need for Syringe Services Programs, Ctrs. for Disease Control & Prevention (Dec. 20, 2023), https://www.cdc.gov/syringe-services-programs/php/need-determination/?CDC_AAref_Val=https://www.cdc.gov/ssp/determination-of-need-for-ssp.html [https://perma.cc/AJ4R-JTFB] (explaining that, "[t]o use DHHS funds for SSPs, state, local, tribal, and territorial health departments must consult with CDC. They must provide evidence that their area is experiencing, or at risk, for significant increases in hepatitis infections or an HIV outbreak due to injection drug use.").

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proscribe SSPs from using federal funds to procure sterile needles or syringes on the theory that such practice would enhance drug use.[277]

The federal government's refusal to fully fund SSPs is particularly odd given that American policymakers have acknowledged for over a quarter of a century that (1) SSPs are effective at reducing drug-use-related health harms and (2) there is no evidence that suggests any association between SSPs and increased drug use.[278] In 1998, for example, then-Secretary of Health and Human Services Donna Shalala stated that a "meticulous scientific review" demonstrated that SSPs "can be an effective part of a comprehensive strategy to reduce the incidence of HIV transmission and do not encourage the use of illegal drugs."[279] Shalala's "meticulous" science, however, was no match for the Clinton Administration drug warriors. Shalala's proposal to fund SSPs was defeated by former United States Army General and then-Drug Control Policy "Czar" Barry McCaffrey, who "firmly opposed funding needle exchange programs" and publicly stated that such funding "would be bad drug policy, bad law enforcement policy and probably also be a bad signal to young people."[280]

McCaffrey, unsurprisingly, was supported in his successful effort to defeat the federal health policy experts' push to fund SSPs by former Drug Czar William Bennett, who told the press: "It's unseemly and terrible, unconscionable for the administration for the government of the U.S. to say we're gonna give out needles to people so they can use illegal drugs. That is not the way to fight the drug war or to reduce AIDS."[281] In

[277] Funding for Syringe Services Programs, Ctrs. for Disease Control & Prevention (Feb. 8, 2024), https://www.cdc.gov/syringe-services-programs/php/funding/?CDC_AAref_Val=https://www.cdc.gov/ssp/ssp-funding.html [https://perma.cc/M9XL-CFUS].

[278] See, e.g., Eileen O'Connor, No Federal Funds for Needle Exchange Programs, CNN (Apr. 20, 1998), https://www.cnn.com/ALLPOLITICS/1998/04/20/clinton.needle.exchange/ [https://perma.cc/H6DA-3EKN] (explaining that "[t]he Clinton Administration will back scientific evidence that says needle exchange programs reduce the spread of AIDS in intravenous drug users, while not increasing the use of drugs [but] . . . will not authorize the use of federal funds for such needle exchange programs").

[279] Press Release, U.S. Dep't of Health & Hum. Servs., Research Shows Needle Exchange Programs Reduce HIV Infections Without Increasing Drug Use (1998); see also Robert S. Broadhead, Yaël van Hulst & Douglas D. Hekathorn, Termination of Established Needle-Exchange: A Study of Claims and Their Impact, 46 Soc. Probs. 48, 48 (1999) (noting that, by 1997, five, separate expert studies had "document[ed] the effectiveness of needle-exchange programs in reducing HIV transmission among injection drug users").

[280] O'Connor, supra note 278.

[281] Id.

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1998, 17,047 Americans died from AIDS-related complications.[282] Black Americans, who comprised 13% of the United States population at the time, accounted for a whopping 49% of those fatalities.[283]

New Drug War policymakers on the state and local level have reinvigorated the Old Drug War's battle against evidence-based, harm-reducing SSPs even in places where those programs have dramatically improved public health outcomes.[284] Scott County, Indiana serves as a case study. In 2015, Scott County was experiencing one of the worst injection-drug-use-related HIV outbreaks in American history.[285] The southeastern Indiana county struggled to meaningfully respond to that public health emergency in its early throes because Indiana law prohibited the operation of SSPs.[286] As the problem intensified, however, state officials relented and passed a law to permit Scott County to temporarily stand up an SSP pursuant to an emergency order.[287] The results were impressive. Scott County's drug-related fatality rate reduced by twenty percent in 2019, and it reported just a single case of HIV transmission countywide in 2020.[288] Consequently, the program became "a model for the rest of the country."[289]

[282] New Data Show Continued Decline in AIDS Deaths, Ctrs. for Disease Control & Prevention (Aug. 30, 1999), https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/pressrel/r990831.htm [https://perma.cc/6N9K-4283].

