Fentanyl and Related Threats

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James A. Crowell IV
Director

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Editor in Chief
K. Tate Chambers

Lead Editor
Nikki Piquette

Law Clerks
Joseph Garfunkel
Aimee Intagliata

Internet Address
https://www justice gov/usao/resources/united-states-attorneys-bulletins

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Introduction

James A. Crowell IV
Director
Executive Office for United States Attorneys

We are facing the deadliest drug crisis in American history. Confronting the nation's opioid epidemic is one of the Department of Justice's highest and most pressing priorities.

Fentanyl—a synthetic opioid much stronger than heroin—and related threats are fueling this lethal crisis. Fentanyl is sold in many forms in the United States—such as powder, crystals, or liquid—and only a couple milligrams can kill. Fentanyl can be mixed into other drugs, such as heroin and cocaine, or pressed into pills and sold as counterfeit prescription drugs. Users who seek to obtain these other drugs often have no idea they are actually putting something much deadlier into their bodies. Even worse, fentanyl analogues, like carfentanil, are even more potent than fentanyl and are being trafficked to users with increasing frequency, further threatening the lives of countless Americans.

In addition to the overdose user deaths, fentanyls pose enormous risks to the safety of law enforcement, first-responders, and postal and package handlers. Police officers, agents, emergency medical personnel, and canine units can accidentally inhale or ingest microscopic yet highly lethal amounts of the substances during calls for emergency services. Because fentanyls are often shipped surreptitiously from China into the United States, package carriers and mail handlers can be exposed if these substances escape their packaging.

The proliferation of fentanyls has resulted in breathtaking increases in fatal drug overdoses. Approximately 64,000 Americans lost their lives to drug overdoses in 2016—the highest drug death toll in American history—with at least 20,000 of those deaths attributable to fentanyls.

Crime rates are not like the tides. We must break out of the vicious cycle of drug abuse, addiction, and overdose that has devastated countless American families. We can and must take action that makes a difference by using every tool at our disposal to end this drug crisis.

Despite the bleak outlook, there is new cause for optimism. The President, the Attorney General, and the Deputy Attorney General have made clear that we will defeat the opioid crisis. The articles that follow demonstrate that federal prosecutors and civil practitioners, brave agents and officers, public health officials, regulators, and other talented women and men are working tirelessly to fulfill that pledge. U.S. Attorneys' Offices (USAOs)—which I am honored to serve and support—are working with the Drug Enforcement Administration, Homeland Security Investigations, the Organized Crime Drug Enforcement Task Forces (OCDETF), and other law enforcement agencies to disrupt fentanyl chains of supply from China into the United States and prosecute the peddlers of this poison in our communities. The Department of Justice is better aligning its training and resources and using sophisticated data to better target opioid- and fentanyl-related crime. Prosecutors and agents are making progress in disrupting dark web fentanyl trafficking. USAOs are engaging their communities with opioid-prevention efforts, working closely with medical examiners to obtain key evidence for trials, and promoting appropriate treatment to quell the ravages of addiction.

We are pleased to address such an important, timely topic in this issue of the *USABulletin.*

My gratitude to the Executive Office for U.S. Attorneys' Office of Legal Education and Office of Legal and Victim Programs and the Executive Office for OCDETF for compiling this compelling issue. I also thank all the authors, reviewers, and editors for their skill and hard work.

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Danger in Milligrams and Micrograms: United States Attorneys' Offices Confront Illicit Fentanyls

Seth Adam Meinero
National Violent-Crime and Narcotics Coordinator
Executive Office for United States Attorneys

From Appalachian hamlets to inner-city streets, from struggling Rust Belt towns to tony suburbs, skyrocketing overdose deaths have cast a pall across the country.

The primary drivers of this alarming trend are fentanyls: the synthetic opioid fentanyl itself and its synthetic derivatives, or analogues.[1] According to estimates from the National Institute on Drug Abuse, over 63,000 Americans died of drug overdoses in 2016. Approximately two-thirds of these deaths involved an opioid, with over 20,000 of the deaths related to fentanyls.[2] The precipitous rise in drug deaths in recent years—fueled by fentanyls—has been so momentous, it has pulled down many Americans' average life expectancy by about two months.[3]

Each United States Attorney's Office (USAO) is confronting this deadly dilemma, implementing a comprehensive strategy to tackle illicit fentanyl trafficking. This article discusses the origins of this grave epidemic and the USAOs' relentless efforts to end it.

I. A Crisis "Impossible to Overstate"

When Belgian physician Paul Janssen developed fentanyl as an analgesic to treat severe pain in 1960,[4] he could have scarcely imagined planting the seeds of a 21st century public health flashpoint.

Fentanyl is a Schedule II controlled substance under the Controlled Substances Act.[5] It has an "accepted medical use," but also a "high potential for abuse" with potential for "severe psychological or physical dependence."[6] Its strong opioid properties—producing both insensitivity to pain and a euphoric high—make it a particularly attractive drug of abuse for opioid users.[7] Medical doses of fentanyl—which can be inhaled, injected, or absorbed through skin—are typically administered in micrograms, usually

