Kicking the Habit
The Opioid Crisis and America’s Addiction to Prohibition

By Josh Bowers and Daniel Abrahamson

EXECUTIVE SUMMARY

There is no single cause of America’s opioid crisis, but overprescription of opioids has undoubtedly contributed. The federal government has responded predictably, criminally prosecuting doctors who prescribe opioids to the drug dependent. The approach may seem sensible, but it is as wrongheaded as our century-old drug war. Law enforcement’s recent push for punishment might succeed in limiting opioid prescriptions but only at the cost of driving drug-dependent individuals into more dangerous criminal markets and toward adulterated street heroin and fentanyl. For individuals addicted to opioids or suffering from chronic pain, a war on drugs has never been a prescription for improving wellness. This dominant abstinence-based policy model is grounded in the logic of prohibition, and it depends not upon healing but upon shame, isolation, prosecution, and penalty. The better model is “harm reduction,” grounded in connection and care, reason and rights, and human dignity and worth.

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

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INTRODUCTION

For a century, the United States has fought a war on drugs. Some strategies have changed over time, of course. The state has diverted manpower from opium to other substances, including heroin, marijuana, hallucinogens, powder and crack cocaine, and prescription and nonprescription opioids. Likewise, police, prosecutors, and politicians have supplemented conventional statutory approaches, such as the Harrison Narcotics Act, with more powerful policies, including the Controlled Substances Act and other state-law corollaries. Other strategies have remained constant. For instance, law enforcement has kept its sights trained throughout the drug war on low-income and minority neighborhoods.

More to the point, the goal of the drug war—punitive prohibition—has never shifted. With the exceptions of alcohol, tobacco, and, to a narrow extent, marijuana, recreational drugs are still forbidden, and users are still prosecuted. The state has consistently prohibited much more, even prosecuting the activists and medical professionals who would help problematic drug users through unconventional but promising means. It has defunded studies searching for innovative approaches to solve the problems arising from drug use and abuse, and it has undermined local reform efforts. The state's objective is a drug-free society—full stop.

An entire study could be devoted to unpacking the reasons for the drug war’s obsession with prohibition. It is enough, however, to flag three principal influences. First, the drug war's preoccupation with prohibition lies partially in America's history and worldview. Second, and to a greater degree, punitive prohibition is rooted in racism. Third, and more subtle, the logic of punitive prohibition follows a fixation with rules. Prohibition is what happens when public policy is left to be shaped from the top down. The war on drugs exposes a particular drawback of law, legal institutions, and the legal turn of mind: all have a tendency toward rigid rules, intimidation, and aversion to risk and experimentation.

While some legal regimes and bureaucratic frameworks have great value, many tend to fall prey to limited perspectives that not only make for misguided public policy but also complicate course correction. Simple answers are preferred to the pursuit of nuanced solutions. On this reasoning, prohibition takes on a certain elegance, captured by the directive, “Just Say No.” One might dismiss this as no more than an anodyne public service message. But those three words succinctly describe much more: a century of a state-sponsored war on drugs that has proven to be a public health failure.

Yet now, in the face of a brutal opioid crisis, there is a modicum of energy for genuine drug policy reform—for a shift from the prevailing just-say-no mentality. The shift is welcome, of course. Still, it is hard to get too excited about a newfound enthusiasm that is, in itself, seemingly grounded in racial bias. White America has opened its eyes to the evils of the drug war at the very moment that the opioid epidemic has begun to plague rural and predominantly white communities. We are witnessing an example of interest convergence theory in action, which posits that white America will only see fit to help black America if white Americans are forced to face the same challenges as black Americans. Simply put, there are limits to a polity's moral imagination when the problem exists “over there” only.

We would rather see reform grounded in a genuine commitment to civil, constitutional, and human rights—in a commitment to the liberty, equality, dignity, and interests of all drug users and their circles of social support. All the same, we are pragmatic drug policy reformers. And, because lives do in fact hang in the balance, we'll take what we can get—including any opportunity to shift the narrative, however slightly, from that of a criminal justice menace to a public health crisis.

In this policy analysis, we address the historical and contemporary approaches to addiction treatment and policy. First, we recall a time, before our centurylong war on drugs, when America responded to an opioid epidemic
not with prohibition but with an intervention known as addiction maintenance—that is, providing drugs in amounts calibrated to maintain the well-being of dependent persons. We examine what changed and how we came to abandon that harm-reduction model. Next, we explore contemporary international efforts to return to an old-style, harm-reduction approach. In the process, we explore some of the advantages of addiction maintenance in its modern form. Then we discuss how, when, and why addiction maintenance works and evaluate what stands in the way of addiction maintenance. Finally, we survey a host of domestic reform efforts and provide a framework for understanding when, how, and to what extent these endeavors have succeeded.

As these reform efforts reveal, addiction maintenance is only one front in harm reduction. Indeed, additional reforms necessarily must precede addiction maintenance because the practice is appropriate only after the failure of other much-needed therapeutic interventions—such as medication-assisted treatment with methadone, buprenorphine, or suboxone, none of which are uniformly available at present. We conclude with a six-point plan, designed to address the current opioid crisis in a manner that moves away from prohibition and toward harm reduction.

