ARTICLES

DRUG-INDUCED HOMICIDE LAWS AND FALSE BELIEFS ABOUT DRUG DISTRIBUTORS: THREE MYTHS THAT ARE LEAVING PROSECUTORS MISINFORMED

Taleed El-Sabawi*, Jennifer J. Carroll**, and Morgan Godvin***

ABSTRACT

An increasing number of criminal legal system actors, including some prosecutors, have acknowledged that the so-called "overdose crisis" is a public health problem. Despite this narrative shift, some prosecutors are responding to local overdoses by charging persons who distribute drugs that are linked to a subsequent death with criminal killing. These charges are brought either through the use of existing, non-specific statutes or so-called drug-induced homicide ("DIH") statutes, which explicitly criminalize the act of delivering a substance subsequently associated with a death. In this Article, we outline three salient themes that have emerged from early literature and from preliminary surveys exploring prosecutors' perceptions of and justifications for filing DIH charges. In doing so, we provide empirical evidence to suggest that these narratives are based on myths about drugs and the people who use and distribute them—myths that are not supported, and are sometimes contradicted by, scientific research. This Article aims to dispel some of these pervasive yet unsound narratives contributing to the prosecutorial belief that DIH prosecutions have the capacity to improve public health and reduce overdose. In doing so, this Article also provides prosecutors with an alternative framework for more accurately conceptualizing how prosecutorial action against people who use and distribute drugs impacts the health and well-being of the entire community—including persons who use drugs. Finally, this Article also elucidates how well-intentioned prosecutors may be unwittingly causing more fatal overdoses by discouraging calls to 911 during an overdose emergency and by disrupting local drug markets in ways that directly increase the risk of overdose.

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* Assistant Professor of Law, Florida International University, College of Law. Sincerest thanks to Professors Maybell Romero and Justin Erwin and to the *American Criminal Law Review* for organizing the 2022 Annual Symposium: Reform-Minded Prosecution. We would also like to thank Cameron Moody for his research assistance. © 2023, Taleed El-Sabawi, Jennifer J. Carroll, and Morgan Godvin.

** Assistant Professor of Anthropology, North Carolina State University.

*** Fellow, Heath in Justice Action Lab, Northeastern University.

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INTRODUCTION

Nearly 108,000 people in the United States are estimated to have died of a drug overdose in 2021—a fifteen percent increase over 2020[1] and the largest number of persons to die from overdoses in the years tracked by the National Center for Health Statistics.[2] Overdose rates among non-Hispanic Black persons and American Indian/Alaska Native ("AI/AN") persons have skyrocketed, rising forty-four percent and thirty-nine percent, respectively, between 2019 and 2020.[3] The continually increasing rates of overdose deaths reinforce the reality that the U.S. is

1. *U.S. Overdose Deaths in 2021 Increased Half as Much as in 2020 - But Are Still Up 15%*, CTRS. FOR DISEASE CONTROL AND PREVENTION (May 11, 2022), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm. For the primary source of data that this press release was based on, see F.B. Ahmad, Y. Chong, J.A. Cisewski, J.M. Keralis, A. Lipphardt, L.M. Rossen & P. Sutton, *Provisional Drug Overdose Death Counts*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Feb. 15, 2023), https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

2. *See* Ahmad et. al., *supra* note 1.

3. Mbabazi Kariisa, Nicole L. Davis, Sagar Kumar, Puja Seth, Christine L. Mattson, Farnaz Chowdhury & Christopher M. Jones, *Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and Social Determinants of Health Characteristics—25 States and the District of Columbia, 2019-2020*, 71 MORBIDITY AND MORTALITY WKLY. REP. 940, 941 (2022), https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7129e2-H.pdf. Of note, the Kaiser Family Foundation found that opioid overdose mortality among non-Hispanic Black persons rose nearly fifty-four percent between 2019 and 2020. *See Opioid Overdose Deaths by Race/Ethnicity*, KAISER FAM. FOUND., https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?data (last visited Feb. 26, 2023).

dealing with a complex public health issue that is driven by social and structural determinants of health and worsened by punitive responses to drug use.[4]

Public health researchers have been sounding the alarm about rising rates of overdose since the mid-2000s,[5] prompting public officials to support stricter regulatory responses to illicit opioid use, such as the U.S. Food and Drug Administration's 2010 OxyContin reformulation, which has since been directly linked to massive increases in heroin overdose.[6] Since then, an increasing number of criminal legal system actors, including some prosecutors, have acknowledged that overdose death is a public health problem, repeating the emergent mantra, "we cannot arrest our way out of this drug epidemic."[7] Despite these acknowledgments, local, state, and federal actors have proactively increased, not decreased, the criminal legal system's role in responding to substance use, pouring significant human and financial resources into police-assisted recovery initiatives,[8] law-enforcement-led post-overdose response teams,[9] and co-response programs that automatically dispatch law enforcement officers to behavioral health emergencies.[10]

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4. Nabarun Dasgupta, Leo Beletsky & Daniel Ciccarone, *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 183 (2018).

5. *See, e.g.*, Mark R. Mueller, Nina G. Shah & Michael G. Landen, *Unintentional Prescription Drug Overdose Deaths in New Mexico, 1994-2003*, 30 AM. J. PREVENTIVE MED. 423, 425 (2006) (reporting a nearly 180% increase in prescription opioid overdoses); *see also, e.g.*, Nina G. Shah, Sarah L. Lathrop, R. Ross Reichard & Michael G. Landen, *Unintentional Drug Overdose Death Trends in New Mexico, USA, 1990-2005: Combinations of Heroin, Cocaine, Prescription Opioids and Alcohol*, 103 ADDICTION 126, 129 (2008) (reporting a nearly 170% increase in prescription opioid deaths); Martha J. Wunsch, Kent Nakamoto, George Behonick & William Massello, *Opioid Deaths in Rural Virginia: A Description of the High Prevalence of Accidental Fatalities Involving Prescribed Medications*, 18 AM. J. ON ADDICTIONS 5, 7 (2009) (reporting a 300% increase in overdose deaths in rural western Virginia).

6. Ellenie Tuazon, Hillary V. Kunins, Bennett Allen & Denise Paone, *Examining Opioid-Involved Overdose Mortality Trends Prior to Fentanyl: New York City, 2000-2015*, DRUG & ALCOHOL DEPENDENCE Dec. 2019, at 1, 4 (2019); David Powell & Rosalie Liccardo Pacula, *The Evolving Consequences of Oxycontin Reformulation on Drug Overdoses*, 7 AM. J. HEALTH ECON. 41, 51 (2021); Abby Alpert, David Powell & Rosalie Liccardo Pacula, *Supply-Side Drug Policy in the Presence of Substitutes: Evidence from the Introduction of Abuse-Deterrent Opioids*, AM. ECON. J.: ECON. POL'Y, Nov. 2018, at 1, 4 (2018).

7. *See* Jill Westmoreland Rose, *We Can't Arrest Our Way out of Growing Opioid and Heroin Epidemic*, CHARLOTTE OBSERVER (Sept. 20, 2016, 6:25 PM), https://www.charlotteobserver.com/opinion/op-ed/article103032432.html; FAIR AND JUST PROSECUTION, ISSUES AT A GLANCE: DRUG-INDUCED HOMICIDE PROSECUTIONS 10 (2022), https://fairandjustprosecution.org/wp-content/uploads/2022/07/FJP-Drug-Induced-Homicide-Brief.pdf ("'This is a public health crisis, and . . . we're not going to prosecute our way out of this problem . . . .'— Berkshire County (MA) District Attorney Andrea Harrington"); *see also* Taleed El-Sabawi, *Carrots, Sticks, and Problem Drug Use: Law Enforcement's Contribution to the Policy Discourse on Drug Use and the Opioid Crisis*, 80 OHIO ST. L.J. 765, 768–69, 780–81 (2019).

8. *See* Scott W. Formica et al., *Characteristics of Post-Overdose Public Health-Public Safety Outreach in Massachusetts*, DRUG & ALCOHOL DEPENDENCE, Feb, 2021, at 1, 2.

9. *See* Melissa Davoust, Valerie Grim, Allie Hunter, David K. Jones, David Rosenbloom, Michael D. Stein & Mari-Lynn Drainoni, *Examining the Implementation of Police-Assisted Referral Programs for Substance Use Disorder Services in Massachusetts*, INT'L. J. DRUG POL'Y, June 2021, at 1, 3, 6 ("[P]olice departments and community partners across the United States have begun to implement programs focused on connecting individuals to substance use disorder services.").