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[1] For efficiency, this article uses the term "fentanyls" as an aggregation of fentanyl itself and analogues such as acetylfentanyl, carfentanil, alfentanil, and sufentanil. However, "due to variations in the legal and scientific definitions of analog[ue]s, it may be inaccurate to call all fentanyl varieties a fentanyl analog[ue]." *Counterfeit Prescription Pills Containing Fentanyls: A Global Threat*, DEA INTELLIGENCE BRIEF 2 (July 2016).
[2] *Overdose Death Rates,* NAT'L INST. ON DRUG ABUSE (Sept. 2017).
[3] Deborah Dowell, MD, MPH, Elizabeth Arias, PhD, & Kenneth Kochanek, MA, et al, *Contribution of Opioid-Involved Poisoning to the Change in Life Expectancy in the United States, 2000-2015*, 11 J. AM. MED. ASS'N NETWORK 1065 (2017). While overall life expectancy rose about two years from 2000 to 2015, opioid overdose deaths pulled down that gain by about two months for non-Hispanic White Americans.
[4] Theodore H. Stanley, *The Fentanyl Story*, 15 AM. J. PAIN 1215 (2014).
[5] 21 U.S.C. § 812(c)(Schedule II)(b)(6) (2012); 21 C.F.R. § 1308.12(c)(9).
[6] § 812(b)(2).
[7] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 57 (Oct. 2017).

well under one milligram.[8] Exposure of over one milligram risks an overdose. Signs of a fentanyl overdose include: labored or shallow breathing; pinpoint pupils; cold, clammy skin; extreme fatigue; inability to walk or talk normally; confusion; fainting; and dizziness.[9] The estimated lethal dose of pharmaceutical grade fentanyl in humans is two milligrams, the mass of approximately two grains of salt.[10]

Figure 1. Two Milligrams of Fentanyl (a lethal dose in most people) Next to a Penny

Fentanyl's emergence as a preeminent threat followed in the wake of a precipitous rise in heroin use during the first half of this decade. According to the National Survey on Drug Use and Health, the number of heroin users in the United States increased by 184 percent from 2007 to 2014.[11] While a dip in

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[8] *Fentanyl Dosage,* DRUGS.COM, https://www.drugs.com/dosage/fentanyl.html (last visited Apr. 20, 2018).
[9] *Fentanyl Overdose Symptoms and Treatment,* WAISMANN METHOD, https://www.opiates.com/fentanyl-overdose/#Signs-of-Fentanyl-Overdose (last visited Apr. 20, 2018). A video from the Canadian Broadcasting Corporation explaining fentanyl's lethal effect on the respiratory system is available on YouTube. CBC News, *How fentanyl kills: A CBC News explainer*, YOUTUBE, https://www.youtube.com/watch?v=jj6C_f0TFoE (last visited Apr. 27, 2018).
[10] *Fentanyl drug profile,* EUROPEAN MONITORING CTR. FOR DRUGS AND DRUG ADDICTION (Jan. 8, 2015).
[11] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 49 (Oct. 2017).

use occurred from 2014 to 2015, the number of users in 2015 was still a 115 percent increase from 2007.[12]

As demand for heroin grew, traffickers increasingly adulterated heroin with fentanyl and other synthetic opioids. Beginning in late 2013, several states reported increases in fatal overdoses due to fentanyl and its analogue acetylfentanyl, a synthetic not as potent as fentanyl, but still five times more potent than heroin.[13] Some of the unlucky heroin-seeking users had no idea they were using fentanyl, which looks and is packaged like heroin powder. Other unfortunates—who had sought street-sold prescription pills—actually purchased counterfeit pills pressed with fentanyl.[14] Eventually, word spread that fentanyl itself was available on the street and was thirty to fifty times more potent than heroin.[15] Seeking more intense highs, some serious users increasingly wanted it.[16]

From 2013 to 2014, the number of deaths related to synthetic opioids, including fentanyl, jumped seventy-nine percent, with at least 5,544 synthetic opioid related deaths in 2014. Those deaths kept mounting. In 2016, at least 20,145 Americans died from overdoses related to fentanyls.[17]

By 2016, an even more harrowing threat emerged in the country's illicit drug supply: the fentanyl analogue carfentanil, another Schedule II controlled substance.[18] Manufactured as a tranquilizer for large animals such as elephants, moose, elk, and bears, this analogue is approximately 100 times more potent than fentanyl.[19] Carfentanil has never been tested in humans, and its precise lethal dose is unclear. However, based on its estimated potency, as little as twenty *micro*grams of carfentanil—half the mass of a single grain of salt, or less—can kill someone.[20]

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[12] *Id.*

[13] *National Heroin Threat Assessment Summary (Updated)*, DEA INTELLIGENCE REPORT 5 (June 2016); David Kroll, *CDC Issues Alert on Deadly New Designer Drug, Acetyl Fentanyl,* FORBES (Aug. 29, 2013).

[14] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 59 (Oct. 2017).

[15] *FAQ's- Fentanyl and Fentanyl-Related Substances,* U.S. DRUG ENFORCEMENT ADMIN., https://www.dea.gov/druginfo/fentanyl-faq.shtml (last visited Apr. 20, 2018).

[16] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 59 (Oct. 2017).

[17] *Overdose Death Rates,* NAT'L INST. ON DRUG ABUSE (Sept. 2017). While a dramatic increase in synthetic-opioid deaths is undisputed, a factor contributing to the steep rate increase in deaths may be underreporting of opioid-related deaths in prior years. Underreporting remains an issue in current data, but more recently, public health officials have become increasingly sensitive to the possibility of synthetic opioids as a cause of death, and medical examiners have become better at testing for synthetic-opioid-involved overdoses. *See Omissions On Death Certificates Lead To Undercounting Of Opioid Overdoses,* NPR (Mar. 28, 2018) (explaining why opioid overdose deaths are not always captured in the data reported to the federal government).

[18] 21 C.F.R. § 1308.12(c)(6).

[19] *Carfentanil,* NAT'L CTR. FOR BIOTECHNOLOGY INFO. (May 19, 2018).

[20] *Carfentanil: A Grain of Salt,* HAZMAT NATION, http://www.hazmatnation.com/carfentanil-response/#sthash.fX1esjfY.dpbs (last visited Apr. 21, 2018).