**EARLY ADDICTION MAINTENANCE EFFORTS**

Throughout the 19th century, drugs remained mostly unregulated. Users purchased products through mail-order catalogs and at local pharmacies. Sears, Roebuck and Company sold syringes with doses of injectable cocaine for one or two dollars. Opiates were packaged into serums with delightfully alliterative names, like “Mrs. Winslow's Soothing Syrup.” And, critically, this legal market was substantially safer than the modern-day criminal market:

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

Medical professionals of the era considered opioid abuse a public health problem. The idea of a drug war would likely have seemed foreign to them. To the contrary, doctors regarded persons suffering from drug addiction as patients deserving of treatment. Even for the profoundly dependent, the medical profession provided a form of palliative care—often termed addiction maintenance—by which cravings were treated by access to the craved substance.

By the turn of the century, the push for prohibition had begun—in part as a means to control minority communities. Politicians, pastors, and the press drew specious links between drug abuse and the exploitation of white women. These early drug warriors pushed for aggressive state responses, playing on racial stereotypes. African Americans were singled out for especially harsh treatment. Unsubstantiated claims linked black drug abuse to “many of the horrible crimes committed in the Southern States,” thus providing another convenient excuse for all varieties of Jim Crow persecution and oppression, including continued disenfranchisement. Notably, Harry Anslinger—the first commissioner of the Federal Bureau of Narcotics—was an unapologetic bigot who waged a ruthless (and almost bizarrely personal and obsessive) campaign against African American jazz singer and drug user Billie Holiday.

Then, as now, whites used drugs at rates comparable to—and perhaps even higher than—other populations. Indeed, historian David Courtwright concludes that “southern whites [of the era] had the highest addiction
Attitudes about recreational drugs were shaped by caste and class—by the desire to prevent the “wrong” type from associating with the “right” type.

What did early regulation look like? In 1914, Congress passed the Harrison Narcotics Tax Act, which taxed, but did not wholly prohibit, the production and distribution of cocaine and opioids. In this way, doctors could still prescribe narcotics, and many continued to do so to treat dependence. In fact, several municipalities ran public addiction maintenance clinics, including opioid clinics in New York City, Los Angeles, New Orleans, Shreveport, Atlanta, New Haven, Albany, and Jacksonville. These dispensaries operated aboveground, granting prescriptions for hard drugs to users. Health officials not only treated but also tracked patients. Participants were required to register with the state, which minimized the risk of diversion of the drugs into criminal markets and provided a data source to measure success empirically—even though such studies were apparently relatively uncommon at the time.

It seems that the efforts were largely successful. If nothing else, they initially enjoyed widespread support from city councils, boards of health, and even local law enforcement. According to one city official in Los Angeles, the city’s maintenance clinic “did more good ... in one day than all the prosecutions in one month.” But the legal landscape was shifting. “Law enforcement officials soon began to move to curtail the medical profession’s freedom to prescribe narcotics in the treatment of addicts.” Initially, law enforcement focused on the so-called script doctors who liberally dispensed opioids to patients. Federal prosecutors argued that addiction maintenance failed to qualify under the Harrison Act’s allowance for good faith prescriptions in the course of professional practice. And the Supreme Court would come to agree. First, in 

[Addicts] . . . are diseased, and proper subjects for such treatment, and we cannot possibly conclude that a physician acted improperly or unwisely or for other than medical purposes solely because he has dispensed to one of them, in the ordinary course and in good faith . . . morphine or cocaine for relief of conditions incident to addiction.

But Linder would prove to be sui generis—an exception to the dominant rule, applied to a case where the doctor had prescribed only a relatively small dose. The Harrison Act had set the stage for punitive prohibition. And, with the passage of the Eighteenth Amendment, the logic of prohibition became a constitutional mandate, shifting both legal and cultural norms. Enforcement of the Harrison Act “stigmatized medication-assisted treatment as well as the patients who received such care.” In short order, the practice of addiction maintenance disappeared. By 1925, the last clinic had closed.

With the repeal of the Eighteenth Amendment in 1933, there was, perhaps,
some hope that the state might soften its approach to prohibition writ large. To the contrary, federal officials, now relieved of alcohol-interdiction duties, were free to devote even more time and criminal justice energy to narcotics.

The government had its reasons, of course, to worry about unscrupulous physicians who indiscriminately dispensed opioids and other drugs. There is a legitimate concern about the diversion of prescription drugs into criminal markets. And the line is fine between treating and creating drug dependency. Thus the Harrison Act replaced the physician's tools with the threats of the criminal justice system.

“The unfortunate consequence of this policy was to drive from the field of treatment not only the unethical ‘script doctor’ but the legitimate doctor as well.”

INTERNATIONAL PUBLIC HEALTH EFFORTS

Beyond our borders, several cities and countries have, for some time, successfully provided free, uncontaminated, comparatively safe narcotics to persons addicted to controlled substances. Among those closest to home, Vancouver has witnessed a grassroots campaign undertaken by drug users—the Vancouver Area Network of Drug Users (VANDU)—to support and care for each other. VANDU initially established an underground, supervised injection facility: a sterile, medically staffed environment to which recreational users could bring drugs to consume in relative safety. And, as VANDU’s successes became apparent, it took its efforts mainstream. It pressured the municipality to declare a public health emergency and won the support of the city’s conservative mayor, Philip Owen. Then Vancouver opened Insite, the first licit drug-consumption safe site in North America. Drug users who brought their drugs to Insite were made safe in three ways: they were insulated from arrest and prosecution, they were given sterile injection equipment and other drug-use paraphernalia, and they were supervised by medical professionals prepared to administer naloxone and oxygen as needed to reverse overdoses.

