

Addressing the Heroin and Opioid Crisis

September
2016
Volume 64
Number 5

United States
Department of Justice
Executive Office for
United States Attorneys
Washington, DC
20530

Monty Wilkinson
Director

Contributors' opinions and statements
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The United States Attorneys' Bulletin
is published pursuant to
28 C.F.R. § 0.22(b)

The United States Attorneys' Bulletin
is published bimonthly by the
Executive Office for United States
Attorneys, Office of Legal Education,
1620 Pendleton Street,
Columbia, South Carolina 29201

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Internet Address
[https://www.justice.gov/usao/resources/
united-states-attorneys-bulletins](https://www.justice.gov/usao/resources/united-states-attorneys-bulletins)

Send article submissions
to Editor,
United States Attorneys' Bulletin,
National Advocacy Center,
Office of Legal Education,
1620 Pendleton Street,
Columbia, SC 29201

Cite as:
64 5 U.S. Attorneys Bulletin (2016)

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Introduction

Sally Quillian Yates
Deputy Attorney General

By now, everyone is familiar with the heroin and opioid epidemic that has gripped our country. Drug overdose deaths—the majority attributable to heroin and opioid use—now exceed car crashes as the leading injury cause of death in the United States. During the most recent year for which complete numbers are available (2014), more than 28,000 died from overdoses involving prescription opioid medications and heroin. This equates to one death every 20 minutes. The epidemic has been years in the making. Between 2006 and 2014, heroin overdose deaths increased by a staggering 406%. Further, this epidemic is pervasive, devastating communities without respect to demographic. The scourge has attacked men and women and people of most age groups, races, and ethnicities. In short, with respect to its direct and immediate toll on human life, the heroin and opioid epidemic is among the Department’s most pressing challenges.

In the face of these bleak facts, is there any reason to hope that things will improve? And, more particularly, can the Department make a difference? It is my firm belief that the answer to both of these questions is “yes.” As an initial matter, the heroin and opioid epidemic has unique characteristics that distinguish it from drug problems of the past and point to possible solutions. There is growing consensus that the epidemic was conceived through a lethal combination of over-prescribing of otherwise lawful opioids and increasing availability of high-purity heroin at cheap prices. Viewed with this understanding, the outline of a possible solution begins to emerge that focuses on the prudent handling of opioids, the disruption of heroin supply chains, and the prevention and treatment of addiction.

The Department recognized the proportions of this epidemic early on and began taking action to address it. Some of the most important Department efforts to combat the heroin and opioid epidemic have been led by our U.S. Attorney’s Offices located in regions that have been most severely impacted. For example, the U.S. Attorney’s Office for the Western District of Pennsylvania, working with EOUSA, developed an Opioid Toolkit, containing a brief bank and outreach and prevention models for use by the prosecutor community (<https://portal.doj.gov/eousa/EO/OpioidToolkit/Pages/default.aspx>). The U.S. Attorney’s Office in Cleveland, as another example, began educating its communities about the epidemic and working with public health officials to stem the tide of opioids flooding that community.

The Department’s efforts have not been limited to the U.S. Attorney community alone. The Drug Enforcement Administration has implemented a 360-degree strategy that tackles the epidemic on multiple fronts, activating community support while utilizing traditional enforcement measures. The Organized Crime Drug Enforcement Task Force Program has instituted a national strategy, funding 32 locally- and regionally-initiated projects across the country to increase information collection and sharing, analysis, investigation and prosecution of heroin and opioid cases. The Bureau of Justice Assistance oversees the Harold Rogers Prescription Drug Monitoring Grant Programs, which have been used to establish PDMP programs where they do not already exist and to enhance and modernize established PDMP programs.

This non-exhaustive listing of Department initiatives reflects an emerging understanding that any solution to this epidemic must be holistic. Traditional law enforcement measures are critical to targeting drug trafficking organizations, whose members conspire to peddle heroin to local communities, and rogue doctors, who don white coats to disguise their trafficking in opioids. As the persistent nature of this problem has revealed, however, law enforcement efforts alone will not bring an end to this epidemic.

Instead, research and experience have begun to make clear that the epidemic is also a public health crisis, the solution to which requires additional tools that range from drug prevention to addiction treatment.

Consequently, the Department finds itself in a position of needing to operate, in part, outside its traditional bailiwick. Even so, the Department is particularly well-suited to the task. U.S. Attorney's offices have considerable stature that can be leveraged to convene regional stakeholders from public health, public safety, and other impacted communities to develop coordinated community solutions. Similarly, the Department's law enforcement components can make use of their intelligence-capacities and inherent credibility to improve the sharing of critical information in an effort to identify and respond to overdose outbreaks. Other Department components have the resources and wherewithal to do everything from funding drug courts to educating the public.

Against this backdrop, I am especially pleased to introduce this issue of the *USA Bulletin*, which examines the Department's role in addressing the heroin and opioid epidemic. Recognizing that there exists no "magic bullet" for solving the epidemic, these articles display an appreciation for the complexity of the problem, discussing its many aspects. Some articles elevate for consideration novel initiatives, like the cutting-edge program by the U.S. Attorney's Office for the Eastern District of Kentucky that seeks to re-channel the grief experienced by the families of overdose victims into a public education campaign. Other articles address obstacles to successful prosecution. For example, U.S. Attorney Bill Ihlenfeld provides guidance for charging and prosecuting "death-resulting" cases, in light of the constraints of *Burrage*. Still other articles describe existing Department programs that address this epidemic, such as Tara Kunkel's article focusing on PDMPs.

As these articles make clear, effective solutions will implicate multiple tools and strategies that require coordinated deployment. These strategies must be tailored to the needs of individual districts to address particularized aspects of the problem. In some districts, for example, the influx of gang activity will feature significantly in the heroin problem and require a focus on traditional gang enforcement and prosecution. Other districts may have a prevalence of "pill mills" and will need to address the over-prescribing of opioids. Yet, these articles also reveal that districts have much in common, and that many strategies will be shared throughout the country. For example, prevention and treatment always should be addressed, given our current understanding of addiction.

In sum, the Department can—and must—continue to play an important role in solving this multi-faceted problem. As such, this issue of *USA Bulletin* is both important and timely. I encourage you to take the time to read all of the enclosed articles and consider adopting those ideas that may prove useful in your particular district. I am confident that with continued focus on this problem, and by adopting "best practices" in this area, many of which are outlined in this Bulletin, we can have a significant impact in helping to stem the tide of opioid and heroin abuse and overdose deaths.

INTEGRATING PUBLIC SAFETY AND PUBLIC HEALTH TO REDUCE OVERDOSE DEATHS

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Western District of Pennsylvania

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Western District of Pennsylvania

I. Introduction

In Western Pennsylvania and across the nation, we are gripped by a public safety and public health crisis. Opioid-involved overdose deaths continue to increase dramatically. According to the Centers for Disease Control and Prevention (CDC), Pennsylvania had the eighth highest rate of overdose deaths in the United States in 2014. CENTERS FOR DISEASE CONTROL, INJURY PREVENTION AND CONTROL, OPIOID OVERDOSE STATE DATA (2013-2014) <http://www.cdc.gov/drugoverdose/data/statedeaths.html>. In 2015, the number of drug-related overdose deaths reported in Pennsylvania increased 23.4 percent to 3,383 deaths. PHILA. FIELD DIV., U.S. DRUG ENF'T ADMIN., ANALYSIS OF DRUG-RELATED OVERDOSE DEATHS IN PENNSYLVANIA 2015, (July 2016) https://www.dea.gov/divisions/phi/2016/phi071216_attach.pdf. In the most recent data for 2015, more than 81 percent of those who died from drug-related overdose were found to have either heroin or other opioids in their system. Several counties in southwestern Pennsylvania outpace the state in the number of deaths per 100,000 people.

The numbers are shocking, but should no longer be surprising to law enforcement and the community at large. The tragic lost opportunity and human toll exacted by heroin and opioids pervade every aspect of our lives. Urban, suburban, or rural, every jurisdiction is prone to the ravages of the opioid epidemic. Traditional law enforcement remains a critical component of any effort to reduce overdoses and stem the supply of heroin and pills, but will not resolve the opioid crisis alone. Every United States Attorney can lead an integrated, regional response to fatal overdoses.

II. United States Attorney's Working Group

Fundamentally, heroin and opioid overdoses and dependency are public health challenges. In Western Pennsylvania, we have worked to forge strong public health and public safety partnerships and to integrate the response to heroin and opioid overdoses.

In early 2014, the Pittsburgh area experienced a sharp uptick in overdose deaths attributable to fentanyl-laced heroin. Although the media reported heavily on overdoses attributable to fentanyl, and law enforcement issued warnings, severely addicted users actually sought the deadly fentanyl-laced heroin looking for a more intense high. Capitalizing upon the concern and alarm shared by law enforcement and the medical community in relation to the fatal fentanyl overdoses, we convened a United States

Attorney's Working Group to focus on drug overdoses and addiction in March of 2014. While the driving objective was to find a coordinated approach to reduce overdose deaths, we recognized a related and equal need to incorporate prevention, intervention, treatment, and recovery.

Part of this process was recognizing that those who possess the much needed knowledge of the science of dependence and treatment worked and existed outside the law enforcement community. We sought advice from renowned experts on substance use disorder and treatment—Neil Capretto, D.O., Medical Director of Gateway Rehabilitation Center, and Michael Flaherty, Ph.D., past head of the St. Francis Institution for Research, Education and Training in Addiction. Dr. Capretto and Dr. Flaherty agreed to oversee the effort to enlist citizens, parents, physicians, providers, regional leaders, and those in recovery to identify ways to prevent and reduce overdose deaths in Western Pennsylvania. Given the severity of the problem, we tasked ourselves with developing comprehensive recommendations within six months.

A. Action Plan

The U.S. Attorney's Working Group divided itself into three component committees: Prevention and Education; Treatment; and Quality Improvement, Adverse Events, and Interdiction. Our first collective conclusion was that meaningful solutions are best developed and implemented locally with strong community participation and regional support. With that in mind, our Working Group developed the following action plan:

Education, Prevention and Family Intervention

1. Develop a comprehensive public awareness and education plan to reduce overdose deaths.
2. Coordinate websites containing information on overdose prevention and links to recovery-based resources.
3. Assure access to and promote a regional hotline dedicated to overdose prevention and enhanced 9-1-1 response.
4. Develop and implement an overdose prevention program for incarcerated populations.
5. Promote physician education and intervention programs.
6. Educate buprenorphine providers on best practice guidelines and enforce adherence to the guidelines through state and federal law enforcement agencies.
7. Develop and educate probation officers and federal and state law enforcement about addiction and medication assisted treatment (MAT).

Treatment

1. Increase the number of drug and alcohol assessments and referrals to MAT for people who are incarcerated or on probation.
2. Promote efforts to increase the availability of naloxone in the community as a safe antidote for opioid overdose.
3. Support Good Samaritan Laws and Prescription Drug Monitoring Programs (PDMPs).
4. Support measures to increase capacity for the treatment of addiction.
5. SBIRT: (Screening, Brief Intervention and Referral to Treatment) should be used in settings where substance abuse is seen as an earlier identifier of clinical need that may reduce overdose.

Quality Improvement, Adverse Events and Interdiction

1. Establish an overdose database that is available to local communities and community leaders working to address overdose deaths.
2. Utilize overdose data, on an ongoing basis, to identify and target interventions to reduce overdoses and overall opioid misuse.
3. Stress the important role that law enforcement agencies play in efforts to reduce overdose deaths.
4. Increase community support for, and participation in, national drug take-back initiatives

WESTERN DIST. OF PA., U.S. ATTORNEY'S OFFICE, U.S. ATTORNEY'S WORKING GROUP ON DRUG OVERDOSE AND ADDICTION: FINAL REPORT AND RECOMMENDATIONS, (Sept. 29, 2014) <https://www.justice.gov/sites/default/files/usaowdpa/legacy/2014/09/29/US%20Attorney%27s%20Working%20Group%20on%20Addiction%20Final%20Report.pdf>.

B. County by County Assessment

Since the publication of our action plan in September 2014, the U.S. Attorney's Working Group has continued to pursue the implementation of our strategy and to better assess the resources and framework for the provision of treatment and services in each of the varied 25 counties that comprise Western Pennsylvania. In Pennsylvania, "single county authorities" or "SCAs" are responsible for the planning, coordination, and implementation of drug and alcohol prevention, intervention, and treatment in each county.

In June of 2016, members of the U.S. Attorney's Working Group, including SCA's from several counties and the University of Pittsburgh School of Pharmacy Program Evaluation and Research Unit (PERU), completed an assessment of each county based upon their voluntary reporting. It gathered data on: 1) the number and location of overdose deaths; 2) accessibility of naloxone in the county; 3) strategies to reduce the opioid supply in the community, including prescription guidelines and drug take-back; 4) available treatment resources; 5) provision of SBIRT to connect individuals to treatment; 6) general awareness of the overdose epidemic and support of prevention and intervention efforts. This assessment helped immeasurably in plotting a baseline for our efforts to reduce overdoses and honing in upon the barriers to effective treatment, treatment capacity, and intervention at the county level. At the same time, single county authorities and coalitions now have a centralized resource for data and best practices to better understand and address the overdose challenge in their respective communities.

C. Naloxone

The county-by-county assessment results also highlighted the need to be more aggressive in promoting universal naloxone deployment and usage. We were concerned to find that many police departments and sheriff's offices were not equipped or trained in the use of naloxone. Naloxone has proven effective in decreasing the frequency of overdose deaths. Naloxone is an opioid antagonist that reverses the respiratory depression associated with opioid overdose. Given the increasing frequency of pure fentanyl, which is up to 50 times more potent than heroin, and heroin-fentanyl mixtures, and fentanyl analogues at overdose and crime scenes, all first responders should carry naloxone for their own safety.

D. Research Partners

Since the inception of our U.S. Attorney's Working Group, we worked to strengthen our relationship to educational institutions to assure that our recommendations are evidence-based and

incorporate public health research and data. These relationships are also vitally important because we will only be able to modify prescribing behavior to reduce over-prescription of opioids if we amplify physician and pharmacist training and continuing education. Most physicians now recognize that opioids have been overprescribed and fuel the current heroin and opioid epidemic, yet they continue to write scripts for excessive quantities. Many well-meaning physicians remain unfamiliar with prescribing guidelines, lack training in the management of complex chronic pain and the addictive potential of opioids, and have concern that if they refuse to prescribe opioids to patients who demand them, then it will affect their income and employment.

In Pennsylvania, and in every state, prescribers can now access more information. The CDC issued guidelines for the prescription of opioids for chronic pain in March of 2016, and many states have adopted their own prescribing guidelines for opioids. CENTERS FOR DISEASE CONTROL, MORBIDITY AND MORTALITY WEEKLY REPORT, GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN (March 18, 2016) <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>. Pennsylvania's prescription drug monitoring program (PDMP), among the last of the state programs to be implemented, began collecting information in June 2016 and will improve access to prescribing information.

The University of Pittsburgh's Institute of Politics has identified the heroin/opioid epidemic as a most pressing issue facing our region and the nation, and has worked in partnership with the U.S. Attorney's Working Group to develop the next generation of needed action items and recommendations to harmonize the law enforcement and public health response to opioids. We targeted September 2016 for the release of these proposals, upon which we will convene with physicians and state and local policy makers to discuss the applicability of Western Pennsylvania's efforts to the state, region, and nation.

III. National Heroin Task Force

While each United States Attorney is confronted with a distinct regional aspect of the opioid epidemic, there are universal, national observations and recommendations that can inform our approach. Because heroin and opioid trafficking know no national or international boundaries, it is important to assure that our district approaches mesh with national priorities. As directed by Congress, in March of 2015, the Department of Justice and the Office of National Drug Control Policy (ONDCP) convened the National Heroin Task Force, consisting of more than 25 federal agencies. Attorney General Loretta Lynch requested that United States Attorney David J. Hickton serve as one of the co-chairs of the National Heroin Task Force representing the Department of Justice. Our mission was to develop a comprehensive national response to the nation's opioid crisis. Recognizing that an overdose death due to heroin and opioids occurs approximately once every 20 minutes, we worked diligently to deliver our findings and recommendations to Congress on December 31, 2015.

After extensive study and research, the Task Force concluded that there are solutions and there is hope to improve our response to the opioid epidemic. Addiction and substance use disorders are brain diseases that can be successfully treated. We crafted actionable, immediate, and long-term action items to guide any community in formulating its strategy. We encourage every community to borrow from, or import, the National Task Force recommendations in whole or in part. OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL HEROIN TASK FORCE REPORT AND RECOMMENDATIONS (Dec. 31, 2015) <https://www.justice.gov/file/822231/download>. Highlights of the National Heroin Task Force findings include:

1. Public safety and public health strategies for opioids must be integrated and complementary.

- a. Prevent opioid misuse and abuse by ensuring safe and appropriate prescribing.

- i. States should consider adopting or recommending uniform prescribing guidelines.
 - ii. Patients should be informed and empowered to actively participate in their pain management.
 - iii. Safe prescribing should be enforced consistently by the DEA and through the Controlled Substances Act (CSA).
 - b. Integrate data management, reporting, and analysis.
 - i. Support interstate interoperability and use of prescription drug monitoring programs.
 - ii. Disrupt supply and focus on prevention, treatment and intervention through real-time sharing of accurate data.
 - c. Reduce excessive supply of opioids through strategic enforcement mechanisms.
 - i. Prioritize prosecution of medical professionals who improperly prescribe opioids.
 - ii. Prioritize prosecution of heroin distributors, particularly when death results.
 - iii. Encourage and promote safe drug disposal.
 - d. Enlist pharmaceutical companies to address the harms associated with prescription opioids.
 - e. Capitalize on examples of robust public health-public safety partnerships.
 - f. Prevent overdose deaths through the effective use of naloxone, real-time data sharing and Good Samaritan laws.
 - i. Ensure access to naloxone.
 - ii. Provide immediate and comprehensive care to those administered naloxone.
 - iii. Consider state limited liability laws to shield those who administer naloxone.
 - iv. Develop public safety and public health rapid response strategies for overdose events.
- 2. Policies regarding opioid and heroin use must be grounded in scientific understanding that substance use disorders are a chronic brain disease that can be prevented and treated, leading to recovery.**
 - a. Provide linkages in services at the first sign of an opioid use disorder.
 - i. Apply a continuum of care approach.
 - ii. Implement screening, assessment, and linkage to treatment.
 - b. Make effective treatment for opioid use disorder, including MAT, available and accessible.
 - i. Make evidence-based MAT readily available.
 - ii. Incorporate treatment for opioid use disorder, including MAT, into the criminal justice system.

- c. Support the availability of long-term treatment and recovery services.
- 3. Visible Community-based recovery supports must be available, affordable, and accessible.**
 - a. Implement coordinated community responses to promote prevention at the local level.
 - b. Improve opioid training and expertise of public and private healthcare providers.
 - i. Ensure greater availability of substance use disorder and recovery support specialists throughout the country.
 - ii. Improve training and expertise of all health care professionals on treatment options.
 - c. Take steps to mitigate public health and public safety consequences of injection drug use at the local level.

IV. Coordinating Enforcement

While the U.S. Attorney’s Working Group and the National Heroin Task Force set forth numerous recommendations and action items, the challenge is bringing the strategies to life through vigorous implementation. In the Western District of Pennsylvania, the geography and demography of our 25 constituent counties requires an individualized approach to each. To assure a multi-disciplinary approach, we assigned Assistant United States Attorneys to each county and tasked them with convening a Heroin Overdose Team, with the goal of reviewing every overdose as a potential criminal investigation and prosecution. Based on our experience in several counties, we believe that coordination among first responders, state and federal prosecutors and investigators, medical examiners, and drug treatment providers has improved.

Through our work on the U.S. Attorney’s Working Group in 2014, we collectively realized that we shared a need for real-time data and intelligence on overdose deaths. In order to target rapid overdose responses—especially to deadly “batches” of fentanyl-adulterated heroin—information and intelligence must be routinely reported, consolidated, and analyzed. Led by the FBI and DEA, and with help from state and local partners, our district established an intelligence clearing house, or fusion center, to receive reports of heroin overdoses and seizures from first responders. Submissions to the fusion center have already resulted in investigation leads and enabled us to link distributors, telephone numbers, and stamped bags for enhanced, coordinated investigation.

Heroin overdoses have historically been treated as medical events rather than serious crimes. We can improve the prospects for survival from overdoses through medical intervention and the administration of naloxone, while also assuring that first responders have received training on how to process the overdose scene, collect evidence, and mine cell phone call history. In Western Pennsylvania, we offered multiple trainings to first responders, including police, fire, and EMT’s from each of the 25 counties. To date, hundreds of police officers in Western Pennsylvania have received training on overdose response, the investigation of physician overprescribing, how to exploit cell phones found at the crime scene for maximum evidentiary value, and the importance of naloxone in saving the lives of those who have overdosed and, as importantly, in preserving the lives of first responders who may unwittingly come into contact with pure fentanyl or other dangerous opioids. While we will continue to work hard to abate the increasing number of overdose deaths, the increased availability of naloxone has allowed us to record a greater proportion of overdose “saves,” giving many survivors another chance at life and recovery.

V. Conclusion

The inspiration for our urgent work comes from many sources. Robert Lee Kerby, III was a veteran who served a tour of duty in Afghanistan with the Air National Guard. Following his service, he became heavily dependent on opioids, used heroin, and struggled in several treatment programs. In 2011, he was convicted in federal court of heroin trafficking. At one point during his supervision, he asked to go back to prison after his probation officer caught him trying to use fake urine in a drug test. Robert did not truly want to return to prison, but simply felt out of options to combat his addiction.

In 2014, Robert volunteered to be among the first class of veterans to participate in the Veterans Treatment Court for the Western District of Pennsylvania in Pittsburgh. Our court was then one of the select federal reentry courts exclusively focused upon veterans. Robert willingly agreed to be subject to intensive supervision and a host of additional conditions imposed through Veterans Treatment Court. He accepted a peer mentor and the structure of the veterans' court team, with a federal public defender, Assistant United States Attorneys, VA representatives, and a federal court judge. Robert excelled in veterans' court, despite the rigorous supervision. He successfully completed inpatient and outpatient drug treatment through the VA. He was accepted into a compensated work therapy program and obtained housing through a veterans' service agency. Robert graduated from veterans' court in June of 2015—healthy, strong, and focused on going back to college. On November 9, 2015, Robert Kerby was found dead of a fatal overdose. He was 30 years old.

For Robert—and for the countless others who desperately need and deserve understanding, effective treatment, and support—we cannot delay. The scope and complexity of the opioid epidemic demands more of us. We must continue to reach outside the bounds of our traditional law enforcement roles and attack this pernicious and deadly hydra from every angle and perspective. Our lives depend on it.

ABOUT THE AUTHOR

□ **David J. Hickton** was nominated as United States Attorney for the Western District of Pennsylvania by President Barack Obama on May 20, 2010, and was confirmed by the U.S. Senate on Aug. 5, 2010. He was sworn in as the District's 57th U.S. Attorney on Aug. 12, 2010. Prior to becoming U.S. Attorney, Mr. Hickton engaged in the private practice of law, specifically in the areas of transportation, litigation, commercial and white collar crime. Mr. Hickton began his legal career serving as a Law Clerk for the Honorable United States District Judge Gustave Diamond from 1981 to 1983. For more than a decade, Mr. Hickton was an Adjunct Professor of Law at Duquesne University School of Law where he taught antitrust.

□ **Soo C. Song** is the First Assistant United States Attorney in the United States Attorney's Office for the Western District of Pennsylvania. Prior to serving in the Western District of Pennsylvania, Ms. Song was an Assistant United States Attorney in the District of Arizona. Ms. Song also served as counsel in the Office of Policy Development and Deputy Director of the Office of Tribal Justice at the United States Department of Justice in Washington, D.C.

Overview of the Drug Enforcement Administration Diversion Control Program

Louis J. Milione
Deputy Assistant Administrator
Office of Diversion Control

I. Introduction to The Diversion Control Program

In 1970, Congress consolidated more than 50 laws related to the control of legitimate channels of narcotics and dangerous drugs into one statute, the Comprehensive Drug Abuse Prevention and Control Act of 1970 ([21 U.S.C. § 801–971](#)), commonly referred to as the “Controlled Substances Act” (CSA). The CSA and its subsequent revisions and additions, coupled with Title 21 of the Code of Federal Regulations (the implementing regulations for the CSA), form the basis for DEA’s authority to investigate criminal and civil violations committed by organizations and individuals involved in the growing, manufacturing, or distribution of controlled substances and listed chemicals. [21 C.F.R. §§1300.01-1321.01 \(2016\)](#).

The CSA also gives DEA the authority to administer and regulate the legitimate manufacture, prescribing, and dispensing of controlled substances and listed chemicals by providing for a “closed” system of drug distribution for legitimate handlers of such drugs, along with criminal penalties for transactions outside the legitimate chain. [H.R. REP. NO. 91-1444 \(1970\)](#), reprinted in [1970 U.S.C.C.A.N. 4566, 4571–4572](#). This closed system was created in an effort to deter, detect, and eliminate the diversion of controlled substances and listed chemicals into the illicit market while ensuring an adequate supply of controlled substances and listed chemicals is available for legitimate medical, scientific, research, and industrial purposes.

The CSA mandates that DEA register persons or entities who manufacture, distribute, dispense, import, export, or conduct research or chemical analysis with controlled substances and listed chemicals. [21 U.S.C. § 822 \(2016\)](#). The regulatory and administrative role of DEA evolved through a series of legislative actions since the CSA was authorized in 1970. Through its diversion control program (DCP), DEA is now responsible for maintaining the closed system of distribution; regulating and controlling more than 1.6 million DEA registrants; and investigating activity related to the diversion of controlled substances and listed chemicals. The DCP is constantly evaluating diversion trends in order to appropriately focus its regulatory, civil, and criminal enforcement activities. This is accomplished in many ways, including: collecting and analyzing targeting data; conducting diversion threat assessments; working with state and local medical or pharmacy boards; and partnering with state and local law enforcement agencies.

The DCP’s regulatory function is accomplished through routine regulatory inspections, by providing guidance to registrants, and by controlling and/or monitoring the manufacture, distribution, dispensing, import, and export of controlled substances and listed chemicals. The DCP’s enforcement function is accomplished by identifying and investigating those persons or entities responsible for

diverting controlled substances and listed chemicals from legitimate commerce. Violators are subject to administrative sanctions and civil and criminal prosecution.

II. Need for Diversion Control

Drug overdoses are the leading cause of injury-related deaths in the United States, eclipsing deaths from motor vehicle crashes or firearms. [Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System \(WISQARS\) \(2014\) http://www.cdc.gov/injury/wisqars/fatal.html](http://www.cdc.gov/injury/wisqars/fatal.html). There were over 47,000 overdose deaths in 2014, or approximately 129 per day, over half (61 percent) of which involved either a prescription opioid or heroin. [Rose A. Rudd, et al. *Increases in Drug and Opioid Overdose Deaths—United States, 2000–2014*, 64 MORBIDITY AND MORTALITY WKLY. REP. 1378–1382 \(2016\)](#).