[283] Id.

[284] Oliva et al., supra note 267.

[285] Adams, supra note 269, at 10S (describing the outbreak as "unprecedented" and "caused by shared syringes"); see Philip J. Peters et al., HIV Infection Linked to Injection Use of Oxymorphone in Indiana, 2014–15, 375 New Eng. J. Med. 229, 230–232, 234 (2016); id. at 236 (describing the "magnitude of the outbreak" as "alarming").

[286] Peters et al., supra note 285, at 237 ("Substantial barriers to syringe exchange (i.e., laws prohibiting syringe exchange or syringe possession, lack of funding or of a community organization to implement the syringe exchange, and stigma) existed in this community before this outbreak."); see Adams, supra note 269, at 10S; Oliva et al., supra note 267.

[287] Ind. Code § 16-41-7.5-4 (2015); see also Paul Demko, How Pence's Slow Walk on Needle Exchange Helped Propel Indiana's Health Crisis, Politico (Aug. 7, 2016, 7:09 AM), https://www.politico.com/story/2016/08/under-pences-leadership-response-to-heroin-epidemic-criticized-as-ineffective-226759 [https://perma.cc/53G2-NFV7] (describing then-Governor Pence's reluctance to permit SSPs in Indiana).

[288] William Cooke & Gregg Gonsalves, Closing an Indiana County's Syringe Services Program Would Be a Public Health Disaster, Stat News (June 1, 2021), https://www.statnews.com/2021/06/01/syringe-services-program-closure-scott-county-public-health-disaster/ [https://perma.cc/3TZ7-NXGS].

[289] Hannah Knowles, Rural Indiana County Ends Needle Swap that Helped Fight HIV—Sparking Fears of Another Outbreak, Wash. Post (June 5, 2021, 8:00 AM), https://www.washingtonpost.com/health/2021/06/05/indiana-needle-exchange-hiv/ [https://perma.cc/WZW6-GSLH].

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Notwithstanding these positive public health outcomes, SSPs have been under attack over the last several years across the United States. In 2021, West Virginia—a state that has high blood-borne infectious disease rates and even higher rates of overdose fatalities—enacted a law that severely restricts the operation and efficacy of SSPs.[290] Fueled by gentrification and the casino industry's economic development concerns, Atlantic City, New Jersey enacted an ordinance in July 2021 outlawing SSPs with the intent to shut down its sole—and the state's largest—SSP, the South Jersey AIDS Alliance.[291] Atlantic City's enactment of that ordinance prompted the *Philadelphia Inquirer* to ask, "What happened to 'trust science'?"[292]

Perhaps most incredibly, Scott County, Indiana officials voted to end the County's successful SSP in June 2021 due to concerns that the program was "enabl[ing] dangerous behavior."[293] As one drug policy expert pointed out, "[t]he Scott County Commission's decision ran counter to the recommendations of both the current and former Indiana Health Commissioners, the latter of whom was also the US Surgeon General in the Trump Administration, as well as both the current and former Scott County Sheriffs."[294] Unfortunately, policymakers have not limited their antiscience, New Drug War campaigns to shuttering or prohibiting SSPs. They also have vigorously opposed the operation and funding of a separate class of evidence-based harm reduction programs—overdose prevention centers—which is the subject of the following Subsection of this article.

[290] Brad McElhinny, Legislature Passes a Syringe Exchange Bill with More Restrictions, Including ID Requirement, WV MetroNews (Apr. 10, 2021, 10:23 PM), https://wvmetronews.com/2021/04/10/senate-passes-a-syringe-exchange-bill-with-more-restrictions-including-id-requirement/ [https://perma.cc/8MG7-YXAD].