The results were transformative. To date, Insite claims to have reversed nearly 5,000 overdoses without suffering a single overdose death. More than that, clean needles have kept injectable-drug users from transmitting communicable diseases, such as HIV and hepatitis. And, as participants have moved their habits—and needles—indoors, quality of life in Vancouver’s formerly derelict Downtown Eastside has improved dramatically. Many heavy drug users have reduced or even ceased their drug use and have secured stable employment and housing. Notably, between 1996 and 2006, life expectancy in the Downtown Eastside rose by several years. These results are in keeping with recent research tracing the roots of addiction. The current phrase is, “The opposite of addiction is connection,” and by normalizing but still discouraging drug use, these international experiments have served to reconnect dependent drug-users with their communities.

But, ultimately, the safe site was not enough to effectively serve the needs of drug-affected Vancouver communities. Thus the city opened the Providence Crosstown Clinic, which operates on a genuine addiction maintenance model. At Crosstown, staff provide addicts with pharmaceutical-grade heroin in a supervised setting with care sometimes paid for by Health Canada (the country’s national public health care provider). The program reaches the very individuals that criminal legal systems label recidivists. Indeed, many participants have previously cycled through Canadian jails and prisons—to no avail. Crosstown makes heroin available to patients for whom all other interventions have failed, including even medication-assisted therapy with methadone, buprenorphine, or suboxone. Out of options, Vancouver took the only viable step left: the city turned to free heroin, turning run-of-the-mill repeat offenders into patients.

The aim is palliative care. First, harm is reduced to the opioid-dependent person by providing clean needles in a clinical setting...
The idea is to transform the heavy drug user into a functional and socially productive individual who need not spend every waking moment evading law enforcement to furtively score and use illicit substances.

And the percentage of participants maintaining full-time employment has tripled, while dependence upon welfare has declined dramatically. In turn, harm reduction efforts have grown in popularity. In 2008, 68 percent of Swiss voters approved a measure to incorporate addiction maintenance into the country's official health policy.

Portugal has implemented even more ambitious harm reduction measures and has achieved even greater success. By the end of the 20th century, a staggering 1 percent of Portugal's population was hooked on heroin. In 2001, the government decriminalized possession and use (but not sale) of all drugs and invested heavily in treatment and social services. Portugal's new philosophy was to treat drug users as patients, not criminals—to keep them "inside the health system, not outside of it." And its efforts have worked. Portuguese rates of drug use remain relatively high, but rates of hard drug use have declined, with heroin use declining by an astounding two-thirds from its peak. More to the point, drug-related HIV infections plummeted more than 90 percent and overdose deaths fell 85 percent—to the lowest death rate in Western Europe and one-fiftieth the rate in the United States. Portugal may have adopted radical policies of decriminalization and harm reduction, but it is not tolerant of drugs; rather, it is intolerant of death and all the other unintended consequences of prohibition. As Nicholas Kristof remarked, "Portugal may be winning the war on drugs—by ending it."

HOW, WHEN, AND WHY ADDICTION MAINTENANCE WORKS

Why have these international efforts proved so successful? First, they are finely targeted to the challenges facing dependent drug users and are designed deliberately to help those users at critical moments. Heroin and other opioids are prescribed only after the failure of other efforts—whether therapeutic interventions or criminal enforcement. Second,
addiction maintenance promotes safety: the drugs must be consumed onsite—in comfortable but sterile settings with well-equipped medical personnel on hand, thereby minimizing risks of death and the diversion of opioids into criminal markets.90 Third, and perhaps most importantly, these efforts are oriented against the logic of prohibition.91

The goal of addiction maintenance is harm reduction—a reduction in the harms that flow from illicit drug markets, infectious diseases, overdoses, and criminal enforcement and punishment.92 And, because addiction maintenance is an intervention of last resort (not unlike “heroic” measures in medicine93), it promises to reduce harm for the most dependent users.94 For those for whom nothing has worked, addiction maintenance provides the possibility to stay off streets, with families, in jobs, and out of emergency rooms, hospitals, jails, and mortuaries.95

And, even though addiction maintenance is intended only to provide palliative care, there is some evidence that—under the right circumstances—it may reduce overall drug use.96 This would seem counterintuitive, of course. How could it be that free access to opioids might help dependent users get clean? Appreciate, first, the context in which drugs are most often abused. The environmental theory of addiction insists that pharmacology is only secondarily related to dependence.97 Chemicals have physiological effects to be sure, but plenty of drug users maintain relative free will to ingest without becoming dependent.98 Indeed, the vast majority of people who try even hard drugs avoid dependence.99 A small subset develop powerful compulsions, but the question of when and whether these compulsions take hold may depend more on an individual’s life circumstances than the chemical composition of the drug.100