According to the 2014 National Survey on Drug Use and Health (NSDUH), 6.5 million people over the age of 12 used psychotherapeutic drugs (i.e., pain relievers, tranquilizers, stimulants, and sedatives) for non-medical reasons during the past month. [SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN. CTR. FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, BEHAVIORAL HEALTH TRENDS IN THE U.S., \(2014\)](#). This represents 24 percent of the 27 million current illicit drug users and is second only to marijuana (22.2 million users) in terms of usage. There are more current users of psychotherapeutic drugs for non-medical reasons than current users of cocaine, heroin, and hallucinogens combined. *Id.*

Approximately 435,000 Americans reported past month use of heroin in 2014. [SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CTR. FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, NATIONAL SURVEY ON DRUG USE AND HEALTH, 2013 AND 2014, Table 1.1A \(2013 and 2014\)](#). The increase in the number of people using the drug in recent years—from 373,000 past year users in 2007 to 914,000 in 2014—is troubling. The misuse of controlled opioid prescription drugs (CPD) and the growing use of heroin being reported in the United States in unprecedented numbers is alarming. According to the United Nations body that monitors treaty compliance, the International Narcotics Control Board (INCB), the United States consumes 78 percent of the world’s oxycodone and 99 percent of the world’s hydrocodone, despite having only five percent of the world’s population. [International Narcotics Control Board, REPORT 2014: ESTIMATED WORLD REQUIREMENTS FOR 2015—STATISTICS FOR 2013, https://www.incb.org/documents/NarcoticDrugs/TechnicalPublications/2014/Narcotic_Drugs_Report_2014.pdf](https://www.incb.org/documents/NarcoticDrugs/TechnicalPublications/2014/Narcotic_Drugs_Report_2014.pdf) (last visited June 23, 2016).

In 2014, over 4.3 million Americans aged 12 or older reported using prescription pain relievers non-medically within the past month. That makes nonmedical prescription opioid use more common than any category of illicit drug in the United States except for marijuana. Even though the vast majority of nonmedical opioid CPD users do not go on to use heroin, this information provides valuable insight into the role that CPDs play in the opioid epidemic and underscores the need to ensure that practitioners are educated on proper prescribing of CPDs.

Black-market sales for opioid CPDs are typically five to ten times higher than their retail value. DEA intelligence reveals the “street” cost of prescription opioids steadily increases with the relative strength of the drug. For example, generally hydrocodone combination products (a Schedule II prescription drug and also the most prescribed CPD in the country) can be purchased for 5 to 7 dollars per tablet on the street. Slightly stronger drugs like oxycodone combined with acetaminophen (e.g., percoet) can be purchased for 7 to 10 dollars per tablet on the street. Even stronger prescription drugs are sold for as much as 1 dollar per milligram (mg). For example, 30 mg oxycodone (immediate release) and 30 mg oxymorphone (extended release) cost 30 to 40 dollars per tablet on the street. The costs that come with greater tolerance make it difficult to purchase these drugs in order to support a developing substance use

disorder, particularly when many abusers first obtain these drugs for free from the family medicine cabinet or friends. Data from NSDUH show that chronic and frequent users are more likely than recent initiates to buy opioid drugs from a dealer. [SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CTR. FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, NATIONAL SURVEY ON DRUG USE AND HEALTH \(2012–2013\). Unpublished special tabulations \(March 2015\)](#)). Not surprisingly, a small number of people who use prescription opioids non-medically—primarily those who are frequent nonmedical users or those with a prescription opioid use disorder—turn to heroin, a much cheaper opioid generally costing 10 dollars per bag, which provides a similar “high” and can keep some individuals who are dependent on opioids from experiencing painful withdrawal symptoms. This cycle has been repeatedly observed by law enforcement agencies. For some time now, law enforcement agencies across the country have been specifically reporting an increase in heroin use by those who began using prescription opioids non-medically. [U.S. DEP’T OF JUSTICE, DRUG ENF’T ADMIN., 2016 NATIONAL HEROIN THREAT ASSESSMENT SUMMARY \(June 2016\) https://www.dea.gov/divisions/hq/2016/hq062716_attach.pdf](#).

Healthcare providers, as well as nonmedical users of CPDs are confirming this increase. According to some reporting by treatment providers, many individuals with serious opioid use disorders will use whichever drug is cheaper and/or available to them at the time. [U.S. DEP’T OF JUSTICE, DRUG ENF’T ADMIN., 2015 NATIONAL DRUG THREAT ASSESSMENT SUMMARY \(October 2015\)](#). Individuals who have switched to heroin are at high risk for unintentional overdose. Heroin purity and dosage amounts vary, as heroin is often cut with other substances (e.g. fentanyl), all of which could cause unintentional overdose. This overdose occurs because users simply cannot predict the opioid dosage in the “heroin” product they purchase on the street. See Stephen E. Lankenau, et al. *Initiation into Prescription Opioid Misuse Among Young Injection Drug Users*, INT’L. J. OF DRUG POL’Y, (Jan. 23, 2012). <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196821/>. See also Mars, SG et al. “Every ‘Never’ I Ever Said Came True”: *Transitions From Opioid Pills to Heroin Injecting*, INT’L. J. OF DRUG POL’Y, (Mar. 25, 2014) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/>. It should be noted as well that the same could be said of diverted or counterfeit prescription opioids purchased on the street.

Some CPD users become dependent on opioid medications originally prescribed for a legitimate medical purpose. Kevin E. Vowles, et al. *Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis*, PAIN, (April 1, 2015) http://idhdp.com/media/400537/rates_of_opioid_misuse-abuse-and_addiction_in3.pdf. Moreover, a SAMHSA study found that four out of five recent new heroin users had previously used prescription pain relievers non-medically (although a very small proportion (3.6%) of people who reported nonmedical use of prescription pain relievers had initiated heroin use within five years of initiating nonmedical use of pain relievers). Pradip K. Muhuri, Joseph C. Gfroerer, M. Christine Davies, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., CTR. FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY, (Aug. 2013), <http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm>.

The reasons an individual may shift from one opiate to another vary, but today’s heroin is high in purity and less expensive and often easier to obtain than illegal CPDs. High-purity heroin can be smoked or snorted, thereby circumventing a barrier to entry (needle use) and avoiding the stigma associated with injection. However, many who smoke or snort are vulnerable to eventually injecting. Heroin users today tend to be younger and more ethnically and geographically diverse than ever before. Cicero, T et al., *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 THE J. OF THE AM. MED. ASS’N. 821 (July, 2014) <http://archpsyc.jamanetwork.com/article.aspx?articleid=1874575>.

III. DCP Operations

To combat this growing epidemic, the DCP has taken an “all of the above” approach to combatting opioid abuse and overdose death by recognizing that the problem is extraordinarily complex. We are focusing our efforts on multiple areas in the regulatory process and in the criminal investigative process to affect the availability of diverted controlled substances, particularly powerful and dangerous opioid pain medicines.

One of the principal methods employed by the DCP to limit the diversion of controlled substances is through the use of the regulatory process to ensure that applicants for DEA registration meet the necessary qualifications to possess a registration, and that the issuance of a registration to the applicant would be in the “public interest.” Once a registration is issued, the DCP continues to monitor the registrant population to ensure compliance with all of the established laws and regulations that apply.

Leading these regulatory efforts are the more than 500 Diversion Investigators (DIs) assigned to DEA Offices across the United States and in certain foreign countries. These DIs are subject matter experts in the regulatory scheme employed by DEA to limit the diversion of controlled substances and in investigating DEA registrants for violations of the laws and regulations that guide the DEA registrant population. For example, DEA registrants are required by [21 C.F.R. § 1304 \(2016\)](#) to keep extensive records of their activities involving controlled substances. In addition, [21 C.F.R. § 1301 \(2016\)](#) requires registrants to report thefts or significant losses of controlled substances to DEA within 24 hours. Diversion Investigators have the authority under Section 880 of Title 21, United States Code, to conduct inspections of registered “premises” to inspect and review records and quantities of controlled substances upon providing the registrant with proper notice.

In addition to the inspection program, DIs have the authority to obtain an Administrative Inspection Warrant (AIW) pursuant to [21 U.S.C. § 880 \(1993\)](#). These warrants are obtained anytime a registrant refuses to agree to a notice of inspection, or in any case in which the DI believes that a civil or administrative sanction is likely to result. AIWs are important and powerful tools for the DCP to use to fulfill its mission and have a different burden of probable cause than a civil or criminal search warrant. For an AIW, Title 21 defines probable cause as “a valid public interest in the effective enforcement of this subchapter or regulations thereunder sufficient to justify administrative inspections of the area, premises, building, or conveyance, or contents thereof, in the circumstances specified in the application for the warrant,” [21 U.S.C. § 880 \(d\)\(1\) \(1993\)](#).

Using these regulatory tools, DIs often uncover significant evidence of the potential diversion of controlled substances which provides the basis for administrative, civil, and criminal investigations and prosecutions. While DIs cannot carry firearms or execute arrest, search, or seizure warrants, they can, and often do, serve as affiants for criminal warrants. Often DIs are utilized to provide critical grand jury and trial testimony in support of diversion investigations.

In addition, DIs serve as one of the principle points of contact between DEA and the 1.6 million registrants on matters of concern for both parties. In recent months, DEA has begun to expand its level of contact and engagement with the pharmaceutical and medical industries to foster closer working relationships and cooperative efforts

The DCP conducts criminal enforcement activities primarily through the Tactical Diversion Squad (TDS) Program. TDSs are designed to address controlled substance diversion in tandem with the traditional Diversion Investigator regulatory efforts, and are comprised of many DEA specialties, including DEA Special Agents, Diversion Investigators, and federal, state and local counterparts. These groups combine varied resources and expertise in order to identify, target, investigate, disrupt, and dismantle those individuals or organizations involved in diversion schemes. As of July 2016, DEA has

staffed 71 TDSs across the United States to attack the illegal diversion and trafficking of pharmaceuticals. DEA has also requested to expand the TDS Program with the addition of several groups in fiscal year 2017. Of particular note, state and local law enforcement agencies have invested full-time officers to work as Task Force Officers (TFOs) in TDSs across the United States. These assignments strengthen partnerships and serve as force-multipliers for investigations.

TDSs develop sources of information and disseminate intelligence to appropriate elements for the development of leads and targets. The TDS Program provides support to a Diversion Group and/or Diversion Staff where law enforcement authority or activities are required (e.g., purchase of evidence/payment for information, conducting surveillance, conducting undercover operations, making arrests, and executing search/seizure warrants). TDSs also play an important role in addressing the growing problem of emerging synthetic designer drugs. These groups have the ability to surreptitiously purchase these substances, which are analyzed and used to support DEA's temporary and permanent scheduling actions.

In an effort to address underserved areas of concern, the DEA is in the process of staffing two Mobile Tactical Diversion Squads (MTDSs). These MTDSs will be based in Virginia and will deploy throughout the United States to address areas of significant pharmaceutical diversion concern.

Due to the significant threat posed by pharmaceutical diversion, opioid abuse, and synthetic drugs throughout the nation, the DCP has partnered with DEA's Intelligence Division to establish a Diversion Intelligence Unit. This headquarters-based group will focus on diversion-related priorities and provide strategic intelligence assessments, evaluations, and trend reporting in furtherance of DCP enforcement/regulatory efforts and DEA's overall objectives in this area.

IV. Administrative Remedies Available to DEA

In addition to pursuing criminal and civil actions against registrants and others engaged in the diversion of controlled substances, DEA engages the registrant population with a series of administrative steps designed to correct actions taken by the registrant that may be in violation of applicable laws and regulations. In cases of significant violations, DEA will act to restrict or revoke the registration. For small issues concerning an otherwise compliant registrant, DEA has the authority to issue a Letter of Admonition (LOA) to registrants which informs the registrant of the violation and requests that they provide DEA with a corrective action. For more serious or serial violations, DEA may enter into a Memorandum of Agreement (MOA) with the registrant that outlines the steps that must be taken by the registrant in order to prevent revocation of the registration. These MOAs often provide specific conditions under which the registrant must operate, and may also limit the types of controlled substances the registrant may prescribe or dispense.

For the most serious violations, DEA may seek an Order to Show Cause (OTSC) to bring the registrant before an Administrative Law Judge and seek a revocation of the registration. While an OTSC action can be taken for a host of reasons (most typically for a failure by the registrant to be actively licensed by their state government), these actions can also be taken under the "Public Interest Analysis" set forth at [21 U.S.C. §§ 823\(f\), 824\(a\)\(4\)](#). Under that analysis, "[a] registration . . . may be suspended or revoked" where "the registrant . . . committed such acts as would render his registration . . . inconsistent with the public interest" considering:

- The recommendation "of the appropriate State licensing board or professional disciplinary authority."
- The registrant's "experience in dispensing . . . controlled substances."

- The registrant’s “conviction record . . . relating to the manufacture, distribution, or dispensing of controlled substances.”
- The registrant’s “[c]ompliance with applicable State, Federal, or local laws relating to controlled substances.”
- “Such other conduct which may threaten the public health and safety.”

Id.

V. Partnering with the United States Attorney’s Offices

The United States Attorneys’ Offices have been great partners with DEA and the law enforcement community in tackling the problems created by the diversion of CPDs. While DEA has effectively leveraged available resources to create enforcement elements specifically trained and focused on combatting the prescription drug epidemic in the United States, the second critical piece to the enforcement component—federal prosecution—has lagged. Unfortunately, due to budget constraints, many of the United States Attorneys’ Offices have observed little or no growth in the number of Assistant United States Attorneys (AUSAs) available to prosecute various crimes, including crimes involving the diversion of CPDs. This has affected drug prosecutions broadly and diversion prosecutions specifically. For example, one critical funding component for prosecutors, the Organized Crime Drug Enforcement Task Force (OCDETF), has seen almost no budgetary growth for the past several years, resulting in a limited number of prosecutors available to prosecute drug-related crimes.

This shortage is not only observed in criminal investigations, but in civil investigations as well. In the investigation of DEA registrants, investigators often encounter registrants whose violations of the law may not rise to the threshold of a criminal prosecution, but who nonetheless show a disregard for the CSA and its implementing regulations. In those cases, the United States Attorneys’ Offices often seek civil penalties in an effort to ensure compliance with the CSA.

Prosecuting diversion cases brings a whole host of challenges that require a degree of experience and knowledge that is not readily obtainable except through specific training and experience. To assist federal prosecutors to gain familiarity with diversion-related cases, DEA routinely holds Federal Diversion Prosecution Training sessions throughout the United States. The DCP hosted a nationwide Federal Pharmaceutical Drug Investigations and Prosecution Training seminar in Dallas, Texas, on August 23-25, 2016. Funding was provided to allow for the attendance of three AUSAs from every judicial district in the United States and its territories. Topics included: an overview and history of diversion prosecutions; types of diversion investigations; investigative techniques; charging decisions; overdose death prosecutions; discovery and sentencing issues; and common defenses encountered in diversion cases.

VI. Conclusion

The challenges of prescription drug abuse, addiction, and overdose require DEA to respond with every available appropriate tool. The DCP is embracing this challenge by bringing together the unique capabilities and abilities of Special Agents, Task Force Officers, Diversion Investigators, Intelligence Research Specialists, and a myriad of support staff to produce one entity that combats the dangers created by drug diversion on multiple fronts and at multiple levels by harnessing the criminal, civil, and administrative authorities available to DEA.

DEA is also committed to expanding public education and awareness of the dangers of these drugs through efforts such as the National Take Back Initiative (designed to get dangerous, unused and unneeded medicines out of medicine cabinets and into incinerators) and the Pharmacy Diversion Awareness Conferences (designed to educate pharmacists and pharmacy employee on controlled substance diversion). Further, DEA is expanding its interactions with industry and professional organizations to create a unified approach to this threat and to foster higher levels of trust and cooperation.

The diversion work of DEA targets an integral element of the opioid/heroin crisis—the improper and illegal prescription and distribution of prescription pain medicine. It is another front in the fight against opioid and heroin abuse. It is an important and vital front.

ABOUT THE AUTHOR

□ **Special Agent Louis J. Milione** was appointed to lead DEA’s Office of Diversion Control as Deputy Assistant Administrator in October 2015. Mr. Milione acts as the principal advisor to the DEA Administrator and DEA senior leadership on all matters pertaining to the regulation and coordination of worldwide programs associated with the diversion of legally produced controlled substances and listed chemicals. Mr. Milione is responsible for overseeing and coordinating major pharmaceutical and chemical diversion investigations; drafting and promulgating regulations; establishing drug production quotas; and conducting liaison with the pharmaceutical industry, international governments, state governments, other federal agencies, and local law enforcement agencies. Mr. Milione is a graduate of Villanova University (BA-English) and the Rutgers School of Law (JD)

Using the Drug Market Intervention Strategy to Address the Heroin Epidemic

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I. Drug Market Intervention Strategy

The Drug Market Intervention (DMI), first developed and implemented in High Point, NC, in 2004, is a proven strategy to eliminate neighborhood level overt drug markets. The DMI strategy mobilizes federal, state, and local law enforcement agencies as well as community leaders and social service providers to identify a drug market and its dealers; arrest violent dealers; suspend cases for nonviolent offenders; and bring DMI partners together for a face-to-face “call-in” meeting with dealers and their family members to clearly communicate that selling drugs openly must stop. The call-in also provides a community message of support and an offer of help. In High Point and many other cities across the county, this approach has worked to close overt drug markets permanently and improve neighborhood safety.

In 2014, the city of Rutland, Vermont, adapted the DMI approach—with initial assistance from my organization, the [National Network for Safe Communities](#) (NNSC)—to test whether its principles could disrupt a citywide covert heroin market with the same results. Rutland’s DMI work brings together a partnership of federal, state, and local law enforcement agencies, public health organizations, and community programs, and has driven significant progress in Rutland. The initial results are promising and may provide a framework for communities across the country struggling to shut down heroin markets and improve community safety.

II. Core DMI Principles

The DMI strategy operates on the core idea that geographically-defined illicit drug markets operate because they have become areas in which dealers know they can sell and users know they can buy illicit drugs. Markets are established, become known to dealers and users, and become entrenched by connecting dealers and users who are strangers to each other. Once that dynamic has been established, the market area has tremendous staying power. Dealers know that users will be present and have a strong motivation to work in that area. Users know that dealers will be present and have a strong reason to “shop” in that area. Heavy law enforcement attention is rarely effective at breaking the cycle. Arrested dealers are released and return or are replaced by new dealers. As long as both dealers and users have a reasonable chance of success, they will frequent the area and the market will be sustained.

DMI’s goal is to permanently break the cycle by disrupting the market long enough for the connection between dealers and users to be broken. If there is no dealing for a meaningful period of time, users will go to the market area and not be able to buy. Given enough time, they will stop trying. In that

situation, dealers who return will find no users, and there will be no reason to keep returning. The market will become like any other location with a next-to-zero chance of becoming a concentrated drug market. At that point, relatively minor “maintenance” activity—such as looking for the first signs of new dealing activity, and preventing it from succeeding and growing—will be enough to permanently eliminate the market.

In the traditional “street” or “overt” market DMI, law enforcement pays concentrated attention to a particular drug market; identifies all or nearly all the dealers; and arrests and prosecutes high-level suppliers and dealers and those with a history of violence. It also develops but suspends—or “banks”—cases against low-level nonviolent dealers. Those “banked cases” allow law enforcement to put low-level dealers on notice that any future dealing will result in certain, immediate sanctions. The DMI partnership then holds a “call-in” meeting to inform drug dealers of the new policies and to offer help if they are in need of rehabilitation. At the call-in, dealers hear a three-pronged message. Law enforcement explains that the market is closed and demonstrates exactly what will happen if the dealing continues; community leaders and dealers’ family members deliver an unequivocal message against dealing; and social service providers give an unconditional offer of help. Law enforcement then crafts a maintenance strategy for the area built on a police and community stand of absolute intolerance for the reemergence of dealing and immediate, visible attention to any such recurrence. Because DMI typically addresses overt drug markets in communities of color that have high levels of distrust for law enforcement, a crucial first step to moving forward with implementation is a reconciliation process aimed at helping to heal police-community relations. (However, this process was omitted in Rutland because of different community dynamics with respect to heroin markets.) When implemented with fidelity to these principles, DMI has a history of shutting down overt drug markets quickly and keeping them closed with no evidence of displacement and markedly improving the quality of life for residents.

Since DMI’s first pilot implementation in 2004, dozens of cities have implemented the strategy with significant reductions in violent and drug-related crime, minimized use of law enforcement, strong endorsement from the community, and improved relationships between law enforcement and residents. Many cities have seen positive results. High Point, NC, saw a 44-56 percent reduction in drug offenses across the four neighborhoods in which DMI was implemented. Rockford, IL, witnessed a 22 percent reduction in non-violent offenses after implementing DMI. Nashville, TN, saw a 55 percent reduction in drug offenses following implementation of DMI. These results have factored into a growing consensus about the effectiveness of such “focused deterrence” approaches. [Anthony A. Braga & David L. Weisburd, *The Effects of ‘Pulling Levers’ Focused Deterrence Strategies on Crime*, 6 *Campbell Systematic Reviews* 1 \(2012\)](#). As in general with such strategies, fidelity to the core principals has emerged as critical to successful implementation. [JESSICA SAUNDERS ET AL., RAND CORP., A COMMUNITY-BASED, FOCUSED-DETERRENCE APPROACH TO CLOSING OVERT DRUG MARKETS \(2016\)](#).

In cities where DMI has been successful, the most important outcome has been the elimination of the overt drug markets and the chaos that surrounded them. That outcome allowed residents to reclaim public space and voice community standards for public safety.

III. Growing National Heroin Problem

In 2015, the DEA declared that heroin was one of the two most “significant drug threats” facing the United States. [U.S. DEP’T OF JUSTICE, DRUG ENF’T ADMIN., 2015 NATIONAL DRUG THREAT ASSESSMENT SUMMARY \(Oct. 2015\)](#). According to the U.S. Centers for Disease Control and Prevention (CDC), heroin use increased 63 percent nationally between 2002 and 2013. In 2013, an estimated 517,000 people reported having used heroin within the past year—a 150 percent increase from 2007. [Alexandra Sifferlin, *Heroin Use in U.S. Reaches Epidemic Levels*, TIME, July 7, 2015](#).

The national heroin epidemic hit Vermont especially hard. In January 2014, Governor Peter Shumlin devoted his entire State of the State Address to the heroin epidemic sweeping Vermont. That year, the state's population of less than 630,000 included 2,258 people treated for heroin use and more than 400 on waiting lists for treatment. [Kenneth Craig, *Heroin Epidemic Hits Vermont Community Hard*, CBS NEWS, Sept. 10, 2015](#). Between 2013 and 2014, heroin-involved deaths increased by 66 percent. [Katharine Q. Seelye, *Vermont Tackles Heroin, With Progress in Baby Steps*](#) NEW YORK TIMES, Feb. 25, 2015. At the center of those increases was Rutland.

Rutland's problem is a microcosm of the one emerging across the United States. Vermont State Police conclude that the heroin epidemic has spread to virtually every community in the state. [Kenneth Craig, *Heroin Epidemic Hits Vermont Community Hard*, CBS NEWS, Sept. 10, 2015](#). Even given the pervasive nature of this problem in Vermont, Rutland is widely considered to be the epicenter of the state's heroin crisis. In recent years, Rutland has become a regional hub whose distribution extends well beyond its own neighborhoods, and the city exhibits all the problems associated with a serious drug market: chaos, violent deaths, elevated crime, and loss of public space.

IV. A “Covert Market” DMI

The governor's 2014 State of the State address marked the moment that Vermont's crisis began making national headlines, but Rutland started dealing with the heroin problem as far back as 2012. While DMI usually addresses neighborhood overt drug markets, Rutland's problem did not fit that description. The market was largely covert, not overt: certain neighborhoods were known havens for heroin, where the dealing largely took place indoors, within houses, temporary residences, and hotels. Nevertheless, it appeared that the core DMI logic might still apply. Rutland had become a place where local dealers could sell heroin and both local and regional buyers knew they could find heroin, a dynamic that had apparently become self-sustaining. And as with small overt markets, it became apparent that a remarkably small number of dealers were driving the problem. Beginning in 2013, the Vermont Drug Task Force, DEA, and FBI began a coordinated, yearlong investigation into the Rutland heroin market. The investigation relied heavily on intelligence from state and federal informants who infiltrated drug trafficking organizations. The information they gathered was shared across law enforcement agencies through periodic command staff meetings and by a Rutland PD detective who served as a liaison to the task force. The initial investigative priority was to identify heavy distributors from New York, but as the operation began, law enforcement started piecing together the larger supply chain. From there the investigation yielded significant information, including the identification of specific neighborhoods in Rutland that were driving much of the problem. Law enforcement also established that the market operated at three distinct levels. The heroin supply came largely from weight distributors traveling from Brooklyn, NY, to Rutland. Once there, a small number of “connectors” put the distributors in touch with addict-dealers who had their own connections to local heroin buyers. Out of town buyers could cruise the active neighborhoods and buy from obvious drug houses or use known contact information to arrange a meet-up at a local shopping plaza. For all the damage the Rutland heroin market was doing in the city and across the region, the core dealer network—out of town suppliers, “connectors,” and the initial addict dealers—represented only a few dozen people. In principle, it seemed that it might be possible to put that network out of action and aspire to breaking the connection between dealers and buyers.

Armed with the logic of DMI, and building on the careful federal, state, and local investigation, the partners developed an enforcement and maintenance strategy to permanently shut down each layer of participation in the market and address the “hot places” where dealing had been facilitated. [Fed Up with Heroin, Vermont Town Fights Back](#), CBS NEWS (Oct. 15, 2015). The initial steps included arresting the outside suppliers on federal charges, arresting the connectors linking the suppliers to local addict-dealers,

and arresting the addict-dealers selling heroin to support their habits. Once law enforcement had performed this initial sweep, the Rutland partnership pursued a tiered approach to engaging with dealers and eradicating the market.

Between 20 and 25 volume distributors and violent dealers faced federal charges. The Vermont Drug Task Force also arrested 27 drug dealers or connectors in Rutland. Of those, 20 faced significant state charges based on prior dealing behavior or their status as connectors. The remaining seven, whom probation and parole identified as low-level addict-dealers, were screened for Rutland's Drug Treatment Court (DTC) and invited to attend a call-in, where representatives from law enforcement presented the details of their case, community members demanded that the dealing stop, and social workers offered help and treatment. (As in the original overt market DMI, the choice of who was prosecuted and who was invited to the call-in was determined locally and according to the characteristics of those arrested. It seems likely that in future covert market DMIs, larger proportions of those arrested might be identified for diversion.) As part of the call-in, all dealers were offered the opportunity to plead to a charge with a reduced sentence and high levels of supervision, including enrollment in drug treatment, support programs, and regular drug testing and inspections of their primary residences. Law enforcement monitored this group to ensure they stopped dealing and to assess their program of recovery from addiction.

Rutland's DTC lasts a minimum of 180 days, depending on whether or not an individual will relapse, in which case he must restart the program. The DTC has three phases, each of which requires participants to attend one mandatory meeting each week and consistently test negative for drug use. The phases last 30, 60, and 90 days, respectively, and address an array of issues affecting the participants. The first phase is meant to stabilize the offenders with an individual needs assessment and orientation. Addressing urgent problems ranging from homelessness to mental health is the most important element of phase one. Phases two and three require participants to build on their successes and continue to progress towards self-sufficiency before graduating from the DTC. At each phase of the program, a Rutland police officer associated with the DTC checks in with participants several times each week outside of the mandatory meetings. Officers ensure that everything is going well, review their emotional state, inspect their premises, and offer support.

V. Tracking and Maintenance

Having disrupted the Rutland heroin market, the DMI partners instituted a maintenance program designed to sustain the disruption. Keeping the market closed in Rutland relied on preventing the first new dealer from setting up following the call-in and offering community support to addict-dealers. DMI seeks not only to eradicate the heroin market in Rutland, but to counter the idea that Rutland provides a haven for heroin trafficking. National experience with the overt market DMI has shown that when that idea is disrupted for several months, the market remains closed and its neighborhoods can return to normal; the aspiration was the same with Rutland's covert market DMI.