[291] Tracey Tully, As Overdoses Soar, This State's Largest Needle Exchange Is Being Evicted, N.Y. Times (Oct. 28, 2021), https://www.nytimes.com/2021/08/10/nyregion/nj-needle-exchange.html [https://perma.cc/XX2U-T3LF]. The State of New Jersey eventually enacted legislation that revoked Atlantic City's authority to shutter the SSP. See Sophie Nieto-Munoz, Filings Signal End of Legal Fight Over Atlantic City Needle Program, N.J. Monitor (Sept. 21, 2022, 7:17 AM), https://newjerseymonitor.com/2022/09/21/filings-signal-end-of-legal-fight-over-atlantic-city-needle-exchange-program/ [https://perma.cc/SMX6-6EXB].

[292] Editorial, Atlantic City Is Forcing Its Syringe Program to Shut Down. What Happened to 'Trust Science'?, Phila. Inquirer (June 21, 2021, 2:28 PM), https://www.inquirer.com/opinion/editorials/syringe-exchange-drug-overdose-hiv-aids-atlantic-city-new-jersey-20210621.html [https://perma.cc/584G-28G4].

[293] Knowles, supra note 289.

[294] Blanchard, supra note 266.

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3. Overdose Prevention Centers

Just like their Old Drug War predecessors, New Drug War policymakers along the political spectrum continue to fight against the operation and funding of overdose prevention centers ("OPCs").[295] OPCs are facilities where individuals who use drugs can do so safely under the supervision of medical professionals or other trained personnel.[296] In addition to providing overdose prevention services, such as drug testing, sterile equipment, and naloxone administration, these programs often offer counseling, social services, legal services, housing, and health care treatment referral services.[297]

OPCs have been operating legally in Canada, Europe, and Australia since the 1980s[298] and are currently operational in a dozen countries around the globe (Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Portugal, Spain, Switzerland, and the United States).[299] OPCs have been extensively evaluated, and there is substantial evidence that they improve drug-use-related health outcomes and reduce overdose fatalities.[300] As the American Medical Association has acknowledged, "[s]tudies from other countries have shown that

[295] Safe consumption spaces are frequently referred to with various terminology, including safe injection sites and safe consumption spaces. See, e.g., Alex Kreit, Safe Injection Sites and the Federal "Crack House" Statute, 60 B.C. L. Rev. 413, 415 n.5 ("Safe injection sites are referred to by a number of different names, including supervised injection facilities, safer consumption services, and overdose prevention sites.").

[296] Jeffrey A. Singer, Cato Inst., Overdose Prevention Centers: A Successful Strategy for Preventing Death and Disease 2 (Feb. 28, 2023), https://www.cato.org/briefing-paper/overdose-prevention-centers-successful-strategy-preventing-death-disease#worsening-overdose-crisis [https://perma.cc/724E-9D8S].

[297] Lawrence O. Gostin, James G. Hodge Jr. & Chelsea L. Gulinson, Supervised Injection Facilities: Legal and Policy Reforms, 321 JAMA 745, 745 (2019); see also The Safehouse Model, Safehouse, https://www.safehousephilly.org/about/the-safehouse-model [https://perma.cc/V3P6-CKHQ] (last visited Aug. 5, 2024) (describing the intake of patients to a safe injection site and the rehabilitation services offered to them).

[298] Jorge Finke & Jie Chan, The Case for Supervised Injection Sites in the United States, 105 Am. Fam. Physician 454, 454 (2022).

[299] Singer, supra note 296, at 2; Hannah Taylor et al., Community Perspectives Surrounding Lisbon's First Mobile Drug Consumption Room, 1 Dialogues Health, 2022, at 1; Eur. Monitoring Ctr. for Drugs & Addiction, Drug Consumption Rooms: An Overview of Provision and Evidence 2–3 (2018), https://www.emcdda.europa.eu/publications/pods/drug-consumption-rooms_en [https://perma.cc/FXW3-2ZDV].

[300] See, e.g., Eric Armbrect et al., Supervised Injection Facilities and Other Supervised Consumption Sites: Effectiveness and Value, Inst. for Clinical & Econ. Rev., at ES3–ES7 (2021), https://icer.org/wp-content/uploads/2020/10/ICER_SIF_Final-Evidence-Report_010821.pdf [https://perma.cc/5HE8-RR5P].