This is the environmental theory of addiction;101 consider a series of animal studies.102 In an early set of studies, rats were placed alone in cages with food, water, and cocaine drips.103 In short order, most rats abandoned their food and water and fixated on the cocaine, consuming copious amounts until death.104 At first blush, the studies seemed to demonstrate the intensity of chemical hooks.105 But, decades later, social scientists replicated the studies with a clever twist: several rats were housed together in nurturing environments, not in isolation in sterile cages, and they were given ample opportunities to interact and socialize.106 These rats still experimented with the cocaine, but not to excess and less so over time.107 Consider also the many heroin-dependent American soldiers fighting in Vietnam who readily gave up substance abuse once they returned home safely.108 These men self-medicated against the horrors of war but were able to alter their behavior once the context changed.109 Like the drug-dependent soldiers in Vietnam, the first set of rats was self-medicating against pain and loneliness. The second set enjoyed meaningful lives, and those rats had less desire or compulsion to fill the void with self-harm.110

Now consider the life of a drug user under the framework of prohibition. The threat of criminal repercussions drives users underground in search of drugs of unknown quality and provenance while isolating them from the resources and support systems needed to address addiction. According to Gabor Maté, a doctor specializing in childhood trauma and addiction,

If I had to design a system that was intended to keep people addicted, I’d design exactly the system that we have right now. . . . I’d attack people and ostracize them. . . . The more you stress people, the more they’re going to use. The more you de-stress people, the less they are going to use. So to create a system where you ostracize and marginalize and criminalize people, and force them to live in poverty with disease, you are basically guaranteeing they will stay at it.111

Maté has been criticized for overstating the influence of isolation and trauma while underplaying pharmacological effects.112 But
The conclusion is inescapable. Addiction need not be a terminal condition.

The Vancouver and European experiences suggest strongly that the isolation and trauma created by prohibition cause substantial harm. When these international municipalities and governments abandoned prohibition and focused instead on eliminating barriers to drug acquisition, drug users were better able to focus on self-improvement. Their ties to family, community, education, and employment were strengthened (or at least left intact). Thus, for instance, a *Lancet* study found that the majority of participants in Switzerland’s addiction maintenance clinics were able to pivot eventually to methadone or abstinence programs. Moreover, as Vancouver’s Downtown Eastside discovered, fewer people are likely to become drug dependent in the first instance once a neighborhood’s quality of life improves.

The conclusion is inescapable. Addiction need not be a terminal condition. And, for the most dependent, the most promising treatment may just be to feed the habit. If nothing else, addiction maintenance facilitates the process known as aging out. Heavy drug abuse and other risk-taking behaviors concentrate in populations of young adult men. As individuals mature, they tend to use less. The more stable people’s lives are, the likelier they are to age out more quickly. The takeaway is obvious: sometimes the best approach is patience—to wait out drug use, misuse, abuse, or dependence—and, in the interim, to minimize the damage done to the individual and his social network.

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

**LEGAL ROADBLOCKS**

But isn’t the current opioid crisis a product of a prescription market and model? Drug manufacturers pushed opioids on doctors. And “pill mills”—the pharmacies and physicians that overprescribed and overdispensed medications—pushed opioids on patients. In short, America already subscribed to a drug-licensing regime, and it led to lives ruined or ended prematurely, families and communities splintered, and support networks broken down. If prescriptions and addiction maintenance are so promising, what went so wrong?

The short answer is that recent American experience cannot be understood as addiction maintenance. Under addiction maintenance, people who abuse opioids and who have failed to respond to other kinds of treatment, including methadone maintenance, would be admitted into medically supervised clinics and provided pharmaceutical-grade narcotics in amounts calibrated to reduce the harms of obtaining and using drugs from illicit markets while maintaining social and physical well-being. The American approach is, in fact, the opposite of addiction maintenance. Our prevailing licensing regime permits doctors to prescribe opioids only until patients become dependent. A recently passed Michigan statute captures this, defining good-faith practice as “the prescribing or dispensing of a controlled substance . . . in the regular course of professional treatment . . . for a pathology or condition other than that individual’s physical or psychological dependence upon or addiction to a controlled substance [italics added].” Once patients get hooked, patient-centered care is displaced and the protocols of mandatory tapering and forced cessation imposed, backed by threat of criminal penalties.

Use-reduction logic might seem simple enough: fewer prescriptions for pills should correspond with less use by the drug dependent. And, indeed, prescription opioid use has dropped dramatically in recent years. Prescriptions peaked in 2012 and have fallen since. In 2017 alone, they plummeted 10 percent, the sharpest decline in a quarter-century. But current enforcement efforts have succeeded only in minimizing prescription
As opioid prescriptions have plummeted, opioid-linked deaths have skyrocketed.

If I am an American who has developed an Oxycontin addiction, as soon as my doctor realizes I’m an addict, she has to cut me off. She is allowed to prescribe to treat only my physical pain—not my addiction. . . . That’s when, in desperation, I might hold up a pharmacy with a gun, or go and buy unlabeled pills from street dealers. Most of the problems attributed to prescription drugs in the United States . . . begin here, when the legal, regulated route to the drug is terminated. . . . The prescription drug crisis doesn’t discredit legalization—it shows the need for it.131

The data bear out Hari’s claims. As opioid prescriptions have plummeted, opioid-linked deaths have skyrocketed.132 Street trade produces unreliable doses that fluctuate in quality and strength. One dealer may find it profitable to dilute a batch and sell more. Another dealer may cut costs by adding cheap fentanyl—an extremely potent and highly lethal synthetic opioid for which even seasoned opioid users may lack tolerance. More to the point, dealers may not even be aware of the purity and potency of their own unlabeled and unregulated goods. And comparatively milder prescription drugs, which were previously more accessible on pharmacy shelves, are often just too expensive and bulky for street-level sellers to keep in stock. “Just as when all legal routes to alcohol were cut off, beer disappeared and whisky won, when all legal routes to opiates are cut off, Oxy disappears, and heroin prevails. This isn’t a law of nature. . . . [It’s] drug policy.”133