10. For an overview of such co-response programs, see Taleed El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMP. L. REV. 1, 11–18

One noteworthy and increasingly significant feature of this contradictory public health/public safety policy landscape is the choice many local prosecutors are making to increase their use of harsh criminal penalties in response to overdose deaths in their communities. More specifically, some prosecutors have responded to local overdose crises by charging persons who distribute drugs that cause an overdose death with criminal killings, either through the use of existing, non-specific statutes or so-called drug-induced homicide ("DIH") statutes,[11] which explicitly criminalize the act of delivering a substance that causes a death.[12] Based on media reports, the number of DIH charges filed increased exponentially from 2009 to 2016[13] in the absence of any meaningful evidence that such charges produced positive public health impacts.[14]

The adoption of a public health-oriented framing towards rising overdose rates amidst increasing prosecutorial responses to overdose deaths presents an apparent misalignment between narrative framing and policy action. DIH prosecutions are part of the criminal legal approach to addressing problem drug use, but they run counter to public health approaches that emphasize harm reduction and

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(2021). For additional evidence of the increased governmental support for such programs, see *Justice Department Awards $34 Million to Support Community Crisis Response*, DEP'T OF JUST. (Dec. 23, 2021), https://www.justice.gov/opa/pr/justice-department-awards-34-million-support-community-crisis-response.

11. *See* Health Just. Action Lab & Legal Sci., *Drug Induced Homicide Laws*, PRESCRIPTION DRUG ABUSE POL'Y SYS. (Jan. 1, 2019), https://pdaps.org/datasets/drug-induced-homicide-1529945480-1549313265-1559075032. In some states, DIH laws are referred to as Death by Distribution, *see, e.g.*, N.C. GEN. STAT. § 14-18.4 (2019), or Drug Delivery Resulting in Death, *see, e.g.*, 18 PA. CONS. STAT. § 2506 (2014).

12. JEREMIAH GOULKA, VALENA E. BEETY, ALEX D. KREIT, ANNE BOUSTEAD, JUSTINE NEWMAN & LEO BELETSKY, HEALTH JUST. ACTION LAB, DRUG-INDUCED HOMICIDE DEFENSE TOOLKIT 7–10 (3d ed. 2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3265510 (showing that as of 2019, 25 states have DIH statutes); *see also* Health in Just. Action Lab & Legal Sci., *supra* note 11.

13. *Drug-Induced Homicide*, HEALTH IN JUST. ACTION LAB, https://www.healthinjustice.org/drug-induced-homicide (last visited Aug. 27, 2022).

14. To the best of our knowledge, only one study to date has attempted to quantitatively assess the impact of DIH laws on opioid overdose mortality. *See* Youngeun Lee, Sung W. Choi & Jonathan Lee, *Longitudinal Study on Deterrent Effect of Drug-Induced Homicide Law on Opioid-Related Mortality Across 92 Counties and the District of Columbia in the U.S.*, J. DRUG ISSUES, 2021, at 8–9. This study, however, is based upon legal data on the enactment dates of DIH laws that are entirely erroneous. *See* Jennifer J. Carroll, Leah Bevis, Taleed El-Sabawi, Mary Figgatt, Nabarun Dasgupta, Leo Beletsky, Amy Judd Leiberman & Corey S. Davis, A Discussion of Critical Errors in the Study "Longitudinal Study on Deterrent Effect of Drug-Induced Homicide Law on Opioid-Related Mortality Across 92 Counties and the District of Columbia in the U.S." 7-10 (2022) (unpublished manuscript) (available at https://papers.ssrn.com/abstract=4171058) ("Specifically, the legal data used by Lee et al. to define their treatment condition (the presence or absence of a state-level DIH law) is incorrect in almost every aspect."). The study's findings are, therefore, completely unreliable. To the best of our knowledge, only one peer-reviewed paper has provided insight into how people who use drugs and are at risk of overdose have been impacted by a local trial in which a community member was found guilty of manslaughter for supplying drugs later implicated in an overdose fatality. *See* Jennifer J. Carroll, Bayla Ostrach, Loftin Wilson, Jesse Lee Dunlap, Reid Getty & Jesse Bennett, *Drug Induced Homicide Laws May Worsen Opioid Related Harms: An Example from Rural North Carolina*, 97 INT'L. J. DRUG POL'Y, Nov. 2021, at 1, 2 [hereinafter *Example from Rural North Carolina*]. The findings of this paper suggest that local residents experienced increased overdose risk as a direct result of those criminal proceedings. *Id.* at 4.

treatment.[15] DIH prosecutions also fail to mitigate or minimize criminal consequences of substance use through evidence-based policies such as 911 Good Samaritan Laws, which provide limited criminal immunity from drug charges when first responders are called to the scene of an overdose.[16]

Nevertheless, a growing body of evidence suggests that at least some prosecutors believe themselves to be supporting the public health response—or having a negligible impact on the public health response, positive or negative, while supporting necessary social and moral responses to overdose deaths—in their use of DIH prosecutions.[17] For example, prosecutors from the U.S. Attorney's Office in Connecticut have voiced their belief that prosecuting overdose deaths to the fullest extent possible constitutes a morally necessary acknowledgment of the value of the life that was lost to overdose.[18] Similarly, preliminary survey data from local prosecutors in North Carolina reveal that prosecutors pursue DIH charges in response to the increase in overdose deaths and in order to "stem . . . fentanyl flooding into [the] community."[19] Even more concerning are statements from prosecutors suggesting that preventing overdose requires leveraging DIH cases to disabuse the public of the idea that substance use is a free choice. For example, one prosecutor responding to the survey explained that these laws aim to "hold[] the dealer accountable[] and tak[e] into consideration that often a user is helpless to stop."[20]

In this Article, we respond to the increasing rates of DIH prosecutions by outlining three salient yet unsupported beliefs that have emerged from early literature and preliminary surveys exploring prosecutors' perceptions of DIH laws. First, some prosecutors believe that harsh penalties will deter illicit drug sales—or at least deter the distribution of powerful synthetic opioids like fentanyl.[21] Second,

15. Leo Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, 2019 UTAH L. REV. 833, 880–87 (2019).

16. *See* JENNIFER J. CARROLL, TRACI C. GREEN & RITA K. NOONAN, EVIDENCE-BASED STRATEGIES FOR PREVENTING OPIOID OVERDOSE: WHAT'S WORKING IN THE UNITED STATES 18 (2018), https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf; Jamie Peck, *Why Heroin Addicts Are Being Charged with Murder*, ROLLING STONE (Aug. 2, 2018), https://www.rollingstone.com/culture/culture-features/heroin-opioid-addicts-charged-with-murder-o-d-703242.

17. There are many motivations other than promoting public health for prosecutorial use of DIH charges, including a desire to deliver retribution to the family of the person who overdoses, *see* Kaitlin S. Phillips, *From Overdose to Crime Scene: The Incompatibility of Drug-Induced Homicide Statutes with Due Process*, 70 DUKE L.J. 659, 700 (2020), or "holding someone accountable for 'peddling poison for profit,'" *see* Kara Berg, *Ingham Prosecutors Now Charge Fewer Drug-Induced Homicide Cases in the 'Interest of Justice'*, LANSING STATE J. (Apr. 9, 2022, 10:00 PM), https://www.lansingstatejournal.com/story/news/2022/04/10/drug-overdose-induced-homicide-delivery-death-prosecute-charge/7268080001/; *see also* Brandon Morrissey, Taleed El-Sabawi & Jennifer J. Carroll, Prosecuting Overdose: An Exploratory Study of Prosecutorial Motivations for Drug-Induced Homicide Prosecutions in North Carolina 22–23 (Dec. 30, 2022) (unpublished manuscript) (available online at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4389026).

18. *See* Rachel L. Rothberg & Kate Stith, *The Opioid Crisis and Federal Criminal Prosecution*, 46 J.L. MED. & ETHICS 292, 301 (2018).