Figure 2. Illustration of Comparative Lethal Doses of Heroin, Carfentanil, and Fentanyl

The continued introduction of new, deadlier analogues such as carfentanil has beleaguered prosecutors. Joseph Pinjuh, a veteran Assistant United States Attorney (AUSA) who has handled countless drug cases in the Northern District of Ohio, expressed federal prosecutors' sense of exasperation at beginning to understand issues related to one opioid, like fentanyl, then confronting newer, more-lethal threats, like carfentanil: "You feel like a kid with his finger in the dike, you know? We're running out of fingers."[21]

[21] *Elephant sedative emerges as new threat in opioid overdose battle*, L.A. TIMES (July 28, 2016).

While diversion of pharmaceutical fentanyl from healthcare facilities has contributed to fentanyl abuse, illicitly produced fentanyls are most responsible for the United States' fentanyl epidemic.[22] A complex of chemical companies in China, operating legally and illegally, is the primary source of supply.[23] American traffickers can buy fentanyl and fentanyl-making products relatively cheaply online from Chinese distributors. Chinese manufacturers can mask their identities through online ordering systems, and exporters can avoid detection through mislabeling and various concealment methods.[24]

Chinese fentanyl—in powder, crystal, and counterfeit prescription pill forms—is transported in parcel packages directly to the United States from China or from China through Canada, and to Mexico and smuggled across the southwest border. The Drug Enforcement Administration (DEA) maintains that most of the United States' fentanyl supply comes directly from China or from China through Mexico. Larger volumes have been seized at the southwest border, with purity levels of around seven percent. Conversely, smaller volumes have arrived directly from China, but with purity values of over ninety percent, and with much higher value than the smuggled fentanyl from Mexico.[25]

Figure 3. Fentanyl Crystals and Pills

Law enforcement agencies around the country are seizing more and more kilogram quantities of fentanyl. In 2016, agencies seized a record high 287 kilograms nationwide, a seventy-two percent

[22] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 59 (Oct. 2017).
[23] Sean O'Connor, *Fentanyl: China's Deadly Export to the United States*, U.S.-CHINA ECONOMIC AND SECURITY REVIEW COMMISSION 3, 7 (2017).
[24] *Id.* at 8-9.
[25] *2017 National Drug Threat Assessment*, U.S. DEPARTMENT OF JUSTICE DRUG ENFORCEMENT ADMIN. 65 (Oct. 2017).

increase from the prior year.[26] That amount was enough to kill up to 143.5 million people—over one third the entire population of the United States.

Besides the risk to users, further troubling is that seizing fentanyls imperils law enforcement officers, first responders, and even police dogs. Because the lethal dose of fentanyl is so small, and the lethal dose of carfentanil miniscule, these drugs can be accidentally inhaled or absorbed through the skin or eyes during enforcement actions or emergency responses. DEA has issued an alert to police and the public about the risk of accidental exposure, and has published a detailed guide to first responders for handling fentanyls and how to treat accidental exposure.[27]

Testifying before a Senate subcommittee in April 2018, United States Attorney Christina Nolan described the impact of the nation's opioid crisis as "impossible to overstate," and discussed the bane of fentanyl in her home district of Vermont:

> On a daily basis, I see the death and destruction caused by fentanyl and fentanyl analogues. In 2017 in Vermont—a state of only 625,000 citizens—we lost 107 people to opioid overdose deaths, about two-thirds of those attributable to fentanyl. In only one year, deaths involving fentanyl increased by more than a third, from forty-nine in 2016 to sixty-seven in 2017. We desperately want all 107 of those people back.[28]

Communities around the country want their people back. As USAO prosecutions in these diverse districts from the last two years show, no region has been spared the scourge:

- *Eastern District of Kentucky*: Fred Rebmann sold a pregnant woman a controlled substance he believed to be heroin, but was actually fentanyl. A toxicology report revealed the victim had five times the therapeutic dose of fentanyl in her system, with no trace of heroin or any other controlled substance in her body. Rebmann pleaded guilty to distributing a controlled substance resulting in death. In December 2016, he received a thirty year prison sentence.[29]
- *Eastern District of Virginia:* Erskine A. Dawson led a drug trafficking conspiracy resulting in over a dozen overdoses and the deaths of two Virginians. He managed over a half-dozen associates who trafficked kilograms of heroin and fentanyl from New Jersey to Virginia. Their product was known for its potency, and they marketed it in wax baggies stamped with Dawson's own moniker, "King of Death," and other names like "Last Call" and "Mad Max." Despite knowing their product had caused multiple overdoses and killed users, Dawson and his associates kept selling it. Dawson pleaded guilty to conspiracy to manufacture, distribute, and possess with intent to manufacture and distribute heroin and fentanyl, distribution of fentanyl resulting in death, and possession of firearms during and in relation to a drug trafficking crime. In November 2017, he was sentenced to thirty-six years in prison. Rashad Clark, Dawson's New Jersey-based supplier, pleaded guilty to trafficking crimes, and in April 2018, received a thirty-seven year sentence. Kenneth Stuart, another New Jersey-based supplier, with ten prior out-of-state drug convictions, was sentenced in April 2018 to life in prison for leading, organizing, and supplying

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[26] *Id.* at 58.
[27] *DEA Issues Carfentanil Warning to Police and Public,* U.S. DRUG ENFORCEMENT ADMIN. (Sept. 22, 2016); *see generally Fentanyl: A Briefing Guide for First Responders*, U.S. DRUG ENFORCEMENT ADMIN. (June 2017) (detailing recommendations for first responders, exposure risks and treatment, fentanyl detection, and remediation and decontamination recommendations).
[28] Press Release, U.S. Dep't of Justice, U.S. Attorney Christina Nolan of the District of Vermont Delivers Testimony on the Dangers of Fentanyl before the Senate Subcommittee on Crime and Terrorism (Apr. 11, 2018).
[29] Press Release, U.S. Attorney's Office (ED. Ky), Man Who Distributed Drugs That Caused Overdose Death Of Pregnant Woman in Fayette County Sentenced To Thirty Years (Dec. 14, 2016).