Recent reform efforts have made the problem only worse. The current war on opioids is, like the first war on drugs, a war on physicians. In the words of former attorney general Jeff Sessions, “We’re going to target those doctors.”134 In January 2018, the Drug Enforcement Agency (DEA) initiated a “surge” in efforts to shut down pill mills.135 The next month, the Justice Department started a task force to pursue manufacturers and distributors.136 According to a press release, “The Department will . . . use all criminal and civil tools at its disposal to hold distributors such as pharmacies, pain management clinics, drug testing facilities, and individual physicians accountable for unlawful actions . . . to prevent diversion and improper prescribing.”137 In March 2018, the administration announced plans to cut opioid prescriptions by a third within three years, and the DEA initiated new drug-production quotas, ultimately producing dramatic opioid shortages.138 In June 2018, Sessions announced charges against 162 individuals, including physicians, for crimes related to prescribing and distributing prescription opioids.139 And, even before this recent crackdown, the DEA had increased actions against doctors from 88 in 2011 to 479 in 2016.140

The escalation and crackdown are not unique to federal law enforcement. The Centers for Disease Control and Prevention (CDC) has promulgated its own guidelines for prescribing higher dosages.141 Initially, these were recommendations only, but several states and medical boards have turned those guidelines into rigid rules, using the CDC template to enact statutory and regulatory limits that help define what constitutes medical malpractice and criminal wrongdoing.142 Likewise, public and private insurers have imposed their own tapering protocols that expand tracking, interfere in the physician-patient relationship, and curtail further the responsible practice of individualized medicine.143

In turn, physicians have stopped treating patients whose health could genuinely benefit from large or long-term doses of prescription opioids. Consider the DEA’s pursuit of Forest
This is overdeterrence in action—another example of how prohibition chills socially valuable conduct at the margins. Tennessee, a prominent California physician who faced criminal investigation for atypical prescribing.144 Tennant specialized in severe chronic pain and was world-renowned for palliative care, often at the end of life.145 He had evidence-based reasons for prescribing such large quantities of opioids.146 Nevertheless, law enforcement successfully pushed Tennant into early retirement, leaving his patients to suffer without effective pain management.147

This is overdeterrence in action—another example of how prohibition chills socially valuable conduct at the margins.148 Indeed, in some states, the wait to see a qualified pain management specialist has increased to a year or longer.149 And it stands to reason that some of the most ethical doctors may be the most easily dissuaded from prescribing opioids consistent with patients’ actual needs; because these physicians are likelier to be comparatively risk averse, they are likelier to overcorrect in order to steer well clear of increasingly pronounced criminal justice threats and consequences. Moreover, they are likelier to be aware of (and comply with) the heightened recordkeeping requirements that law enforcement may use to trawl for patient and physician targets. At a certain point, it’s just not worth the effort. As one primary care doctor put it, “I will no longer treat chronic pain. Period…. There is too much risk involved.”150

THE FUTURE OF REFORM

Meaningful domestic drug reform has only ever arisen from the bottom up. Take the example of syringe exchanges. Starting in Europe in the 1980s, activists experimented with exchanges as a response to the deadly epidemic of HIV/AIDS.151 American reformers took note, but federal and state governments worked actively against such initiatives. The DEA, for example, had previously promulgated the Model Drug Paraphernalia Act, which provided a template for 46 states to criminalize the manufacture, possession, or distribution of drug paraphernalia, broadly defined.152 Moreover, the federal government refused to fund syringe exchanges until they were proven “safe and effective” (and, of course, it refused also to fund research into the question).153 Indeed, Sen. Jesse Helms (R-NC) equated any public effort to implement a syringe exchange to government-supported drug abuse.154 Nevertheless, activists persisted in doing what they could, typically underground.155 Over time, some mainstream stakeholders even began to buy in. Ultimately, a number of municipal and state authorities authorized syringe-exchange programs, maneuvering politically and legally to prevent pushback.156 By 2015, even the federal government had lifted its funding ban—albeit only partially (and more than a quarter century too late).157 Overall, reform efforts proved successful.

Consider the example of medical cannabis. Today, a majority of states permit at least some form of medical use.158 But these statutory public health interventions were slow in coming, even though, as early as the 1970s, it was already well established that cannabis could quell cancer patients’ nausea and stimulate their appetites.159 Over the next 20 years, patients and advocates raised awareness that cannabis could also alleviate suffering from other illnesses and afflictions—glaucoma, AIDS-related wasting syndrome, epilepsy, neuropathic pain, and the side effects of ingesting certain drug cocktails.160 Nevertheless, the federal government remained largely intransigent. In 1996, after California voters passed the Compassionate Use Act by proposition, federal authorities threatened physicians with civil and criminal penalties merely for recommending medical cannabis.161 Even today, the Controlled Substances Act classifies marijuana as a Schedule I drug—a substance purported to have no therapeutic benefits and a high potential for abuse.162 Simply put, federal law continues to criminalize cannabis.163

In spite of these hurdles, activists found a way to build a grassroots movement around medical cannabis, establishing a collection of underground dispensaries.164 Municipalities and states began to follow their
lead, primarily, at first, by citizen-initiated resolutions, referendums, and propositions.165 Lawmakers only began to act once the issue of medical cannabis had become obviously expedient.166 Until then, the path to meaningful reform was direct democracy and direct action.