19. Morrissey et al., *supra* note 17, at 22–23.

20. *Id.*

21. *Id.* at 27; *see infra* Part I.A.

some prosecutors believe that decreasing the drug supply will decrease overdose deaths.[22] Third, some prosecutors who pursue DIH charges believe that by doing so, they are protecting people who use drugs (the "victims") from the dangerous people who deal dangerous drugs (the "bad guys").[23] Indeed, by constructing two exclusive categories consisting of people who use drugs and people who deal drugs, some prosecutors believe they are avoiding past mistakes of imposing criminal sanctions on people living with substance use disorder, a medical condition. Though these three themes suggest some acceptance of substance use disorders as a clinical and public health issue, not a criminogenic one, and suggest that at least some prosecutors recognize the value of public health-oriented responses to overdose, much of the underlying logic that leads to the filing of DIH charges is based on mistaken beliefs fueled by narratives supported neither by scientific evidence about substance use disorders nor the lived experiences of people who use drugs. Moreover, the best available evidence suggests that DIH prosecutions increase overdose deaths rather than prevent them. In fact, some experts believe that DIH prosecutions have led to over 32,000 additional overdose events between 2000 and 2017.[24]

This Article aims to dispel some of the pervasive yet scientifically unsound narratives contributing to the prosecutorial belief that DIH prosecutions improve public health and reduce the harms of illicit substance use. In doing so, this Article also provides prosecutors with an alternative framework for more accurately conceptualizing how prosecutorial action against people who distribute drugs impacts the health and well-being of the entire community—including persons who use drugs. Further, this Article elucidates how well-intentioned prosecutors may be unwittingly interfering with public health efforts and increasing overdose deaths by discouraging calls to 911 after an overdose and by disrupting local drug markets in ways that increase the risk of overdoses.

I. THE MISTAKEN BELIEFS UNDERLYING THE NARRATIVES

Prosecutors across the U.S. report varied, sometimes contradictory motivations for pursuing DIH charges in their districts. Some utilize DIH charges with the intent of helping to decrease overdose deaths, inspired by the logic that harsh criminal penalties will deter illicit drug distribution or because prosecuting drug distribution will beneficially disrupt the local drug supply.[25] The confidence that either

22. *See infra* Part I.B.

23. *See infra* Part I.C.

24. Kelly Kung, Leo Beletsky, Natasha Martin & Judith Lok, Analysis of Drug Induced Homicides: How Do Prosecution Media Alerts Affect the Risk of Drug Overdose Deaths? 5 (Feb. 19, 2020) (unpublished manuscript) (available at https://www.dropbox.com/s/kkgicr3to3fwkb5/Kung%20Beletsky%20et%20al%20Drug_Induced_Homicide_Paper_1_30_20%20%283%29.pdf?dl=0).

25. *See, e.g.*, Peck, *supra* note 16 (quoting Madison County State's Attorney Tom Gibbons saying: "We intend to absolutely make an example of these people in public . . . I want to scare people from getting into this"); *see also* Richard A. Wasserstrom, *Strict Liability in the Criminal Law*, 12 STAN. L. REV. 731, 737 (1960) (stating that strict liability offenses may "keep[] a relatively large class of persons from engaging in certain kinds of activity").

of these outcomes might prevent overdose deaths relies on two unfounded beliefs: first, that drug availability directly shapes patterns of drug use,[26] and second, that so-called bad actors who distribute drugs prey on persons who are slaves to their addiction and helpless to stop using.[27]

Some prosecutors endorse another unfounded belief: that the sheer presence of fentanyl in the U.S. drug supply is solely and directly responsible for rising overdose rates—a view that wholly fails to recognize the complex system of structural and institutional drivers of overdoses (of which the criminal legal system is one)[28] that act synergistically to shape patterns of fatal and non-fatal overdose.[29] Thus, the belief that DIH prosecutions are able not only to deter drug distribution but deter the distribution of fentanyl, in particular, motivates many prosecutors to pursue these cases.[30] Each of these narratives relies on a number of myths about drug use, substance use disorder, and people who use or distribute drugs. The myths that serve as the building blocks for this narrative are discussed separately below, with evidence provided to rebut their claims.

A. Myth #1: Harsh Criminal Penalties, Like Those for Homicide, Deter Illicit Drug Use and Drug Distribution—Including Distribution of Illicitly-Manufactured Fentanyl—Which, in Turn, Decrease Overdose Deaths and Other Harmful Behaviors

Prosecutors may utilize DIH charges due to a belief in the power of harsh criminal penalties to deter drug use and drug distribution. In general, deterrence theory assumes that individuals are rational actors who choose to engage in behavior

26. *See* Morrissey et al., *supra* note 17, at 22–23.

27. Mark Neil, *Prosecuting Drug Overdose Cases: A Paradigm Shift*, NAT'L ASS'N OF ATT'YS GEN. (Feb. 12, 2018), https://www.naag.org/attorney-general-journal/prosecuting-drug-overdose-cases-a-paradigm-shift/ (stating that DIH laws are "one tool in the law enforcement arsenal . . . [that] can assist locally in focusing on the drug dealers who take advantage of those who have become addicted to opioids"); *see also* N.J. STAT. ANN. § 2C:35-1.1 (West 1987) (stating its purpose of "deterrence and incapacitation of the most culpable and dangerous drug offenders, and . . . ultimately to reduce the demand for illegal controlled dangerous substances and the incidence of drug-related crime").

28. Sasha Mital, Jessica Wolff & Jennifer J. Carroll, *The Relationship Between Incarceration History and Overdose in North America: A Scoping Review of the Evidence*, DRUG & ALCOHOL DEPENDENCE, Aug. 2020, at 1, 9, 12.

29. *See* STACY STANFORD, KAMYA RAJA, SARAH WELLER PEGNA, JASMYN RUDD, CADEN GABRIEL, JULIA MANDEVILLE & JASMINE AKUFFO, IDENTIFYING THE ROOT CAUSES OF DRUG OVERDOSE HEALTH INEQUITIES AND RELATED SOCIAL DETERMINANTS OF HEALTH: A LITERATURE REVIEW 50–54 (2021), https://www.naccho.org/uploads/downloadable-resources/IdentifyingtheRootCauses-ofDrugOverdoseHealthInequities.pdf; Radhouene Doggui, Keyrellous Adib & Alex Baldacchino, *Understanding Fatal and Non-Fatal Drug Overdose Risk Factors: Overdose Risk Questionnaire Pilot Study—Validation*, 12 FRONTIERS PHARMACOLOGY, Sept. 2021, at 6, https://www.frontiersin.org/articles/10.3389/fphar.2021.693673 (finding "mental health factors were positive predictors of both fatal and non-fatal overdoses" and that these "results were in agreement with a growing body of literature showing that early life stress is associated with both forms of overdoses" and that drug use and lack of treatment "was found to be a predictor of recent and lifetime non-fatal drug overdose").

30. *See* Morrissey et al., *supra* note 17, at 27.

because the benefits outweigh the costs.[31] At its simplest, deterrence theory posits that the threat of swift, certain, and severe punishment will deter undesirable behavior.[32] The implementation of criminal-legal strategies to address illicit drug use has long been justified under theories of deterrence.[33] As applied to illicit drug distribution, deterrence theories would suggest that enhancing the severity, swiftness, or assurance of the penalty for drug distribution may decrease drug sales because the perceived benefit of the crime will be outweighed by its cost.[34]

For example, some data suggest that certain modified deterrence approaches decrease overall crime rates and that concentrated enforcement of criminal penalties against repeat offenders may decrease drug crime rates in the community.[35] Variations of deterrence theory that are coupled with social services, like focused deterrence, have been shown to decrease overall levels of crime when targeting open-air drug markets (without diffusing crime to nearby neighborhoods).[36] However, other studies have shown that increased enforcement of drug crimes did not reduce participation in those activities but markedly increased the harms those activities produced, including increased rates of HIV.[37]

Though increased enforcement may, in certain contexts or circumstances (which are not totally clear), contribute to reduced crime rates, it does not necessarily follow that a lower crime rate represents a decrease in the drug supply or a lower risk of overdose and other substance use-related harms. In-depth qualitative studies offer compelling evidence that the perceived risk of DIH charges as a consequence of drug market participation (as the *certainty* of being caught and punished is considered the linchpin feature of this deterrence effect)[38] have little impact in this regard. For example, people who use and/or distribute drugs have reported adjusting to increased enforcement efforts by simply relocating drug selling and using

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31. Anthony A. Braga & David L. Weisburd, *The Effects of Focused Deterrence Strategies on Crime: A Systematic Review and Meta-Analysis of the Empirical Evidence*, 49 J. RSCH. CRIME & DELINQ. 323, 324 (2012).

32. *See id.* at 328.

33. *See id.* at 347–51. We acknowledge that deterrence theory has evolved since its inception to include greater nuance. Our purpose here is only to familiarize the reader with its general principles rather than summarizing its current theoretical complexity.

34. *See generally* George L. Kelling & James Q. Wilson, *Broken Windows*, THE ATL. (Mar. 1982), https://www.theatlantic.com/magazine/archive/1982/03/broken-windows/304465/; *see also* Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 189–90 (1968).

35. *See* Braga & Weisburd, *supra* note 31, at 347–51; David Kennedy, *Drugs, Race and Common Ground: Reflections on the High Point Intervention*, 262 NAT'L INST. JUST. J. 12, 12, 17 (2009); Nicholas Corsaro, Rod K. Brunson & Edmund F. McGarrell, *Problem-Oriented Policing and Open-Air Drug Markets: Examining the Rockford Pulling Levers Deterrence Strategy*, 59 CRIME & DELINQ. 1085, 1097–98 (2013).