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[OPCs] reduce the number of overdose deaths, reduce transmission rates of infectious disease, and increase the number of individuals initiating treatment for substance use disorders without increasing drug trafficking or crime in the areas where the facilities are located."[301] OPCs also serve a public safety function in the areas where they are located. This is because these centers are "associated with reduced public drug consumption, litter of drug consumption equipment, and crime."[302] Incredibly, no OPC has ever reported an overdose fatality, a startling fact that bolsters the notion that every overdose death is a preventable, public health failure.[303]

Due to significant federal and state drug warrior resistance, the United States has been slow to support OPCs relative to its European, Canadian, and Australian counterparts.[304] As law professor Alex Kreit explained,

> Despite strong empirical support for [overdose prevention centers], U.S. policymakers have traditionally been resistant to them. Like many other public health-oriented drug strategies—from needle exchange to heroin-assisted treatment—[overdose prevention centers] were long considered to be off-limits in the United States simply because they were incompatible with the war on drugs. Through the lens of the drug war, these sort of harm reduction measures were seen as a "form[] of surrender" and rejected out of hand.[305]

[301] Am. Med. Ass'n, AMA Wants New Approaches to Combat Synthetic and Injectable Drugs (June 12, 2017), https://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs [https://perma.cc/Y4N3-53GB].

[302] Elizabeth A. Samuels, Dennis A. Bailer & Annajane Yolken, Overdose Prevention Centers: An Essential Strategy to Address the Overdose Crisis, 5 JAMA Network Open, July 15, 2022, at 1, 1.

[303] See Armbrect et al., supra note 300, at ES4 (stating that "[p]ublished evidence and unpublished reports from stakeholders suggest that no client of a SIF has ever experienced death from overdose within a facility").

[304] Kreit, supra note 295, at 416; European Monitoring Centre for Drugs & Addiction, supra note 299, at 1–3 (explaining that "[s]upervised drug consumption facilities . . . have been operating in Europe for the last three decades" and "they represent a 'local' response, closely linked to policy choices made by local stakeholders, based on an evaluation of local need and determined by municipal or regional options to proceed"); Elana Gordon, Lessons from Vancouver: U.S. Cities Consider Supervised Injection Facilities, WHYY (July 5, 2018), https://whyy.org/segments/lessons-from-vancouver-u-s-cities-consider-supervised-injection-facilities/ [https://perma.cc/RT4T-7EL6] (profiling the oldest North American supervised injection site, which is located in Vancouver, British Columbia, Canada as well as the Canadian government's approval of the site as a pilot program).

[305] Kreit, supra note 295, at 416 (footnotes omitted).

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Our unprecedented overdose crisis, however, has reinvigorated political interest in OPCs over the last few years.

Largely due to escalating drug poisoning fatalities in Philadelphia, for example, Mayor Jim Kenney and other city officials, including District Attorney Larry Krasner, announced their support for the proposed opening of Safehouse, a private OPC, in 2019.[306] Federal threats of arresting and prosecuting the directors and staff of Safehouse quickly ensued.[307] The chief public proponent of those federal threats, DOJ Deputy Attorney General Rod Rosenstein, took to the *New York Times* to pen a classic War on Drugs op-ed railing against the possibility that any American city or county might sanction an OPC.[308] While Rosenstein advanced dramatic arguments in his "opinion" piece about the purported public safety and health harms that attend to OPCs, he failed to cite a single credible source in support of any of those allegations.[309] To be fair to Rosenstein, as well as make clear that drug war logic runs deep across party lines in the United States, then-Attorney General and now-Governor of Pennsylvania, Democrat Josh Shapiro, has made no attempt to hide his equally staunch opposition to OPCs.[310]

Shortly after Philadelphia officials announced their support for Safehouse, William McSwain, the then-U.S. Attorney for the Eastern District of Pennsylvania, filed a federal lawsuit to enjoin Safehouse from opening on the theory that OPCs violate the "crack house" provision of

[306] Brandon Longo, Safe Injection Site Coming to South Philadelphia, Councilman Says, ABC Action News (Feb. 26, 2020), https://6abc.com/safe-injection-sites-philadelphia-safe house-site-supervised/5967177/ [https://perma.cc/C3J5-LQMP]; Christopher Moraff, Philadelphia to Make History with Nation's First Supervised Injection Facility, The Appeal (Jan. 25, 2018), https://theappeal.org/philadelphia-to-make-history-with-nations-first-supervised-injection-facility-7d7d7b7946ef/ [https://perma.cc/P4J4-CYNN]; see also Ernest Owens, Kenney Was A Coward in Letting Philly's Safe Injection Site Fail, Philly Mag. (Mar. 3, 2020, 7:00 AM), https://www.phillymag.com/news/2020/03/03/kenney-safe-injection-site-opioids/ [https://perma.cc/V5AQ-XENU] (explaining that city of Philadelphia "has become the deadliest in the nation in the current opioid crisis").