To these examples, we could add the drug-court movement, which now boasts over 2,000 courts currently operating nationwide.167 In the interest of full disclosure, we should make it clear that we, as authors, are deeply skeptical of the ability of drug courts to provide appropriate treatment and to function effectively as an alternative to incarceration (much less to avoid the collateral harms of the drug war).172 The drug-court model embraces and perpetuates the same prohibitionist and coercive paradigm of abstinence that we believe is so misguided. The movement operates within criminal justice, retaining the threat of punishment as a backstop for the noncompliant participant. Disappointingly, but perhaps unsurprisingly, many leading drug-court advocates have tended, therefore, to publicly oppose more ambitious drug policy reform, including the decriminalization of cannabis (even for medical use), reduction of felony possession offenses to misdemeanor or noncriminal offenses, and acceptance of (and reliance upon) medication-assisted treatments.171

The origins of the drug-court movement can be traced to a small handful of ground-level advocates (in this case, county judges and local law enforcement) who could no longer countenance the most egregious excesses of the drug war, such as lengthy jail and prison sentences for low-level, nonviolent drug offenders.172 With no other viable option, these officials began to experiment, first quietly, then vocally, with alternative judicial interventions intended to avoid draconian penalties for chemically dependent persons.

These examples illustrate the failure of the drug war and the role of grassroots activism in driving meaningful change. Although there has been some progress, such issues remain with respect to the opioid epidemic. Until relatively recently, federal and state laws largely prevented most people from preemptively gaining access to naloxone, an opioid antagonist, which reverses overdoses.173 Naloxone (trade name Narcan) is called the Lazarus drug for a good reason: injecting naloxone into a person’s bloodstream revives the sufferer by counteracting respiratory distress.174 For a long time, however, possession of naloxone was limited principally to emergency medical technicians and emergency room staff.175 Thus its benefits could reach only those overdose victims who lived long enough to see the inside of an ambulance or hospital.

Technically, some physicians could still prescribe naloxone, but any such efforts were resisted by public officials, law enforcement, and even many within the medical community.176 In a classic example, opponents of naloxone relied upon the argument that ready access to naloxone would encourage opioid users (antidote in hand) to use drugs more often and more recklessly.177 Naloxone is neither an addictive nor mind-altering chemical compound, and it is incapable of recreational abuse.178 It is, first and foremost, a lifesaver. To withhold it is to endorse the view that death is an appropriate punishment for those who overdose.

Enter the street activists. Piggybacking on the highly successful work of a syringe exchange program in Chicago, activists began distributing naloxone to syringe-exchange clients and taught them how to administer naloxone to reverse an overdose.179 Days after distribution of the first naloxone dose, a “save” was recorded.180 Hundreds and then thousands of saves followed.181 Other syringe exchanges took note of the Chicago experiment, as did local public health departments. In short order, communities across the country began to distribute (or turn a blind eye to the distribution of) naloxone; municipal and state-level law and policy reform followed thereafter. By July 2017, all 50 states and the District of Columbia had taken legal steps to increase access to naloxone.182

Four dynamics describe these drug policy reforms. First, until harm reduction interventions are well established, public officials and...
A precursor to the addiction maintenance clinic has already begun to find traction—the safe site, or supervised injection facility, which does not supply drugs but provides a space for relatively safe consumption.

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

Second, and relatedly, public health innovations typically start underground. For years—without any change in local, state, or federal law—sterile syringes were exchanged, medical marijuana was ingested, and naloxone was distributed and injected. If “Just Say No” is the mantra of the drug war, then the ethos of drug reform is Nike’s motto, “Just Do It.” Grassroots activists have proven to be willing to risk everything to defy the status quo by purposefully violating drug laws. For these advocates, protecting and saving lives is worth the gamble.

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

Fourth, all the while, the federal structure stays largely intact. Its orientation remains prohibition first. At best, federal officials may tolerate local experimentation. But the federal law remains criminal law—the Controlled Substances Act and other punitive statutes like it. Even today, federal support for syringe exchanges is largely passive. Likewise, the federal government continues to oppose medical cannabis. And, perhaps more importantly, it continues to stifle medical-cannabis research, thereby keeping technically true the hollow claim that the substance has no proven medical benefits.

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

More to the point, a precursor to the addiction maintenance clinic has already begun to find traction—the safe site, or supervised injection facility, which does not supply drugs but provides a space for relatively safe consumption.
Our success would not be measured by our proximity to a drug-free America but whether we have minimized drug-related deaths, disease, crime, and suffering, whether we have improved health and welfare, and whether we have preserved and expanded autonomy and dignity.

CONCLUSION

The drug-free society is a pipe dream. If, instead, we were to acknowledge that drugs are an often (but not always) unfortunate fact of life, we might come to regard drug misuse, abuse, dependence, and addiction for what they are—questions of health, not morality, and of social policy, not penology. Our success would not be measured by our proximity to a drug-free America but whether we have minimized drug-related deaths, disease, crime, and suffering, whether we have improved health and welfare, and whether we have preserved and expanded autonomy and dignity.