36. *See* Corsaro et al., *supra* note 35, at 1097–98.

37. Samuel R. Friedman, Hannah L. F. Cooper, Barbara Tempalski, Maria Keem, Risa Friedman, Peter L. Flom & Don C. Des Jarlais, *Relationships of Deterrence and Law Enforcement to Drug-Related Harms Among Drug Injectors in US Metropolitan Areas*, 20 AIDS 93, 95–96 (2006).

38. *Five Things About Deterrence*, NAT'L INST. OF JUST. (May, 2016), https://nij.ojp.gov/topics/articles/five-things-about-deterrence ("The *certainty* of being caught is a vastly more powerful deterrent than the punishment . . . . Police deter crime by increasing the perception that criminals will be caught and punished.").

activities to less policed communities.[39] Further, arrests of people who distribute drugs have not been shown to meaningfully reduce the drug supply.[40] Research has also found that people who distribute drugs find the idea that DIH charges could, as one North Carolina prosecutor suggested, "stem . . . fentanyl flooding into communit[ies]"[41] preposterous, as distributors have little to no control over the contents or contaminants of the supply they distribute.[42] Indeed, the fact that fentanyl contamination so regularly occurs high up in the drug supply chain is one of the primary motivators for many people who distribute drugs to seek out and engage drug checking services such as fentanyl test strips or other more advanced technologies to gain insight into the contents of illicit drug products.[43] Community-based drug checking services allow people who distribute drugs to better understand their supply, better inform their clients, and take other concrete steps to reduce the risks of overdose that their supply may pose.[44]

Studies suggest that criminal prosecutions are similarly ineffective at reducing substance use,[45] injection drug use, and infectious diseases associated with

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39. *See* Samuel R. Friedman, Enrique R. Pouget, Sudip Chatterjee, Charles M. Cleland, Barbara Tempalski, Joanne E. Brady & Hannah L. F. Cooper, *Drug Arrests and Injection Drug Deterrence*, 101 AM. J. PUB. HEALTH 344, 347–348 (2011); Campbell Aitken, David Moore, Peter Higgs, Jenny Kelsall & Michael Kerger, *The Impact of a Police Crackdown on a Street Drug Scene: Evidence from the Street*, 13 INT'L J. DRUG POL'Y 193, 199 (2002).

40. Leslie E. Scott, *Federal Prosecutorial Overreach in the Age of Opioids: The Statutory and Constitutional Case Against Duplicitous Drug Indictments*, 51 U. TOL. L. REV. 491, 523–24 (2020).

41. Morrissey et al., *supra* note 17, at 23.

42. Meghan Peterson, Josiah Rich, Alexandria Macmadu, Ashley Q. Truong, Traci C. Green, Leo Beletsky, Kimberly Pognon & Lauren Brinkley-Rubinstein, *"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, 49 (2019). The study noted that:

> [One] participant felt that given the ubiquity of fentanyl, it was impossible for a seller to control what was in their supply. She conceptualized sellers as distributors for those who had manufactured the supply elsewhere and had little control over what was in their supply once it got to them. This sentiment was echoed by other participants, including those who expressed that the law would fail to stop fentanyl-contamination and instead only affect those lower on the distribution hierarchy.

Id.

43. *See* Alex Betsos, Jenna Valleriani, Jade Boyd, Geoff Bardwell, Thomas Kerr & Ryan McNeil, *"I Couldn't Live with Killing One of My Friends or Anybody": A Rapid Ethnographic Study of Drug Sellers' Use of Drug Checking*, 87 INT'L J. DRUG POL'Y, 2021, at 1, 4; *see generally* Corey S. Davis, Amy Judd Lieberman & Madelyn O'Kelley-Bangsberg, *Legality of Drug Checking Equipment in the United States: A Systematic Legal Analysis*, DRUG & ALCOHOL DEPENDENCE, May 2022, at 1.

44. *See* Betsos et al., *supra* note 43, at 4; Jennifer J. Carroll, Sarah Mackin, Clare Schmidt, Michelle McKenzie & Traci C. Green, *The Bronze Age of Drug Checking: Barriers and Facilitators to Implementing Advanced Drug Checking Amidst Police Violence and COVID-19*, HARM REDUCTION J., Feb. 2022, at 1, 5; Bruce Wallace, Thea van Roode, Flora Pagan, Paige Phillips, Hailly Wagner, Shane Calder, Jarred Aasen, Bernie Pauly & Dennis Hore, *What is Needed for Implementing Drug Checking Services in the Context of the Overdose Crisis? A Qualitative Study to Explore Perspectives of Potential Service Users*, HARM REDUCTION J., May 2020, at 1, 9.

45. *See* J. S. Melo, R. S. Garfein, K. Hayashi, M. J. Milloy, K. DeBeck, S. Sun, S. Jain, S. A. Strathdee & D. Werb, *Do Law Enforcement Interactions Reduce the Initiation of Injection Drug Use? An Investigation in Three North American Settings*, 182 DRUG & ALCOHOL DEPENDENCE 67, 71 (2018).

injection drug use.[46] One nationwide study found that higher rates of incarceration had no effect on substance use, overdose, or drug arrests whatsoever.[47] Ethnographic interviews with people who inject drugs have shown greater threats of criminal enforcement to be associated with riskier injection behavior, decreased use of syringe services, and worse access to evidence-based substance use disorder treatment.[48] Limited data from North Carolina suggests that the aftershocks of DIH prosecutions in rural communities may lead to increased injection events and increased financial costs for maintaining pre-established substance use habits.[49] Each of these bodies of evidence indicates that increased prosecutorial use of DIH charges may, in fact, worsen public health and public safety.

DIH prosecutions have also been shown to discourage bystanders from seeking help during an overdose event for fear of prosecution, thereby increasing the likelihood that the overdose victim will die a preventable death.[50] Fear of police involvement is a major reason that bystanders do not call first responders to the scene of an overdose—a fact that has single-handedly (and appropriately) justified the implementation of 911 Good Samaritan Laws across the United States.[51] In many states, DIH laws directly undermine the limited immunity that enable 911 Good Samaritan Laws to save lives. Most 911 Good Samaritan laws do not offer protection against felony charges (like DIH).[52] Unsurprisingly, the limited qualitative research available supports the conclusion that DIH prosecutions actively

46. *See* Kora DeBeck, Tessa Cheng, Julio S. Montaner, Chris Beyrer, Richard Elliott, Susan Sherman, Evan Wood & Stefan Baral, *HIV and the Criminalization of Drug Use Among People Who Inject Drugs: A Systematic Review*, 4 LANCET HIV 357, 362 (2017).

47. *See* Adam Gelb, Phillip Stevenson, Adam Fifield, Monica Fuhrmann, Laura Bennett, Jake Horowitz & Erinn Broadus, *More Imprisonment Does Not Reduce State Drug Problems*, PEW (March 8, 2018), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2018/03/more-imprisonment-does-not-reduce-state-drug-problems.

48. *See* Melo et al., *supra* note 45, at 71; *see also* Will Small, Thomas Kerr, John Charette, Martin T. Schechter & Patricia M. Spittal, *Impacts of Intensified Police Activity on Injection Drug Users: Evidence from an Ethnographic Investigation*, 17 INT'L. J. DRUG POL'Y 85, 91 (2006); Friedman et al., *supra* note 37, at 95–97.

49. *See Example from Rural North Carolina*, *supra* note 14, at 4.

50. *See* 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, 85 (2017); Katherine McLean, *Good Samaritans vs. Predatory Peddlers: Problematizing the War on Overdose in the United States*, 41 J. CRIME & JUST. 1, 3 (2018).

51. *See* CARROLL ET AL., *supra* note 16, at 19.

52. *See* Amy Lieberman & Corey Davis, *Legal Interventions to Reduce Overdose Mortality: Overdose Good Samaritan Laws*, NETWORK FOR PUB. HEALTH L. (June 2021), https://www.networkforphl.org/wp-content/uploads/2021/08/2021-50-State-Survey-Legal-Interventions-to-Reduce-Overdose-Mortality-Overdose-Good-Samaritan-Laws-8-18.pdf; *see also* Policy Surveillance Program Staff, *Good Samaritan Overdose Prevention Laws*, PRESCRIPTION DRUG ABUSE POL'Y SYS. (June 1, 2021), https://pdaps.org/datasets/good-samaritan-overdose-laws-1501695153 (displaying protections of 911 Good Samaritan Laws from all 50 states and the District of Columbia).

discourage overdose witnesses from seeking help during an overdose event,[53] thereby contributing to higher rates of overdose death.