Preventing the area from tipping back towards disorder required constant attention at first. The maintenance process is coordinated by police Sergeant Matthew Prouty, who also oversees the DTC. Law enforcement in Rutland provides surveillance to monitor potential dealers trying to set up shop and uses a variety of methods to disrupt them:

- “Custom notifications” respond to intelligence indicating heroin trafficking by certain people or from certain residences. Officers visit high-risk people at home, tell them the legal consequences of continued dealing, and offer help and drug treatment.
- Strict building code enforcement acts as a sanction for dealers who continue dealing following a

notification.

- Saturation patrols demonstrate police presence in former markets.
- Strict enforcement of dealers' probation and parole conditions reduces opportunities for continued dealing.

Rutland's DMI employs a multi-level tracking strategy. Specifically assigned officers track those enrolled in the DTC, as well as overall drug-related crime in Rutland. The DTC subjects are tracked through the weekly meetings and urinalysis testing. Staff members and officers keep logs to detail their progress and updates.

Rutland PD has also implemented a Community Response Team (CRT) that employs a data analyst as it seeks to build the operation. Members of the CRT debrief frontline officers and hold weekly meetings to review trends and developments in heroin-related crime and offenders. The product of those meetings is a "hot sheet," distributed to every officer in Rutland, which allows officers to identify people involved in the DMI who require extra enforcement or treatment attention.

Additionally, the DMI partners work closely with the Department of Probation to identify high-risk individuals to receive custom notifications. Law enforcement partners in Rutland have specified 50 offenders who are at the highest risk for recidivism based on intelligence from confidential informants and officers' knowledge of dealing patterns within the community. The officers deliver a message of support while reiterating that the market is closed and dealing must stop.

VI. Results & Lessons from Rutland DMI

Since the implementation of DMI, Rutland has seen significant declines in both overall and drug-related crime. Since 2013, larceny and motor vehicle theft are down 31 percent; disorderly conduct is down 37 percent; vandalism is down 49 percent; and burglaries are down 53 percent. [Brian MacQuarrie, *In Rutland, Vt., a Rare Glimmer of Hope in Battle Against Opioid Addiction*. THE BOSTON GLOBE, Oct. 26, 2015.](#) Those declines have contributed to a 17 percent decrease in overall crime in Rutland. [Kenneth Craig, *Heroin Epidemic Hits Vermont Community Hard*, CBS NEWS, Sept. 10, 2015.](#) Rutland law enforcement officers attribute these significant drops to the city's DMI work. While city-specific heroin use and overdose data are not available for Rutland, law enforcement and city sources report their own observations and "street" information that heroin availability has diminished (they cite as additional evidence a local methadone clinic that was launched as part of the larger strategy and which now serves a caseload of 750 clients).

Federal and state authorities continue prosecution of the cases against the 25 suppliers arrested in the initial sweep, as well as the connectors and dealers with violent records. Of the seven dealers who attended the call-in and enrolled in the DTC, none have committed new crimes since the call-in. Three former addict-dealers have graduated from the DTC, with two more in the final phase. The combination of drug treatment, intense monitoring, and custom notifications appear to have helped keep the market in Rutland closed. It has also helped some dealers.

Prior to the implementation of DMI, heroin traffickers in Rutland believed they were untouchable. The community had lost control of the streets, and many Rutland neighborhoods faced the chaos of open heroin markets. Today, the community has taken major steps towards reclaiming its neighborhoods, taking back public space, and resetting standards for public safety. Additionally, the city has secured private investors who have volunteered to renovate homes in dilapidated areas of Rutland. [Brian MacQuarrie, *In Rutland, Vt., a Rare Glimmer of Hope in Battle Against Opioid Addiction*. THE BOSTON GLOBE, Oct. 26, 2015.](#) The DMI framework continues to be the central component of Rutland's

long-term strategy.

The early results in Rutland suggest that the DMI approach may hold promise for other cities struggling with heroin markets and may represent a useful tool in addressing the nation's current heroin epidemic. Federal, state, and local government should consider the possibility that the strategy might be adapted to other cities and market areas; should explore whether Rutland's finding that its market was driven by a small core network of dealers is also true in other locales; and should conduct research to assess whether market disruption interventions have an impact on heroin use and addiction, overdose deaths, and related crime and disorder.

About The Author

□ **David Kennedy** is the director of the **National Network for Safe Communities (NNSC)**, a project of **John Jay College of Criminal Justice** in New York, NY. Mr. Kennedy and the NNSC support cities implementing strategic interventions to reduce violence and improve public safety, minimize arrest and incarceration, and strengthen relationships between law enforcement and communities. These interventions have been proven effective in a variety of settings by a Campbell Collaboration evaluation, and are currently being implemented in cities nationwide. Mr. Kennedy's work has won two Ford Foundation Innovations in Government awards, two Webber Seavey Awards from the International Association of Chiefs of Police, and the Herman Goldstein International Award for Problem-Oriented Policing. He was awarded the 2011 Hatfield Scholar Award for scholarship in the public interest. He helped develop the High Point Drug Market Intervention strategy; the Justice Department's Strategic Approaches to Community Safety Initiative; the Treasury Department's Youth Crime Gun Interdiction Initiative; the Bureau of Justice Assistance's Drug Market Intervention Program; and the High Point Domestic Violence Intervention Program. Mr. Kennedy is the author of *Deterrence and Crime Prevention: Reconsidering the Prospect of Sanction*, co-author of *Beyond 911: A New Era for Policing*, and has published a wide range of articles on gang violence, drug markets, domestic violence, firearms trafficking, deterrence theory, and other public safety issues. His latest book is *Don't Shoot: One Man, a Street Fellowship, and the End of Violence in Inner-City America*.

Will it Play in Peoria? Using Community Engagement to Address the Heroin Crisis in the Heartland.

Jim Lewis
United States Attorney
Central District of Illinois

I. Introduction

“Will it Play in Peoria?” No one is certain where the phrase originated, but it was popularized during the vaudeville era and in movies by Groucho Marx and radio shows by Jack Benny and Fibber McGee. Peoria was a Midwestern stop for vaudeville acts, and if a show was successful in Peoria, it was believed that it would be successful anywhere. Later the phrase was adopted by the general public as shorthand for American mainstream culture. Peoria was representative of the nation. It was in the middle of the heartland. Peoria’s diversity in terms of race, income, age and other key criteria reflected the nation as a whole. For many years Peoria served as a test market for products and ideas. If it “played in Peoria” it would play across the nation.

II. Peoria of Today

The Peoria of today is a beautiful city hugging the western shore of the Illinois River. At night, sparkling bridges connect Peoria on the west bank with its suburbs on the east bank. It is the largest metropolitan area in the Central District of Illinois. The city has a population over 130,000. The Greater Peoria Metropolitan area has a population over 400,000. It is home to the world headquarters of Caterpillar, Inc., Bradley University, and the United States Department of Agriculture’s Northern Regional Research Lab. It is also home to three major hospital complexes, the University of Illinois School of Medicine, a minor league baseball team affiliate of the St. Louis Cardinals, several museums and art galleries, a symphony orchestra, an award-winning ballet company, several theater companies and a world-class zoo. It is also home to a heroin crisis.

Nearly twenty-four hours a day, heroin addicts drive west across those sparkling bridges spanning the Illinois River and head to locations throughout the city to meet their dealers and score their fix for the day. These are not the heroin addicts of yesteryear. They are students and laborers, white collar, blue collar, no collar, wealthy and poor, every race and every walk of life. They hope that the heroin will get them through the day. But in many cases it does not. Each day several of them do not make the return trip across the bridge. They overdose in the restrooms of local fast food restaurants, in parking lots, and in their cars at stoplights. They end up in the emergency room of one of the three hospital complexes. And many of them die. Unfortunately, heroin plays in Peoria.

In 2014 and 2015, law enforcement started to see the rise of heroin in Peoria. Instead of cocaine, methamphetamine, or marijuana dealers, they began to see heroin dealers. Where heroin had been a very small percentage of law enforcement’s caseload, it now became the overwhelming majority of their cases. And the casualties from this explosion of heroin soon became evident in the hospital emergency rooms

and funeral homes of the greater Peoria area. It was clear. Peoria was now the source city for heroin for West Central Illinois. The question was what would Peoria do about it.

III. Community Action

A. Looking for Answers

In 2012, a group of Peoria area leaders came together to battle rising gang gun violence in Peoria. These leaders, Jim Ardis, Mayor of Peoria, Mike McCoy, the Peoria County Sheriff, Jerry Brady, the Peoria County State's Attorney, Jerry Mitchell, now the Peoria Police Chief, Carl Cannon, a Community Leader, and myself, organized a team effort to fight gun violence. We modeled our "Don't Shoot" strategy after the strategy outlined by David Kennedy in his book, Don't Shoot: One Man, A Street Fellowship and the End of Violence in Inner-City America. DAVID M. KENNEDY, DON'T SHOOT: ONE MAN, A STREET FELLOWSHIP, AND THE END OF VIOLENCE (2011). Working under the mentorship of Kennedy and his team, the "Don't Shoot" team made large strides toward reducing gun violence in Peoria.

Now three years later, when faced with the heroin crisis, the team turned to Kennedy again and adopted the strategy Kennedy was using in Vermont to battle heroin. *See* David M. Kennedy, *Using the Drug Market Strategy to Address the Heroin Epidemic*, 64 U.S. Attorneys' Bulletin, 51, 2016. In December, 2015, the team formed the Mayor's Community Coalition Against Heroin (MCCAHA) and started an intensive law enforcement effort modeled after Kennedy's work in Vermont. That law enforcement effort continues today.

But the team knew that law enforcement was only one element of the solution to the heroin crisis. We realized that we needed community education, outreach to the medical community, and a call-to-arms for engagement with the community aimed toward the development of a community "action plan" that engages all stakeholders and addresses all parts of the problem and all parts of the solution. In the summer of 2016, we executed these parts of the plan.

B. Engaging the Community

We started in July of 2016 with two Community Forums. At each Forum, Mayor Ardis addressed the community, explained the scope and nature of the heroin problem, drew the connection between opioid abuse and heroin addiction, asked for community support, and introduced the DEA/FBI documentary CHASING THE DRAGON. CHASING THE DRAGON, (Fed. Bureau of Investigation, 2016). FBI Director James Comey and DEA Administrator Chuck Rosenberg introduce this 30-minute documentary, then a series of young people and families describe just "what happens when drugs take hold of real people and don't let go." Young people tell how they started with oxycodone, how they chased the "high" and went on to heroin, how heroin "became [their] best friend" and the only way to get through the day, and how their lives disintegrated. An FBI agent comments that the "best thing [is to] be arrested and go to jail. Everything other than that is worse." In the end, a few people do pull through. A doctor concludes that "the consequences of those drugs are far more devastating than anything else we've seen in the past." This documentary is quite informative, powerful and persuasive. Several members of the audience were visibly shaken after viewing the video.

After the documentary played and the leadership team made brief comments, the Mayor turned the floor over to a treatment provider and to a young woman who is working courageously to recover from heroin addiction. They spoke to the crowd. The impact was tremendous. People were clearly moved.

The next step in our engagement strategy was a community-wide reading of Sam Quinones' book Dreamland. SAM QUINONES, DREAMLAND: THE TRUE TALE OF AMERICA'S OPIATE EPIDEMIC (2015). Every year, the Peoria Public Library and Common Place pick one book for reading and discussion throughout the community in their "Peoria Reads" program. In 2012, they selected David Kennedy's book, Don't Shoot, and Kennedy came to Peoria and addressed the community in several large gatherings. This summer the Peoria Library and Common Place, with the assistance of Sheriff McCoy, selected Quinones' book, Dreamland, which details the rise of the heroin problem in the United States and the connection between opioid abuse and heroin addiction.

Dreamland begins in Portsmouth, Ohio, population 20,000, with an industrial base that is fading away, and opiate-based pills and heroin arrive to fill the void. The book also begins in a rural Mexican county, where young people like Enrique find opportunity in growing black tar heroin and selling it in the United States, particularly in medium-sized cities. The book spells out how opiate-based pharmaceuticals are marketed through a sales network that reaches out to the medical profession while minimizing the risk of potential addiction. At the same time, the book spells out how black tar heroin is marketed with a network of low-level distributors who are easy to replace if caught. The book details the story of these pills and the story of heroin as they expand their reach across America, destroying lives.

In mid-August, Quinones came to Peoria and participated in a series of public meetings including one evening event where hundreds of people showed up to learn about the heroin crisis, the connection between opioids and heroin, and what they could do as citizens to fight back against the heroin surge. Quinones also appeared on local radio and held meetings with law enforcement to discuss his experience reporting on the heroin crisis.

As I read Dreamland, my anger turned to dismay that our society's checks and balances failed to stop or significantly slow this human disaster. To be specific, the pharmaceutical industry pushed opiate-based prescription medication without fully examining and fully disclosing the reasonably-expected consequences. Too often, the medical profession went along with the pharmaceutical industry. The regulators imposed few limits on the pills. Law enforcement, including the Department of Justice, did take some specific action set forth in the book, and this did reduce a bit of the damage. The final line of defense, whistle-blowers, did not make their voices heard in a manner sufficient to motivate our society to truly intervene. As a consequence, we find ourselves today in the midst of human tragedy.

IV. The Doctors' Roundtable and The Community Summit

After the Community Forums, the medical community held a Roundtable to discuss the opiate and heroin crisis. Doctors spoke from varied perspectives: the emergency room, the hospital practitioners, the pain managers, the poison center, and the treatment providers. These doctors acknowledged that certain policies and approaches toward pain have led the medical community toward excessive prescriptions of opiates, such that our country's fraction of the world's population now consumes almost all the world's opiate-based medicine. And these doctors also acknowledged that we are just now beginning to change these policies and approaches so that opiate-based medicine will be used only when proven to be appropriate, and only so long as appropriate.

The Forums and the Roundtable created the basis for the Community Summit. This Summit opened with remarks from the Mayor, followed by FBI and DEA representatives introducing *Chasing the Dragon*. Following this documentary, an addiction specialist walked the audience slowly through the details of the history that led to the explosion of opiate-based prescriptions and heroin, and then he concluded with the details of the changes in policy and approach that are just now beginning to take hold. After lunch and a quick explanation of law enforcement's approach, the Mayor turned the floor over to a

recovering heroin user from a solidly middle-class family, then to several treatment providers, so they could tell their stories and provide the all-too-human perspective on this crisis.

Now that the Mayor's Coalition has the community's attention, we know that we have to follow up with actions toward further community education, including education within schools, colleges and workplaces, further monitoring of the changes of policy within the medical profession, and further accountability to the community on what is being done and whether we are successfully reducing the scope of the crisis.

V. Lessons Learned

This present crisis is not the end of the story. We are allowed to learn from our mistakes. CHASING THE DRAGON and Dreamland may help us understand these mistakes so that we can begin to work our way out of this tragic situation. One of those ways is to work with the medical community to dampen the overprescribing of prescription pain medicine. It is now well-established that excessive prescription leads to opioid abuse and addiction and often leads to heroin addiction.

I believe that there is an answer that is supported by experience and reason, if not research and metrics. This answer depends on whether community education stands alone or is, instead, part of a larger effort to reduce supply through law enforcement and to reduce demand through prescription limitation and effective treatment for addiction.

Community education alone will likely accomplish little unless the pharmaceutical industry, the medical profession, the regulators, and the treatment providers engage together and impose safe limits on prescription of opiates, and unless we apply law enforcement to disturb, disrupt, and limit the delivery of heroin. If we expect community education to reduce demand while supply is so prevalent, or if we expect law enforcement to reduce supply while demand is so prevalent, we should reasonably expect our success to be limited.

There is straightforward logic to this: if a community needs (1) supply reduction for both opiate-based pills and heroin, and (2) demand reduction through community education and effective treatment, we can easily reach the conclusion that we need all these elements to work together toward their common interest. Alone, each element should have limited effect; together, these should have maximum effect.

Therefore, Peoria's community engagement will likely accomplish its purpose, if it is part of a broader "action plan" that engages the community and the schools with local medical and treatment providers, along with law enforcement, in order to bring about reduction in demand as well as supply. If these elements all pull together, we should be able to free more people from potential addiction and from actual addiction, if we use education and prevention and diversion and treatment, as well as law enforcement.

In addition, there is quite recent federal legislation, the Comprehensive Addiction and Recovery Act. Will it help toward the solution? It might, when it is supported with funding.

VI. Conclusion

We share a goal: addiction reduction that will save lives, many lives. Therefore, we should try to have effective community education about opiates as one part of an effective “action plan” for pills and heroin, and we in law enforcement should be part of this education and “action plan” as we seek this goal.

Yes, community engagement will play in Peoria.

About the Author

□ **Jim Lewis** is a graduate of Yale University and the University of Chicago Law School, with a further law degree from Duke University Law School. He began his career as a civil rights lawyer in Jackson, Mississippi, in 1966, and worked as a civil rights and legal service attorney in Mississippi through 1973. From 1974 through 1977, Jim taught seminars at Duke and was an Assistant Professor at North Carolina Central University Law School. In 1977, Jim joined the Civil Division of the United States Department of Justice, and in 1983, Jim came to the United States Attorney’s Office in the Central District of Illinois. After many years in the Office, Jim became the United States Attorney on June 24, 2010.

The Northern District of Ohio Model: Community Action

Carole S. Rendon
United States Attorney
Northern District of Ohio

I. Introduction

It's the kind of 9-1-1 call that's hard to shake.

A 7-year-old girl found her mother unconscious. She poured cold water on her, but she remained unresponsive. The girl called 9-1-1. Emergency workers did everything they could, but the 27-year-old Ashtabula woman died from a heroin overdose.

It was the summer of 2012, and this death was just the latest in a steady increase we had noticed throughout the Northern District of Ohio.

Although four years does not seem that long ago, it feels like another lifetime in terms of the public's awareness of the heroin, opioid, and now fentanyl epidemic that is gripping our nation. Celebrities like Philip Seymour Hoffman and Prince had not yet died from overdoses. News programs had not yet caught on to the epidemic or the link between prescription pills and heroin addiction. Heroin use remained a shameful secret that happened someplace else and involved someone else, not our neighbors, friends, relatives, and colleagues.

However, here in the Northern District of Ohio, we already were confronting a wave of death that was impossible to ignore. In Ohio's largest county, Cuyahoga, heroin overdose deaths had increased fourfold in a matter of three years, to 160 deaths in 2012.

II. Heroin and Opioid Use in Northern Ohio

At the same time the overdose deaths increased, our OCDETF unit noticed a change in drugs flowing into the District. Just a few years earlier, their caseload was almost exclusively cocaine, both cocaine base and powder. Heroin cases were rare. But at the same time that overdose deaths were beginning to spike, cocaine was supplanted by heroin as the drug of choice among the traffickers.

We also could not ignore the rapidly growing number of pill mill cases we were prosecuting or the reality that the number of Ohio's per capita dosage of opioids increased from 7 pills per person to 67 pills per person. [GOVERNOR'S CABINET OPIATE ACTION TEAM, OPIATE ADDICTION AND ABUSE STATISTICS \(last visited Aug. 26, 2016\)](#). That is an increase of nearly 900 percent over the prior decade.

At the time, we did not realize the problem would get much worse long before it got better. But, recognizing that heroin deaths had surpassed car accidents and homicides, we knew we needed to do something. We needed a bold, new strategy to address this crisis brewing on the horizon. Our law enforcement plan had to be combined with a broader effort that included drug prevention, treatment for people struggling with addiction, and a concerted effort to reduce the number of prescription painkillers flowing into our community.

In 2012, we partnered with the Cleveland Clinic to host a day-long summit on the prescription pill crisis. The summit included a keynote address from Gil Kerlikowske, then the head of the Office of National Drug Control Policy. One of the attendees was the father of a college football player who became addicted to painkillers prescribed to treat a separated shoulder. That addiction morphed into heroin abuse, stints in rehab, removal from the football team, and ultimately a tragic fatal overdose. I later learned that the deceased young man with a promising future had been coached in grade school by our Criminal Chief. It was a reminder of something I would learn all too well in the coming years—that heroin abuse knows no boundaries. It cuts across all demographic categories; it touches all of our lives.

In 2013, the death rate continued to climb in Cleveland, Toledo, Akron, and throughout the District. In response, we decided to convene a second summit, this time focused on heroin. However, we wanted the summit to result in real tangible action. We did not want to spend a day where people gathered, agreed there was a problem, and then went on with their daily lives.

III. Community Action

To accomplish our goal of tangible action, we began to draft a community-wide action plan that would address all facets of the problem and identify specific actions that could be taken. [U.S. ATTORNEY'S OFFICE, N. DIST. OF OHIO, THE HEROIN AND OPIOID EPIDEMIC—OUR COMMUNITY'S ACTION PLAN \(March 12, 2015\)](#). Drafting the plan started with assessing what was already being done and determining where there were overlaps and where there were gaps. That assessment required listening and assuring people that we were not interested in pushing them aside or ignoring the important work already taking place. It also required us to cast a wide net, well beyond our traditional law enforcement partners, and beyond the borders of any one city or county. We found that convening stakeholders from all facets of our community is a place where U.S. Attorney's Offices can be particularly effective because our districts supplant city and county borders, and we are accustomed to working side by side with federal, state and local law enforcement partners, community groups, and public and private entities.

We invited people from a diverse cross-section of the community to come talk about what was happening in the community and what more needed to happen. The groups included people you would expect to see at the U.S. Attorney's Office: police officers, DEA and FBI agents, and local prosecutors and judges. But it also included physicians, including those who treat substance abuse disorder, chronic pain doctors, and emergency-room physicians. It included pharmacists, legislators, and educators. We met with people who run treatment centers and with people who operate needle-exchange programs. We met with clergy and faith leaders. We met with parents who lost children to heroin and people struggling with recovery. We also relied heavily on the expertise of the Cuyahoga County Medical Examiner's Office. Their detailed testing and record-keeping regarding heroin and opioid deaths has provided an undeniable set of statistics that have become central to the narrative of this crisis.

People talked. People listened. Ideas were kicked around. Sometimes people disagreed, even argued. But we also understood that we were all working toward the same goal.

Over the course of several meetings, a framework began to take shape. We formed committees looking at the problem from four critical perspectives: law enforcement, education/prevention, treatment, and healthcare policy. Our goal was to develop a community-wide action plan that would be finalized at our second day-long summit. With that goal in mind, the U.S. Attorney's Heroin and Opioid Task Force was created.

Our ground rules were simple. Not everyone is going to agree on every issue or every planned approach. Not everyone will have expertise in every aspect of the problem. And some members will not be able to participate in every facet of the proposed response. For example, many members of the Task

Force felt strongly that changes needed to be made to state law. Obviously, members of federal law enforcement could not and would not lobby for those changes. But doctors, recovery professionals, and other private-sector members were free to seek changes to our state laws.

The second summit was held in November 2013. It was a time when deaths continued to increase, but the burgeoning heroin epidemic was not yet front and center in the media. We implemented a public awareness campaign before the summit that resulted in a week-long series in the local newspaper, as well as several television stories. More than 700 people attended the summit, reaching the maximum capacity of the venue. From the attendance alone, we knew we were on to something. The day flew by. We heard new ideas we had not considered. We met new experts who were doing important work, and we asked them to join our task force. We made adjustments to our action items and rallied the community to get involved in making change.

The action items, like the task force itself, were broken into four areas.

The Law Enforcement Subcommittee's initial priorities were:

- Create a specialized unit of detectives and prosecutors to respond to every fatal heroin overdose in an effort to gather evidence as part of an effort to file more "death specification" indictments in federal court and manslaughter indictments in state court targeting the dealers who are selling the most deadly drugs.
- Create a regional notification system for law enforcement alerting them whenever there is a fatal overdose.
- Continue to push for treatment for heroin users, when appropriate, while focusing our limited resources on heroin traffickers.

The Education/Prevention Subcommittee's priorities were:

- Create a local "speakers' bureau" made up of law enforcement, doctors, judges, treatment professionals and other stakeholders who could coordinate and staff public meetings regarding heroin and opioids at schools, recreation centers, civic centers, union halls and anywhere else people wanted information about the epidemic.
- Expand the drug drop-box program so every police department has a secure place where people can drop off unused prescription pills.
- Continue and expand a public awareness campaign about the dangers of heroin and opioids.

The Healthcare Policy Subcommittee's priorities were:

- Advocate for the passage of state laws that expand access to Narcan, needle-exchange programs, and a Good Samaritan law that gives limited immunity in state court to those who call 9-1-1 to report an overdose.
- Require all hospitals and doctors to enter data into the state prescription database so doctors can identify "frequent fliers" and doctor-shopping patients.
- Expand training for doctors and medical students on the dangers of overprescribing painkillers.

The Treatment Subcommittee's priorities were:

- Increase access to medically assisted treatment, in addition to traditional 12-step programs, including use of Suboxone, residential treatment centers, and sober housing programs.

- Expand access to treatment beds, including seeking a waiver of the IMD exclusion, which limits facilities to 16 in-patient treatment beds.
- Train clinicians to recognize the disease of substance abuse, including how to respond effectively to patients not yet ready to change their behavior.

Id.

Over the course of the next year, we made progress achieving our goals. Since 2014, Task Force members have reached 47,000 people through more than 200 meetings at schools, churches, and union halls. Doctors on the Task Force testified at the statehouse and successfully lobbied for the passage of legislation that made Narcan available to friends and relatives of addicts without a prescription. To date, more than 500 lives have been saved by reversing overdoses through providing Narcan to first responders, friends and relatives of addicts.

Detectives now respond to every fatal overdose and treat it as a crime scene. They check phones for text messages, test for fingerprints, interview witnesses, and gather evidence. That work has resulted in scores of manslaughter indictments in state court and nearly a dozen death-specification indictments in federal court. As a result, we have obtained sentences of up to 20 years for dealers who sold drugs that killed people in Elyria, Akron, Cleveland, Marion, and elsewhere—including Jamarce Miller, who sold the dose of heroin that killed the Ashtabula mother.

Yet there is still so much more work to do. The deaths continue, in part because heroin has given way to its deadlier cousin, fentanyl. In fact, in 2016 in Cuyahoga County alone, we already have had 219 overdose deaths from heroin, fentanyl, or a combination of the two drugs. [Press Release, Christopher Harris, Cuyahoga Cty., Heroin-Related Deaths Decrease for first time since 2007; Fentanyl-Related Deaths finish at all-time high in 2015, \(Feb. 2, 2016\)](#). By the time you read this article, that number will have increased further. With each life lost, the collateral consequences to that person’s family, friends, colleagues, and neighbors ripple through our community.

IV. Conclusion

We cannot arrest our way out of this problem, but we need to continue to aggressively prosecute drug traffickers and disrupt the supply of drugs into the United States. Simply getting treatment for everyone suffering from addiction will not solve the problem, but given the existing population of heroin and opioid users, we must make sure we have enough beds so that when someone says “enough” and wants help, treatment is immediately available. Changing prescribing practices alone also will not cure the problem, but we must continue to curb the rate at which doctors are prescribing opioids and address the underlying incentives that have led to that practice. Finally, every one of us must continue to talk to our children, our friends, and our co-workers about the dangers of opioids and how no one is immune from the threat. Opioid addiction knows no boundaries. It is an equal opportunity killer of old and young, men and women, urban, suburban, and rural, rich and poor, black, white and Hispanic. We are all at risk.

Bluntly, I believe it will take what we have come to call the “all of the above” approach, everyone working together in concert to push back on what appears to be, at least in our corner of the world, a public health and law enforcement crisis, the likes of which we have rarely seen before.