We remain doubtful that American society and its legal and medical institutions can reorient wholly from a criminal-legal model to a public health model. The logic of prohibition has enjoyed too much dominance for far too long. Few medical schools meaningfully incorporate addiction treatment into core curricula, and few new doctors choose to specialize in addiction medicine. Perhaps doctors have avoided practicing addiction medicine because the professional and legal risks are too great. Moreover, until relatively recently, insurance providers could legally refuse to cover addiction treatment—at least, more readily than other accepted medical interventions. But, for many in the industry, the problem is likewise cultural. Although many medical professionals have been on the front lines of the most ambitious drug policy reforms, it is still not uncommon to encounter doctors who harbor the same attitudes as prohibitionists.

However, precisely because culture plays such an influential role in drug policy and medical practice, there is a silver lining to the immediate epidemic. The opioid crisis has awoken a previously indifferent America to the failings of prohibition. We are hopeful, but not overly so, that this awakening could translate to meaningful change all the way up to the federal level. We are especially encouraged—and somewhat surprised—that the Senate, by a remarkable vote of 99 to 1, recently passed sweeping legislation that could make it easier for doctors to prescribe suboxone (buprenorphine) and other forms of medication-assisted treatment for addiction. Again, interest convergence has a way of making the seemingly impossible suddenly possible, even if not for entirely admirable reasons.

But these welcome developments are counterbalanced by more conventional resistance, like the Justice Department’s recent crackdown against prescribing doctors. All in all, we expect to see mainly street-level activism and politically popular local initiatives but too few positive steps beyond that. The logic of prohibition will continue to predominate, and the machinery of criminal
The empirical and anecdotal evidence is persuasive that these interventions will save lives, alleviate suffering, and lessen drug-related crime.

Still, we offer this pragmatic six-point plan for addressing our current opioid crisis:

1. Grant 911 amnesty from arrest for all drug offenses for all individuals who contact authorities to report overdoses or people in need of aid.

2. Make naloxone available without a prescription at pharmacies, fire stations, public libraries, police stations, hospitals, jails and prisons, and supervised injection facilities.

3. Make pill and powder testing available to assess drug purity and to detect the presence of fentanyl and other dangerous compounds as a means to enable drug users to make informed choices about whether and how to use substances.

4. Make medication-assisted treatment available with prescription, within and beyond clinical settings, for all individuals who require it, inmates included, without forced detoxification after fixed time periods.

5. Make supervised injection facilities, drug consumption rooms, and syringe exchanges available in areas of concentrated injection drug use.

6. Make physician-supervised addiction maintenance programs available with prescription for individuals for whom other forms of medication-assisted therapy have failed.

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

Criminal law is the wrong tool for addressing the opioid epidemic. People are dying in record numbers, and we must acknowledge and abandon our addiction to punishment and broaden our legal horizons to adopt measures proven to reduce and avoid harms related to both drug use and enforcement of the drug war.
NOTES
Many thanks to Rebecca Rubin for her exceptional research assistance.


17. Weber, “Failure of Physicians,” p. 34 (quoting Henry Smith Williams, “The doctor knows just what should be done . . . that he has but to write a few words on the prescription blank that lies at his elbow, and the patient . . . will receive the remedy that would restore him miraculously to a semblance of normality”); and Henry Smith Williams, Drug Addicts Are Human Beings (Washington: Shaw Publishing, 1938).

18. Weber, “Failure of Physicians,” p. 17 (describing the racist
belief, prevalent during the era, that marijuana made black men “forget the appropriate racial barriers—and unleashed their lust for white women”).


30. Musto, American Disease; Hari, Chasing the Scream, pp. 151, 156–78


34. Webb v. United States, 249 U.S. 96, 99–100 (1919). (“[T]o call such an order for the use of morphine a physician’s prescription would be so plain a perversion of meaning that no discussion of the subject is required.”)

35. Jin Fuey Moy v. United States, 254 U.S. at 194 (holding that the physician’s exemption did not include “a distribution intended to cater to the appetite or satisfy the craving of one addicted to the use of the drug,” and noting that a “prescription’ issued” for addiction maintenance “protects neither the physician who issues it, nor the dealer who knowingly accepts and fills it”).


42. See Pagano, “The Racist Origins of Marijuana Prohibition,” pp. 58–60. (“The American Medical Association issued a resolution in 1920 opposing ambulatory maintenance clinics and condemning the use of heroin, which sanctioned the further prosecution of physicians who continued to prescribe maintenance medication.”)


44. “Eighteenth Amendment,” Encyclopedia Britannica.


49. Peter Reuter, Can Heroin Maintenance Help Baltimore? (Baltimore: Abell Foundation, January 2009). (“A small but growing number of Western nations are experimenting with heroin maintenance.”)


52. Hari, Chasing the Scream, p. 200. “Suddenly, VANDU was an international news story . . . from the BBC to the New York Times.”


58. Evan Wood et al., “Changes in Public Order after the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users,” Canadian Medical Association Journal 171, no. 7 (2004): 731, 733. (“Our observations suggest that the establishment of the safer injecting facility has resulted in measurable improvements in public order, which in turn may improve the livability of communities and benefit tourism while reducing community concerns stemming from public drug use and discarded syringes.”)