the conspiracy. Eight coconspirators indicted in the case were convicted and sentenced to significant prison terms.[30]

- *Northern District of New York*: In November 2015, Anthony Vita sold seven bags of fentanyl-laced heroin and a syringe to a twenty-four year old pregnant woman. After injecting the mixture, she died from acute opiate intoxication. Vita pleaded guilty to distribution of a controlled substance. In August 2017, he was sentenced to fifteen years.[31]
- *District of Oregon*: In March 2015, Channing Lacey distributed fentanyl that caused the death of one inmate and nonfatal overdoses of three other inmates inside the Multnomah County jail. Lacey had been arrested on allegations she tampered with evidence related to another federal case involving her boyfriend, who had previously been arrested for distributing fentanyl on the dark web. Lacey concealed an amount of packaged fentanyl within her body. After arriving inside the jail, she retrieved the fentanyl and distributed it to another inmate, who distributed some more of it to other inmates. From March 7 to 9, 2015, three inmates overdosed on that fentanyl and required administration of naloxone—an emergency opioid overdose antidote—to save their lives. On March 21, a fourth inmate overdosed from the same batch and died. Lacey pleaded guilty to two distribution related counts in a superseding indictment. In August 2017, she was sentenced to 135 months in federal prison.[32]
- *Southern District of Iowa:* In June 2015, Charles Jesse Beuterbaugh distributed acetylfentanyl to a twenty year old victim who fatally overdosed from it. Beuterbaugh had obtained the acetylfentanyl from an organization that distributed fentanyl or fentanyl analogue until April 2016. Around the same time of the twenty year old's death, Beuterbaugh distributed to a second man who overdosed, required hospitalization, and was placed on life support. Two others responsible for distributing the acetylfentanyl were sentenced in October 2017 to 162 months and 144 months, respectively, in prison. Beuterbaugh pleaded guilty to conspiring to distribute a fentanyl analogue resulting in death. In November 2017, he was sentenced to twenty years in prison.[33]
- *Eastern District of Wisconsin:* In May 2017, Anthony R. Chaplin sold a woman methamphetamine and what he believed to be heroin, but was actually fentanyl. The woman died, and a medical examiner concluded the combination of both substances killed her. Chaplin pleaded guilty to distributing fentanyl and methamphetamine. In February 2018, he was sentenced to twenty years in prison.[34]
- *Southern District of Texas:* In March 2017, Customs and Border Protection authorities arrested Jeffrey Layne Parker after he was found at a border checkpoint in Laredo with 11.77 kilograms of fentanyl, 1.85 kilograms of heroin, seventy-six grams of cocaine, and 1.41 kilograms of marijuana. Due to a medical issue, Parker was released from custody. Three months later, Parker was stopped at the same checkpoint, and authorities found him possessing another 11.15

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[30] Press Release, U.S. Attorney's Office (E.D. Va.), "King of Death" Dealer Sentenced for Heroin and Fentanyl Distribution (Nov. 1, 2017); Press Release, U.S. Attorney's Office (E.D. Va.), "King of Death" Supplier Sentenced to 37 Years (Apr. 2, 2018); Press Release, U.S. Attorney's Office (E.D. Va.), "King of Death" Heroin Supplier Sentenced to Life in Prison (Apr. 24, 2018).
[31] Press Release, U.S. Attorney's Office (N.D. N.Y.), Anthony Vita Sentenced in Fentanyl-Laced Heroin Death (Aug. 22, 2017).
[32] Press Release, U.S. Attorney's Office (D. Or.), Portland Woman Sentenced to 135 Months in Prison for Distributing Fentanyl inside Multnomah County Jail (Aug. 28, 2017).
[33] Press Release, U.S. Attorney's Office (S.D. Iowa), Fentanyl Overdose Sentenced (Nov. 7, 2017).
[34] Press Release, U.S. Attorney's Office (E.D. Wis.), Oshkosh Drug Dealer Receives 20 Years in Federal Prison for Overdose Death (Feb. 12, 2018).

kilograms of heroin concealed in his pickup truck. Had he distributed it, the fentanyl he possessed alone could have killed up to 5.8 million people. Parker pleaded guilty to trafficking fentanyl, heroin, and cocaine. In March 2018, he was sentenced to 168 months in prison.[35]

II. USAO Strategies to Combat Illicit Fentanyls

By September 2016, United States Attorneys, such as Bill Ihlenfeld of the Northern District of West Virginia, were recognizing that fentanyls had changed the landscape. The prior month, that district alone had suffered clusters of overdoses, including thirty overdoses in Huntington in just four hours.[36] The Department of Justice needed to respond.

On September 21, 2016, Attorney General Loretta E. Lynch announced the Department of Justice's comprehensive "Strategy to Combat the Opioid Epidemic." The strategy rested on three pillars: (1) preventing individuals from succumbing to addiction; (2) enforcing the Nation's federal drug laws to deter and punish traffickers and others responsible for the epidemic; and (3) ensuring that the Department partner with other government agencies, nonprofits, and private individuals to ensure that all citizens get the opioid treatment they need.[37]

Concurrent with Lynch's memorandum, Deputy Attorney General Sally Q. Yates directed all ninety-three United States Attorneys to consult with their local stakeholders and draft district-specific opioid strategies focusing on each pillar of prevention, enforcement, and treatment. The strategy's enforcement prong required prosecutors to direct their resources toward "the greatest threats, including but not limited to individuals and institutions responsible for the trafficking of heroin and fentanyl, those who improperly prescribe or divert opioids, and those who use violence to further drug-trafficking activities."