B. Myth #2: Seizing Drugs and Removing a Person Who Distributes Drugs from the Drug Market Will Decrease the Drug Supply, and Decreasing Drug Availability Will Decrease Overdose Deaths

Some prosecutors believe that their focus on prosecuting drug distribution will help reduce the drug supply and thereby reduce overdose deaths.[54] However, studies investigating this relationship show that harsh criminal penalties do not impact the illicit drug market in this way. At best, drug market interdiction and arrests produce negligible impacts because, as one study points out, "[when] [o]ne guy goes to jail, two people are ready to take his spot."[55] At worst, drug market interdiction and arrests increase overdose risk in the surrounding community.

Moreover, the desire to decrease drug availability in order to decrease overdose deaths rests on the assumption that the U.S. has high overdose death rates because of the sheer fact of drug availability. In other words, it assumes that people use drugs because they are available, and if they are no longer easily accessible, then people will stop using drugs. Lack of drug availability may lead to lower rates of drug use among adolescents.[56] Historically, however, most efforts to meaningfully reduce drug availability have broadly failed. In fact, the price of fentanyl fell fifty percent between 2016 and 2021 despite focused interdiction efforts.[57] Thus, the very idea that the prosecution of drug sales or possessions can meaningfully impact drug availability is far-fetched.

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53. *See Example from Rural North Carolina*, *supra* note 14, at 4. For example:

> [Syringe services program ("SSP")] staff report participants regularly responding to their 911 Good Samaritan Law education efforts with declarations that they will never call 911 when witnessing an overdose due to the expectation that they will inevitably be arrested by responding officers. These declarations have been substantiated in at least one alleged incident, when a few participants told SSP staff that they had recently fled the scene of an overdose due to fear of arrest. We also note that opioid-overdose related [Emergency Department] visits declined by more than 50% in the two years between 2017 and 2019 . . . , which may indicate a reduction in opioid-overdose related 911 calls during that time . . . . Over time, SSP staff began to discern, based on their regular community interactions and outreach efforts, that the participants with closest interpersonal ties to the defendant in the 2018 DIH case were more likely to state their refusal to call 911 when witnessing an overdose and to state that refusal more adamantly.

Id. (citation omitted).

54. *See* Morrissey et al., *supra* note 17, at 27.

55. *See* Peterson et al., *supra* note 42, at 47.

56. Craig A. Gallet, *Can Price Get the Monkey Off Our Back? A Meta-Analysis of Illicit Drug Demand*, 23 HEALTH ECON. 55, 58 (2014).

57. Beau Kilmer, Bryce Pardo, Toyya A. Pujol & Jonathan P. Caulkins, *Rapid Changes in Illegally Manufactured Fentanyl Products and Prices in the United States*, 117 ADDICTION 2745, 2745 (2022) (showing that, historically, efforts to reduce drug availability have broadly failed and that the price of fentanyl has only fallen).

Even if supply reduction is achieved, however, the premise that overdose prevention will naturally ensue is significantly undermined by the demonstrable truth that reducing the illicit drug supply does not, in turn, reduce the demand for illicit drugs. To illustrate this fact, one needs to look no further than the devastating public health impacts of the 2010 reformulation[58] of Oxycontin, a long-acting prescription opioid that is widely blamed for the onset of today's so-called "opioid crisis."[59] That reformulation was intended to prevent the misuse of diverted Oxycontin by rendering the tablets sticky and gummy when crushed or dissolved.[60] The reformulation was extraordinarily successful at meeting this goal of reducing OxyContin misuse, which, in turn, caused even higher overdose rates as people who had been using OxyContin turned to the next best option for meeting their (still unmet) physical and behavioral needs: heroin.[61]

For most people who use drugs today, however frequently or sporadically, drug market interdiction and drug crime prosecution have similarly harmful effects as a direct result of drug market disruption. In addition to the fact that the loss of a reliable supply often forces people who use drugs to seek out potentially riskier drug products, those who lose access to their primary, trusted supplier immediately experience increased overdose risk as they are forced to seek an alternative, less familiar supplier with a less familiar supply.[62] The seriousness of these risks—and the reliability with which drug interdiction actions produce them—has been endorsed by people who use drugs[63] and by the first responders who have observed

58. Reformulation is the development of different formulations for the same drug. Susana Murteira, Zied Ghezaiel, Slim Karray & Michel Lamure, *Drug Reformulations and Repositioning in Pharmaceutical Industry and its Impact on Market Access: Reassessment of Nomenclature*, J. MKT. ACCESS & HEALTH POL'Y, Aug. 2013, at 1, 2. The term "reformulation" refers to an adjustment in the component ingredients of pharmaceutical products. *Id.* at 18. The 2010 OxyContin reformulation was intended to render the tablets "abuse-deterrent" (i.e., impossible to crush or dissolve for non-oral administration). *See* U.S. FOOD & DRUG ADMIN., REPORT ON ABUSE-DETERRENT OPIOID FORMULATIONS AND ACCESS BARRIERS UNDER MEDICARE 3–4, 11, https://www.fda.gov/media/140805/download (last visited Mar. 11, 2023).

59. Abby Alpert, William N. Evans, Ethan M.J. Lieber & David Powell, *Origins of the Opioid Crisis and its Enduring Impacts*, 137 Q. J. ECON. 1139, 1163, 1172-73 (2022).

60. "OxyContin was reformulated with a polyethylene oxide matrix in August 2010 to reduce the potential for intravenous abuse and for abuse by insufflation." Daniel C. Daniel C. Beachler, Kelsey Hall, Renu Garg, Geetanjoli Banerjee, Ling Li, Luke Boulanger, Huseyin Yuce & Alexander M. Walker, *An Evaluation of the Effect of the OxyContin Reformulation on Unintentional Fatal and Nonfatal Overdose*, 38 CLINICAL J. PAIN 396, 396 (2022); U.S. FOOD & DRUG ADMIN., *supra* note 58, at 3 ("Section 6012 defines an abuse-deterrent opioid formulation (ADF) as 'an opioid that is a prodrug or that has certain abuse-deterrent properties, such as physical or chemical barriers, agonist or antagonist combinations, aversion properties, delivery system mechanisms, or other features designed to prevent abuse of such opioid.'").

61. William N. Evans, Ethan Lieber & Patrick Power, *How the Reformulation of OxyContin Ignited the Heroin Epidemic*, CATO INST. (Aug. 15, 2018), https://www.cato.org/research-briefs-economic-policy/how-reformulation-oxycontin-ignited-heroin-epidemic.

62. *See* 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, Apr. 2020, at 1, 5.

63. *Id.*

increases in non-fatal overdose events after major drug arrests.[64]

A recent study concretely demonstrates the harms caused by drug interdiction efforts. Specifically, each unique drug seizure made by the Indianapolis Municipal Police department is significantly associated with more overdose events in the area where that seizure took place in the subsequent days.[65] The root cause of these harms, therefore, is not simply the drugs themselves; if this were the case, drug seizures would have the opposite effect of that observed. Rather harm stems from the disruption of the local drug supply caused by drug seizures and arrests, which increases uncertainty and decreases the predictability of that supply, thus resulting in more overdoses.[66]

C. Myth #3: People Who Use Drugs Need Protection from People Who Distribute Drugs

This is a compound myth that comes in several forms, composed of several independent facets, many of which are often mutually exclusive or contradictory, and all of which are based on false or problematic assumptions about the social, structural, and personal realities that shape substance use in the United States. We address each of these facets in turn below.

1. Myth #3(a): People Who Use Drugs and People Who Distribute Drugs Are Two Mutually Exclusive Categories

In the survey of prosecutors in North Carolina, the predominant view was that diverting people who use drugs away from the criminal legal system (ostensibly treating substance use as a medical or public health concern) and entangling more people who distribute drugs within it through enhanced policing and prosecution are two halves of the same morally-sound corrective: that of shifting prosecution

64. Blythe Rhodes, Betsy Costenbader, Loftin Wilson, Rebecca Hershow, Jennifer Carroll, William Zule, Carol Golin & Lauren Brinkley-Rubinstein, *Urban, Individuals of Color Are Impacted by Fentanyl-Contaminated Heroin*, 73 INT'L. J. DRUG POL'Y 1, 4 (yielding results "imply[ing] that removing trusted sellers from the community may have the opposite of the intended effect . . . [because] [p]eople who use drugs consequently may be forced to obtain heroin from people they do not know and, according to our participants, purchasing from an unknown source more frequently results in a fentanyl-induced overdose," and noting that "[s] imilar patterns have been observed in Manchester, NH, where first responders have informally reported localized spikes in overdoses immediately following law enforcement interdiction in the local drug market").