ABOUT THE AUTHOR

□ **Carole Rendon** was sworn in as United States Attorney for the Northern District of Ohio on July 15, 2016. She served from 2009 through 2016 as the First Assistant United States Attorney. During that time, she was lead counsel on *U.S. v. City of Cleveland*, an exhaustive investigation of the Cleveland Division of Police, which resulted in significant changes, including use of force, crisis intervention with the mentally ill, community engagement, bias-free policing, search and seizure, accountability, training, equipment, and staffing. It is viewed as a national model for police reform. She was also instrumental in developing the U.S. Attorney's Task Force on Heroin and Opioids, which seeks to find comprehensive solutions to Northern Ohio's opioid epidemic. She also was a driving force behind the Northeast Ohio Cyber Consortium, a cross-sector public-private partnership designed to reduce the region's vulnerability to cyber-attacks.

Responding to the Heroin Crisis: Two Initiatives in the Eastern District of Kentucky

Kerry B. Harvey
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Eastern District of Kentucky

I. Heroin in the Bluegrass Region

In many ways, Lexington, Kentucky, and the surrounding counties that form our Commonwealth's Bluegrass Region is an unlikely location for ground zero of the opioid epidemic. Lexington is a vibrant, prosperous city of 310,000. The Bluegrass Region is home to the University of Kentucky, the thoroughbred horse industry, and 500,000 Kentuckians. Though our region is not beset by a chronically depressed economy or an attendant sense of hopelessness, it suffers from a debilitating and widening opioid epidemic. The problem worsens by the day, as heroin and fentanyl, a synthetic painkiller that resembles heroin but is up to 50 times more powerful, are increasingly available. Users are younger, more susceptible to overdose because of intolerance for the drug, and impossible to pigeonhole by socioeconomic status. Central Kentucky typifies the new reality of the heroin epidemic that is spreading rapidly through middle class communities. No longer confined to "the other side of the tracks," heroin knows no geographic or demographic boundaries. It now attracts younger users in large numbers. Unlike the generations that preceded them, most young people today will be directly confronted with the decision of whether to abuse opioids.

The history that brought us to this lamentable juncture will be familiar to many. In the 1980s and 1990s, the medical profession adopted an aggressive approach to pain management. Though incapable of objective measurement, many medical professionals characterized pain as the "fifth vital sign." Physicians and hospitals were "graded" on their success in treating pain by patients, accrediting agencies, and others. This more aggressive approach to pain treatment coincided with the introduction of a new generation of potent opioids, most notably OxyContin. Their prolific use and abuse created tens of thousands of new addicts. Over time, it diminished the stigma associated with the nonmedical use of these extraordinarily potent drugs. Abuse of powerful opioids skyrocketed among younger, inexperienced initiates to the dark world of drug abuse. Enterprising drug trafficking organizations built well-defined distribution networks into places like Kentucky from such far flung cities as Detroit and Miami. "Pill mills" dotted the landscape. Drug dealers in lab coats joined those who worked the street corners.

As the number of addicts and abusers multiplied, the limited supply and rising price of pharmaceutical opioids restricted their availability. This contributed to the rapid and unanticipated resurgence of heroin, now readily available on the streets of cities like Lexington. Today's heroin is much cheaper and far more potent than earlier versions. Due to its purity, many initiates are introduced to its use through inhalation, a less intimidating method than injection, which leads many new users to believe erroneously that they need not fear overdose. Our quarter century history with highly addictive pharmaceutical opioids softened the resistance of a generation to the dangers of heroin. The introduction

of fentanyl into this already toxic mix has resulted in a steadily growing crisis throughout much of America.

The Bluegrass Region is at the epicenter of this crisis, as the data grows grimmer with each passing year. The Lexington-Fayette County Coroner reports that as recently as 2008 our community suffered only 29 overdose fatalities, and only a handful of these deaths were related to heroin. By 2015, that number had swelled to 141, and many of these senseless deaths were caused by heroin, fentanyl, or a combination of the two. Overdose deaths in Kentucky increased 16 percent from 2014 to 2015, totaling 1,248 last year. And in truth, the devastation is even worse than these numbers suggest. Overdose deaths are underreported because many victims are not autopsied and are not recorded as overdose fatalities. Moreover, the fatality statistics do not account for the scores of Kentuckians enslaved to addiction whose lives are spared when first responders administer increasingly available naloxone.

Our office, like many others, strives to deploy every available tool in the fight against this scourge. We have found no silver bullet. Yet, the tragic story of a young lady named Elizabeth sparked dual initiatives that hold promise in the fight against the heroin epidemic.

II. Elizabeth's Story

Everyone who does this work encounters a case or, more accurately, a person, who captures their focus and won't let go. For me, that person is Elizabeth. Elizabeth Hulsing died on Christmas Eve 2014, at age 24. Though I did not know Elizabeth, I have learned a great deal about her incredible life, tragic death, and the pain of her lost promise.

Elizabeth was born on September 16, 1990, to Dennis and Lynne Hulsing, the oldest of four children. Dennis and Lynne are salt-of-the-earth people. Dennis is self-employed, Lynne is a nurse, and both are wonderful parents. The Hulsings were the kind of family anyone would love to call their neighbors. Elizabeth was, by all accounts, a beautiful, talented young lady, who had much to offer the world.

Elizabeth cared about people. At 18, she moved to inner city Philadelphia to spend a year serving those less fortunate than her. A story told at her funeral speaks volumes about her heart: She walked by a homeless person on the street who commented on her shoes, so Elizabeth stopped, gave the homeless person her shoes, and walked home barefoot.

Elizabeth graduated with honors from Berea College. She was on the Dean's List every semester for high academic achievement. Along the way, however, Elizabeth made some very bad choices. She formed a relationship with an older man and experimented with drugs. Eventually, Elizabeth developed an opioid addiction. As she struggled with addiction, she withdrew from much that she loved, leading her family to sense that something was wrong.

Elizabeth was determined to overcome her illness. With the support of her family and countless friends, she sought treatment to put opioid abuse behind her. She appeared to be well on her way to fulfilling her substantial potential. Elizabeth entered the University of Miami on a full academic scholarship, working toward a Ph.D. Her grades were excellent. She was teaching herself Spanish to better adapt to her new community. Her future seemed bright when she returned home to Kentucky for Christmas break.

Though she had been clean for months, she succumbed to her addiction. On what would be the last night of her life, she reconnected with her old friend, Nathan Metzger. Unknown to Elizabeth, Metzger provided her with pure fentanyl, not heroin. Though her choice was a terrible one, it should not have been a death sentence. Elizabeth died in the early hours of December 24, 2014.

The initial investigation developed the evidence against Metzger, as well as promising leads concerning his supplier. But as the weeks passed, the criminal justice system was not at its best. The drug amounts were small, and Kentucky has no homicide law covering these circumstances. Our office had prosecuted a number of dealers for illegally distributing drugs resulting in death or serious bodily injury, triggering a 20-year mandatory minimum sentence (Overdose Case). The local investigating officers did not consider, and perhaps did not know, of this possibility. The investigation stalled. Although they knew the identity of the man who gave Elizabeth the lethal fentanyl, Lynne and Dennis Hulsing were told that there was little to be done. A deep sense of injustice added anger to their grief. For Lynne and Dennis, the “system” seemed to reduce Elizabeth to a statistic—just another overdose.

Much later, the case was brought to my attention, and we began to investigate. Having daughters about Elizabeth’s age, I could not imagine the nightmare that Lynne and Dennis faced. As they shared their daughter’s story with me, I realized that their principles, their parenting, and their dreams for their children were no different than mine. I had not raised my daughters any better than they raised theirs.

Understanding that this is a horror that can strike anyone in any family is crucial to mobilizing our communities to resist this epidemic. Too often, we indulge in the comforting fiction that heroin is found only in other cities, or other neighborhoods, far from the places we call home. An unspoken assumption suggests that there must be something inherently inferior in those who fall into the trap of drug abuse: “It couldn’t happen to our children; we raised them better.” We must eliminate these stereotypes to mobilize the unified response that this epidemic demands. If we are to win this fight, every segment of our community must join the fray. We must know in our heads and feel in our hearts that the heroin epidemic threatens us all.

As our belated investigation progressed, the Hulsing family’s loss was compounded by their perception that the “system” had let them down and that justice was beyond their reach. I apologized to them on behalf of all of us in the criminal justice system and promised to do what we could. We ultimately charged Metzger with distributing the fentanyl that killed Elizabeth. Because of its unique circumstances, we made the difficult decision not to charge it as an Overdose Case. Our involvement with Lynne and Dennis and others living through the same tragic circumstances, left all of us with the conviction that we needed to do more to save others from Elizabeth’s fate.

Our interactions with the Hulsings and families like them inspired us to launch two initiatives that have shown promising results. First, from a nuts-and-bolts law enforcement perspective, we needed more effective partnerships with our local law enforcement agencies to prosecute Overdose Cases. We believe that these are important, impactful cases. While not every overdose circumstance warrants the enhanced penalties available under federal law, many do. We were losing far too many opportunities to review these cases because of insufficient coordination with local law enforcement.

We also saw that many in our region failed to appreciate the scale of the widening heroin epidemic. Too many found false comfort in the beguiling notion that heroin could not be in our neighborhoods and would never tempt anyone in our families. Law enforcement has a key role in combatting the heroin epidemic, but the solution ultimately lies in mobilizing a total community response. That response cannot occur without broad acceptance of the challenges we face.

III. The Overdose Prosecution Initiative

[Title 21 U.S.C. § 841\(a\)\(1\), \(b\)\(1\)\(A\)–\(C\)](#) imposes a 20-year mandatory minimum sentence on anyone who unlawfully distributes a Schedule I or Schedule II drug when “death or serious bodily injury

results from the use of such substance.” If the defendant has been previously convicted of a felony drug offense, the penalty is mandatory life imprisonment.

These are stiff penalties that should be applied advisedly. We believe, however, that these enhanced penalties are an important tool considering the carnage inflicted on our communities by heroin dealers. Our office prosecuted these cases prior to our involvement with the Hulsing case and others of a similar nature. We came to realize, however, that greater collaboration with local law enforcement was required if we were to prosecute these cases in sufficient numbers to serve as an effective deterrent.

A. Building Overdose Cases

The enhanced penalties available in Overdose Cases are appropriately applied to drug traffickers who engage in predatory behavior resulting in death or serious bodily injury. Prudent use of this prosecutorial tool serves as a general and specific deterrent, strongly encourages cooperation against higher level drug dealers, and provides some sense of justice for victims’ families.

The necessary elements of an Overdose Case are straightforward: (1) the drugs in question must be the “but for” cause of death or serious bodily injury; and (2) the defendant must have illegally distributed the subject drugs. Developing the evidence necessary to prove the charge is more difficult. Absent well-trained first responders, essential evidence can be lost long before a federal law enforcement officer or prosecutor learns of the overdose.

In our district, overdose sites were rarely treated as crime scenes. Kentucky law does not include a homicide statute for Overdose Cases, and they were rarely viewed as potential grounds for federal prosecutions. Investigations can be difficult when the victim is deceased and the source of the drugs is not immediately obvious. We learned that our local law enforcement agencies often had only a vague understanding of the federal implications of a drug overdose. First responders typically handled these matters as an accidental death. If police were at the scene at all, it was generally to supervise the removal of the body or the drugs, and to notify the next of kin. And because coroners rarely ordered an autopsy, the evidence, and thus the potential for prosecution, was gone by the time federal authorities learned of the fatality.

In partnership with the DEA, we launched an initiative to alter the trajectory of these cases. Our goals were to educate local law enforcement agencies and county coroners concerning the federal prosecutorial potential of Overdose Cases and to recruit them to partner with us to develop the evidence necessary for such prosecutions. We then provided detailed training to equip our local partners to properly conduct these investigations.

We first aimed at convincing local law enforcement partners that these cases are worth their effort. Proper investigation requires additional work by these agencies—a daunting task in many communities, given the sheer number of overdose deaths. During this phase, we hosted a series of meetings throughout the hardest hit areas of our district. We invited not only law enforcement officers, but mayors, county executives, and other local leaders.

We discussed the magnitude of the problem in each community and shared our view of federal law enforcement’s role in addressing the issue. Assistant United States Attorneys (AUSAs) provided a tutorial on the federal drug laws, including the enhanced penalties available for Overdose Cases. We invited a candid discussion of the potential benefits of these prosecutions. The meetings concluded with a solicitation to join us in a partnership focused on investigation and prosecution.

We then conducted detailed training sessions for the law enforcement agencies and county coroners who joined the partnership. The basic work is comprised of common sense investigative steps:

questioning witnesses at the scene; gathering heroin, pill bottles, drug paraphernalia, or other physical evidence; and perhaps most importantly, collecting the victim's cell phone, as text messages often lead directly to the source of the drugs. For promising cases, we ask our partners to order an autopsy and toxicology analysis so that we can definitively determine the cause of death. And, of course, we urge our partners to contact the DEA or the U.S. Attorney's office sooner rather than later.

These cases require a new approach to overdose deaths. Investigating officers must consider the site a potential crime scene from the moment of arrival. They must engage with the coroner and other first responders with an eye toward preserving evidence for a potential prosecution. Moreover, the victim's family is often eager to assist and frequently provides important information. They must be candidly informed of the circumstances of the death, the investigative steps to be taken, and the potential for criminal charges.

We have three AUSAs who prosecute Overdose Cases, one in each of our branch offices. Because Overdose Cases present only one opportunity to preserve the evidence, these AUSAs provide their direct contact information to our law enforcement partners, who are encouraged to call from an overdose scene any time that questions arise, day or night.

Finally, we honestly inform our law enforcement partners that many, even most, overdoses they investigate will not lead to federal charges. Nonetheless, when the pieces fall into place, these high impact cases make a difference.

B. Our Results

As of July 1, 2016, we have charged more than 20 defendants in Overdose Cases. Fifteen or more are finished—all with convictions. Given adequate proof, juries are quite willing to convict defendants in these cases. The “but for” causation standard has not been a significant impediment. Our participating law enforcement partners are enthusiastic about the success of these cases and believe they make a difference.

We find evidence of truly predatory behavior in many of the cases we prosecute. We have prosecuted defendants believed to be actively engaged in trading heroin to young women for sex. In another case, the defendant sold heroin that resulted in the death of a young woman in the last trimester of her pregnancy. Other defendants evidenced a subjective awareness that they were selling fentanyl or heroin laced with fentanyl to the unwary. One defendant imported large quantities of pure fentanyl pressed into pill form and disguised as prescription drugs. The defendants we charged in Overdose Cases are professional drug dealers; they are not addicts supporting a habit. Most have prior drug felonies.

As we complete more of these cases, our law enforcement partnerships are growing. Our law enforcement partners and coroners, initially skeptical, are increasingly enthusiastic as they see the results. Success breeds success. We have more cases in the investigative pipeline than ever before, many of which will enable us to move up the chain and prosecute higher level distributors.

Thanks to naloxone, we are prosecuting more cases with a surviving overdose victim. The enhanced penalty applies to cases that result in death or serious bodily injury, and, by definition, an overdose victim who survived only due to the timely administration of naloxone has suffered serious bodily injury. Such cases, of course, present far fewer proof problems. We are training our local partners that overdose victims saved by naloxone may present more opportunities to remove dangerous heroin dealers from our streets.

Finally, we ask the media to publicize the results of these cases in order to achieve the maximum deterrent effect. Jail calls, proffers with defendants, and wire intercepts indicate that the target audience is paying attention.

Our effort produces laudatory by-products. In cases like Elizabeth's, a charge triggering the 20-year mandatory minimum may not be appropriate. A federal charge for distribution will be available, however, and the court can consider the overdose as relevant conduct. In other cases, the on-the-scene investigation results in significant state charges. Leads to those higher in the distribution chain are often developed and have directly led to additional prosecutions. Our ties to our local partners are strengthened as they see that we are fully committed to this effort.

IV. USA HEAT

One of the great challenges in combatting today's heroin problem lies with raising public awareness. Most community leaders have never confronted a large scale heroin crisis, and they may not understand that it is a pervasive threat in every neighborhood, rich or poor.

To design more effective prevention efforts, we must recruit effective messengers. Those who have walked this dark path with a son, a daughter, a sibling, or a parent are uniquely positioned to give voice to their experiences, sounding a warning to this insidious threat. This realization spawned the U.S. Attorney's Heroin Education Action Team, known as "USA HEAT."

We formed a small but growing group of surviving family members of overdose victims. We meet one evening a month and brief them on our law enforcement and outreach activities related to the heroin problem. We listen to their observations and learn from their experiences. The dialogue informs our decisions as we seek to deploy limited resources most effectively.

As new members come onboard, our Public Information Officer and Victim/Witness Coordinator spend several hours working with them to craft a presentation centered on their experience. This is a critical element in the success of our program. All of our team members have a compelling story to tell, but each of them begins from a different place. Some are experienced public speakers, while others are terrified at the thought. While they each deal with grief differently, they share an incredible commitment to use their loss to save other families from tragedy.

The typical result is a powerful presentation lasting 30 to 60 minutes that features childhood photographs and stories memorializing their loved one. The audience witnesses firsthand the consequences of opioid addiction. Our USA HEAT partners convey in viscerally understood terms that this can happen to anybody in any family. The audience learns the telltale signs of a drug problem that might otherwise be missed.

For most of our presentations, our First Assistant U.S. Attorney, one of our drug prosecutors, or I serve as the warmup act, providing the facts and figures that empirically demonstrate the scope of the problem. We can help our audience understand intellectually that our community has a terrible and worsening heroin problem. An intellectual understanding of the problem, however, will never sufficiently motivate the necessary action to fight this battle. Our HEAT partners deliver a powerful message that inspires positive action from the heart. Their audiences leave changed.

Building on our reentry partnership with the Bureau of Prisons, we recently took USA HEAT to prison. On July 19, 2016, we travelled to FCI Manchester, a medium security facility. We spoke to more than 75 inmates—most of them convicted drug dealers—who are nearing release. I spoke regarding the legal consequences of reoffending. HEAT partners David and Kayla Greene delivered a far more powerful message. David and Kayla shared the story of their son, Domonique, who died of a heroin/fentanyl overdose last year after a long battle with addiction. In addition to his parents and countless friends, he left behind a young daughter.

David and Kayla shared the details of their son's struggles and the devastating impact of his passing on so many whom he left behind. I have made a number of visits to state or federal prisons over the years, but I have never witnessed a room so quiet or an audience so attentive. David and Kayla demonstrated in stark terms that selling heroin is not a victimless crime. The audience plainly understood, perhaps for the first time, the far-reaching consequences of distributing these deadly drugs in our communities. The opportunity to witness the response of the inmates to Mr. and Mrs. Greene, and the incredible grace exhibited by these grieving parents, was a profoundly moving experience. We hope that these men will carry Domonique's story with them as they reenter communities all across our nation.

I have boundless admiration for the courageous and selfless people who have partnered with us in this initiative to share with groups of strangers the most personal details of the worst moments of their lives. As of this writing, our USA HEAT partners have spoken to over two thousand community leaders, law enforcement officers, and students. This is only the beginning.

We have produced a number of videos to amplify the message of USA HEAT and are rolling out a website for the same purpose. We expect this initiative to grow, and we plan to sail all of our anti-heroin messaging and outreach under the USA HEAT flag.

I am convinced that USA HEAT holds great promise. These programs could be replicated in any district. With that said, we can't claim victory. Kentucky's overdose death toll continues to rise. We can leave no stone unturned as we search for positive answers to this horrible problem.

As for the epilogue to Elizabeth's story, U.S. District Judge Danny Reeves heard compelling presentations from Lynne Hulsing and Rebekah Hulsing, one of Elizabeth's sisters. He considered Metzger's record and his involvement in Elizabeth's death and ultimately varied upward, sentencing Metzger to 14 years imprisonment. Dennis and Lynne feel that justice—at least some measure of justice—was done.

That is how the case ended. But Elizabeth and others like her inspired us to try harder and think more creatively. And so, in a very real sense, Elizabeth's story goes on.

ABOUT THE AUTHOR

□ **Kerry B. Harvey** has served as the U.S. Attorney for the Eastern District of Kentucky since 2010. In 2014, Mr. Harvey was appointed by Attorney General Eric Holder to the Attorney General's Advisory Committee. He also serves as Co-chair of the AGAC's Healthcare Fraud Working Group.

“Death Results” Prosecutions Remain Effective Tool Post-*Burrage*

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I. Introduction

As the United States finds itself in the middle of one of its worst drug epidemics, federal prosecutors continue to look for ways to reign in drug traffickers who profit from the sale of heroin, fentanyl, and other illicit substances. One of their greatest weapons is the statute that permits an enhanced sentence for any person involved in the distribution of controlled substances when “death . . . results from the use of such substance.” 21 U.S.C. § 841 (a)(1), (b)(1)(A)–(C) (2012). A defendant convicted of a delivery that results in death faces a minimum of 20 years and up to life in prison. While a recent decision by the United States Supreme Court has made these cases more challenging for prosecutors, the new standard is both reasonable and attainable when pursuing a defendant deserving of a lengthy sentence. The possibility of a 20-year prison term can be an effective tool in the effort to disrupt and dismantle drug trafficking organizations throughout the country.

This article will provide an in-depth analysis of *Burrage v. United States*, 134 S. Ct. 881, (2014), a critique of the application of *Burrage* at the trial and appellate court levels, and, finally, some practical advice for successfully satisfying *Burrage* in mixed-drug intoxication cases.

II. Analysis of *Burrage*

In *Burrage*, the Supreme Court held that “at least where use of the drug distributed by the defendant is not an independently sufficient cause of the victim's death or serious bodily injury, a defendant cannot be liable under the penalty enhancement provision of 21 U.S.C. § 841(b)(1)(C) unless such use is a but-for cause of the death or injury.” *Id.* at 892.

On appeal, the government voiced its concern for requiring “but-for” causation in mixed-drug intoxication cases, e.g., where the decedent was found to have consumed multiple drugs, only one of which was unlawfully distributed by the defendant. Following *Burrage*, this concern has persisted, if not intensified. But with a proper understanding of the requirement, and after adequate preparation for potential issues, prosecutors can continue to pursue “death results” charges in mixed-drug intoxication cases.

In *Burrage*, multiple drugs were present in the decedent’s system, including heroin (which *Burrage* had distributed) and oxycodone (which *Burrage* had not distributed). *Id.* at 885. After the district court instructed that the government was required to prove that the heroin distributed by *Burrage* was “a contributing cause” of the death, the jury convicted *Burrage* of distribution of heroin and found that death resulted from the use of that substance. *Id.* at 886. The Eighth Circuit Court of Appeals affirmed. *Id.* The Supreme Court granted certiorari, in part, to decide whether a defendant may be convicted under the “death results” provision when the use of the controlled substance was a “contributing cause” of the death. *Id.*

As an initial matter, the Court outlined the expert testimony heard at trial. Two medical experts testified on the cause of the decedent's death. *Id.* at 885. One of the experts opined that heroin "was a contributing factor," meaning that the heroin "contributed to an overall effect that caused [the decedent] to stop breathing." *Id.* at 885-86. The other expert "described the cause of death as 'mixed-drug intoxication' with heroin, oxycodone, alprazolam, and clonazepam all playing a 'contributing' role." *Id.* at 886. This expert "could not say whether [the decedent] would have lived had he not taken the heroin, but observed that [the decedent's] death would have been '[v]ery less likely.'" *Id.*

Before addressing these particular causation opinions, the Court elaborated on the parameters of "but-for" causation. First, the Court recognized the classical starting point, namely: "The harm would have not occurred in the absence of—that is, "but for"—the defendant's conduct." *Id.* at 887-888. The Court then provided an example of this classic definition: "Where A shoots B, who is hit and dies, we can say that A [actually] caused B's death, since but for A's conduct B would not have died." *Id.* at 888 (internal quotation marks omitted).

Next, the Court added an accepted "incremental effect" gloss to this classical starting point. "The same conclusion follows if the predicate act combines with other factors to produce the result, so long as the other factors alone would not have done so—if, so to speak, it was the straw that broke the camel's back." *Id.* at 888. The Court then provided an example of this gloss: "Thus, if poison is administered to a man debilitated by multiple diseases, it is a but-for cause of his death even if those diseases played a part in his demise, so long as, without the incremental effect of the poison, he would have lived." *Id.*

The Court then explained what would not constitute "but-for" causation by distinguishing between essential and nonessential contributing factors:

"Consider a baseball game in which the visiting team's leadoff batter hits a home run in the top of the first inning. If the visiting team goes on to win by a score of 1 to 0, every person competent in the English language and familiar with the American pastime would agree that the victory resulted from the home run. This is so because it is natural to say that one event is the outcome or consequence of another when the former would not have occurred but for the latter. It is beside the point that the victory also resulted from a host of *other* necessary causes, such as skillful pitching, the coach's decision to put the leadoff batter in the lineup, and the league's decision to schedule the game. By contrast, it makes little sense to say that an event resulted from or was the outcome of some earlier action if the action merely played a nonessential contributing role in producing the event. If the visiting team wound up winning 5 to 2 rather than 1 to 0, one would be surprised to read in the sports page that the victory resulted from the leadoff batter's early, non-dispositive home run."

Id. at 888 (emphasis added in original).

Following these extrapolations on the definition of "but-for" causation, the Court addressed the government's argument that such causation should be dispensed with for drug overdose cases because nearly half of drug overdoses are the result of mixed-drug intoxication. Specifically, the Court described the government's argument as requesting "an interpretation of 'results from' under which use of a drug distributed by the defendant need not be a but-for cause of death, nor even independently sufficient to cause death, so long as it contributes to an aggregate force (such as mixed-drug intoxication) that is itself a but-for cause of death." *Id.* at 890.

The Court then addressed two prongs of this argument. The first prong asked the Court to require only that the target drug, i.e., heroin, was the "independently sufficient cause of death." However, the

Court “need not accept or reject” this argument because “no expert was prepared to say that [the decedent] would have died from the heroin use alone.” *Id.* at 890. The second prong of the argument asked the Court to require only that the targeted drug was a “substantial” or “contributing factor” in producing the death. The Court declined to adopt this “permissive interpretation” of “results from.” The Court declined to adopt the “substantial” or “contributing factor” standard, stating that it was a “permissive interpretation” of “results from.” *Id.* at 891. The Court further explained that if Congress intended to require only a “substantial” or “contributing factor” causation standard it would be clear. *Id.* (“The language Congress enacted requires death to ‘result from’ use of the unlawfully distributed drug, not from a combination of factors to which drug use merely contributed.”). *Id.*

In the end, because the government had conceded that there was “no evidence that [the decedent] would have lived but for his heroin use,” the Court reversed the “death-results” conviction. *Id.* at 892.

III. Analysis of Courts of Appeals Cases after *Burrage*.

A. *United States v. Ford*, 750 F.3d 952 (8th Cir. 2014).

In *Ford*, the defendant was convicted of, among other offenses, “knowingly and intentionally distributing a mixture of heroin to [the decedent] resulting in [the decedent’s] death.” *United States v. Ford*, 750 F.3d 952, 953 (8th Cir. 2014). Reviewing the expert testimony in light of *Burrage*, the *Ford* Court reversed *Ford*’s death results conviction for failure to prove that heroin was the “but-for” cause of the decedent’s death.