By February 2017, each USAO had developed a district-specific opioid strategy. While the strategies are as diverse as the districts the USAOs serve, some common efforts to address fentanyl emerged. In addition, some USAOs developed innovative initiatives that serve as models for other districts.

A. Prevention

USAOs have taken a broad approach in tackling the opioid problem, not only performing their traditional law enforcement function, but also engaging in prevention initiatives and community outreach.

United States Attorneys, AUSAs, and USAO staff have participated in outreach efforts that educate their communities about the dangers of heroin and opioids, including fentanyl. Many USAOs have used *Chasing the Dragon: The Life of an Opiate Addict,* a documentary the DEA and the Federal Bureau of Investigation (FBI) released that compiles heart-wrenching, first-person accounts by users and users' family members about their experiences.[38] USAOs have hosted innumerable showings of *Chasing the Dragon* nationwide, often presenting it at schools and using the film as a springboard for an interactive discussion among AUSAs, law enforcement officers, healthcare professionals, grade school and college students, faith-based groups, and other community members. Among other offices, USAOs in the districts of Middle Alabama, Northern California, Central Illinois, Southern Indiana, North Dakota,

[35] Press Release, U.S. Attorney's Office (S.D. Tex.), Man Sentenced for Trafficking Enough Fentanyl to Possibly Kill Nearly 6 Million People (Mar. 23, 2018).
[36] Press Release, U.S. Attorney's Office (N.D. W. Va.), Focus on Fentanyl: Awareness week shines light on emerging threat (Sept. 19, 2016).
[37] Memorandum from the Attorney General to the Heads of Dep't of Justice Components 1, 2, 4, 7 (Sept. 21, 2016).
[38] U.S. Drug Enforcement Administration, *Chasing the Dragon: The Life of an Opiate Addict* (2016), https://www.dea.gov/media/chasing-dragon.shtml.

Middle Pennsylvania, Rhode Island, South Dakota, Eastern Tennessee, and Western Texas have used *Chasing the Dragon* in their outreach and prevention activities.

USAOs have supported deploying naloxone to local law enforcement and first responder partners. Naloxone, known commercially as Narcan, is a lifesaving medicine that reverses the negative effects of opioids on the nervous and respiratory systems and can be used to treat acute fentanyl or carfentanil overdoses. Naloxone can quickly restore breathing and consciousness and can be easily administered in multiple ways, including as a nasal spray. It has become a critical tool for first responders and law enforcement officers in their efforts to reduce fentanyl overdose deaths. Many USAOs—including in the districts of Colorado, Delaware, Northern Florida, Kansas, Eastern and Western Louisiana, Middle North Carolina, Eastern Washington, and Wyoming—have promoted and shared DOJ's Bureau of Justice Assistance Law Enforcement Naloxone Toolkit with their law enforcement partners. This internet resource provides answers to frequently asked questions about naloxone, as well as sample documents and templates such as data collection forms, standard operating procedures, and training and community outreach materials. These templates can be downloaded and customized for any law enforcement agency.[39]

The USAO for the Northern District of Ohio provides an eminent example of using outreach to address its region's opioid and fentanyl crisis. The USAO collaborated with local partners to develop a community action plan that includes numerous education and prevention activities: educating middle and high school students on the dangers of heroin and prescription drugs; promoting an education program based on the National Health Education Standards and the Centers for Disease Control's Characteristics of Health Education; participating in town hall meetings on opioid issues throughout the district; collaborating with pharmacies to inform customers of proper prescription drug disposal; and establishing prescription drug "takeback" boxes in all municipalities within Cuyahoga County.

B. Enforcement

USAOs are vigorously prosecuting fentanyl traffickers and bringing them to justice. USAOs and their partners with the Organized Crime Drug Enforcement Task Forces (OCDETF) are building complex, large scale investigations to identify sources of supply and bring the full force of federal authority to thwart fentanyl trafficking organizations with high impact prosecutions. USAOs and OCDETF work together with federal, state, local, and tribal law enforcement agencies to interdict international shipments of heroin and fentanyl.[40]

USAOs and their partners have bolstered their investigations of overdose cases, identifying and pursuing traffickers and street distributors responsible for causing deaths and serious bodily injury. Prosecutors have a strong statutory tool for pursuing fentanyl overdose cases: under 21 U.S.C. § 841(b)(1)(C), individuals responsible for distribution of any amount of fentanyl or of any Schedule I or II fentanyl analogue resulting in death or serious bodily injury are subject "to a term of imprisonment of not less than twenty years or more than life."[41] These prosecutions are particularly potent to deter and punish distributors who inflict the gravest harms on communities.

The USAO for the Eastern District of Kentucky has successfully used the § 841(b)(1)(C) enhancement in at least two high profile cases. First, the USAO prosecuted Navarius Westberry, a man from Detroit, Michigan, living in Richmond, Kentucky, who led a drug ring that trafficked heroin and fentanyl from Detroit to Richmond. From January 2014 until August 2015, Westberry's operation

[39] *Law Enforcement Naloxone Toolkit,* BUREAU OF JUSTICE ASSISTANCE NAT'L TRAINING AND TECHNICAL ASSISTANCE CTR., https://www.bjatraining.org/tools/naloxone/Naloxone%2BBackground (last visited Apr. 20, 2018).

[40] *Organized Crime Drug Enforcement Task Forces,* U.S. DEP'T OF JUSTICE (June 9, 2015).