65. Bradley Ray, Steven J. Korzeniewski, George Mohler, Jennifer J. Carroll, Brandon del Pozo, Grant Victor, Philip Huynh & Bethany J. Hedden, *Spatiotemporal Analysis Exploring the Effect of Law Enforcement Drug Market Disruptions on Overdose, Indiana, 2021-2022*, AM. J. PUB. HEALTH (forthcoming, issue not yet assigned).

66. *See* Daniel Ciccarone, *Fentanyl in the US Heroin Supply: A Rapidly Changing Risk Environment*, 46 INT'L. J. DRUG POL'Y 107, 108 (2017); Daniel Ciccarone, Jeff Ondocsin & Sarah G. Mars, *Heroin Uncertainties: Exploring Users' Perceptions of Fentanyl-Adulterated and -Substituted 'Heroin'*, 46 INT'L. J. DRUG POL'Y 146, 152–53 (2017); Raminta Daniulaityte, Kaylin Sweeney, Seol Ki, Bradley N. Doebbeling & Natasha Mendoza, *"They Say It's Fentanyl, but They Honestly Look Like Perc 30s": Initiation and Use of Counterfeit Fentanyl Pills*, HARM REDUCTION J., May 2022, at 1, 8.

strategies to target those intended.[67] These survey results are one piece in a wider body of evidence suggesting that some prosecutors believe people who distribute drugs do not use drugs or are not living with substance use disorder.[68]

This neat and tidy dichotomy between people who distribute drugs and people who use them is false, with demonstrable overlap between the two populations and a true sociological distinction that is not as crisp as this myth leads one to believe. For example, a 2011 survey of 412 people who inject drugs found that seventeen percent also distributed drugs during the previous six months.[69] Those who both distributed and used drugs were more likely to exhibit "several markers of higher intensity addiction."[70] Those who use drugs and are living with substance use disorder were found to be located in the most dangerous part of the "drug-[distribution] hierarchy."[71] Another study, which examined the prevalence of distribution amongst a sample of people who use methamphetamines, found that twenty-nine percent of participants reported distributing methamphetamine in the last two months.[72]

More importantly, research from the Northeastern University Health in Justice Action Lab suggests that as many as half of all people accused of DIH in the United States—and, therefore, are alleged to have distributed or delivered the drugs later implicated in a fatal overdose—are either low-level suppliers or friends, family members, caretakers, and romantic partners of the persons who tragically lost their lives.[73] The prevalence of close social network members among those accused of DIH is a reflection of how often the so-called "trafficking" of illicit drugs takes place within selling, bartering, and gifting systems maintained by people with close, trusting relationships—a phenomenon many researchers have called "the social supply."[74]

In sum, while not all people who distribute drugs use drugs, many do. Further, while not all people who use drugs share, sell, or distribute drugs within their social

67. *See* Morrissey, *supra* note 17, at 22–24.

68. This survey result is not surprising given public statements by some prosecutors that drug distributors "fake" their addiction to avoid incarceration. *See NYC Prosecutor Says Drug Dealers Hide Behind Fake Addiction*, ALCOHOLISM & DRUG ABUSE WKLY., July 2010, at 1, 8.

69. *See* Thomas Kerr, William Small, Caitlin Johnston, Kathy Li, Julio S. G. Montaner & Evan Wood, *Characteristics of Injection Drug Users Who Participate in Drug Dealing: Implications for Drug Policy*, 40 J. PSYCHOACTIVE DRUGS 147, 149 (2008).

70. *Id.* at 150.

71. *Id.* (noting that the most dangerous part of the drug distribution hierarchy is the lowest, most visible level as persons at the lowest level are most likely to experience violence and confrontations with police).

72. Shirley J. Semple, Steffanie A. Strathdee, Tyson Volkmann, Jim Zians & Thomas L. Patterson, *'High on My Own Supply': Correlates of Drug Dealing Among Heterosexually Identified Methamphetamine Users*, 20 AM. J. ON ADDICTIONS 516, 518 (2011).

73. *Drug-Induced Homicide*, HEALTH JUST. ACTION LAB, https://www.healthinjustice.org/drug-induced-homicide (last visited Mar. 2, 2023).

74. *See* Matthew Taylor & Gary R. Potter, *From "Social Supply" to "Real Dealing": Drift, Friendship, and Trust in Drug-Dealing Careers*, 43 J. DRUG ISSUES 392, 394 (2013); David Moxon & Jaime Waters, *Sourcing Illegal Drugs as a Hidden Older User: The Ideal of 'Social Supply'*, 26 DRUGS: EDUC., PREVENTION & POL'Y 412, 414 (2019).

network, many do. Prosecutorial narratives that make clear distinctions between people who use drugs and people who distribute drugs, framing the former as the "victim" and the latter as the "bad guy," conveniently ignore this reality.

2. Myth #3(b): People Who Use Drugs Are Helpless and Are Physically or Psychologically Incapable of Stopping Their Use, Which Makes All Drug Distribution Inherently Harmful

This view is problematic for a multitude of reasons. First, it assumes that all (or even most) people who use drugs are also living with a substance use disorder. This is not true. In fact, according to data collected by the U.S. Substance Abuse and Mental Health Services Administration in their annual National Survey on Drug Use and Health, of the estimated 9.5 million people aged 12 years and older who used illicit or diverted opioids without medical supervision in 2020, 2.7 million (or fewer than one-third) meet the criteria for opioid use disorder.[75] That means nearly 7 million Americans—or more than two-thirds of those aged 12 and older who have consumed opioids in the past year—used opioids without having an opioid use disorder. Trends in the use of central nervous system stimulants (cocaine, methamphetamine, prescription drugs like Adderall(R) and Vyvanse(R), etc.) follow similar patterns, with 10.3 million people aged 12 years and older reporting past year use and 3.2 million—again, fewer than one-third—meeting the criteria for stimulant use disorder.[76]

Even limiting the discussion to persons living with a substance use disorder, it is erroneous and stigmatizing to assert that such persons inherently lack free will and are, therefore, not capable of exercising free choice—that they are, in essence, a slave to drugs. The idea that drugs cause one to lose free will is a figment of culturally and historically contingent social imaginations,[77] a trope often used in the stories our society tells about drugs, not an observable phenomenon in the real world.

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75. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2020 NATIONAL SURVEY ON DRUG USE AND HEALTH 2, 30 (2021), https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf.

76. *Id.*

77. *See generally* E. SUMMERSON CARR, SCRIPTING ADDICTION: THE POLITICS OF THERAPEUTIC TALK AND AMERICAN SOBRIETY (2011) (documenting how counseling staff in American substance use treatment programs conceptualize or "imagine" addiction in metaphysical terms—not biological or psychological terms—that implicate self-knowledge and self-awareness. These counselors subsequently seek to therapeutically intervene upon clients' socially-constructed self-presentation and referential speech more than they seek to intervene on clients' physiological relationships with drugs); JENNIFER J. CARROLL, NARKOMANIA: DRUG USE, HIV, AND CITIZENSHIP IN UKRAINE (2019) (documenting how common-sense understandings or "imaginations" of addiction held by clinicians and lay persons in Ukraine define the condition in metaphysical terms—namely, that an addicted person suffers from a metaphysical disconnect between their personal will and their ability to act upon that will).

It is neither a criterion for diagnosis of substance use disorder[78] nor a recognized medical symptom.[79]

People who use drugs regularly make concrete, rational choices in the context of their substance use. An excellent illustration of this principle in action is the use of fentanyl test strips—a cheap, portable, single-use technology that can be used for drug checking purposes to test for the presence of fentanyl in unfamiliar drug products.[80] A minority of voices among national drug policy leadership have erroneously argued that fentanyl test strips constitute a futile intervention because "[p]eople who are addicted to opioids are not making a rational choice to continue their drug use."[81] Yet, multiple studies have found that the use of fentanyl test strips prior to consuming drugs is associated with risk reduction behaviors (such as using slower, using less, not using alone, or not using drugs at all).[82] Interviews with persons who distribute drugs suggest that people who buy drugs are increasingly requesting drug-checking results of drugs at purchase to help them reduce the harms of drug use and prevent accidental overdose.[83] Perhaps even more compelling is a 2019 study conducted among women using drugs in Baltimore, which found that those who enjoyed regular access to fentanyl test strips and other resources were significantly less likely to be using opioids daily after only ten months.[84]

Thus, data shows that people who use drugs, when given access to meaningful and accessible methods for reducing the risks of substance use or reducing substance use altogether, regularly make rational choices about whether and how to

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78. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483–84 (Am. Psychiatric Ass'n & Am. Psychiatric Ass'n eds., 5th ed. 2013).