[307] Singer, supra note 296, at 3; Bobby Allyn, DOJ's Rosenstein: If Philly Opens Safe Injection Site, U.S. Crackdown Will Be Swift, WHYY (Aug. 29, 2018), https://whyy.org/segments/dojs-rosenstein-if-philly-opens-injection-site-u-s-crackdown-will-be-swift/ [https://perma.cc/U3CQ-AGCZ].

[308] Rod J. Rosenstein, Opinion, Fight Drug Abuse, Don't Subsidize It, N.Y. Times (Aug. 27, 2018), https://www.nytimes.com/2018/08/27/opinion/opioids-heroin-injection-sites.html [https://perma.cc/6AG2-THTW].

[309] Id.

[310] Moraff, supra note 306.

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the federal Controlled Substances Act.[311] The CSA "crack house" provision makes it a federal crime for anyone to "manage or control any place . . . [and] make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance."[312] The U.S. District Court for the Eastern District of Pennsylvania rejected the federal government's "crack house" arguments and ruled in Safehouse's favor on the grounds that the OPC's purpose was to save lives and not to increase drug use and, therefore, its operation was lawful under the CSA.[313]

The U.S. Court of Appeals for the Third Circuit reversed.[314] That court adopted the government's argument and ruled that the operation of an OPC violates the federal "crack house" statute.[315] It is important to point out, however, that the federal government has not been the only culprit in the ongoing Safehouse saga. Philadelphia residents adopted a "NIMBY"[316] stance in response to the city's support of the OPC and succeeded in blocking Safehouse from securing a community-approved site long before the Third Circuit issued its ruling.[317]

The federal government quietly and temporarily shifted its position on OPCs subsequent to the Safehouse litigation.[318] In early 2022, the Biden DOJ announced that it was "evaluating [OPCs], including discussions with state and local regulators about appropriate guardrails for such sites,

[311] Katie Zezima, Justice Department Sues Philadelphia Over Supervised Injection Facility that Aims to Prevent Fatal Drug Overdoses, Wash. Post (Feb. 6, 2019, 7:00 PM), https://www.washingtonpost.com/national/justice-department-sues-philadelphia-over-supervised-injection-facility-that-aims-to-prevent-fatal-drug-overdoses/2019/02/06/ed9815a4-2a55-11e9-984d-9b8fba003e81_story.html [https://perma.cc/QC74-7ZNA]; Bobby Allyn, Federal Prosecutors Sue to Stop Nation's First Planned 'Supervised Injection Site' in Philly, WHYY (Feb. 6, 2019), https://whyy.org/articles/federal-prosecutors-sue-to-stop-nations-first-planned-supervised-injection-site-in-philly/ [https://perma.cc/5F3Z-UCYT].

[312] 21 U.S.C. § 856(a)(2).

[313] United States v. Safehouse, No. 19-cv-00519, 2020 WL 906997, at *3 (E.D. Pa. 2020).

[314] United States v. Safehouse, 985 F.3d 225, 229–30 (3d Cir. 2021).

[315] Id. at 232–38.

[316] Jerusalem Demsas, The Next Generation of NIMBYs, The Atlantic (July 20, 2022), https://www.theatlantic.com/newsletters/archive/2022/07/the-next-generation-of-nimbys/670590/ [https://perma.cc/XB57-K9ZX] (explaining that NIMBY is "a pejorative term (short for 'Not in My Backyard') for someone who opposes change in their community, especially if they don't oppose that change somewhere else").

[317] Owens, supra note 306.

[318] See, e.g., Thomas F. Harrison, Biden Quietly Making a Radical Shift in Opioid Policy, Courthouse News Serv. (Sept. 19, 2022), https://www.courthousenews.com/biden-quietly-making-a-radical-shift-in-opioid-policy/ [https://perma.cc/5T57-4BXL].