The government’s medical examiner testified at trial that “the cause of death was ‘polydrug toxicity, with methamphetamine [not distributed by *Ford*] being the major contributing drug.’” *Id.* at 955. The medical examiner said she was “confident that the cause of death was the combination of multiple drugs.” *Id.* She explained, “I don’t think I took into account the fact that morphine [a derivative of the heroin], a benzodiazepine, which is alprazolam, and alcohol combined are a very lethal combination.” *Id.* Upon further research, she felt that the most significant drugs contributing to the decedent’s death were methamphetamine, morphine, alcohol, and Xanax. *Id.* The medical examiner stated, “[I]n doing more research, I think the combination of those other [three] drugs is a much more common cause of death in a multidrug toxicity than methamphetamine is.” *Id.* When asked whether “[her] opinion [was] that the morphine found in [decedent’s] system was a contributing factor to the death,” she replied, “A contributing factor, yes.” *Id.* On cross-examination, the medical examiner acknowledged that she could not say whether the decedent would have died without the heroin in his system. *Id.* Furthermore, the government’s forensic toxicologist “concluded that heroin could have been the source of the morphine in [the decedent’s] blood and that a combination of the drugs found in [the decedent’s] system contributed to [the decedent’s] death.” *Id.* Finally, the defense pathologist testified that “methamphetamine was the major cause of death and that the presence of the combination of morphine, codeine, Xanax, ethanol, and citalopram could also have contributed to [the decedent’s] death.” *Id.*

Based upon this evidence, the court concluded that the government proved only that the decedent “died as a result of the ingestion of multiple narcotics, including heroin distributed to him by *Ford*.” *Id.* In other words, the court elaborated, the Government “proved only that the heroin was a contributing factor to [the decedent’s] death, not that heroin was a “but-for” cause of [the decedent’s] death.” *Id.*

Ford demonstrates the significance of particular terms used by experts including “polydrug toxicity,” “combination,” and “contributing factor.” *Ford* also illustrates the need to focus the inquiry on whether, in the absence of the target drug, the decedent would have lived despite the presence of the other

non-targeted drugs. In *Ford*, neither government expert could testify that absent the morphine (heroin), the decedent would have lived despite the presence of the other drugs.

B. *United States v. Alvarado*, 816 F.3d 242 (4th Cir. 2016).

The jury convicted Alvarado of distributing heroin resulting in death. On appeal, he claimed that the district court erred “in failing to clarify for the jury that the results-in-death element meant that the jury could not convict him of the charged offense if heroin was only a contributing cause of the death.” *United States v. Alvarado*, 816 F.3d 242, 244 (4th Cir. 2016). The court concluded that, “because there was no evidence in the record that [the decedent] could have died without the heroin, the jury’s verdict was necessarily consistent with the Supreme Court’s requirement of but-for causation.” *Id.*

The forensic toxicologist testified at trial that the decedent had a “high concentration” of morphine (the metabolized form of heroin), a “therapeutic level” of Xanax, and an amount of Benadryl that was “below the associated toxic level.” *Id.* at 246. The toxicologist acknowledged that Benadryl could “aggravate” the effects of heroin and that the combination of heroin, Benadryl, and Xanax could have “synergistic effects.” *Id.* However, the toxicologist did not give an opinion on the role that each of the drugs played in the death. *Id.*

The medical examiner testified at trial that the death was caused by “heroin intoxication.” *Id.* The medical examiner acknowledged the presence of Xanax and Benadryl, but testified that neither drug “contributed to” the death. *Id.* The medical examiner explained that “without the heroin, [the decedent] doesn’t die.” *Id.*

After closing arguments, the district court instructed the jury:

“If you find the government has proved beyond a reasonable doubt that the defendant knowingly or intentionally distributed a mixture or substance containing a detectable amount of heroin on or about March 29, 2011, you must then determine whether the government has proved beyond a reasonable doubt that death resulted from the use of such substance.”

Id. at 246.

During deliberations, the jury sent the district court two questions on the “death-results” element, specifically asking whether evidence of contribution was sufficient. On both occasions, with agreement of counsel, the district court declined to define the requirement further. *Id.* at 246-47. The jury convicted the defendant, finding that the “death-results” element was satisfied. *Id.* at 247.

The court held that the district court did not abuse its discretion in declining to give a further clarifying instruction. As an initial matter, the court summarized the *Burrage* holding as follows:

“The *Burrage* Court held that “results from” in § 841(b)(1)(C) invokes the “ordinary, accepted meaning” of the phrase. And the ordinary meaning of “results from” is but-for causation— i.e., that death would not have occurred in the absence of heroin. Or, as the Court explained, a drug qualifies as a but-for cause of death “if, so to speak, it was the straw that broke the camel’s back.” Thus, a drug that plays a “nonessential contributing role” does not suffice to apply the § 841(b)(1)(C) penalty enhancement. The Court further noted that “results from” was employed in § 841(b)(1)(C) in a way similar to other phrases of but-for causation, such as “because of,” “based on,” and “by reason of.” *Id.* at 248 (internal citations omitted).”

In applying *Burrage*, the court found that “[t]here was no evidence in this case that would allow a jury to find that heroin was a nonessential contributing cause of [the] death.” *Id.* The court noted that the expert testimony had been that neither of the other drugs contributed to the death and that without the heroin, the decedent would not have died. *Id.* Moreover, the court continued, “no party suggested that, even without the heroin, [the decedent] would have died.” *Id.* at 249. Accordingly, the court held that the district court did not abuse its discretion but noted that if the case had involved a decedent who had “ingested heroin but might have died nonetheless from the effects of other substances,” and thus was a more “ambiguous” case, a court may be required to provide a clarifying instruction. *Id.*

Alvarado appears to teach that where a decedent has a high concentration level of the unlawfully distributed drug but only a therapeutic level of other drugs, the *Burrage* standard will be satisfied without complication.

IV. Analysis of District Court Cases after *Burrage*.

A. *United States v. MacKay*, 20 F. Supp. 3d 1287 (D. Utah 2014).

Mackay, having been convicted of two resulting-in-death charges, one for oxycodone and the other for hydrocodone, was before the district court for resentencing because the appellate court had sought clarification on a sentencing issue. *United States v. MacKay*, 20 F. Supp.3d 1287,1292 (D. Utah 2014). Applying *Burrage*, which had been issued after the remand, the district court vacated the resulting in death convictions for insufficiency of evidence because multiple medical examiners testified that the decedent had died from a “combination” of oxycodone and hydrocodone. *Id.* at 1295.

The medical examiner listed the cause of death as “drug poisoning due to a combination of hydrocodone and oxycodone, and pneumonia as a complication of the drug poisoning.” *Id.* at 1291. The evidence also indicated that “the concentrations of each drug were ‘below the concentration range that has been reported to cause death when it is the only drug present.’” *Id.* At trial, the medical examiner testified that the victim “died as a result of combined effects of drug toxicities, specifically with oxycodone and diazepam (Valium) as well as bronchopneumonia.” *Id.* (internal citation omitted). The medical examiner also testified that “the level of hydrocodone was ‘above expected therapeutic and just below the lower limit of what is considered potentially toxic’ and that the level of oxycodone was in the ‘high therapeutic range.’” *Id.* (internal citation omitted).

A forensic toxicologist testified that “the hydrocodone and oxycodone were the drugs that resulted in his death.” *Id.* The toxicologist explained, “And I would also list out the Valium, the diazepam, as contributing, as well as the Soma, which is listed on this report as carisoprodol. That would add as well into the central nervous system depression, but none of this would have occurred without the oxycodone and hydrocodone.” *Id.* at 1291-92.

Ultimately, the court found “[n]ot one of the four medical experts testified that either the oxycodone or hydrocodone, acting alone, was a but-for cause of [the decedent’s] death.” *Id.* at 1295. In so finding, the court focused on the medical examiner’s use of the word “combination” in reference to the different drugs that caused the death. *Id.*

As an initial matter, *MacKay* illustrates the significance to a reviewing court of an expert’s use of the term “combination” in a cause of death finding. In fact, the *MacKay* court appears to treat such use as insurmountable and conclusive. This treatment ignores the fact that *Burrage* teaches that the “but-for” causation requirement may be met by a combination of the target drug and a non-target drug, as long as without the incremental effect of the target drug, the decedent would have lived. *Burrage*, 134 S. Ct. at

888 (“Thus, if poison is administered to a man debilitated by multiple diseases, it is a but-for cause of his death even if those diseases played a part in his demise, so long as, without the incremental effect of the poison, he would have lived.”).

The *MacKay* court turned its focus to the target drug and asked whether it “acting alone” was a but-for cause of the death. *Burrage*, however, teaches us the opposite when there is a “combination” of drugs. A reviewing court should focus on the non-target drug and ask whether it, acting alone, would have caused the death. *See id.* (“The same conclusion follows if the predicate act combines with other factors to produce the result, so long as the other factors alone would not have done so—if, so to speak, it was the straw that broke the camel’s back.”). Of course, the target drug must still be at a level sufficiently high to cause death, but it does not need to have acted alone to cause death. If the target drug acted alone to cause the death it would be an “independently sufficient cause of death,” and no but-for causation would be required. *See id.* at 892 (“[A]t least where use of the drug distributed by the defendant is not an independently sufficient cause of the victim’s death or serious bodily injury, a defendant cannot be liable under the penalty enhancement provision of 21 U.S.C. § 841(b)(1)(C) unless such use is a but-for cause of the death or injury.”) (emphasis added).

B. *United States v. Thomas*, No. 7:10CR00016, 2016 WL 1070868 (W.D. Va. Mar. 16, 2016).

In this habeas case, Thomas collaterally attacked his conviction for distributing fentanyl resulting in death, relying upon *Burrage*, which was decided after his trial. *United States v. Thomas*, No. 7:10CR00016, 2016 WL 1070868 at *1 (W.D. Va. Mar. 16, 2016). The district court rejected the challenge, concluding that “Thomas’s trial comport[ed] with the more stringent burden-of-proof standard enunciated in *Burrage*.” *Id.* at *3.

At trial, a medical examiner testified that the decedent had died from acute combined fentanyl and methadone poisoning. *Id.* at *1. The medical examiner explained that the amount of methadone in the decedent’s body was small and that the decedent “had a clearly lethal level” of fentanyl. *Id.* The medical examiner elaborated that the level of methadone would not have been lethal without the fentanyl. *Id.* However, because the two drugs have similar effects on the body, the medical examiner could not discount the methadone as “potentially making the situation worse.” *Id.* In addition, a forensic toxicologist testified that the level of fentanyl found in the decedent’s system was “clearly fatal.” *Id.*

On the resulting-in-death charge, the district court instructed the jury that the Government was required to prove that “‘the use of the fentanyl resulted in the death of another,’ without additional explanation.” *Id.* at *2. For the resulting-in-serious-bodily-injury charge, the district court instructed the jury that the government was required to prove that the serious bodily injury “resulted from” the use of the fentanyl. *Id.* (defining “‘resulted from’ as ‘the victim would not have suffered the serious bodily injury but for (had it not been for) the fentanyl. In other words, if the fentanyl was not used by the victim, the victim would not have suffered the serious bodily injury’”).

The jury convicted Thomas on all counts, including the resulting-in-serious-bodily-injury charge and resulting-in-death charge. *Id.* The Fourth Circuit Court of Appeals reversed the resulting-in-serious-bodily-injury conviction, remanding it for lack of evidence. *Id.* at *2 (referencing *United States v. Thomas*, 489 Fed.App’x 688 (4th Cir. 2012)). The Fourth Circuit affirmed the resulting-in-death conviction. *Id.*

In rejecting the collateral attack, the district court explained that the evidence at trial would have satisfied the *Burrage* standard.

Every medical professional who testified at trial concluded that the level of fentanyl found in [the decedent's] body was fatal.

The . . . medical examiner testified both on direct and cross examination that [the decedent] would have died from the fentanyl even without the methadone. Moreover, she described the level of methadone as “just enough . . . for them to tell that it was there, but not actually enough for them to measure it.” She said that she included the methadone as a contributing factor because it has a similar effect to fentanyl and so might have “potentially ma[de] the situation worse.” Nonetheless, she stated unequivocally . . . that the fentanyl without the methadone would have caused [the decedent] to die.

A forensic toxicologist also testified at trial that the amount of fentanyl in [the decedent's] system was “clearly fatal” as death often results from levels less than half as high as those found in [the decedent]. *Id.* at *4.

Finally, the district court found dispositive of the “but-for” causation issue that “the level of fentanyl in [the decedent's] system was so high and the level of methadone so low.” *Id.* at *5.

Thomas reinforces that where a decedent had a lethal concentration level of the unlawfully distributed drug and a low level of another drug, the *Burrage* standard will be easily satisfied. Importantly, *Thomas* correctly reached this holding despite the medical examiner's opinion that the non-targeted drug could have “potentially ma[de] the situation worse.” *Id.* at *1 (internal quotations omitted).

V. Practical Takeaways

A. Expert's Use of Term “Combined Intoxication.”

Burrage and the subsequent cases illustrate the increasing need for specificity when identifying the cause of death, such as “mixed-intoxication,” “combined intoxication,” and “contributing cause.” Moving forward, the prosecutor should clarify for jurors through direct examination and cross-examination the ambiguous terms used either by expert witnesses or in evidence. As illustrated by the *Mackay* decision, a court could be led astray by the term and ultimately misapply *Burrage*, i.e., by finding that the target drug could not have been the “but-for” cause of the death because the term “combined” implies that the target drug had to “combine” with the non-target drug to cause the death. If necessary to identify more than one drug in the cause of death determination, it would be advisable to use the term “mixed-intoxication” in lieu of “combined intoxication.” This term softens the causation implication while maintaining the integrity of the medical opinion, and presents a more workable transition to proving but-for causation.

B. Expert's Need to Articulate “But-For” Causation.

Rarely will a medical examiner include a “but-for” causation opinion in an autopsy report, but [Rule 16\(a\)\(1\)\(G\) of the Federal Rules of Criminal Procedure](#) requires the government to give the defendant a written summary of any expert testimony it intends to use during its case-in-chief at trial. Equally rarely will a medical examiner agree to amend or supplement their autopsy report to include a “but-for” causation opinion, instead opting to provide the opinion orally. Once received, it is advisable to summarize the opinion in a letter, have the medical examiner review and approve the summary, and then send the letter to defense counsel. As previously emphasized, these opinions should state that the non-target drug(s) could not have caused the death alone and that the death would not have occurred in the absence of the target drug. Below are examples from the Northern District of West Virginia:

- But for the heroin, the decedent would not have died. The primary basis of this opinion is the toxicology report. Specifically, [the medical examiner] reasoned that the other drugs, alprazolam and diazepam, were at such low concentrations that those drugs could not have caused the death alone, and thus that the death would not have occurred in the absence of the heroin.
- But for the heroin, the decedent would not have died. The primary basis of this opinion is the toxicology report. Specifically, [the medical examiner] reasoned that alcohol was not at such a high level as to have caused the death alone, and thus that the death would not have occurred in the absence of the heroin.

C. The Effect of Evidence Collection on Expert’s Opinion

While an expert’s opinion is based primarily on science, the importance of fact evidence on their opinion, and the jury’s acceptance of the opinion, cannot be overstated. For example, in a case involving an unlawful distribution of heroin resulting in death, assume that the cause of death opinion is “combined heroin and oxycodone intoxication.” Assume the investigation discovers the following fact evidence. The decedent had ingested the oxycodone a few hours before the heroin. The decedent was found in a bathroom. The scene indicates that the decedent had immediately collapsed upon taking the heroin, i.e. (1) the decedent is found face-down on the floor; (2) the decedent’s glasses are broken; (3) there are signs of trauma to decedent’s nose and mouth, including coagulated blood; (4) the needle used to administer the heroin is found in close proximity to the decedent, or even still penetrated to the arm of the decedent; and (5) other indicia of heroin use in close proximity to the decedent, including a spoon, an ignition source, and an empty “straw pack” in which the heroin had been packaged. These are facts which a jury could rely on, in conjunction with the medical examiner’s opinion, to find that the heroin was the but-for cause of the death because these facts clearly establish, in a layman’s sense, that despite the oxycodone, the heroin was the “straw that broke the camel’s back.” *Burrage*, 134 S. Ct. at 888.

VI. Conclusion

The ability to hold offenders accountable when the drugs they deal lead to the death of another remains a viable option. Armed with a comprehensive working knowledge of the *Burrage* standard and an adequate preparedness for the issues it presents, federal prosecutors can and should continue to pursue these cases when appropriate.

ABOUT THE AUTHOR

□ **William J. Ihlenfeld II** was sworn in as the United States Attorney for the Northern District of West Virginia in August of 2010. Ihlenfeld served for 13 years as a state prosecutor before assuming his current position. He represents the Department of Justice in the federal government’s inter-agency effort to reduce the availability of heroin in the United States, and on the Global Advisory Committee as the Attorney General’s representative in the oversight of interjurisdictional and multidisciplinary justice information sharing. Ihlenfeld serves as the Vice-Chairman of the Appalachia HIDTA Executive Board, as a member of the Washington/Baltimore HIDTA Executive Board, and as a member of the Controlled Substance/Asset Forfeiture Subcommittee of the Attorney General’s Advisory Committee.

Assistant United States Attorney Jarod J. Douglas and West Virginia University College of Law student Frances M. Lazell assisted with the article.

NDOH Reaches Out to Non-traditional Audiences to Warn of the Dangers of Opioids

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I. Introduction

Standing in front of a jury can be intimidating to even some seasoned Assistant U.S. Attorneys, but it might be easier than talking to 300 gruff construction workers about how abusing prescription painkillers can put them on the road to heroin addiction. Still, talking in union halls—as well as schools, community centers, and hospitals—is how Carole S. Rendon, U.S. Attorney for the Northern District of Ohio (OHN), and her colleagues have spent several nights and weekends over the past few years, as Ohio, like many parts of the country, has struggled with the opioid epidemic. U.S. Attorney Rendon often points out that in some ways these meetings are the most important thing the U.S. Attorney’s Office (USAO) can do to combat the heroin and opioid epidemic. In these talks, USA Rendon promises to continue to vigorously prosecute drug dealers, but if the USAO could put itself out of the drug business by eliminating demand, that would go a long way toward saving lives in Ohio.

II. Northern District of Ohio Efforts

Ohio ranks second in the nation in the number of overdose deaths, according to a recent report from the Centers for Disease Control. Heroin death rates have more than tripled in the past four years, the report says, while overdose death rates for synthetic opioids, such as fentanyl, increased by 80 percent since 2014. [Rose A. Rudd, et al. *Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014*, 64 MORBIDITY AND MORTALITY WKLY. REP. 1378–1382 \(2016\)](#). Rendon and other lawyers convened meetings in 2013 in response to the staggering death toll. The meetings included police, prosecutors and federal agents, but also included doctors, treatment professionals, educators, and people in recovery, among others.

The group developed a community action plan that focused on four facets—law enforcement, healthcare policy, treatment, and education/prevention. Members of what came to be known as the U.S. Attorney’s Task Force on Heroin and Opioids agreed that keeping people from experimenting with the drugs in the first place was crucial, and special emphasis should be placed on education and prevention.

Since then, members of the Task Force have given more than 80 talks and reached nearly 50,000 people. Many of these talks include speaking to parents and students at area schools, and town hall-style meetings at city halls and recreation centers.

However, members of the Task Force wanted to reach non-traditional audiences as well, in part because the people dying in Northeast Ohio range from their 20s to their 60s. Members reached out to leaders of the area unions, particularly the building trades unions, like laborers, plumbers, painters and electricians, where the members work with their bodies all day, every day.

“If these guys are hurt, they’re not working, so they tend to self-medicate,” said Joseph M. Pinjuh, who runs the OHN office’s OCDETF unit and is a frequent presenter at these talks. “We tell them if you’re using Oxycontin or Percocet without a prescription, you can be the next guy using heroin. Everyone in the room knows somebody affected by this.”

Another group targeted for talks are doctors. Working with Greater Cleveland’s three largest hospital systems, prosecutors teamed with judges, police officers, and other physicians to discuss with doctors the dangers associated with prescribing too many painkillers and prescribing them too freely. Doctors were challenged about the necessity of writing prescriptions for 60 Vicodin, for example, when maybe only five or six pills are necessary to adequately address the patient’s pain issues.

Vince Caraffi, who works for the Cuyahoga County Board of Health and is a member of the Task Force, said there was initial resistance from doctors, some of whom perceived the talks as being told how to do their jobs by non-physicians. “But everyone can use a little more education,” Caraffi said. “It’s helpful to get in front of them and at least plant the seed so they think about it the next time they’re writing a script.” The appeal to doctors appears to be working, at least in some small way. The number of opioid pills prescribed in Ohio decreased slightly in 2015, after nearly two decades of dramatic increases.

Cuyahoga County Common Pleas Judge Michael Astrab began organizing community meetings in schools and city halls in 2013. He was moved to do so after noticing the increase in deaths in his community, as well as the fact that so many cases before him—whether they involved robberies, car thefts, prostitution, or shoplifting, or other crimes—could be traced to heroin addiction. Judge Astrab, an active member of the U.S. Attorney’s Task Force, said those early efforts at outreach were met with mixed reaction. Some communities welcomed him, while others denied there was a problem. “We were seeing all these people die, but I’d hear ‘that’s not really happening here,’” he said. “They had no clue that it was happening all around them, they had to be educated, not just about the drug but the pipeline from pills to heroin.”

USA Rendon receives an e-mail alert on her phone whenever someone dies from an opioid overdose in Greater Cleveland. This year they are on pace for nearly 500 deaths just in Cuyahoga County, one of the 40 counties that make up NDOH. It is a grim reminder of the urgency of the mission and the importance of educating all segments of the community.

III. Conclusion

“We talk all the time about the need for an ‘all of the above’ approach that includes law enforcement, but changing the way pain pills are prescribed, as well as more treatment and more efforts focused on prevention,” impacts the problem. Rendon said. “There’s no one way to turn the tide on this epidemic. We need everyone working together around the clock to save our community.”

About the Author

□ **Mike Tobin** serves as Community and Public Affairs Specialist for the U.S. Attorney’s Office for the Northern District of Ohio. He coordinates community outreach efforts for the office, including work forming the U.S. Attorney’s Heroin and Opioid Task Force and on the Justice Department investigation into the Cleveland Division of Police. He also oversees media relations for the office, including the largest public corruption investigation in Ohio history, in which 60 people have been convicted of crimes, including two judges, a county commissioner and a county auditor.

DEA's 360 Strategy: Attacking the Opioid Crisis on Three Fronts

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I. Introduction

The United States is in the grip of a national crisis—an unprecedented surge in the misuse of opioid prescription drugs and heroin. Today, drug overdoses are the leading cause of injury-related deaths in the United States, eclipsing deaths from motor vehicle crashes or firearms. There were more than 47,000 overdose deaths in 2014, or approximately 129 per day, more than half (61 percent) of which involved either a prescription opioid or heroin. Those numbers are on the rise and are further complicated by increased availability and abuse of fentanyl, a synthetic opioid that is 50 times more powerful than heroin.

In response to this opioid crisis, the Drug Enforcement Administration (DEA) developed and deployed the 360 Strategy, which takes an innovative three-pronged approach to combating the epidemic through: (1) coordinated **Law Enforcement** actions against drug cartels and traffickers in specific communities; (2) **Diversions Control** actions against DEA registrants operating outside the law, and long-term engagement with pharmaceutical drug manufacturers, wholesalers, pharmacies, and practitioners; and (3) **Community Outreach** through local partnerships that empower communities to take back affected neighborhoods after enforcement actions to prevent the same problems from cropping up again.

DEA initially rolled its 360 Strategy out in November 2015 in Pittsburgh (together with the U.S. Attorney and state and local partners). Since that time, DEA has deployed the strategy in other pilot cities, including St. Louis, Missouri, and Milwaukee, Wisconsin. Four more cities will be announced in the upcoming months. The pilot program allows DEA to use its limited resources to focus our efforts and identify best practices for other cities. In the meantime, the three-pronged strategy is being used in all DEA Field Divisions across the United States.

II. Law Enforcement: Targeting and Stopping the Most Significant Drug Trafficking Threats

The 360 Strategy's enforcement component has several facets, all focused on the roots of the drug trafficking problems plaguing our communities. Through our collective law enforcement experience, the DEA team knows that drug problems are often unique to the communities we serve—the strategies that work in one particular area may not work in another. With that in mind, the leaders within DEA's Field Divisions are working closely with their state and local counterparts to identify major drug trafficking threats and develop unique enforcement strategies to effectively combat those problems. Those strategies include targeting and prosecuting the most significant drug traffickers and taking advantage of enhanced penalties provided by law for dealers linked to drug overdoses.

In addition to the community-based enforcement approach, the 360 Strategy relies heavily on Project Rolling Thunder, an enforcement initiative that uses investigative techniques to target the link between the cartels and the drug trafficking networks operating within the United States, which often are made up of violent street gangs. This approach allows investigators to effectively identify the full spectrum of the criminal network, including the street-level drug dealer, the distribution sources of supply, and the highest levels of cartel leadership.

The foundation of DEA's 360 enforcement operations is built on close working relationships with our federal, state, and local partners. In all major offices across the United States, DEA has established task forces made up of federal, state, and local law enforcement officers who work alongside DEA Special Agents to identify and target the most significant drug trafficking threats. Together, these partners continue to devise and implement investigation strategies to address the drug problems facing our communities.

III. Diversion Control: Enlisting DEA's Registrant Population in the Fight Against Opioid Abuse

The nonmedical use of prescription opioids is a strong risk factor for heroin use, with 80 percent of new abusers starting their opioid addiction by misusing controlled prescription drugs (CPDs). DEA has regulatory authority over 1.6 million registrants involved in manufacturing, distributing, prescribing, and dispensing CPDs. The agency is actively working to engage the registrant community and enlist their help in the fight against opioid abuse and addiction.

DEA's Diversion Control efforts are geared toward preventing the non-medical use of CPDs by providing education and training within the pharmaceutical and medical communities and pursuing those practitioners who are operating outside of reasonable medical standards. DEA is actively engaging with industry, practitioners, and government health organizations to facilitate an honest and frank discussion about the prescription drug misuse fueling the opioid crisis.

The majority of misused prescription drugs are obtained from family and friends, including from the home medicine cabinet. To address this problem, DEA coordinates nationwide prescription drug take-back days to collect unwanted, unneeded, or expired prescription drugs. DEA's 11th National Take Back event was held on April 30, 2016. Through state and local partnerships across the country, it resulted in collection of more than 447 tons of prescription drugs from more than 5,300 locations. The next National Take Back is scheduled for October 22, 2016.

DEA also remains vigilant in identifying and pursuing doctors and other registrants operating outside of the law. This process is enhanced locally through the use of tactical diversion squads, which can mobilize to address regional or local issues. It is also enhanced by additional diversion investigators.

IV. Community Outreach: Leaving Something Lasting and Positive in the Communities We Serve

After an enforcement operation targets drug trafficking criminals, there's an opportunity for a prepared community to prevent the same problems from cropping up again. A key component of the 360 Strategy is the community outreach effort, which is designed to maximize all available resources to help communities prevent recurring drug and violent crime problems from resurfacing after enforcement operations.

Enlisting community support and leadership to tackle the crisis, the Community Outreach portion of 360 strives to develop and strengthen partnerships outside of traditional law enforcement circles. Using DEA, the United States Attorney, and other law enforcement partners' leadership, the strategy aims to get all of the key partners around the table, including community groups, public health officials, treatment and medical experts, national organizations, and others. Through these discussions and the establishment of new coalitions, communities are empowered to use all available resources and work on solutions that create long-term success in tackling the opioid crisis.