79. *See* CTR. FOR SUBSTANCE ABUSE TREATMENT, MANAGING CHRONIC PAIN IN ADULTS WITH OR IN RECOVERY FROM SUBSTANCE USE DISORDERS 21 (2012), https://www.ncbi.nlm.nih.gov/books/NBK92053/table/ch2.t5/ (reproducing criteria in AM. PSYCHIATRIC ASS'N. *supra* note 78).

80. *Rapid Response Fentanyl Test Strip*, BTNX INC., https://www.btnx.com/files/BTNX_Fentanyl_Strips_Harm_Reduction_Brochure.PDF (last visited Apr. 1, 2023).

81. *See* Elinore F. McCance-Katz, *For Beating the Opioid Crisis, America has Better Weapons than Fentanyl Test Strips*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Oct. 3, 2018), https://web.archive.org/web/20190401075354/https://blog.samhsa.gov/2018/10/03/for-beating-the-opioid-crisis-america-has-better-weapons-than-fentanyl-test-strips.

82. *See* Nicholas C. Peiper, Sarah Duhart Clarke, Louise B. Vincent, Dan Ciccarone, Alex H. Kral & Jon E. Zibbell, *Fentanyl Test Strips as an Opioid Overdose Prevention Strategy: Findings from a Syringe Services Program in the Southeastern United States*, 63 INT'L. J. DRUG POL'Y 122, 125; Mohammad Karamouzian, Carolyn Dohoo, Sara Forsting, Ryan McNeil, Thomas Kerr & Mark Lysyshyn, *Evaluation of a Fentanyl Drug Checking Service for Clients of a Supervised Injection Facility, Vancouver, Canada*, 15 HARM REDUCTION J., Sept. 2018, at 1, 7; Jacqueline E. Goldman, Katherine M. Waye, Kobe A. Periera, Maxwell S. Krieger, Jesse L. Yedinak & Brandon D. L. Marshall, *Perspectives on Rapid Fentanyl Test Strips as a Harm Reduction Practice Among Young Adults Who Use Drugs: A Qualitative Study*, 16 HARM REDUCTION J., Jan. 2019, at 1, 9; Ju Nyeong Park, Sari Frankel, Miles Morris, Olivia Dieni, Lynn Fahey-Morrison, Martin Luta, Derrick Hunt, Jeffrey Long & Susan G. Sherman, *Evaluation of Fentanyl Test Strip Distribution in Two Mid-Atlantic Syringe Services Programs*, 94 INT'L. J. DRUG POL'Y, Aug. 2021, at 1, 4.

83. *See* Betsos et al., *supra* note 43, at 4.

84. Ju Nyeong Park, Catherine Tomko, Bradley E. Silberzahn, Katherine Haney, Brandon, D. L. Marshall & Susan G. Sherman, *A Fentanyl Test Strip Intervention to Reduce Overdose Risk Among Female Sex Workers Who Use Drugs in Baltimore: Results from a Pilot Study*, 110 ADDICTIVE BEHAVS., Nov. 2020, at 1, 7.

use drugs—and those choices clearly center ethical priorities, including concerns for one's own well-being and for the well-being of others. Moreover, it is estimated that approximately one in ten American adults have experienced a substance use disorder in their lifetimes,[85] and about forty-six percent did not require treatment to resolve that disorder.[86] Clearly meaningful supports, such as evidence-based harm reduction and treatment strategies, assist people who use drugs in reducing the harms of substance use, reducing their substance use, or ceasing substance use altogether. The myth that people who use drugs are truly stripped of their free will stands in direct contradiction to these widely researched, scientifically supported, and expert-endorsed realities.

3. Myth #3(c): People Who Distribute Drugs Are Poisoning the Drug Supply and Causing More Overdose Deaths

The narrative that people who distribute drugs are cavalierly or, worse, purposefully poisoning the drug supply is by no means new and neither is the evidence refuting it. Even in the 1990s, this narrative was believed by researchers, law enforcement actors, and medical treatment providers.[87] Studies from more than two decades ago demonstrate that harmful adulteration of the drug supply by drug distributors occurs much less frequently than the countervailing narrative suggests and that when adulteration by drug distributors does occur, it is with benign substances.[88] For example, the addition of "cut" or "filler" products with real but minimal side effects can reduce the potency of a batch of drug products, as is frequently observed.[89] Even in the current context, evidence suggests that the findings from previous research continue to be true.

The current poisoning narrative is focused on illicitly manufactured fentanyl (IMF), which is frequently described as the primary—or even sole—root cause of accidental overdose.[90] As the narrative goes, drug distributors adulterated the

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85. Bridget F. Grant, Tulshi D. Saha, June Ruan, Risë B. Goldstein, S. Patricia Chou, Jeesun Jung, Haitao Zhang, Sharon M. Smith, Roger P. Pickering, Boji Huang & Deborah S. Hasin, *Epidemiology of DSM-5 Drug Use Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions–III*, 73 JAMA PSYCHIATRY 39, 42 (2016).

86. *See* John F. Kelly, Brandon Bergman, Bettina B. Hoeppner, Corrie Vilsaint & William L. White, *Prevalence and Pathways of Recovery from Drug and Alcohol Problems in the United States Population: Implications for Practice, Research, and Policy*, 181 DRUG ALCOHOL DEPENDENCE 162, 164 (2017).

87. *See* Ross Coomber, *The Adulteration of Drugs: What Dealers Do to Illicit Drugs, and What They Think Is Done to Them*, 5 ADDICTION RSCH. 297, 297 (1997).

88. *See id.* at 297, 299; Ross Coomber, *Vim in the Veins–Fantasy or Fact: The Adulteration of Illicit Drugs*, 5 ADDICTION RSCH. 195, 197 (1997).

89. *See generally* Jose Broséus, Natacha Gentile & Pierre Esseiva, The Curring of Cocaine and Heroin: A Critical Review, 262 FORENSIC SCI. INT'L 73 (2016).

90. *See, e.g.*, *Most Overdose Deaths Involve Illicitly Manufactured Fentanyls*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 3, 2020), https://www.cdc.gov/drugoverdose/featured-topics/overdose-deaths-data.html; *see also* Joseph Pergolizzi, Peter Magnusson, Jo Ann K. LeQuang & Frank Breve, *Illicitly Manufactured Fentanyl Entering the United States*, 13 CUREUS 1, 6, 8 (2021) (explaining IMFs are primarily manufactured in China and Mexico and then enter the United States through the mail, passenger vehicles, or cargo loads); DRUG

supply of heroin with fentanyl in an effort to poison their users.[91] It is true that fentanyl was initially introduced to many (but not all) people who use drugs as an unexpected—and initially unwanted—adulterant to heroin or counterfeit opioid pills.[92] However, fentanyl is generally introduced into the drug supply far upstream, long before anyone whose actions might reasonably be considered "distribut[ing]" get their hands on it.[93]

In the case of counterfeit pills, any fentanyl that may be present is mixed in by the pill manufacturers, far upstream from the distributor connecting those products with consumers who want to use them.[94] In the case of "dope" or heroin-like products (which may or may not contain any actual heroin), IMF in powder form is sold by IMF manufacturers to regional distributors,[95] who then distribute the product with IMF to "retail distributors," who subsequently distribute it to their network of local distributors to sell to the end user,[96] where the drug products become part of the "social supply" that circulates among close personal contacts.[97] Many people who distribute drugs report not being aware of the amount or even the presence of IMF in the end product.[98] It is this unpredictability that increases the risks of overdose.[99]

Research also shows that when people who distribute drugs are given access to drug checking services (the use of portable technologies to gain insight into the

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ENF'T ADMIN., 2020 NATIONAL DRUG THREAT ASSESSMENT 4, 11–12, (2021), https://www.dea.gov/documents/2021/03/02/2020-national-drug-threat-assessment.

91. *See* Bryce Pardo, Jonathan P. Caulkins & Beau Kimer, *Tackle Fentanyl like a Poisoning Outbreak, Not a Drug Epidemic*, RAND BLOG (Sept. 3, 2019), https://www.rand.org/blog/2019/09/tackle-fentanyl-like-a-poisoning-outbreak-not-a-drug.html ("For most victims, fentanyl was not their drug of choice. Rather, they were poisoned by dealers who mixed it into baggies of heroin or pressed into fake-opioid tablets.").