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as part of an overall approach to harm reduction."[319] Since Biden's election, Rhode Island became the first state to enact legislation that legalized the operation of privately-funded OPCs.[320] Shortly thereafter, New York City authorized and stood up the nation's first active OPCs, which began operating at two sites in Manhattan in November 2021.[321] Those New York City OPCs, which are operated by OnPoint NYC, a private non-profit organization, and exclusively funded by private donors, have already intervened in hundreds of potentially fatal overdoses.[322] The United States Attorney for the Southern District of New York nonetheless threatened to shut OnPoint down.[323]

New Drug War policymakers' preference for punitive, law-and-order Old Drug War tactics and resistance to evidence-based harm reduction methods nonetheless persist. Even the Administration's conservative announcement that it was "evaluating OPCs" was met with fierce criticism by political opponents.[324] In a letter to President Biden dated February 15, 2022, fourteen Republican Senators contended that they were "stunned and concerned over recent developments by [the] administration that would weaken our fight against drug use" and emphasized that the Administration's "prioritization of '[e]nhancing

[319] Id.; see also Jennifer Peltz & Michael Balsamo, Justice Dept. Signals It May Allow Safe Injection Sites, Associated Press (Feb. 8, 2022, 12:37 AM), https://apnews.com/article/business-health-new-york-c4e6d999583d7b7abce2189fba095011 [https://perma.cc/7TX3-3T72] (describing the shift in federal policy under the Biden Administration).

[320] Sarah Doiron, RI's 1 Safe Injection Site Expected to Open in Providence, WPRI.com (Apr. 5, 2023, 5:44 PM), https://www.wpri.com/news/local-news/providence/ris-1st-safe-injection-site-expected-to-open-in-providence/ [https://perma.cc/48TP-CVM2]; Aaron Warnick, Rhode Island Approves Nation's First Sites for Safe Injection Use, The Nation's Health (Oct. 2021), https://www.thenationshealth.org/content/51/8/7 [https://perma.cc/W934-BC9G].

[321] Jeffrey C. Mays & Andy Newman, Nation's First Supervised Drug-Injection Sites Open in New York, N.Y. Times (Nov. 30, 2021), https://www.nytimes.com/2021/11/30/nyregion/supervised-injection-sites-nyc.html [https://perma.cc/7YDB-2ND9].

[322] Caroline Lewis, Supervised Injection Sites in NYC Have Saved Lives. But Officials Won't Provide Funds, NPR (June 4, 2022, 5:11 PM), https://www.npr.org/2022/06/04/1103114131/supervised-injection-sites-in-nyc-have-saved-lives-but-officials-wont-provide-fu [https://perma.cc/D3XB-FJYY] (explaining that "[t]he two centers that opened have since intervened in more than 300 potentially fatal overdoses, but . . . city and state officials have refused to provide funding").

[323] Sharon Otterman, Federal Officials May Shut Down Overdose Prevention Centers in Manhattan, N.Y. Times (Aug. 10, 2023), https://www.nytimes.com/2023/08/08/nyregion/drug-overdoses-supervised-consumption-nyc.html [https://perma.cc/LL3J-GRXB].

[324] Letter from Charles E. Grassley et al., U.S. Sens., to President Biden (Feb. 15, 2022), https://www.grassley.senate.gov/imo/media/doc/grassley_et_al.tobidenfundingforsmokingkitsandsupervisedinjectionsites.pdf [https://perma.cc/WS3M-UPKM].

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evidence-based harm reduction efforts,'" including the Department of Justice's reconsideration of OPCs, "as part of a national drug strategy . . . . has resulted in radicalized, illegal, and dangerous acts."[325] The Senators concluded their letter by "urg[ing] DOJ, as our nation's chief law enforcement agency, to respect and follow the rule of law and not support illegal supervised injection sites."[326] Perhaps coincidentally, the talks between Safehouse and the Biden DOJ ultimately broke down.[327]

In addition, several of the states that were viewed as early advocates for OPCs have doubled down on Old Drug War tactics. In response to the Biden Administration's temporary reconsideration of OPCs, the Pennsylvania Senate passed a law in 2023 aimed at imposing a statewide ban on such programs.[328] Just months later, the Philadelphia City Council went a step further by enacting a law—over a mayoral veto—that prohibits the operation of OPCs within nine of the city's ten districts.[329] Similarly, in August 2022, Democratic Governor Gavin Newsom vetoed a bill passed by California's Democratic-controlled legislature that would have permitted the operation of OPCs in designated cities in the nation's most populous and, purportedly, most progressive state.[330]

CONCLUSION

The war on people who use drugs is far from over. It may have been rebranded or concealed by public health rhetoric as a response to shifts in public opinion that support treatment over incarceration but, at its core, it continues to undermine evidence-based, public health policy proposals to

[325] Id. at 1.