The 360 Strategy's Community Outreach portion also fosters a more comprehensive strategic approach to preventing drug use within a particular community. A key part of that effort is building a public education and marketing campaign aimed at changing perceptions and attitudes within its target audiences. DEA identified the primary target audience with the most impressionable of minds as our youth and their circle of influence—parents, caregivers, and educators. With those target groups (and others) in mind, the 360 Strategy uses a comprehensive communication approach with aggressive public messaging through mass media, television, radio, and social media outlets, coupled with a grassroots movement within each community, to empower our citizens to take back their neighborhoods and create a safer place for their children.

These efforts involve a vigorous campaign designed to promote knowledge and awareness about the opioid threat. One of the best approaches on that front is to get the message out to youth in schools and their surrounding communities. To enhance those outreach efforts, DEA offices are using their strongest assets to spread the word—our Special Agents and Task Force Officers (TFOs) who work in these communities and understand the problems they are facing. Along with those efforts, DEA and its partners are continuing to develop outreach materials to help anyone who wants to pitch in on the effort to effectively and accurately deliver the message.

The following are a few examples illustrating various 360 community strategies being used to empower coalitions and increase awareness of the opioid threat:

1. Law Enforcement's Active Engagement with Families Who Have Lost Loved Ones

In January 2016, the DEA office in St. Louis held a press rally to announce the arrival of the 360 Strategy in the area. The next day, the Public Information Officer, Special Agent Karen Caito, was flooded with calls from the media and community groups throughout the St. Louis area, asking how they could get involved in the strategy.

One e-mail that particularly stuck out to Agent Caito was from a parent who heard about the 360 Strategy on the news. In his e-mail, Ellis Fitzwalter explained that he and his wife, Patti, lost their son, Michael, to a heroin overdose two years ago. The couple wanted to know what they could do to help make sure that other families did not have to go through the loss and pain that they live with every day.

Agent Caito and her partner, DEA TFO Juan Wilson, scheduled a meeting with the Fitzwalters to find out more about what happened to their son and to help them get involved in the 360 movement.

Agent Caito and TFO Wilson met Ellis and Patti at their house and spoke with them for two hours. They learned that Michael had the unfortunate timing of overdosing on heroin during the same week as the Ferguson riots. Due to this unusual circumstance, Ellis and Patti were not able to get answers to their questions, including how someone who just went through rehab could die from one dose of heroin. TFO Wilson and Agent Caito talked with the couple about addiction and the progression from using prescription drugs to heroin, providing them with answers that had eluded them in the past. The law enforcement officers also explained how the 360 Strategy would help get the couple involved in community efforts with active groups in the St. Louis area, such as the National Council on Alcoholism and Drug Abuse.

Since that first meeting, the Fitzwalters are actively engaged in the effort and work with several community coalitions on the opioid epidemic. For example, when the Partnership for Drug-Free Kids came to St. Louis to meet with general managers and news directors of the local media, they invited Ellis along so that he could tell his personal story of loss. Also, on May 26, 2016, Ellis and Patti held the first “Walking for Wellness—Stop Heroin” walk in Ferguson, Missouri. Impressively, this event was supported by more than 75 people. Although the weather forecast predicted severe thunderstorms, the event’s participants were pleasantly greeted with a nice bright sky for the community event. Participants included Ferguson’s mayor, members of the Ferguson Police Department, Ferguson residents, and several parents who had lost a loved one to prescription drug or heroin overdose. During his opening remarks at the event, Ellis thanked the DEA for answering his e-mail and taking the time to explain the issues around heroin. The St. Louis community, in turn, is fortunate to have members such as the Fitzwalters who are willing to step up, raise awareness, and help save lives.

2. Using Law Enforcement Leadership to Engage the Community

Prior to publicly launching the 360 Strategy in Pittsburgh, Pennsylvania, the 360 partners held a coalition meeting in downtown Pittsburgh at the U.S. Attorney’s Office. Attendees included law enforcement leaders, public health experts, community leaders, family members who had lost loved ones to overdoses, and several others. The United States Attorney and DEA leadership explained the strategy and issued a “call to action” for everyone in attendance to join forces and work together on the crisis, and to build on strong coalitions and efforts that had already been established by leaders in the community. After the presentation, a mother who had lost her son to an overdose came to the front and with tears in her eyes, asked to hug all of the presenters to thank them for taking on the challenges ahead. The same level of devotion and appreciation came from others in attendance—everyone was anxious to continue the fight against a crisis that had taken so many lives from the community.

Since that time, the 360 effort has continued in the Pittsburgh area. The program was publicly launched in November 2015, at UPMC Passavant Hospital. The launch involved a candlelight vigil orchestrated by the Bridges to Hope parent organization, which commemorated the lives of overdose victims. The education outreach efforts have continued in Pittsburgh, and include deploying a training module designed by the Partnership for Drug-Free Kids to train officers from Pittsburgh Bureau of Police, Allegheny County Sheriff’s Office, Allegheny County Police, and smaller law enforcement departments in the region. Those officers, in turn, have since been using the presentation at local community outreach events at local high schools and middle schools.

3. Using Community Summits to Strengthen Partnerships and Keep the Momentum Going

Within months of first starting the 360 program in a community, DEA uses Community Summits to bring all of the partners together in one venue to discuss where they are on the crisis and the next steps they need to take. For example, the strategy officially kicked off in Milwaukee in February 2016. Since that time, DEA, the U.S. Attorney's Office, and other key law enforcement, public health, and community leaders have been coordinating their efforts on the crisis. On June 15, 2016, DEA hosted the 360 Community Summit in Milwaukee, and brought key partners and others to the table. In total, over 250 leaders from different local, state, and federal organizations attended the meeting to discuss continued joint efforts under the program to address the opioid epidemic.

Those in attendance included the Wisconsin Medical Society, Safe and Sound Coalition, Milwaukee Women's Center, Milwaukee Public Schools, Hopewell Missionary Baptist Church, and more than 100 other organizations from across the prevention, treatment, recovery, and law enforcement fields. The group engaged in strategy development for continuing to address the drug use, abuse, and trafficking problems in their region, and refined the community-based efforts to keep the momentum going forward.

4. Public Screening of Chasing the Dragon

In February 2016, the DEA office in St. Louis, along with the local FBI office, organized a special theater screening of the [CHASING THE DRAGON](#) movie (Fed. Bureau of Investigation, 2016) for school superintendents, principals, and educators from both public and private schools in the greater St. Louis area, as well as members from several local coalitions. These coalitions included prevention and treatment organizations, the Public Health Department, and a group of parents who have lost a child to heroin. The movie, named for the slang term referring to heroin use, provides a sobering account of the effects of prescription opioid and heroin abuse and how these drugs can destroy families and lives.

Over 70 people attended the screening. Afterwards, the enforcement partners held a panel discussion including DEA and FBI representatives, a recovering heroin addict, a mother who lost a daughter to heroin, and an epidemiologist from the Department of Health. The panel provided details about the actual impacts of opioid abuse on the St. Louis community and answered several questions from the audience. Three local television stations also attended the event and provided coverage about the community-based approach. Law enforcement and community leaders in St. Louis and other cities across the United States are continuing to distribute copies of the movie and host screening events as part of the DEA 360 public awareness campaign.

5. Law Enforcement Officers Speaking in Schools

Like many law enforcement officers across the country, DEA St. Louis TFO Juan Wilson speaks often at schools in the region about the opioid threat. One of his target schools, Hope High School in O'Fallon, Missouri, is viewed as a "last chance opportunity" for struggling students in the school district before they are expelled. Over the course of several months, TFO Wilson visited Hope High School on numerous occasions as part of the 360 strategy. He did not know the impact his message would have on the students.

After one of his recent visits, TFO Wilson had the opportunity to meet with several of the students and their parents in an open and candid conversation. During that discussion, he heard firsthand how the opioid threat impacted these families. Whether it was a best friend, family member, or some other loved one, everyone had been touched by the epidemic and wanted to discuss resolutions and hope. After the meeting, one of the school counselors approached TFO Wilson and handed him a manila envelope and told him that some of the students from the last presentation had written him some notes. The note that affected TFO Wilson the most was one that simply said "Stay strong! Never give up

on us. We need more of this.” TFO Wilson, along with other DEA Special Agents and TFOs across the country, are continuing to carry the message to our schools and other places where people need to learn about the dangers of the epidemic and what we can do about it.

6. DEA and Discovery Education: Nationwide Prevention Education

As part of the effort to bring the DEA 360 Strategy to all DEA offices across the country, DEA recently signed an agreement with Discovery Education, a division of Discovery Communications, to develop and distribute a prescription opioid and heroin education curriculum to middle and high school students, their teachers, and parents nationwide. DEA and Discovery Education will roll out the program nationwide during the Fall 2016 school semester. Our goal is to provide communities with a multi-platform prevention initiative designed to educate students about the true impacts of prescription opioids and heroin, and to kick-start lifesaving conversations in the home and classroom. This program will run for three consecutive school years up through Spring 2019, and will be available free of charge for all law enforcement, prevention, treatment, and community groups to use and distribute.

V. Conclusion

These are just a few examples of the ongoing 360 Strategy efforts in our communities. Through this process, the DEA team learned the importance of working with all available partners, including community members, to identify the unique drug problems facing each city and to devise targeted strategies to address those challenges. As the 360 Strategy continues to grow, we will learn more about the effectiveness of these efforts and how to refine our strategies. By using that knowledge and leveraging all of our partnerships across the United States, we will take back our communities and turn the tide on the opioid crisis.

ABOUT THE AUTHOR

□ **Mike Gill** is Chief of Staff for the Drug Enforcement Administration. Mike is originally from the Texas Panhandle, where he grew up on his family’s cattle ranch in Miami, Texas—a town of 600. He graduated from Texas Christian University with degrees in political science and Spanish and earned his law degree at the University of Virginia. From 2000 up through 2015, Mike served as a federal prosecutor in both the Eastern District of Virginia and the Northern District of Texas. As an AUSA, he handled a wide range of prosecutions, including complex Title 21 matters with the DEA, as well as violent crime, financial fraud, public corruption, and national security cases.

□ **Gary Owen** is the Chief of Congressional and Public Affairs for the United States Drug Enforcement Administration. In this position, he directs three programs with agency-wide areas of responsibility—Public Affairs, Congressional Affairs, and Drug Education and Prevention. Gary oversees all aspects of DEA’s interactions with Congress and engages daily with national and international media on issues related to the DEA. He started working for DEA in 1997 and is a career Special Agent. Gary has two degrees in political science, a Bachelor of Arts from Gettysburg College, and a Master’s Degree from the American University in Washington, DC.

□ **Sean Fearn**s has served as the Chief of Community Outreach for DEA since 2015, a position that includes management of the DEA Museum as well as the DEA Community Outreach section. In this capacity Sean is responsible for guiding a diverse and creative staff to develop and implement strategic national partnerships with other organizations which help educate the public on the current drug threats facing the country, communicate key Administration drug prevention messages, and reduce the demand for those drugs, including implementing the DEA 360 Strategy.

Winning through Collaboration and Communication: OCDETF's Multi-front Battle Against Opioids: A Personal Call to Arms

M.J. Menendez

Coordinator

OCDETF's National Heroin/Fentanyl/Opioid Initiative

"The dark and the light are braided and bound." Author Marc Ian Barasch

I. Introduction

The heroin/fentanyl/opioid epidemic has undoubtedly reached you personally, professionally, or both. As I execute the great privilege of acting as Organized Crime Drug Enforcement Task Forces' (OCDETF) Coordinator for the National Heroin/Fentanyl and Opioid Initiative, I awake daily to reports from the field as to how many daughters, sons, mothers, fathers, and friends have died the night before from opioid overdose deaths. One need only look at the headlines such as this one from the Columbus Dispatch: "Man sent to prison in heroin-overdose death of 11-month-old", to feel the dire reality. John Fuddy, *Man sent to prison in heroin-overdose*, COLUMBUS DISPATCH, June 1, 2016, <http://www.dispatch.com/content/stories/local/2016/06/01/heroin-sentence.html>. The newspaper account details how the child's mother and father were using heroin and fentanyl in bed. The drugs had been "poorly packaged" with "dust all over the inside and outside of the baggie." One or both of the parents failed to wash the heroin/fentanyl off of their hands while preparing the baby's bottle, and that dusting of drugs killed a child that never felt the celebration of a birthday. I personally attended the funeral of a dear friend's daughter in the last three months. The daughter died from a heroin overdose. While I have cheerleader tendencies as when I interact with you, I am not a Pollyanna. The battle is grave, immediate, and deadly.

Yet, my position has allowed me to see and experience the great light emanating from the work of the committed, dedicated, passionate professionals engaged in the fight. As we enter into new innovative partnerships, establish linked communication sharing platforms, and develop collaborative strategies between public safety and public health, we demonstrate our awakening to the understanding that "business as usual" is no longer acceptable. The people and places experiencing the most deadly and profoundly devastating effects of the epidemic are the same people and places rising each day to create light in their communities by taking suppliers off the street, working with surviving families, partnering with medical examiners for more timely and accurate data sharing, and educating tens of thousands of school children. The pride felt at the OCDETF Executive Office for the work of the field to stem this deadly tide simply cannot be overstated. In this article, I will discuss the origins of the Initiative and cite a small portion of the excellent Initiative work in the field. At the end of this day, as all others, I urge you to continue to rise up, create light and noise in your community, and defeat this formidable enemy by taking one small step, every day, together.

II. The Start of the Initiative

As you are all aware, traditional OCDETF work has targeted major drug trafficking organizations, sources, and cartels since the program's inception more than thirty years ago. In the last several years, OCDETF investigators and prosecutors attacked the opioid epidemic by prosecuting rogue physicians, pharmacists, internet sales, and pill mill operations. Our traditional diversion investigations involved overwriting of oxycodone by doctors, and misuse of fentanyl patches by users who clipped the edges to consume the gel inside. OCDETF statistics witness the great successes in our field. At the conclusion of the second quarter of Fiscal Year 2016, 634 cases, or 13.5% of the OCDETF active caseload involved the diversion, abuse or misuse of prescription drugs and 2,021 cases, or 42.9% of the active caseload involved heroin. The 2016 Consolidated Priority Target List (CPOT) is a multi-agency target list of "command and control" elements of the most prolific international drug trafficking and money laundering organizations. Seventeen of thirty-nine CPOT list targets are linked to heroin trafficking.

Despite these significant accomplishments, the emergence of the heroin epidemic caused the OCDETF Executive Office to launch the National Heroin/Opioid Initiative on December 14, 2014. *See Memorandum from Exec. Dir. Bruce Ohr to OCDETF Operations Chiefs and U. S. Attorneys on OCDETF National Heroin Initiative (December 15, 2014) <https://usnet.sp.usa.doj.gov/staffs/olvp/opioid/Documents/Memo-OCDETF%20National%20Heroin%20Initiative.pdf#search=OCDETF%20National%20Heroin%20Initiative>*. The Initiative supports OCDETF field efforts to fill existing gaps in intelligence, enforcement activities, and prosecutions. The successful Initiative work currently ongoing in the field is not a result of the Initiative. Rather, the Initiative was born of the progressive and aggressive work modeled in the field. The Boston Heroin Enforcement Action Team, Boston HEAT, led by Drug Enforcement Administration (DEA) Assistant Special Agent in Charge (ASAC) Kevin Lane, Group Supervisor Jimmy Connolly, and Massachusetts State Police Lieutenant Kevin O'Neal had established a heroin overdose rapid response team and were modeling best practices in federal/state/local collaboration and data sharing before I assumed my position as Coordinator in May of 2015. Assistant United States Attorney Joseph Pinjuh in the Northern District of Ohio formed partnerships and collaborations with the Cleveland Clinic, the treatment community, and the Cuyahoga Medical Examiner's Office as early as November of 2013 as a result of Cleveland's first Opioid Summit. That great work continues today. United States Attorney Andrew M. Luger and DEA Minneapolis Division ASAC Dan Moren demonstrated that best practices in combatting the heroin/opioid crisis could consist simply of a paper form, fax machine, email, and countless community meetings where partnerships were formed, promises were made, and promises were kept. These leaders and many others carried the flag and taught all of us.

III. Community Collaboration

Today, OCDETF funds sixty Initiatives in all OCDETF regions of the country, with a concentration of resources in the Eastern and Midwestern regions of the country that have been particularly devastated by the opioid/heroin epidemic. While the ultimate goal of the Initiative is to help components develop multi-agency, multi-jurisdictional cases against criminal organizations, the Initiative leverages the national structure, resources and information sharing capabilities to identify the local street-level distributors who are responsible for overdose deaths, as well as their network of suppliers at the local and regional level. The Dayton Heroin Eradication and Apprehension Team (HEAT Team), led by DEA ASAC Chris Melink and AUSA Michael Hunter in the Southern District of Ohio, works countless

hours to enforce and prosecute; to partner with local public health and non-profit agencies; and to identify and gain immediate access to treatment sources. OCDETF's Southwest Regional Director, AUSA Gerald Doyle, maintains constant communication regarding the special needs and strategies being advanced at the Southwest border. United States Attorney for the Eastern District of Kentucky, Kerry Harvey, and AUSA Todd Bradbury formed the USA Heroin Education Action Team (USA HEAT Team). USA Harvey and AUSA Bradbury enforce and prosecute by day and meet with surviving family members of overdose victims by night to prepare them to speak their heart-wrenching messages to community action and educational forums. DEA Newark Division ASAC Chris Jakim and New Jersey State Police Captain Juan Colon have received no funds for their jurisdiction thus far. Yet, they always answer the phone to assist and educate the field about lessons learned in New Jersey. Indeed, Captain Colon has shared hundreds of hours on telephone calls, at conferences, and in travels throughout the country, discussing and preparing others to replicate New Jersey's Drug Monitoring Initiative.

The persons cited above represent a very small percentage of the leaders in the field using OCDETF funded data collection and telephone exploitation tools, computers, analysts, state and local overtime, surveillance tools, and other resources to advance our collective mission. The mission of the OCDETF Heroin Initiative continues. Funding requests submitted by a federal agency partner that aim toward new, innovative strategies and methodologies for attacking the heroin epidemic on the ground, while working toward complex case designation, can still be made. Funding applications are available on the OCDETF Management Information Systems site, or feel free to contact me directly.

The OCDETF Fusion Center (OFC), is a multi-agency operational intelligence center that leverages multiple investigative and financial data sources from OCDETF member agencies and from non-OCDETF partners to produce actionable leads. It is the largest repository of federal investigative intelligence in the nation. The OFC has stepped up to the challenges of the epidemic by creating the Heroin Response Group (HRG). The HRG works with the Special Operations Divisions (SOD) to identify links between street distributors of heroin and fentanyl and the criminal network sourcing the opioids. The HRG provides timely intelligence support based upon the specific needs of the investigation and utilizes all data sources available to the OCDETF Fusion Center to tailor and create a wide range of intelligence products. All recipients funded under the OCDETF National Initiative are expected to fully utilize the resources of the HRG to develop OCDETF level investigations.

In addition to funding and monitoring the Initiative requests, the OCDETF Executive Office works tirelessly to expand parameters of communication, collaboration, and information sharing; to open doors and unblock avenues; and to support the work of the field. While OCDETF embraces its role as the center-piece of the Department's counter-narcotics strategy, OCDETF also recognizes the need to partner with the public health and prevention communities to better inform and further our mission. Examples of these partnerships include OCDETF partnering with the High Intensity Drug Trafficking Areas' (HIDTA) Heroin Response Strategy, the Centers for Disease Control and Prevention, the DEA's 360 Initiative, FBI and DEA's [CHASING THE DRAGON](#) educational efforts, and multiple state public health / public safety coordination efforts.

The Minneapolis Convention Center was the site of a seminal federal, state, and local public health/public safety collaborative conference on September 7 and 8, 2016. Partners discussed the realities and challenges facing us in this epidemic, and also presented best practices in enforcement, treatment, education and prevention. Those in attendance made a pledge to collaborate by telling us a bit about themselves, their work, and their passion. They also committed to engage with professionals in their locality, district, or region after the conference to identify one, two, three, or five changes that can make their community safer, better and stronger. No one of us alone can change the world, but all of us, working together, can so change the world.

IV. Conclusion

I am often asked whether the field is judged on, and whether I get personally discouraged by, statistics indicating that heroin, opioid, and fentanyl overdose and overdose numbers continue to rise, often spiking in deadly multi-death surges. The unequivocal and resounding answer is “NO!” Like a cancer, our opioid threat is worsening and expanding through widespread, intentional distribution of imported and illicit powder fentanyl and heroin adulterated with fentanyl. The opioid epidemic is merging with the synthetic drug scourge, such as the drugs W-18 and U-4770, which kill like opioids, but are not identifiable or prosecutable like a traditional heroin prosecution. The Centers for Disease Control and Prevention report that the number of overdose deaths from heroin and fentanyl reported are a mere fraction of the actual number, due to overwhelmed medical examiners and pathologists, lack of resources for expedited toxicology, and newly focused attention on the need for accuracy in reporting and sharing accurate data. [Rose A. Rudd, et al. *Increases in Drug and Opioid Overdose Deaths - United States, 2000–2014*, 64 MORBIDITY AND MORTALITY WKLY. REP. 1378–1382 \(2016\)](#). Increasing overdose and overdose death numbers emphasize and exemplify the multi-faceted nature of the epidemic, and they speak the truth about the societal cost of the epidemic. The increasing number of overdoses, deaths, and naloxone administrations should serve only to renew our strength and commitment to fight harder, fight smarter, and fight on.

A set of statistics does not adequately measure the success of your Initiative funding or your global approach to the darkness of the heroin/fentanyl/opioid epidemic. Your success is evident in your recognition that the heroin/fentanyl/opioid scourge will be contained only through a passionate, personal, committed, and collaborative approach. So many of you have stepped out beyond your traditional role and job description to perform work that is most meaningful and necessary to your jurisdiction’s particular challenges. More of you will follow that path. Your success is measured by every state, local and federal partnership, every ground level investigation that takes a source of supply off the street while working toward OCDETF case designation, every act of outreach to the OCDETF Fusion Center to share information, and every new and innovative strategy employed. Your work and success is measured by the light you bring daily to the darkness, and I am very proud to call you partners, colleagues, and friends.

ABOUT THE AUTHOR

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Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases

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I. Introduction

This article will address strategies for investigating and prosecuting medical practitioners involved in the unlawful distribution of prescription controlled drugs. These are called “diversion” cases, as the drugs are diverted from their intended legitimate use by patients.

As narcotics, also known as opioids or opiates, drugs like OxyContin and Vicodin are in the same family as heroin and pose parallel dangers of addiction and overdose. Yet prescription narcotics have important medical benefits in treating severe pain. The same is true for other controlled prescription drugs such as Xanax or Adderall, which are also addictive and dangerous and yet have legitimate medical value.

In striking a balance between the dangers of these drugs and their medical value, the law entrusts medical practitioners to serve as gatekeepers. Licensed doctors, pharmacists, and other practitioners are authorized to provide these drugs to patients during the course of treatment. However, this gatekeeping authority is not absolute. Where a medical practitioner distributes a controlled drug in bad faith, the act is treated no differently than a sale by a street dealer.

These are important cases. Using little more than a prescription pad and a pen, a corrupt doctor can introduce a potentially unlimited quantity of deadly and addictive drugs into the black market. Diversion also is linked to fraud on public health programs such as Medicare and Medicaid, as drug dealers often recruit beneficiaries to cover the cost of filling prescriptions at taxpayer expense.

Thus, each successful prosecution of a corrupt doctor or pharmacist effectively shuts down a large-scale pipeline for dangerous drugs and protects the integrity of public welfare programs. Moreover, due to the high cost of entry for a practitioner to profit from diversion—the time, education, and licensure required—such prosecutions also have a lasting deterrent effect.

II. The Legal Landscape

A. The DEA Registration Requirement

Under 21 U.S.C. § 841(a)(1), it is illegal to distribute a controlled drug “[e]xcept as authorized by this subchapter.” In the context of diversion cases, this exception refers to the handling of prescription controlled drugs by medical practitioners who are specially authorized to do so by the Attorney General. See 21 U.S.C. §§ 822, 823. This special form of licensure is commonly called a Drug Enforcement Administration (“DEA”) registration. To prescribe or otherwise handle prescription controlled drugs,

doctors, pharmacists, and other practitioners must have a valid DEA registration number in addition to any state licensure.

The DEA maintains a body of attorneys, investigators, and administrative judges tasked with overseeing the DEA registration program nationwide. Their duties include reviewing applications to obtain or renew a DEA registration and maintaining a disciplinary system for practitioners who violate governing regulations.

As outlined in the next section, a valid DEA registration number effectively provides a safe harbor for the good-faith distribution of controlled drugs. This safe harbor applies both to DEA registrants and to employees working under their authority. *See* 21 U.S.C. § 822(c).

A DEA registration number thus acts as a line in the sand demarcating those who have and those who lack lawful authority to handle prescription controlled drugs. Those who do not have a DEA registration number or work under a registrant, such as street dealers, lack any special protection from criminal liability. Even a state-licensed practitioner who does not have a valid DEA registration number is not entitled to safe harbor protection, regardless of whether the practitioner distributes a controlled drug with the intent to treat a medical condition. *See United States v. Blanton*, 730 F.2d 1425, 1430 (11th Cir. 1984).

Similarly, there is no “medical necessity” defense available to non-registrants. *United States v. Oakland Cannabis Buyers’ Cooperative*, 532 U.S. 483, 494-95 (2001). Nor can a patient who receives a controlled drug via a valid prescription lawfully distribute the drug to others. *See United States v. Goldberg*, 538 F.3d 280, 285 n.4 (3d Cir. 2008).

B. Elements for Diversion Prosecutions Against Registrants

A prosecution against a DEA registrant under Section 841(a)(1) requires proof of additional elements beyond what must be proven in the ordinary drug trafficking case. Although the precise contours of the additional elements vary by circuit, what must be proven is essentially uniform nationwide:

1. The defendant knowingly and intentionally distributed or dispensed a controlled substance; and
2. In doing so, the defendant acted and intended to act without a legitimate medical purpose and outside the usual course of professional practice.

See United States v. Moore, 423 U.S. 122, 124 (1975); *United States v. Brown*, 553 F.3d 768 at *781(5th Cir. 2008); *United States v. Hurwitz*, 459 F.3d 463, 475 (4th Cir. 2006); *United States v. Feingold*, 454 F.3d 1001, 1008 (9th Cir. 2006). There is little (if any) meaningful distinction between acting with a “legitimate medical purpose” and acting within “the usual course of practice,” and multiple cases have upheld indictments or jury instructions that include one term but not the other. *See, e.g., United States v. Daniel*, 3 F.3d 775, 778 (4th Cir. 1993); *United States v. Boettjer*, 569 F.2d 1078, 1081 (9th Cir. 1978).

In the context of medical practice, “dispensing” includes the act of filling a prescription or directly giving a drug to a patient, while “distribution” and “delivery” include the act of writing a prescription. *See* 21 U.S.C. §§ 802(8), (10), (11); *United States v. Davis*, 564 F.2d 840, 844-45 (9th Cir. 1977).

The term “usual course of professional practice” is objective, and “implies at least that there exists a reputable group of people in the medical profession who agree that a given approach to prescribing controlled substances is consistent with legitimate medical treatment.” *Feingold*, 454 F.3d at 1012 n.3. Thus, a defendant’s “idiosyncratic view of proper medical practices” cannot constitute the

“usual course of professional practice.” *Hurwitz*, 459 F.3d at 478; *see also United States v. Smith*, 573 F.3d 639, 647-48 (8th Cir. 2009); *United States v. Merrill*, 513 F.3d 1293, 1306 (11th Cir. 2008); *United States v. Vamos*, 797 F.2d 1146, 1153 (2d Cir. 1986).