92. *See* Lucy Nguyen, Alexandra Evans, Gabriela Frank, Morgan Levitas, Allie Mennella & Luke C. Short, *Genuine and Counterfeit Prescription Pill Surveillance in Washington, D.C.*, FORENSIC SCI. INT'L, Aug. 2022, at 1, 2–4, https://www.sciencedirect.com/science/article/abs/pii/S0379073822002444; Jennifer J. Carroll, Brandon D. L. Marshall, Josiah D. Richa, Traci C. Green, *Exposure to Fentanyl-Contaminated Heroin and Overdose Risk Among Illicit Opioid Users in Rhode Island: A Mixed Methods Study*, 40 INT'L. J. DRUG POL'Y 136, 143 (demonstrating for the first time that IMF contaminated heroin is a supply-side phenomenon).

93. Jennifer J. Carroll, *Auras of Detection: Power and Knowledge in Drug Prohibition*, 48 CONTEMP. DRUG PROBS. 327, 337 (2021) ("Most people do seem to trust their dealer. Like, he's a regular person. But then my next step in that conversation is, yea, but who's their guy? And who's that guy's guy? . . . Cause that bag stopped eight times since it was a brick, and it's cut in every spot.").

94. *See Hundreds of Counterfeit Oxycodone Tablets Seized at Port of Entry Contained Ultra-Deadly Fentanyl*, DRUG ENF'T ADMIN. (Apr. 15, 2016), http://www.dea.gov/press-releases/2016/04/15/hundreds-counterfeit-oxycodone-tablets-seized-port-entry-contained-ultra (reporting a seizure of "counterfeit oxycodone tablets containing fentanyl as they were being smuggled from Mexico into the United States").

95. Pergolizzi et al., *supra* note 90, at 8 ("Once in the US, the IMF may go to regional distribution points run by criminal enterprises, who may then refine the product with dyes, press them into counterfeit pills, or mix them with inert substances to add to drugs such as heroin.").

96. *Id.*

97. *See* Taylor & Potter, *supra* note 74, at 401–02; Moxon & Waters, *supra* note 74, at 418.

98. *See* Pergolizzi et al., *supra* note 90, at 5, 8 ("In many cases, the drug user (and in some cases even the drug dealer) are not aware that the product contains IMF and likewise are unaware of the strength, quantity, or purity of the IMF.")

99. *See* Carroll et al., *supra* note 92, at 142; Carroll et al., *supra* note 62, at 2.

contents of illicit drug products), they readily engage them,[100] often in ways that reduce the risk of overdose.[101] In a 2021 study, Dr. Betsos and colleagues found, "[w]hen they had access to drug checking knowledge, sellers were able to modify risks related to the fentanyl market, including tailoring drugs sold to clients, returning dangerous batches and modifying fentanyl in order to make it safer to consume."[102] Some people who distribute drugs cited reasons for participating in drug checking and harm reduction efforts that were greater than a desire to maintain or increase profits. One study participant who sold small amounts of methamphetamine and utilized drug checking services confided, "I couldn't live with killing one of my friends, or anybody. Anybody's kid. [. . .] Anybody's kid out there. Because a lot of us just don't want to die. A lot of us just want to get out of our own heads for a couple hours, right?"[103]

People who distribute drugs not only regularly seek to reduce the risk posed to consumers by utilizing drug checking services but also engage in other acts of care that reduce the harms of drug use, such as serving as secondary distribution points for harm reduction supplies like sterile syringes and the overdose-reversal medication naloxone.[104] In sum, when people who distribute drugs are empowered by accessible drug checking tools and services, they act as conduits of harm reduction and have the potential to lower rates of overdose among their customers.

100. *See* Geoff Bardwell, Jade Boyd, Jaime Arredondo, Ryan McNeil & Thomas Kerr, *Trusting the Source: The Potential Role of Drug Dealers in Reducing Drug-Related Harms via Drug Checking*, 198 DRUG & ALCOHOL DEPENDENCE 1, 3–4 (discussing qualitative interviews with PWUD in Downtown Eastside Vancouver—participants expressed a lower level of interest when buying from dealers whom they trust, but greater interest when buying from an unfamiliar source; and consumers suggested that dealers could use drug checking services to learn about their supply and pass that information onto consumers); Viseth Long, Jaime Arredondo, Lianping Ti, Cameron Grant, Kora DeBeck, M-J Milloy, Mark Lysyshyn, Evan Wood, Thomas Kerr & Kanna Hayashi, *Factors Associated with Drug Checking Service Utilization Among People Who Use Drugs in a Canadian Setting*, 17 HARM REDUCTION J. 100, 102 (2020) (discussing three prospective cohort studies in Vancouver that were combined to create a large sample of PWUD using drug checking services. Factors significantly associated with drug checking service utilization were homelessness (AOR—1.47) and involvement in drug dealing (AOR—1.59)); Ashley Larnder, Piotr Burek, Bruce Wallace & Dennis K. Hore, *Third Party Drug Checking: Accessing Harm Reduction Services on the Behalf of Others*, 18 HARM REDUCTION J., Sept. 2021, at 1, 2–3 (explaining survey of 1,653 users of a drug checking service in Victoria Canada—more than half (fifty-two percent) were checking for reasons beyond personal use, of those forty-six percent who were checking drugs for others, and twelve percent who reported checking to sell or for a supplier); Amy Peacock et al., *Profile and Correlates of Colorimetric Reagent Kit Use Among People Who Use Ecstasy/MDMA and Other Illegal Stimulants in Australia*, 97 INT'L. J. DRUG POL'Y, Nov. 2021, at 1, 4 (explaining study of 792 colorimetric reagent drug checking participants who regularly use MDMA or stimulants in Australia— drug checking correlates included being younger, male, past six-month use of new psychoactive substances, accessing community-based health services for alcohol or other drug reasons, and selling).

101. *See* Carroll et al., *supra* note 44, at 11.

102. *See* Betsos et al., *supra* note 43, at 1.

103. *Id.* at 4.

104. Gillian Kolla & Carol Strike, *Practices of Care Among People Who Buy, Use, and Sell Drugs in Community Settings*, 17 HARM REDUCTION J., May 2020, at 1, 4.

In sum, broad misconceptions about the rationality and motivations of people who use and sell drugs remain present in the prosecutorial discourse justifying the enforcement of DIH laws. These beliefs are not supported by the lived reality of persons who use or deal drugs. The majority of people who use opioids do not, in fact, have opioid use disorders. Moreover, just because someone meets the criteria for a substance use disorder does not imply that they utterly lack free will. Likewise, despite tropes to the contrary, drug sellers are largely rational actors who do not intend to poison their consumers. They have been shown to facilitate harm reduction among their customers when they are empowered to do so. The infantilization of people with substance use disorders and the vilification of people who sell drugs might make for a neat binary, but it does not align with the evidence that both groups remain rational actors with complex motivations. Motivations that suggest that the meting out of harsher penalties with the enforcement of DIH laws will not deter drug using behaviors.

CONCLUSION

In this Article, we have systematically described and disproven three pervasive myths that may, to varying degrees, motivate prosecutors to pursue DIH charges: 1) that harsher criminal penalties deter drug distribution, which in turn reduces overdose deaths, 2) that drug market interdiction and disruptions reduce drug availability, which in turn reduces overdose deaths, and 3) that people who use drugs need protection from people who distribute drugs. Each of these claims—and the assumptions upon which they are founded—are demonstrably untrue. Instead, harsher penalties do not effectively deter drug distribution, drug interdiction does not reduce the harms posed by the illicit drug supply, and rather than needing protection from drug distributors, people who use drugs often find significant protection against overdose in the meaningful, trusting relationships they have forged with suppliers. Disrupting those relationships—especially through law enforcement and criminal punishment—does not serve public health but rather puts people who use drugs at greater risk of immediate harm.

Much has been written about the gross under-availability of evidence-based care for substance use disorders in the United States, about the financial and institutional barriers to treatment for those who seek it, and about the rampant drivers of substance use in our communities—such as adverse childhood events, poverty, injury, chronic pain, economic marginalization, and lack of access to care. It is in the context of these realities that prosecutors must decide whether to contribute to the enhanced criminalization of drug market participation—a context wherein many circumstances conspire to push people into the drug market and precious few resources are available to facilitate

stepping out of it. These social barriers and swiss-cheese social safety nets, which have produced the staggering rates of overdose seen in the U.S. today, are not prosecutors' problems to solve. But prosecutors do have a choice in how they wield the law: they can pursue DIH prosecution on their faith in the myths that this Article has dispelled, or they can refuse to be complicit in these all-too-familiar cycles of harm, participating instead in alternative responses to substance use, such as mediation, case management, and diversion, and contributing to a future in which overdose claims fewer of our friends, relatives, and neighbors.