[41] 21 U.S.C. § 841(b)(1)(C) (2012).

distributed between 750 grams and one kilogram of heroin and fifty grams of fentanyl into Richmond. His organization was among the first to introduce large amounts of fentanyl into Richmond, and his product caused multiple overdoses and fatalities, including the death of a twenty-five year old victim from Madison County, Kentucky. The victim's toxicology report and autopsy revealed that fentanyl Westberry had distributed in March 2015 caused the victim's death.[42]

Four of Westberry's coconspirators pleaded guilty, including Benjamin Frederick Charles Robinson, who was sentenced to the twenty year minimum for distribution that caused the serious bodily injury of another victim. On January 9, 2017, following an extensive sentencing hearing, a district judge sentenced Westberry to life imprisonment. This was the first Eastern Kentucky case in which a life sentence was imposed as a result of fentanyl overdose.[43]

Second, the USAO prosecuted Robert Lee Shields, a resident of Cincinnati, Ohio, who in August 2016 distributed carfentanil, resulting in the death of one person and multiple near fatal overdoses in Montgomery County, Kentucky. In July 2017, a jury found Shields and his codefendant, Wesley Scott Hamm, guilty of conspiring to distribute heroin, fentanyl, and carfentanil, distribution of carfentanil resulting in death, and distribution of carfentanil resulting in serious bodily injury. In January 2018, a district judge sentenced Shields to two terms of life imprisonment and Hamm to a total term of 420 months in prison.[44]

A key to building successful fentanyl overdose prosecutions is ensuring that critical evidence is secured at the overdose scene. USAOs and their local partners are increasingly treating these overdose scenes as homicide scenes.

For example, following a forty percent increase in fentanyl and other opioid related deaths in Louisville from 2014 to 2016, the USAO for the Western District of Kentucky and its local partners formed the Heroin Investigation Team (HIT). HIT is a unit of DEA Special Agents, Louisville Metro Police Department (LMPD) Major Case Narcotics Unit detectives, an Assistant Commonwealth's Attorney, and an AUSA. Because homicide detectives alone have inadequate resources to fully process every overdose scene like a homicide scene, HIT worked closely with the LMPD Homicide Unit to develop a set of criteria for overdose scenes that, when present, triggers a call to HIT personnel. HIT brings additional resources to bear, responding to the opioid overdose scene, obtaining all available evidence (e.g., cell phones, cell records and data, and witness statements), and attempting to exploit all the evidence to identify anyone responsible for selling the fentanyl to the victim.

HIT members coordinate their investigative efforts with state prosecutors and the USAO, and work closely with the DEA to develop the investigation to its fullest potential. Depending upon the facts of the case, the objective is to work toward the prosecution of the supplier in state court for manslaughter charges or in the federal system under the twenty year mandatory minimum death-resulting enhancement. Additionally, investigators make every attempt to expand the investigation and identify those responsible for supplying fentanyl to the charged street level dealer.

Numerous USAOs have partnered with DEA regional offices to support the DEA 360 Strategy. The 360 Strategy takes a multifaceted approach to combating opioid use. Among other things, it calls for coordinated law enforcement actions against drug cartels and heroin and fentanyl traffickers in specific communities. Further, it promotes community outreach through local partnerships that empower communities to take back affected neighborhoods following enforcement actions, and prevent the same

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[42] Press Release, U.S. Attorney's Office (E.D. Ky.), Leader of Drug Trafficking Ring Sentenced to Life For Distributing Fentanyl That Caused Overdose Death Of Madison County Man (Jan. 11, 2017).
[43] *Id.*
[44] Press Release, U.S. Attorney's Office (E.D. Ky.), Cincinnati Man Sentenced to Life Imprisonment for Distributing Carfentanil that Resulted in Death (Jan. 26, 2018).

problems from recurring.[45] Some of the USAO strategies that have supported DEA 360 include those in the districts of Southern Ohio, Western Texas, and Eastern and Western Wisconsin.

C. Treatment

Success in combating fentanyls requires addressing the ravages of addiction: the inexorable pull that draws users to opioids and puts them in fentanyls' path. While USAOs have traditionally operated in a system focused on prosecution, conviction, and incarceration, they have increasingly supported alternatives to incarceration for low level, nonviolent offenders whose unlawful conduct has been driven by their addiction.

Where feasible or practical, USAOs have supported establishing or expanding drug courts or other specialty courts, such as veterans or tribal wellness courts, that address substance abuse. AUSAs assigned to drug courts are promoting the use of medication assisted treatment for drug court participants, and are ensuring that defendants who need treatment for opioid abuse are having that need noted by judges at sentencing in judgment-and-commitment orders. USAOs have also considered establishing or expanding pretrial diversion programs for low level, nonviolent offenders who suffer from opioid addiction. Defendants who successfully complete the court programs typically receive reduced sentences of supervised release or deferred prosecution. USAOs that have furthered these kinds of treatment efforts include offices in the districts of Connecticut, District of Columbia, Middle Louisiana, Southern Georgia, Guam and Northern Marianas, Utah, Vermont, Eastern Washington, and Northern West Virginia.

III. Enhanced Efforts to Combat Fentanyls

Following the change in administration in January 2017, the Department and the USAOs intensified their efforts to address fentanyls.