Moreover, in cases against pharmacists (or other practitioners not personally present when unlawful prescriptions were written), prosecutors can present a deliberate ignorance theory to prove knowledge that the prescriptions were issued outside the usual course of practice. *See, e.g., United States v. Darji*, 609 F. App’x 320, 335-36 (6th Cir. 2015); *United States v. Ly*, 543 F. App’x 944, 946-47 (11th Cir. 2013); *United States v. Lovern*, 590 F.3d 1095, 1108 n.5 (10th Cir. 2009); *United States v. Fuchs*, 467 F.3d 889, 901-02 (5th Cir. 2006); *United States v. Lawson*, 682 F.2d 480, 482 (4th Cir. 1982).

C. The Law Concerning Common Defenses

Practitioners charged with diversion often argue that there is a stand-alone “good faith” defense, or that the prosecution must prove “bad faith” in addition to the other elements. In recent cases in Los Angeles, we have successfully opposed this argument on the ground that “good faith” is simply shorthand for what the elements already encompass, namely, intending to act within the usual course of practice. *See, e.g., Feingold*, 454 F.3d at 1008; *see also United States v. Kelley*, 471 F. App’x 840, 846-47 (11th Cir. 2012); *United States v. DeBoer*, 966 F.3d 1066, 1068 (6th Cir. 1992); *cf. Hurwitz*, 459 F.3d at 476 (district court erred in instructing jury that good faith was irrelevant to drug charge). Similarly, practitioners often try to raise a “good intentions” defense, arguing that they cannot be criminally liable so long as they made an honest effort to practice medicine. However, this defense is inconsistent with the objective nature of the term “usual course of professional practice.” *See United States v. Joseph*, 709 F.3d 1082, 1097 (11th Cir. 2013); *United States v. Wexler*, 522 F.3d 194, 205-06 (2d Cir. 2008).

Practitioners also often argue at trial that the prosecution is seeking to hold them criminally liable for medical malpractice. However, the intent element distinguishes criminal liability from civil malpractice liability. *See Smith*, 573 F.3d at 649; *United States v. Wexler*, 522 F.3d 194, 206 (2d Cir. 2008); *United States v. McIver*, 470 F.3d 550, 559 (4th Cir. 2006); *Feingold*, 454 F.3d at 1009. Similarly, because the “usual course of practice” refers to baseline standards of care—those accepted by at least a reputable group—Section 841(a) thus does not require practitioners to live up to a “gold standard” of professional conduct.

Defendants also often try to argue that they acted within the usual course of practice because they prescribed the narcotic drugs at issue to treat addiction or withdrawal, rather than pain, to help wean patients off of opiate dependence. Yet this is not a valid defense. Narcotic addiction treatment is the “only one area in which Congress set general, uniform standards of medical practice.” *Gonzales v. Oregon*, 546 U.S. 243, 271 (2006). While the body of regulations concerning narcotic addiction treatment is complex (and is addressed in more detail in Section VI(C) below), one bright-line rule is clear: in recent cases in Los Angeles, we have successfully excluded defenses that the defendants prescribed narcotics in a purported effort to taper patients off their narcotic addiction or help with withdrawal. *See, e.g., United States v. Bussam*, 513 F. App’x 665 (9th Cir. 2013); *see also United States v. Hayes*, 794 F.2d 1348, 1351-52 (9th Cir. 1986).

III. Evidentiary Tools

Proving bad faith can appear to be a daunting task, as it requires a jury to assess the medical legitimacy of a trained professional’s conduct. Moreover, corrupt practitioners often take precautions to thwart prosecution. For example, corrupt doctors commonly require patients to claim to feel pain or to provide an x-ray or similar paperwork, even though doctor and patient alike know that this is a fiction.

In overcoming these hurdles, my suggestion is to treat diversion like a crime of fraud. Like a securities broker engaged in fraud—who may have a real office, real licensure, and engage in what on the surface appears to be real professional conduct—the corrupt medical practitioner is using a veneer of legitimate practice to conceal what is in fact a criminal operation. The goal of the investigation is to develop evidence piercing that veil of legitimacy.

With this perspective in mind, investigators and prosecutors have two key advantages in these cases. First, diversion falls at the intersection of multiple highly regulated industries, each of which create potentially massive paper trails that can be used both to identify leads and as evidence at trial. Second, medical practitioners act against the backdrop of well-defined standards of conduct, including bright-line rules that offenders cannot credibly violate in good faith.

A. Data Analysis

The paper trail left by diversion offenses commonly includes data compilations (*e.g.*, prescription or billing data) or records from which data can be summarized (*e.g.*, bank records). Seeking out and analyzing these sources of evidence allows investigators to build a “big picture” view of the practitioner’s professional conduct.

Where a practitioner is profiting from diversion, this “big picture” view will almost inevitably reveal red flags of diversion, that is, deviations from ordinary or appropriate medical practice and evidence of consciousness of guilt. For example, in order to profit from diversion, corrupt practitioners generally must give patients what they want: repeating patterns of the same drugs and drug cocktails, often at a scale beyond what would be expected from ordinary outpatient treatment.

While a single red flag may be explained away, a confluence of red flags is powerful evidence that the practitioner acted in bad faith.

PDMP Data: Almost every state has a prescription drug monitoring program (“PDMP” or “PMP”), a government-run electronic database tracking prescriptions for controlled drugs statewide, based on information submitted by the dispensing pharmacy or doctor to a central clearinghouse. Each state has its own procedures regarding when and how law enforcement can obtain PDMP data. The PDMP in California (the “CURES” database) has been an indispensable resource for criminal and administrative investigations. CURES tracks all prescriptions filled at pharmacies for Schedules II through IV drugs, and it also tracks such drugs that are directly dispensed to patients by doctors. Like PDMPs generally, the data kept by CURES includes the drug prescribed (type, strength, and quantity), the prescribing doctor, the patient, and the pharmacy at which the prescription is filled.

Significantly, PDMP data is admissible at trial under Federal Rule of Evidence 803(8)(A)(ii), and courts have held that “prescription data sets outside those specifically charged in the indictment” are relevant “to determine whether a physician has exceeded the legitimate bounds of medical practice and as evidence of a plan, design, or scheme.” *United States v. Merrill*, 513 F.3d 1293, 1302 (11th Cir. 2008); *see also United States v. Tran*, 609 F. App’x 295, 297-99 (6th Cir. 2015); *United States v. Harrison*, 651 F.2d 353, 355 (5th Cir. 1981) (admitting evidence of prescriptions other than those charged as evidence of broader criminal practice).

PDMP data can reveal the extent to which red flags pervade the practice under investigation, often with the help of expert review. For example, PDMP data will show whether the doctor is prescribing repeating patterns of the same controlled drugs or cocktails (including cocktails like opiates and sedatives that, when taken together, are particularly dangerous); whether the dosages are uniform (evidencing a lack of individualized treatment or drug strengths in excess of ordinary treatment); and whether the drugs are being filled at only one or a select set of pharmacies (reflecting collusion).

Prescription data analysis can also demonstrate that a pharmacy is engaged in diversion. Like the examples cited above, the pharmacy may be filling anomalous prescriptions or an abnormally large volume of prescriptions from a particular set of corrupt doctors. Similarly, the pharmacy's customers may travel long distances to fill prescriptions despite the hundreds of other pharmacies in between.

Billing Data: Medicare, Medicaid, and other insurance billing data is admissible as public or business records. *See Fed. R. Evid. 803(6), (8)*. Such data can also assist in providing a “big picture” view of the drugs prescribed by a doctor or dispensed by a pharmacy and offers the advantage of including non-controlled drugs billed to the respective provider. This evidence can support fraud charges and can be presented as a red flag corroborating that a practitioner is operating a corrupt medical practice.

Corrupt doctors can be equal-opportunity offenders who seek to profit both from controlled drug diversion and from health care fraud. For example, they may receive kickbacks for other types of medically unnecessary prescriptions, such as for durable medical equipment or for expensive non-controlled drugs, or they may submit fraudulent billings for office testing like urinalysis. Investigators who come across indicia of fraud will benefit from expanding the investigation and should consider partnering with agencies such as the Department of Health and Human Services—Office of Inspector General.

ARCOS Data: ARCOS (the Automation of Reports and Consolidated Orders System) is a federally operated database that tracks wholesale distributions of certain controlled drugs, including Schedule II and III narcotics. This data can be particularly useful in pharmacy investigations, in identifying discrepancies evidencing that a pharmacy is underreporting to a state PDMP to fraudulently conceal diversion. ARCOS data can also help identify pharmacies that are receiving unusually high volumes of controlled drugs.

Financial Data: Data from financial records is also an essential component of diversion investigations. For example, in cases in which a practitioner is receiving cash payment or kickbacks, analysis of bank records can show the patterns and spikes of cash deposits. Likewise, it is common for offenders in diversion cases to engage in money laundering or structuring, which can support separate criminal charges, evidence consciousness of guilt, and demonstrate motive. Moreover, financial data analysis assists in securing fines and in forfeiting criminal proceeds or criminally derived assets.

B. Undercover Operations

Whereas data analysis provides a big picture view of a corrupt practitioner's conduct, undercover operations—namely, officers or cooperators meeting with a practitioner while posing as patients—provide a small picture view of individual patient treatment. Prescriptions issued to undercover agents also often serve as the specific distributions or overt acts charged in indictments.

The number of undercover operations required is case-dependent. My rule of thumb is to use two to three undercover patients, each of whom conducts around three patient visits, although fewer may be necessary in the case of a particularly blatant criminal operation. The strategy of using multiple visits by multiple patients offers important benefits. Showing a pattern of illicit prescriptions undermines any defense argument concerning good-faith error or entrapment. Moreover, this strategy highlights deficiencies in the practitioner's ongoing course of treatment (*e.g.*, increasing the potency of the prescribed drugs without a medical basis, ignoring continuing signs of addiction, or failing to inquire whether the injury purportedly justifying the original prescription had abated).

As noted above, corrupt practitioners usually take precautions against an undercover investigation, such as requiring all patients to claim to have some form of pain (often a condition that is

difficult to objectively diagnose, such as low back pain) or doing cursory examinations in an effort to maintain a false veneer of legitimacy. Yet the undercover meetings can evidence bad faith even where corrupt doctors employ such precautions. For example, did the meeting last only a few minutes? Did the doctor make a serious effort at conducting a physical examination and collect a full medical history, encourage alternative treatments, such as physical therapy, or less dangerous drugs? Did the doctor ignore signs of addiction, charge by the type of drugs prescribed, rather than by the treatment provided, suggest what symptoms the patient should claim to feel, inquire about which recruiter “referred” the patient, or instruct the patient on which pharmacy to use? Did the meeting devolve into a negotiation over drugs rather than a discussion of the patient’s condition?

Similarly, the undercover operation (or perhaps officer surveillance) can reveal incriminating evidence of the doctor’s broader practice. For example, agents may see stuffed waiting rooms or long lines of patients, with patients seeing the doctor for only a few minutes at a time. They may see patients at the office reception desk pre-negotiating the drugs to be prescribed or repeatedly paying identical sums in cash.

Data analysis and undercover operations go hand-in-hand. “Big picture” evidence establishes the context for the undercover prescriptions, reflecting that the recorded visits were simply a small slice of a broader pattern of corruption and, thus, were not the product of good-faith mistake or entrapment. The “big picture” evidence also is important in corroborating that precautions taken by corrupt practitioners were in fact false efforts to conceal the drug diversion. Undercover recordings, in turn, corroborate that the red flags present in the “big picture” data, in fact, evidence bad-faith practice. Similarly, while data analysis relies on a cold record, an undercover recording presents a direct view of the defendant’s conduct and statements.

C. Expert Testimony

A medical expert is a key component of diversion cases, by providing a medical perspective on “whether a practitioner's conduct has deviated so far from the usual course of professional practice that his actions become criminal.” *Feingold*, 454 F.3d at 1007. Medical expert opinions can be used in establishing probable cause for search warrants and in trial testimony.

In testifying at trial, the expert can provide an overview of the various standards of care that exist in the medical system, such as those set by professional groups and state medical boards, or those taught in medical schools and in continuing education programs. While the expert cannot testify about a defendant’s state of mind, the expert can render a specific opinion that the practitioner’s conduct in fact violated accepted medical practice. *McIver*, 470 F.3d at 561-62; see also *United States v. Chube*, 538 F.3d 693, 696-97 (7th Cir. 2008); *Feingold*, 454 F.3d at 1005; *United States v. Katz*, 445 F.3d 1023, 1032 (8th Cir. 2006).

Experts can also provide important assistance in cases against pharmacies, such as by highlighting red flags in the prescriptions that a pharmacist should have identified and whether the pharmacist responded appropriately. For example, experts may identify failures to properly respond to a large volume of patients presenting repeating patterns of dangerous prescriptions issued by the same doctor, such as failing to conduct follow-up verification. Experts may also identify deficiencies in a pharmacy’s handling of drug stock, paperwork (e.g., patient signature logs), and billing, or improprieties in responding to audits or inspections.

Prosecutors can also present *modus operandi* expert testimony to provide context for the charged offenses, either through a medical expert or through a law enforcement witness. It is generally accepted in drug cases that experts can testify about common “methods and techniques employed in an area of

criminal activity.” *United States v. Espinosa*, 827 F.2d 604, 612 (9th Cir. 1987). For example, *modus operandi* testimony may address the prevalence of the black market for prescription controlled drugs, the types/strengths/cocktails of drugs that are particularly valued, the methods by which such drugs are typically acquired by drug traffickers, and the methods commonly employed by corrupt practitioners to conceal the offense. *See, e.g., United States v. Boccone*, 556 F. App’x 215, 244-45 (4th Cir. 2014) (testimony on “indicia or red flags of diversion” admitted to show “that the entire course of treatment of patients . . . was illegitimate and outside the usual course of medical practice”); *see also Tran*, 609 F. App’x at 299. While *modus operandi* testimony is routinely admitted in drug trafficking cases, there is little case law addressing it in the specific context of prescription drug diversion. Accordingly, defense attorneys in diversion cases often seek to exclude such testimony with varying success.

D. Search Warrants

Once the undercover/covert stage of the investigation is complete, the execution of search warrants can provide significant evidence, including the seizure of a practitioner’s medical charts. While patient records are often kept in paper form in the practitioner’s office, doctors are increasingly using online “cloud” patient record services. Such providers will generally accept preservation letters, following which search warrants can be obtained under 18 U.S.C. § 2703.

Medical charts for undercover patients will often show that the practitioner made falsified entries reflecting consciousness of guilt, such as documenting physical examinations that did not occur or symptoms that were never discussed. Similarly, expert review of third-party patient records may also reveal red flags, even where corrupt practitioners attempt to conceal the diversion by falsifying medical charts. For example, experts may find duplicated entries or patterns of the same diagnoses across patient files, indicating hasty efforts to falsify records. In handling third-party medical records, investigators and prosecutors should be mindful to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Executing search warrants often also yields other types of incriminating evidence. For example, in recent diversion cases in Los Angeles, investigators seized incriminating text messages with patient recruiters and drug dealers, bulk cash or drug stashes, and patient “profiles” commonly used in identity theft schemes.

E. Percipient Witnesses

Patients: Sometimes, corrupt practitioners use precautionary measures that thwart agents’ ability to conduct undercover operations, in which case patients can be essential witnesses. Like undercover operations, patient testimony can provide an inside perspective on the practitioner’s conduct and support specific distribution charges or overt acts. Yet, unlike undercover operations, the patient’s interactions with the defendant are not recorded. Accordingly, the credibility and memory of patient-witnesses are generally attacked on cross-examination on the basis of drug addiction, criminal history, and alleged bias. The defense also will likely argue that the witness lied to and manipulated the defendant to acquire controlled drug prescriptions. Also, the defendant may have falsified patient records in a manner that contradicts the patient’s testimony. As with any witness, these issues can be addressed through independent corroboration, such as consistent testimony from other patients and incriminating evidence from data analysis, search warrants, and other sources.

Patient testimony also can provide key evidence in cases involving identity theft and fraud. Patient witnesses can verify that prescriptions were not issued to them, that they never visited pharmacies where prescriptions were filled in their names and/or billed using their benefits, and that records

purporting to bear their signatures (pharmacy signature logs, delivery confirmations, “caretaker” forms, etc.) were not in fact signed or completed by them.

Pharmacists and coroners: In complying with their professional obligations, pharmacists will often contact doctors’ offices to verify prescriptions or even take further steps such as visiting a doctor’s office to assess whether it is a legitimate practice. Thus, pharmacists may testify that they notified a doctor about dangerous drug dosages or combinations. They also may testify (and have supporting written communications or other records) about false information provided by doctors to fraudulently “verify” prescriptions.

Similarly, coroners, law enforcement, or family members may testify about notifying doctors of patient addiction or overdose deaths. As medical experts can testify, a patient’s overdose death—let alone a series of deaths—is a major event in any medical practice. A practitioner’s unabated pattern of issuing dangerous prescriptions despite such warnings can serve as strong evidence of bad faith.

Office staff: Office staff members (*e.g.*, clerical employees, medical assistants, pharmacy technicians, nurses, or physician’s assistants) can provide a broad insider view of the doctor’s office, clinic, or pharmacy, regardless of whether they conspired in the offense. For example, they can testify about how the defendant was paid by patients, how many patients would be seen in a day and for how long, patterns in prescriptions, the involvement of patient recruiters, the use of pre-filled or pre-signed prescriptions, or incriminating statements made by the defendant.

Co-conspirators: Cooperating conspirators (*e.g.*, drug dealers, cappers, or other corrupt practitioners) can testify about the existence of the criminal conspiracy and can facilitate undercover operations by providing a “referral” to the doctor under investigation.

F. State Disciplinary Records

Corrupt medical practitioners are often recidivists with a history of administrative discipline for misconduct including prior acts of diversion. As a general matter, multiple courts have affirmed the admission of prior administrative disciplinary records against professionals as proof of state of mind. *See, e.g., United States v. Jaszcult*, 330 F. App’x 367, 370 (3d Cir. 2009); *United States v. Fox*, 69 F.3d 15 at *7 (5th Cir. 1995). Such records can provide direct evidence of the defendant’s knowing violations of the standard of care (*e.g.*, that the defendant was put on direct notice that it is improper to prescribe a narcotic without conducting a physical examination). Similarly, administrative disciplinary orders often require practitioners to undergo educational courses, such as courses on prescribing practices or recordkeeping, which can also establish knowledge and absence of mistake. Additionally, disciplinary records may reflect the defendant’s past deceptive conduct, such as lying to investigators or providing falsified records, which can support cross-examination under Federal Rule of Evidence 608.

G. Separate Investigations or Litigation

Evidence developed from separate administrative, civil, or criminal investigations or litigation is admissible in criminal cases, with the important caveat that the separate matter cannot be a pretext to benefit the criminal case or circumvent a defendant’s rights. *See United States v. Kordel*, 397 U.S. 1, 11 (1970); *United States v. Stringer*, 535 F.3d 929, 939 (9th Cir. 2008); *SEC v. Dresser Industries, Inc.*, 628 F.2d 1368, 1374 (D.C. Cir. 1980) (*en banc*). For example, records independently developed or obtained by state medical boards, DEA administrative personnel, Medicare or Medicaid auditors, or civil litigants (*e.g.*, from wrongful death or malpractice lawsuits) can be a significant source of evidence. This evidence may include prior statements by the defendant in response to auditors or in depositions, records obtained from the defendant’s place of practice, or leads to identifying witnesses for trial.

V. Charging Tools

In addition to drug trafficking and conspiracy charges under 21 U.S.C. §§ 841(a)(1), 846, additional categories of criminal charges are also potentially available in diversion cases.

A. Fraud, Kickbacks, and Identity Theft

As discussed above, diversion schemes often involve both controlled drug violations and fraud on government health programs such as Medicare and Medicaid. This can include fraudulent billings by pharmacies for filling invalid prescriptions or fraudulent billings by doctors connected to outpatient treatment. In these cases, the health care fraud statutes can be important charging tools. See 18 U.S.C. §§ 1035, 1347, 1349; 42 U.S.C. § 1320a-7b(a). It is also illegal to receive, solicit, or offer remuneration (including any kickback, bribe, or rebate) in exchange for “any item or service” that is billed “in whole or in part” to a federal health care program. See 42 U.S.C. § 1320a-7b(b). This statute is particularly helpful in cases involving patient recruitment.

In cases involving fraud—particularly those involving patient recruitment or stolen identities—the aggravated identity theft statute can also be an important charging tool. 18 U.S.C. § 1028A. Significantly, Section 1028A is not limited to identity theft in the literal/colloquial sense; the statute precludes *any* possession or use of a third party’s identity in furtherance of fraud (or some other predicate offense), even if the third party consented to it. See *United States v. Ozuna-Cabrera*, 663 F.3d 496, 498 (1st Cir. 2011); *United States v. Retana*, 641 F.3d 272, 275 (8th Cir. 2011); *United States v. Abdelshafi*, 592 F.3d 602, 607-09 (4th Cir. 2010); *United States v. Mobley*, 618 F.3d 539, 547-48 (6th Cir. 2010); *United States v. Carrion-Brito*, 362 F. App’x 267, 273 (3d Cir. 2010).

Title 21 also contains anti-fraud provisions, including prohibitions against obtaining controlled drugs via fraud or deceit and against false statements in a DEA registration application or in any “report, record, or other document” that DEA registrants are obligated to maintain. See 21 U.S.C. §§ 843(a)(3), (4). Additionally, it is unlawful to use a revoked, suspended, fictitious, or stolen DEA registration number. See 21 U.S.C. § 843(a)(2).

B. Food, Drug, and Cosmetic Act Violations

The Food, Drug, and Cosmetic Act (“FDCA”) is an essential tool in combating corruption among pharmacies in particular. One of the most important criminal provisions in the FDCA is the prohibition against drug misbranding. See 21 U.S.C. § 331(k). Significantly, misbranding—like criminal violations of the FDCA generally—is a strict liability offense as a misdemeanor, and thus does not require proof of criminal knowledge or intent; as a felony, a misbranding charge requires proof of intent to defraud or mislead. See 21 U.S.C. § 333(a); *United States v. Dessart*, 2016 WL 2893267 at *2 (7th Cir. 2016); *United States v. Carlson*, 810 F.3d 544, 555 (8th Cir. 2016); *Roseman v. United States*, 364 F.2d 18, 26 (9th Cir. 1966); *United States v. Hohensee*, 243 F.2d 367, 371 (3d Cir. 1957); *United States v. Quality Egg, LLC*, 99 4. Supp. 920 (N.D. Ill. April 14, 2015).

The term “misbranding” is broadly defined and includes, for example, drugs dispensed by pharmacies without a prescription or that bear false labeling. See 21 U.S.C. §§ 352(a), 353(b); see also *Goldberg*, 538 F.2d at 288. Of particular significance, multiple courts have recognized that, under 21 U.S.C. § 353(b)(1), a drug is misbranded when it is dispensed pursuant to an invalid prescription. *Smith*, 573 F.3d at 650 (“[A]n invalid prescription is not a prescription within the meaning of § 353(b) at all.”); *United States v. Munoz*, 430 F.3d 1357, 1367-68 (11th Cir. 2005); *United States v. Nazir*, 211 F. Supp. 2d

1372, 1375 (S.D. Fla. 2002); *United States v. Lovin*, 2009 WL 3634194 at *7-8 (S.D. Cal. October 30, 2009).

The FDCA also prohibits unlicensed wholesale drug distribution (*i.e.*, “to a person other than a consumer or patient”). Any person making such a distribution must have a state or federal wholesale distributor license. *See* 21 U.S.C. §§ 331(t), 353(e)(2), (e)(4), 360eee-2. Like the FDCA’s criminal provisions generally, the statute does not include a *mens rea* requirement for a misdemeanor violation. For a felony conviction, the violation must be knowing. *See* 21 U.S.C. §§ 333(a)(1), (b)(1)(D). Thus, for example, a pharmacist selling bulk drugs to black market dealers is criminally liable under this statute, so long as the pharmacist does not have a wholesale license or meet any of the narrow exceptions under 21 U.S.C. § 353(e)(4).

VI. Parallel Proceedings

The United States Attorney’s Manual, Section 1-12.000, requires prosecutors to “timely communicate, coordinate, and cooperate” with partners in administrative, civil, and criminal agencies “to the fullest extent appropriate to the case and permissible by law, whenever an alleged offense or violation of federal law gives rise to the potential for criminal, civil, regulatory, and/or agency administrative parallel (simultaneous or successive) proceedings.” So long as parallel proceedings are not a pretext to benefit the criminal case, there is no prohibition against pursuing such further remedies against a corrupt practitioner.

A. Administrative Proceedings

Imagine obtaining a court order that effectively disables a drug trafficking organization’s illicit operation. In diversion cases, prosecutors have two sources for obtaining this type of order, either of which terminates the practitioner’s authority to prescribe, dispense, or otherwise distribute controlled drugs. Like the DEA, state professional boards (medical, pharmacy, etc.) have disciplinary authority and can sanction practitioners for professional violations. In addition to suspending or revoking the practitioner’s license or registration number, regulatory authorities can impose narrower sanctions, such as prohibiting a doctor from prescribing specific schedules of drugs. Medicare and Medicaid have similar authority regarding billing authority or coverage, which can cut off a fraud scheme’s source of criminal proceeds.

Of equal significance, state and federal authorities have the power to impose interim suspension orders (“ISOs”), that is, orders suspending a license or registration number during the pendency of disciplinary proceedings. This can be a powerful tool to protect the public welfare during the pendency of an indictment or pre-indictment resolution.

Practitioners may agree to voluntarily surrender their DEA registration to show good faith for sentencing or as part of plea settlements. Moreover, in imposing pretrial release conditions that ensure the public’s safety under 18 U.S.C. § 3142(c)(1), the judge may order the practitioner to surrender his or her DEA registration, prohibit medical practice, or restrict the drugs that the practitioner can prescribe or dispense.

B. Civil Fines and Asset Forfeiture

Title 21 provides a schedule of civil fines for regulatory or criminal violations by DEA registrants. *See* 21 U.S.C. § 842(a). Potential bases for fines include unlawfully distributing or dispensing a controlled drug, recordkeeping violations, labeling violations, or failures to cooperate with an

administrative inspection. Similarly, the criminal proceeds of diversion and related offenses are subject to forfeiture. *See* 18 U.S.C. § 982; 21 U.S.C. § 853.

C. State Criminal Charges

State prosecutors also can pursue criminal charges beyond what is available federally. California, for example, imposes criminal penalties for prescribing or dispensing to an addict under [California Health and Safety Code Section 11156](#), whereas Title 21 does not include a parallel criminal statute.

VII. Additional Considerations

A. Overdoses and Sentencing

Section 841(a)(1) imposes enhanced penalties, including mandatory minimum sentences, where “death or serious bodily injury results from the use” of the drug underlying the criminal charge. This language “imposes a requirement of but-for causation,” that is, the prosecution must prove that the victim would not have died but for his or her consumption of the drug unlawfully distributed or dispensed by the defendant. *Burrage v. United States*, 134 S. Ct. 881, 889-90 (2014). Once this causation is established, the defendant is strictly liable for the death or injury, and the prosecution need not prove foreseeability. *See United States v. De La Cruz*, 514 F.3d 121, 137 (1st Cir. 2008). Moreover, the United States Sentencing Guidelines separately impose a heightened base offense level where “death or serious bodily injury” results from the offense. *See* U.S.S.G. § 2D1.1(a).