[326] Id. at 2.

[327] Nicole Leonard, Safehouse Supervised Injection Settlement Talks Fail as the DOJ Pushes to Dismiss Civil Lawsuit, WHYY (July 30, 2023), https://whyy.org/articles/safehouse-supervised-injection-suit-department-justice-dismiss/ [https://perma.cc/R7Z2-H5AC].

[328] Marley Parish, Pa. Senate Votes to Ban Supervised Injection Sites, Pa. Cap. Star (May 1, 2023, 6:00 PM), https://www.penncapital-star.com/government-politics/pa-senate-votes-to-ban-supervised-injection-sites/ [https://perma.cc/7EXN-SXQ6].

[329] Dan Snyder & Will Kenworthy, City Council Essentially Bans Safe Injection Sites Opening in Philadelphia, CBS News (Sept. 29, 2023, 6:06 AM), https://www.cbsnews.com/philadelphia/news/safe-injection-sites-in-philadelphia-banned/ [https://perma.cc/3HZU-WYHZ]; Nicole Leonard, Philadelphia City Council Passes Near-Total Ban on Future Supervised Consumption, Overdose Prevention Sites, WHYY (Sept. 14, 2023), https://whyy.org/articles/philadelphia-city-council-passes-near-total-ban-on-future-safe-consumption-overdose-prevention-sites/ [https://perma.cc/3HUJ-SGM8].

[330] Jill Cowan, Governor Newsom Vetoes Bill for Drug-Injection Sites in California, N.Y. Times (Aug. 22, 2022), https://www.nytimes.com/2022/08/22/us/gavin-newsom-vetoes-drug-injection-sites.html [https://perma.cc/EUP7-KLDN].

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address overdose deaths by maintaining its emphasis on surveillance, punitive policies, and the creation of an illusive "drug-free" society. Acknowledging the ways in which the tenets of the War on Drugs continue to permeate policy, despite explicit acknowledgments by Congress that addiction and overdose are public health issues,[331] is imperative to critically engaging with future policy proposals aimed at decreasing chaotic drug use, preventing the development of substance use disorders, and preventing overdose events.

As the old adage goes, "the first step in solving any problem is admitting there is one." America's problem is its prohibitionist approach to drug use that idealizes abstinence, glorifies supply control, and uses severe punishment to address behavior (chaotic drug use) that is caused by structural and social determinants that are the product of America's distaste for solidarity and insistence on rugged individualism.

It is imperative to acknowledge that recent efforts to adopt a more health-oriented approach to drug policy in the United States fall short of abandoning the War on Drugs paradigm and, instead, continue to ensure its endurance. In doing so, it prevents the adoption of more evidence-based policies grounded in public health and principles of harm reduction. Harm reduction, which focuses on reducing the health harms of drug use, celebrating positive, incremental change, and respecting the human rights of people who use drugs, "establishes itself, at least potentially, as a motor of social transformation" and "[t]he liberation of the drug use phenomenon from the War on Drugs paradigm."[332]

The War on Drugs has claimed many lives, whether by encouraging the development of a volatile illicit drug supply—the unpredictable nature of which contributes to overdose deaths—or facilitating the incarceration of generations of Black people and other persons of color. It has long been time to put an end to our ineffective, expensive, racist, and failed War on Drugs. Lives literally depend on it.

[331] Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, § 708, 130 Stat. 695, 754–55.

[332] Ximene Rêgo, Maria João Oliveira, Catarina Lameira & Olga S. Cruz, 20 Years of Portuguese Drug Policy—Developments, Challenges and the Quest for Human Rights, 16 Substance Abuse Treatment Prevention & Pol'y, 2021, at 1, 3.