USAOs made progress in disrupting fentanyl trafficking on the dark web. On July 17, 2017, the Department announced the seizure of AlphaBay, the largest underground market of the dark web. The FBI's investigation into AlphaBay revealed that numerous vendors used it to sell fentanyl and heroin. Multiple overdose deaths across the country were attributed to purchases on the site, including a fentanyl overdose in Orange County, Florida, in February 2017. The USAO for the Eastern District of California indicted Alexandre Cazes, a Canadian citizen residing in Thailand, for conspiracy charges related to racketeering, drug distribution, identity theft, money laundering, and other offenses. Following his arrest in Thailand, on July 12, 2017, Cazes apparently took his own life while in custody. The USAO also filed a civil forfeiture complaint against Cazes and his wife's assets throughout the world, including in Thailand, Cyprus, Lichtenstein, and Antigua and Barbuda. In addition, the USAO has pursued other AlphaBay traffickers, including Emil Vladimirov Babadjov. He accepted orders for heroin, fentanyl, and methamphetamine through AlphaBay, and mailed drugs from a post office in San Francisco, California, to customers throughout the United States. In January 2018, a district judge sentenced Babadjov to seventy months in prison.[46]

Recognizing that "more and more of our citizens are killed by fentanyl," Attorney General Jefferson Beauregard Sessions, III, on November 29, 2017, directed each United States Attorney to appoint an Opioid Coordinator to lead his or her district's efforts to combat opioids. Sessions set forth several responsibilities for these Coordinators, including: facilitating their offices' intake of cases involving prescription opioid, heroin, and fentanyl; convening a task force of federal, state, local, and

[45] *DEA 360 Strategy*, U.S. DEP'T OF JUSTICE, https://www.dea.gov/prevention/360-strategy/360-strategy.shtml (last visited Apr. 21, 2018).

[46] Press Release, U.S. Attorney's Office (E.D. Cal.), AlphaBay, the Largest Online "Dark Market," Shut Down (July 20, 2017); Press Release, U.S. Attorney's Office (E.D. Cal.), Dark-Web Traffickers Sentenced in Separate Cases to 80 Months and 70 Months in Prison (Jan. 16, 2018).

tribal law enforcement to identify opioid cases for federal prosecution, facilitate interdiction efforts, and tailor districts' response to local needs; providing legal advice and training to other AUSAs regarding opioid prosecutions; and developing and continually evaluating the effectiveness of their offices' strategies to combat the opioid epidemic. Sessions also directed USAOs to take a "fresh look" at the strategies they developed beginning in September 2016, and determine if their office's strategy needed updating.

By February 2018, each USAO had appointed an AUSA to serve as its district's Opioid Coordinator, and every USAO had reviewed—and if necessary, revised—its district-specific opioid strategy. Each USAO is either continuing the promising plan it developed since September 2016, or has revamped its strategy to improve its effectiveness and address new issues. Some examples of reinvigorated strategies are being implemented in the following districts:

- *Western District of New York:* Similar to the HIT initiative in Western Kentucky, the USAO has encouraged all state and local chiefs of police to treat overdose scenes as homicide scenes so that an appropriate death-resulting investigation can occur, with a view toward a possible federal prosecution. The USAO and Erie County Central Police Services have spearheaded an effort to create a mandatory overdose form, electronically accessible to all state and local officers in their patrol vehicles. The form will ensure and facilitate collection of evidence from the overdose scene and transmit it to a High Intensity Drug Trafficking Area Drug Intelligence Officer, with assistance from the DEA, for an immediate investigation and for tracking where fatal overdoses are occurring. In addition, the USAO is aggressively pursuing prosecution of distribution or possession with intent to distribute fentanyl and fentanyl analogues of any amount, even in instances involving small quantities that do not trigger mandatory minimums under 21 U.S.C. §§ 841(b)(1)(A) and (b)(1)(B) or that do not involve fatal or serious bodily injury overdoses. The USAO's and its partners' collective efforts may be having an impact: after opioid related fatalities in Erie County rose steadily from 2012 to 2016, fatal overdoses *decreased* approximately eleven percent from 2016 to 2017.[47]
- *Middle District of Florida:* The USAO has reenergized all pillars of its strategy. On the prevention front, the USAO is continuing to educate community groups about synthetic opioids and to publicize its opioid reduction efforts through its Twitter feed (@USAO_MDFL). As for enforcement, the USAO pioneered a digital method to acquire real time data from state medical examiners. The USAO uses this information to identify the dealers and opioids that kill people in the district, improve law enforcement's responses to overdoses, and support death-resulting prosecutions under 21 U.S.C. § 841(b)(1)(C). The USAO also employs opioid "hot spot" focused operations to maximize the impact of its efforts. Florida has strong mandatory minimum provisions pertaining to distribution or possession with intent to distribute fentanyl and analogues such as carfentanil, alfentanil, sufentanil, and other fentanyl derivatives.[48] Coordination between the USAO and local prosecutors' offices ensures that the most serious, readily provable offenses are brought against each fentanyl trafficker in the most appropriate venue. In the treatment realm, the USAO continues to request, during bail hearings, sentencings, and other hearings, that the district court addresses the needs of defendants who require treatment for opioid abuse. The USAO participates in a district reentry court and supports effective efforts to combat addiction.
- *Western District of Washington:* Part of the USAO's revised strategy has focused on enhancing fentanyl and other opioid prosecutions in the district's Indian Country. Following coordination with tribes and law enforcement, the USAO designated an AUSA to work with tribal agencies to target serious, repeat drug offenders for federal prosecution when they distribute the most dangerous drugs—including fentanyl and fentanyl-laced heroin—on tribal land. Factors the

[47] Tracey Drury, *Erie County overdose deaths decline, but remain high*, BUFFALO BUSINESS FIRST (Feb. 28, 2018).
[48] Fla. Stat. § 893.135(1)(c)(4)(b).

USAO considers when deciding whether to prosecute include the defendant's criminal history in Indian Country, links between the defendant and fatal and nonfatal overdoses, the harm the defendant has caused in tribal communities, and the adequacy of local or tribal prosecution as an alternative. The USAO has promoted better investigative processing of overdose scenes and training for first responders and detectives in Indian Country so that investigations can better support federal prosecutions in overdose cases.

IV. A Sense of Purpose

The fentanyl crisis is daunting. Overdose deaths have risen. New, increasingly deadly fentanyl analogues keep hitting the streets and putting people in further peril. Fentanyl is now appearing laced in other drugs beside heroin, like cocaine, and users of those drugs are at risk. Misery still spreads.