Proving but-for causation generally requires expert review of hospital and autopsy records and can be difficult in cases involving polydrug overdose. Additionally, the prosecution must establish that the victim died because of drugs that were unlawfully prescribed or dispensed by the defendant. This can be established, for example, based on the coroner or law enforcement investigation following the death (*e.g.*, whether an open pill bottle was found in the vicinity of the victim), percipient testimony regarding the victim’s conduct leading to the death, prescription data or pharmacy records (*e.g.*, whether the victim filled one of the defendant’s prescriptions just prior to the death, and whether the victim was filling a pattern of prescriptions reflecting red flags), and expert review of the defendant’s patient file for the victim.

In cases that do not involve such an enhancement, the base offense will be calculated using the drug quantity underlying the offense, including both the charged violations and relevant conduct. *See* U.S.S.G. §§ 1B1.3, 2D1.1(a), (c). While establishing drug quantity is a case-specific task, needless to say, the drugs underlying the counts of conviction (*e.g.*, the prescriptions sold to undercover agents) will serve as the floor. Prosecutors can establish a higher drug quantity by proving that the undercover transactions were part of a broader course of criminal conduct, such as through expert review of prescription data and patient records, financial analysis, and the testimony of office staff or co-conspirators. Once drug quantity is established, controlled prescription drugs are subject to the equivalency tables in Section 2D1.1.

Practitioners convicted of diversion are also subject to a two-level enhancement for the abuse of a position of trust or the use of a special skill. *See* U.S.S.G. § 3B1.3.

B. Online Pharmacies

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (“the Act”) sought to tackle the problem posed by the online prescription drug trade. The statute applies to any person who “deliver[s], distribute[s], or dispense[s] a controlled substance by means of the internet,” and, thus, is not

limited to practitioners. *See* 21 U.S.C. § 841(h)(1). No formal website is required to qualify as an online pharmacy. Any person using the internet to facilitate a drug transaction can be subject to the Act. *See, e.g., United States v. Williams*, 549 F. App'x 813, 822 (10th Cir. 2013). The Act requires that practitioners obtain a special DEA registration prior to using the internet in the course of distributing or dispensing a controlled drug. 21 U.S.C. § 823(f). The Act also imposes other heightened requirements, such as additional reporting obligations for online pharmacies and that doctors have conducted at least one prior in-person evaluation of the patient. 21 U.S.C. §§ 827(d)(2), 829(e).

Because Section 841(a)(1) and the criminal provisions under the Act (Section 841(h)) overlap in scope, prosecutors may elect to charge a doctor or pharmacist engaging in diversion via the internet under either statute. *See e.g., United States v. Tobin*, 676 F.3d 1264, 1274-75 (11th Cir. 2012); *United States v. Bansal*, 663 F.3d 634, 657 (3rd Cir. 2011); *United States v. Birbragher*, 603 F.3d 478, 488-89 (8th Cir. 2010).

C. Addiction Treatment

Another area that is a common source of concern among law enforcement is diversion by operators of narcotic addiction treatment programs, also called opioid treatment programs (“OTPs”). Like online pharmacies, OTPs must be specially registered to treat narcotic addiction and are subject to an array of statutory and regulatory requirements, such as regarding the types of drugs that can be used for treatment (which, significantly, do not include any Schedule II narcotics). *See* 42 C.F.R. § 8.12(h).

The Drug Addiction Treatment Act of 2000 (“DATA”) also allows physicians to obtain a special form of DEA registration authorizing narcotic addiction treatment. This registration is often called a DATA waiver. However, DATA-waived doctors are also subject to a number of limitations, such as regarding how many patients at a time can be treated and the restriction noted above regarding the types of narcotics that can be used. *See* 21 U.S.C. § 823(g)(2)(B)(iii); 21 C.F.R. § 1301.28; 42 C.F.R. § 8.12(h).

Like all DEA registrants, OTPs and DATA-waived doctors enjoy “safe harbor” protection only if they handle controlled drugs in good faith. The evidentiary tools discussed above apply in such investigations, with one important difference. Investigators must obtain court authorization prior to any undercover operations involving an addiction treatment provider. *See* 42 C.F.R. § 2.17(a). Such an order requires a finding of good cause, including a showing of necessity and that there is reason to believe that an employee or agent of the program is engaged in criminal activity. *See* 42 C.F.R. § 2.67(c).

VIII. Conclusion

Corrupt medical practitioners enjoy opportunity and privilege far beyond most drug offenders. Yet they forsake a legitimate and noble career to profit from violating the first principle of medicine: above all, do no harm. Indeed, they well know the harm that narcotics cause, yet they willfully expose the highest-risk users to those drugs. These are surely among the least sympathetic offenders that we encounter in the justice system.

Thankfully, diversion cases also offer some of the most effective tools in protecting the public from the devastating impact of the opioid epidemic. The tracks left by diversion are easy to find. It is up to investigators and prosecutors to seek them out.

I hope this article has helped in identifying and harnessing those tools. I am happy to speak with investigators or prosecutors regarding specific case issues or to provide briefing from prior cases.

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Data-Driven Approaches to Responding to the Opioid Epidemic

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I. Introduction

Since 2013, the Department of Justice’s Bureau of Justice Assistance has invested in multi-disciplinary, data-driven, pilot projects that encourage the proactive use of Prescription Drug Monitoring Program (PDMP) data as well as other local, state and national data sources. The projects developed under this program enhance the capacity of state and local organizations to analyze and leverage data from a variety of sources to monitor drug abuse trends, identify sources of diversion, and improve decision-making. Thirteen pilot programs have been funded to date. The 13 projects are diverse, but include initiatives that support provider education and outreach, data integration and analysis, overdose prevention activities, naloxone access, and increased access to treatment. This article highlights three of the unique efforts underway across the country.

II. Arizona’s Prescriber Report Cards

As of 2016, forty-nine states, the District of Columbia, and Guam have passed legislation authorizing a Prescription Drug Monitoring Program (PDMP). PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. PDMPs play a critical role in patient care but can also be used to reduce and prevent prescription drug abuse and drug overdoses.

In 2014, the Arizona Board of Pharmacy, which operates Arizona’s PDMP, began issuing prescriber report cards based on data maintained in the state’s PDMP. The report cards detail the provider’s prescribing history, including their ranking compared to the “average” prescriber of the same specialty and a summary or graphical representation of their prescribing history. The project began as a pilot program in four counties (Yavapai, Pinal, Graham, and Greenlee) and was later expanded statewide. The prescriber report cards are generated and distributed by the PDMP every quarter. They are sent to prescribers who have issued at least one controlled substance prescription during the previous quarter. Approximately 26,000 prescribers in Arizona receive the reports, representing 84 percent of the registrants with authority to prescribe controlled substances. Each prescriber receives a report specific to his or her prescribing history. The report also shows comparisons to other prescribers with the same specialty within the county and statewide. The report cards focus on five major drugs: Carisoprodol, benzodiazepines, hydrocodone, oxycodone and other pain relievers. The report card categorizes the prescriber’s prescribing as “normal,” “high,” “severe,” or “extreme.” A letter is sent with the report explaining the program and emphasizing its purpose in promoting appropriate prescribing for the selected drugs. The Arizona PDMP saw evidence that more prescribers were querying the PDMP and adjusted their prescribing habits after Arizona PDMP began issuing prescriber report cards. In Pinal County, for example, the percentage of prescribers meeting the “outlier” criteria for total dosage units fell 26 percent, and prescriber PDMP usage increased 14 percent in just one year. For additional information about how

prescriber report cards are being used in other states. See U.S. DEP'T. OF JUSTICE, BUREAU OF JUSTICE ASSISTANCE, PRESCRIPTION REPORT CARD (March 15, 2016) http://www.pdmpassist.org/pdf/Report_Card_TAG_20160315_final.pdf.

III. Maryland's Overdose Fatality Review Teams

In 2013, the Maryland Department of Health and Mental Hygiene (DHMH) implemented pilot Overdose Fatality Review (OFR) teams in Cecil County, Wicomico County, and Baltimore City. OFR teams were modeled after the successful Child Fatality Review program. OFR teams conduct confidential reviews of fatal overdose incidents within their county to identify key risk factors for overdose, opportunities for intervention with high-risk individuals, and changes to laws, policies, procedures, and programs that may prevent future fatal and non-fatal overdoses. To facilitate the case review process, DHMH's Behavioral Health Administration, in cooperation with the DHMH Office of the Chief Medical Examiner and Vital Statistics Administration, provides OFR teams with detailed information on overdose decedents and the circumstances of death. This state level information augments data available from local health departments, probation, the courts, community health care providers, hospital emergency departments, EMS providers, social services, law enforcement, and other sources.

A State Overdose Advisory Council, composed of public health and safety authorities and overdose prevention experts, advises and provides support for the OFR process, including issuing reports on best practices in data sharing and analysis. As of August 2016, Maryland's OFR program has been expanded to 18 operational teams. Some notable trends have emerged from the teams, which have led to: changes in intake questionnaires, to include questions about overdose history, increased focus on outreach to families to provide treatment services and overdose prevention training, and improvements to the quality of referral systems.

IV. New York RxStat

In 2012, New York City launched the RxStat initiative in response to the growing number of overdose deaths. Led by the New York City Department of Health and Mental Hygiene, in partnership with the New York/New Jersey High Intensity Drug Trafficking Area (HIDTA), a multi-disciplinary data-focused group began examining data related to overdose deaths, physician prescribing patterns, and crime rates. The RxStat initiative used existing datasets to compare and triangulate findings across all datasets. The information generated from this analysis was used to target interventions and policy responses to reduce deaths and illness. The datasets used by the RxStat initiative are documented in a technical assistance manual U.S. DEP'T. OF JUSTICE, BUREAU OF JUSTICE ASSISTANCE, TECHNICAL ASSISTANCE MANUAL (2014) <http://www.pdmpassist.org/pdf/RxStat.pdf>. The technical assistance manual also provides a roadmap that can be used by communities interested in replicating the RxStat approach.

V. Funding Opportunities

The three initiatives detailed above were all partially funded through the Bureau of Justice Assistance's Harold Rogers Prescription Drug Monitoring Program (HRPDMP) grant program. The Bureau of Justice Assistance normally releases solicitations in the winter or early spring of each year with grant awards being made each fall. Awards under the HRPDMP grant program are typically for a project period of 12 to 36 months, and award amounts have historically been up to \$600,000 for the project period. All solicitations are released at www.bja.gov and through www.grants.gov.

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Drug Ledger Analysis Capabilities of the FBI's Cryptanalysis and Racketeering Records Unit

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I. Introduction

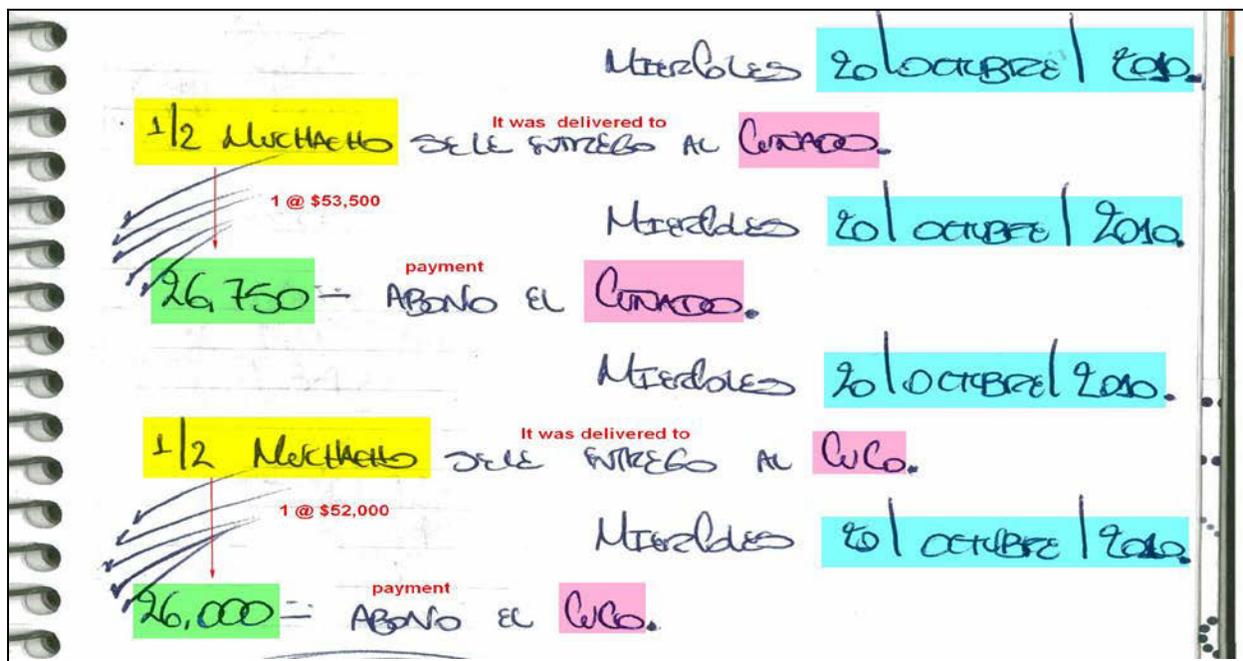
The Cryptanalysis and Racketeering Records Unit (CRRU) is one of the most unique but lesser known units of the Federal Bureau of Investigation (FBI) Laboratory. Forensic television shows have made “fingerprints” and “DNA” household words, while disciplines covered in the CRRU often require a more detailed explanation. Members of this small niche unit refer to themselves as code breakers; however, they do much more. In addition to breaking codes and ciphers, the CRRU analyzes records of suspected illicit businesses, such as sports gambling, loan sharking, prostitution, alien smuggling, and drug trafficking. This article will focus specifically on the analysis of drug ledgers and how that analysis can benefit investigations and prosecutions.

II. Records Analysis

Businesses of a certain size must keep records to track their spending, profits, and products; in this regard, illegal and legal businesses are the same. However, they differ in their maintenance of these records. A legitimate business pays taxes and is subject to audits, and as a result must maintain detailed records. These records typically include full names and addresses, the dates that transactions take place, product identifiers, and accurate descriptions of transactions that occurred. Illicit business records often contain the antithesis of these qualities. Since the ledgers are usually for the record keeper's eyes only, they are often filled with incomplete and cryptic entries. The documents may contain shorthand and abbreviations or coded language purposefully meant to disguise the true nature of the business. CRRU examiners are trained to identify characteristics that will determine if the business is licit or illicit, and if illicit, to determine the type of criminal activity. Characteristics of a drug distribution business may include: cryptic account designations, drug terminology or slang, packaging terminology, manufacturing instructions or recipes, weight indicators, unit pricing, and inventories.

In their analysis, examiners are trained to look for duplicative entries. In drug records, the same transaction may be recorded multiple times. This may occur for several reasons: there may be multiple people keeping track of the same transactions, or one person might write a transaction on a temporary piece of paper and then later transfer that transaction to a larger list or record. Duplicate entries are extremely common in drug records. On one occasion, documents submitted to the CRRU from two different seizure locations and a year apart contained the same drug sale transactions. For that reason, and because the records often lack dates, if there is any possibility that two entries represent the same transaction, the examiner will only count the entry once. This is an effort on the examiner's part to be as conservative as possible.

The annotated image below contains many of the drug characteristics mentioned. Dates are highlighted in blue, accounts in pink, units in yellow, and monetary amounts in green. The record, written in Spanish, details a transaction on October 20, 2010, in which half of a “muchacho” (boy) was delivered to “Cuñado” (brother in law) for \$26,750. Even a quick reading of the record indicates that there is code present. Boys being sold in half quantities is nonsensical at best and horrifying at worst. The word “boy” (in both English and Spanish) is known slang for heroin. This terminology is confirmed by the pricing. If half of a unit is valued at \$26,750, then a whole unit is valued at \$53,500. This price is consistent with kilogram quantities of heroin. Using this page and the rest of the ledgers submitted in this case, the examiner determined that the records were from a multi-drug business that distributed 20 kilograms of cocaine and 80 kilograms of heroin.



III. Reports of Analysis

An examiner’s report will include, if possible, the specific drug distributed, transported, or manufactured; the quantity of drug(s) purchased, sold, and/or manufactured; price per unit; accounts to which units were distributed; dates; and inventory amounts. Reports may also identify code words and relevant findings, such as bank account numbers or money wire transactions. The information in the examiner’s report can give the size and scope of the operation and potentially offer new intelligence information. The analysis can provide a means to verify informant information, tie seizure locations, and link investigations. It might also identify possible cooperating witnesses or informants. CRRU reports

have been used in plea agreements and as part of indictments. These reports also serve as an independent analysis of the business which may be submitted as evidence to assist the trier of fact.

IV. Expert Testimony

Expert testimony involving the analysis of drug records dates back to the 1930s. In fact, one of the most recognized American code breakers, Elizebeth Friedman, appeared as an expert witness in several smuggling cases throughout the prohibition era. Examiners can testify to their qualifications, the methods of their examinations, and the conclusions of their analyses. Defendants may be sentenced on the information found in the records, not just the seizure amounts. In the case from the example above, a CRRU examiner testified at the sentencing hearing. Although the defendant had previously only admitted to cocaine distribution, following the examiner's drug records testimony, the defendant conceded to the heroin distribution and received an enhanced sentence.

V. Evidence Submissions

The Cryptanalysis and Racketeering Records Unit supports domestic law enforcement agencies and prosecutors' offices at all levels of government—federal, state, local, and tribal. Physical evidence such as ledgers, loose papers, and notebooks may be submitted for examination. Digital images of these documents (JPG or PDF) will be accepted with prior approval.

ABOUT THE AUTHOR

□ **Jessica Affeldt** is a forensic examiner in the Cryptanalysis and Racketeering Records Unit of the Federal Bureau of Investigation, where she has worked since 2013. Ms. Affeldt examines suspected drug ledgers and decrypts ciphers and other cryptic communications. Prior to working in the CRRU, Ms. Affeldt worked as an examiner in the FBI's Latent Print Operations Unit.

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Multi-Media Resources: Tools to Build a District Strategy Addressing the Heroin/Opioid Crisis

I. The Opioid Toolkit

The Attorney General's Advisory Committee, under the leadership of then-Chair, Loretta Lynch, and then-Vice Chair, Sally Yates, in coordination with the Executive Office for U.S. Attorneys assembled and published an Opioid Toolkit in 2014. The website contains a brief bank (e.g. pleadings, cooperation agreements, summaries of creative prosecutions, and taskforce initiatives) and outreach and prevention models used by the USAOs across the country. These models include public service announcements, summits with law enforcement and the medical community, and collaboration with local educational institutes. The website also serves as a repository for related webinars, PowerPoints, and other training materials helpful to the USAO community. The Opioid Toolkit can be accessed at <https://portal.doj.gov/eousa/EO/OpioidToolkit/Pages/default.aspx>.

II. Pills to Needles

Pills to Needles is a collaborative initiative begun in 2014 to respond to the sharp spike in heroin deaths in Northern Alabama. Beginning in 2012, the U.S. Attorney's Office for the Northern District of Alabama, under the leadership of United States Attorney Joyce White Vance lead a law enforcement push that resulted in the dismantling of a major heroin and cocaine trafficking organization in Birmingham, as well as the roundup and prosecution of more than 40 street dealers and suppliers in the area. Following those prosecutions, the U.S. Attorney's Office collaborated with key partners, including the University of Alabama at Birmingham School of Public Health, the Jefferson County Department of Health, and the non-profit Addiction Prevention Coalition, to present a one-day summit focused on building awareness of the growing epidemic of opioid abuse and overdose death in Alabama and throughout the country.

Not content to present a summit and be done, the partners used the momentum from the summit to build the community-engaged Pills to Needles Initiative. The initiative's mission is to create a comprehensive and responsive community infrastructure to address this serious public health issue; develop strategies to reduce the ill-effects of heroin and prescription drug abuse; and give voice to those affected by heroin and prescription drug abuse.

The initiative developed by focusing on coalition building and strategic planning. It has six active working groups formed around key impact areas—public awareness, partnership with law enforcement, medical community engagement, research, policy, and access to treatment.

As part of its contribution to the initiative, the U.S. Attorney's Office, working with University of Alabama at Birmingham Digital Media, created six public service announcement videos on opioid abuse, and a short documentary on the effects of heroin addiction on families in the area. The PSAs and documentary are housed on a public website, <http://www.knowdope.org/initiative/>. To place this work in context, the website's homepage is a scrolling graphic that explains the connection between prescription opiate abuse and heroin addiction. The videos are targeted for different age groups, from middle school students to adults, and also have been placed on a YouTube channel so Pills to Needles members have

ready access to them for outreach and public speaking. The initiative is rolling out a social media awareness campaign, as well, using the videos and the hashtag, #knowdope.

The Pills to Needles Initiative is continuing its work with a multi-faceted approach. Through its public health partnership, it is supporting establishment of a proposed University of Alabama System Center for Addictive Behaviors. The center would conduct pure research on addiction and also be a feedback loop for law-enforcement activity in the field. Organizers agree that plans for such a center would not have emerged or been considered as a university system project without Pills to Needles.

The initiative works with the Drug Enforcement Administration in promoting its regular prescription drug take-back days, and is working with DEA and Walgreen's Drugs to establish permanent take-back locations in Alabama Walgreen's stores. Pills to Needles also seeks to promote and provide drug-neutralizing pouches that can be used at home to safely dispose of prescription drugs. The patented Deterra Drug Deactivation System contains a proprietary activated carbon which, when narcotics are emptied into the foil packets and water is added, renders the drugs ineffective for misuse and safe for the environment.

III. UCANSTOP Traffick

In Vermont and elsewhere, heroin dealers are coercing addicts into performing commercial sex for the profit of drug dealing organizations. Sometimes that coercion takes the form of violence or threats of violence. But just as often, it is the result of drug dealers providing, and then withholding the heroin to which users have become addicted. This dangerous intersection of drug and sex trafficking has remained in the shadows, even as Vermont has worked to de-stigmatize addiction. In order to raise awareness of the issue and to put human trafficking victims and survivors in touch with the services they need, in 2015 the U.S. Attorney's Office for the District of Vermont, under the leadership of United States Attorney Eric S. Miller, created a PSA that provides an intense look at the trafficking cycle. The PSA has since won a prestigious Telly Award. It can be seen, along with the audiotaped "in-their-own-words" stories of three trafficking survivors, at <http://www.ucanstoptraffick.org>.

IV. U.S. Attorney's Office for the Northern District of Ohio

On November 21, 2013, many of Northern Ohio's leading institutions gathered for a day-long summit in an effort to find solutions to the region's heroin epidemic. A Community Action Plan was formulated over the course of several planning meetings and finalized during the summit. The purpose of this document is to serve as a guiding master plan as they move forward as a community. The Action Plan is divided into four specific areas: Prevention and Education, Healthcare Policy, Law Enforcement, and Treatment.

The hope is that this Action Plan will serve as a road map and tie together various efforts toward the same goals—preventing people from using heroin, helping treat those who have become addicted, choking off both the supply of and demand for heroin in Northern Ohio, and working collaboratively to make the region healthier, safer and stronger. The Community Action plan is *available at* <https://www.justice.gov/usao-ndoh/heroin-epidemic>.

V. U.S. Attorney's Office for the Western District of Pennsylvania

The United States Attorneys' Office under the leadership of United States Attorney David J. Hickton convened a Working Group to study what they could do better in the areas of heroin addiction, prevention, treatment and recovery. With the guidance of Dr. Mike Flaherty and Dr. Neil Capretto, this

group worked quickly to develop the recommendations set forth in this report. The Overdose, Reduction, Action Plan is *available at* <https://www.justice.gov/sites/default/files/usao-wdpa/legacy/2014/09/29/US%20Attorney%27s%20Working%20Group%20on%20Addiction%20Final%20Report.pdf>

VI. U.S. Attorney’s Office of the District of New Mexico

At a time when the entire nation is confronting an opioid crisis that is affecting Americans in every state and from every background and walk of life, New Mexico, with one of the nation’s highest overdose death rates, is among the states hardest hit. Chancellor Paul B. Roth of the University of New Mexico’s Health Sciences Center and U.S. Attorney Damon P. Martinez launched the New Mexico Heroin and Opioid Prevention and Education (HOPE) Initiative in January 2015 (<http://www.hopeintiativenm.org>).

HOPE is a collaborative effort with the principal goals of protecting their communities from the dangers associated with heroin and opioid painkillers and reducing the number of opioid related deaths in New Mexico. The HOPE Initiative is comprised of five components: (1) prevention and education; (2) treatment; (3) law enforcement; (4) reentry; and (5) strategic planning

HOPE recognizes that medical science and law enforcement have key roles in responding to this crises, but acknowledges that prosecution and treatment are not enough. It is committed to working collaboratively with a diverse cross-section of community stakeholders to develop new strategies for education, prevention, and intervention. At its core, the HOPE Initiative is about making New Mexico healthier, safer, stronger, and drug free.

VII. U.S. Attorney’s Office for the Northern District of West Virginia

Project FUTURE, <https://www.justice.gov/usao-ndwv/project-future>, is a comprehensive strategy to educate parents and children about the dangers of prescribed medicine, synthetic drugs, and other illegal drugs that are plaguing communities in West Virginia.

Throughout the school year members of the United States Attorney’s Office for the Northern District of West Virginia, under the leadership of United States Attorney William J. Ihlenfeld, II travel to middle schools and high schools around the state to educate young people about the dangers of drugs. Special guest speakers with real-life experience in dealing with addiction are part of each program. In addition, community awareness meetings are held in the evening so that parents are aware of warning signs that their children may be using drugs. A discussion of emerging trends and threats, including synthetic drugs, are held at each event.

VIII. U.S. Attorney’s Office for the District of New Hampshire

New Hampshire has the third-highest rate of per capita drug overdose deaths nationwide. Four hundred and thirty-three individuals died from drug overdoses in New Hampshire in 2015. Two hundred and eighty-three of these deaths resulted from overdose of fentanyl, either alone or in combination with other drugs.

United States Attorney Emily Gray Rice and New Hampshire Attorney General Joseph Foster formed a joint team to prosecute drug overdose cases. The purpose of the team is to increase and coordinate the prosecutorial resources focused on overdose deaths. Attorney General Foster emphasized that “Our joint team effort to prosecute those who are criminally responsible for overdose deaths is a

critical element of the multi-faceted law enforcement approach needed to combat the drug epidemic in our state.” See Press Release, U.S. Attorney’s Office, Dist. of N. H. <https://www.justice.gov/usao-nh/pr/united-states-attorney-emily-gray-rice-and-new-hampshire-attorney-general-joseph-foster>.

Note from the Editor . . .

First, I want to thank Jason Cunningham, National Narcotics Issues Coordinator, EOUSA, for his invaluable work with the authors and reviewers of this issue. He was instrumental in allowing us to produce this important and timely issue of the Bulletin addressing the heroin and opioid crisis.

Second, you may note some changes in format and font in this issue. You may also note that this Bulletin is substantially longer than issues in the past. In part, that is a result of the importance of the topic. It is also a result of our efforts to provide a comprehensive discussion of the major strategies being used to address the heroin and opioid crisis. We are constantly striving to improve the Bulletin by increasing its usefulness to United States Attorneys and Assistant United States Attorneys across the nation. If you have any suggestions, please share them with us.

Third, we are always looking for ideas for topics for the Bulletin. We are also always looking for authors to write in their area of expertise. If you have any suggestions for an issue topic or if you are interested in authoring an article or serving as a reviewer, please contact me.

One final note. Jim Donovan served as Editor of the Bulletin for over 18 years. He brought the publication from an enhanced newsletter to a quality law journal focusing on the most important issues of the day. Jim retired in late June. We wish him well in his retirement and thank him for his many significant contributions to helping us all in the work we do every day. He will be missed.

Thank you,
Tate Chambers