63. Lopez, “Case for Prescription Heroin.”

64. Lopez, “Case for Prescription Heroin.”

65. Lopez, “Case for Prescription Heroin.”

66. Lopez, “Case for Prescription Heroin.”


69. Lopez, “Case for Prescription Heroin.”

70. Lopez, “Case for Prescription Heroin.”

71. Lopez, “Case for Prescription Heroin.”


73. Lopez, “Case for Prescription Heroin”; and Hari, *Chasing the Scream*.

74. Lopez, “Case for Prescription Heroin.”

75. Lopez, “Case for Prescription Heroin”; and Hari, *Chasing the Scream*.


84. Faria, “Portugal Solved Its Drug Crisis”; and Frayer, “In Portugal, Drug Use Is Treated as a Medical Issue, Not a Crime.”

85. Faria, “Portugal Solved Its Drug Crisis.”


87. Hari, *Chasing the Scream*; Weber, “Failure of Physicians,” pp. 249–50, 268; Faria, “Portugal Solved Its Drug Crisis” (noting decline in death rate from one per day to only a couple per month); Naina Bajekal, “Want to Win the War on Drugs? Portugal Might Have the Answer,” *Time*, August 1, 2018; Caitlin

88. Kristof, “How to Win” (Belgium, Germany, the Netherlands, Sweden, and Uruguay have undertaken similar harm-reduction reforms with similarly promising results); Hari, Chasing the Scream; Weber, “Failure of Physicians,” pp. 264–73; and Shirley Haasnoot, “Dutch Drug Policy, Pragmatic as Ever,” The Guardian, January 3, 2013.

89. Lopez, “Case for Prescription Heroin”; and Bowers, “What If Nothing Works?”


100. Hari, Chasing the Scream, pp. 171–73.

101. Hari, Chasing the Scream.

102. Hari, Chasing the Scream, pp. 171–73.

103. Hari, Chasing the Scream.

104. Hari, Chasing the Scream, pp. 171–73.

105. Hari, Chasing the Scream, p. 171.


107. Hari, Chasing the Scream.


109. Hari, Chasing the Scream.


111. Hari, Chasing the Scream, p. 166.


113. Reuter, Can Heroin Maintenance Help Baltimore?


116. Laura Duberstein Lindberg, Scott Boggess, Laura Porter, and

117. Szalavitz, “Most People with Addiction”; and Lopez, “Case for Prescription Heroin.”

118. Szalavitz, “Most People with Addiction”; and Lopez, “Case for Prescription Heroin.”

119. Hari, *Chasing the Scream*; Weber, “Failure of Physicians,” pp. 171–73 (“Most addicts will simply stop, whether they are given treatment or not, provided prohibition doesn’t kill them first.”); and Richard Lawrence Miller, *The Case for Legalizing Drugs* (Westport, CT: Praeger Publishers, 1991), p. 53. (“Researchers have found chronological age to be a prevalent reason for drug use. Abuse is typically a young person’s habit, given up as the individual matures.”)

120. Nedelman, “Doctors Increasingly Face Charges.”

121. Malbran, “What’s a Pill Mill?”


128. “U.S. Opioid Prescribing Rate Maps”; and Malbran, “What’s a Pill Mill?”


130. Levine, “Government’s Solution.” (“There’s evidence that thousands of prescription users cut off by fearful doctors are turning to dangerous street drugs, or being left to suffer.”)


133. Hari, *Chasing the Scream*; and Weber, “Failure of Physicians,” p. 231 (noting that, on the streets, Oxycontin is three times more expensive than heroin).


135. Levine, “Government’s Solution”; and McCoy, “Unintended Consequences” (internal quotations omitted).


144. Anson, “Dr. Forest Tennant Retiring.”

145. Anson, “Dr. Forest Tennant Retiring.”


147. Anson, “Dr. Forest Tennant Retiring.”

148. Brianna Ehley, “How the Opioid Crackdown Is Backfiring,” Politico, August 28, 2018; Levine, “Government’s Solution”; McCoy, “Unintended Consequences”; and Marso, “Opioid Backlash.” (“The result . . . has been a chilling effect nationally that has reduced the number of doctors willing to prescribe opioids and has left patients already dependent on them in the lurch.”)


153. Des Jarlais, “Harm Reduction in the USA,” p. 3; Jessie Balmert, “What Is Ohio Issue 1? Separating Fact from Fiction on Divisive Drug Ballot Initiative,” WKYC.com, November 5, 2018; and 42 U.S.C. § 300ee–5 (1988). (“None of the funds provided under this Act . . . shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.”)


161. Conant v. Walters, 309 F.3d 629 (9th Cir. 2002).


183. Davis, Legal Interventions.


196. Cherri Gregg, “Krasner: Philly DAs Office Won’t Prosecute
Those Using Safe Injection Sites,” CBS Philly, February 14, 2018; and Joyce Chen, “Philadelphia Wants to Be First U.S. City to Open Safe Injection Sites,” Rolling Stone, January 24, 2018 (quoting Philadelphia police commissioner Richard Ross, who is “kept[ing] an open mind” about supervised injection facilities).


198. Allyn, “As Philly Moves.”

199. Allyn, “As Philly Moves.”


213. “Safe Injection Sites: Are They Helping or Hurting?,” Nova Recovery Center, November 14, 2018 (summarizing research on safe injection sites).


CITATION

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