Despite these challenges, there is a continuing commitment among USAOs to confront them with aggressive enforcement and comprehensive strategies to prevent opioid use, prosecute and punish fentanyl traffickers, and pursue treatment for those who need it.

USAOs are engaging in an unprecedented level of coordination with their district partners to implement their strategies and solve the crisis. As John E. Kuhn, Jr., the former United States Attorney for the Western District of Kentucky, wrote in 2017:

> Only two things can defeat us in our battle against this epidemic: a lack of commitment and a failure to collaborate. A serious and sustained commitment to resolve this crisis will bring us the resources we need, and our collaboration will broaden our impact immeasurably.[49]

With this sense of purpose, the USAOs are up to the task.

ABOUT THE AUTHOR

❑ **Seth Adam Meinero** is the National Violent-Crime and Narcotics Coordinator at the Executive Office for United States Attorneys. From 2007 to 2012, he was a violent-crime Assistant United States Attorney for the District of Columbia. He was also a civil rights attorney at the Environmental Protection Agency for eight years before becoming a prosecutor. Mr. Meinero currently serves as an advisor to the Violent and Organized Crime and Controlled Substances Subcommittees of the Attorney General's Advisory Committee of United States Attorneys, and has previously contributed four articles to the *United States Attorneys' Bulletin.*

The author thanks AUSA John E. Kuhn, Jr. (W.D. KY.), National Heroin and Opioid Coordinator for the Executive Office for United States Attorneys, for his assistance with this article.

[49] *A Call to Action: Louisville Heroin and Opioid Response Summit—Report and Recommendations*, U.S. ATTORNEY'S OFFICE (W.D. KY.) iii (Mar. 24, 2017).

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A Primer on Investigating Doctors Who Illegally Prescribe Opioids

K. Tate Chambers
Assistant Director
Office of Legal Education

Although much of the blame for the current opioid epidemic has been placed at the feet of the medical community for overprescribing opioids, the vast majority of physicians in the United States prescribe opioids to their patients for a legitimate medical purpose. However, in spite of efforts at education and raising the community awareness of the dangers of overprescribing opioids, there remains a minority of physicians who knowingly prescribe opioids for their personal gain outside of a legitimate medical purpose. The investigation of those physicians is the focus of this article.

I. The Opioid Crisis

In 2015, over 52,000 Americans lost their lives to drug overdoses.[1] In 2016, that number was over 64,000.[2] That represents the largest increase in death toll in American history.[3] As Attorney General Jeff Sessions pointed out in a speech in Charleston, West Virginia, in September 2017, "That would be the highest drug death toll and the fastest increase in that death toll in American history. And every day this crisis continues to grow, as more than 5,000 Americans abuse painkillers for the first time." He noted, "More Americans die of drug overdoses than died from car crashes or died from AIDS at the height of the AIDS epidemic."[4]

General Sessions pointed out the cost of these statistics, "These trends are shocking and the numbers tell us a lot—but they aren't just numbers. They represent moms and dads, brothers and sisters, neighbors and friends. They represent unique, irreplaceable people, and fellow Americans."[5] Telling of a recent event he attended, he said:

> I recently had the opportunity to address the National Alliance for Drug Endangered Children. It was during this event that I was able to view this crisis through the eyes of a child—just imagine for a moment you are a helpless toddler who cries for their mother to wake up and she never does, or the poor infant that is wailing in the NIC-U due to opioid withdrawal—you just entered this world and are already suffering and for sins you did not commit.[6]

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[1] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017).
[2] Attorney General Sessions, Remarks at the DEA Graduation Ceremony (Jan. 26, 2018).
[3] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017).
[4] Attorney General Sessions, Remarks at "West Virginia on the Rise: Rebuilding the Economy, Rebuilding Lives" About the Opioid Epidemic (Sept. 21, 2017).
[5] *Id.*
[6] *Id.*

He also discussed the monetary cost of opioid addiction:

> It is estimated that prescription opioid addiction costs our economy some $78 billion a year . . . Drug abuse reduces the productivity of our workers, eliminates many otherwise qualified individuals from our work force due to addiction and criminal records, and puts a strain on health care programs like Medicaid. It is filling up our emergency rooms, our foster homes, and our cemeteries.[7]

In a speech in Harrisburg, Pennsylvania, later that month, General Sessions spoke of two recent instances in that state:

> They [the statistics] represent the 26-year-old pregnant mother who overdosed in Charleston, accidentally killing both herself and her unborn child. They represent the couple who were found dead in their Kernville home a week after they had overdosed on heroin. Their five-month-old daughter was found with them—dead from starvation and dehydration.[8]

In a speech to DEA graduates in January 2018, General Sessions shared, "No community in America has been immune to this crisis. I personally know people whose families have been bankrupted and torn apart by drug addiction. These days it is a safe assumption that most of you do, too."[9]

In remarks in Washington D.C. in February 2018, General Sessions explained the scope of the problem:

> In the United States . . . we consume the vast majority of the world's hydrocodone and more than 80 percent of its oxycodone. It is estimated that we use many times more opioids than is medically necessary for a population our size. Millions of Americans are living with an addiction . . . The Medicare prescription drug program paid more than $4 billion for opioids in 2016.[10]

"Every day, 180 Americans die from drug overdoses. This epidemic actually lowered American life expectancy in 2015 and 2016 for the first time in decades, with drug overdose now the leading cause of death for Americans under age 50."[11]

II. Attorney General Sessions' Response

Since taking office, General Sessions made addressing this epidemic by fighting the overprescribing of opioids by health care professionals a top priority of the Department of Justice. In August 2017, he announced the formation of the Opioid Fraud and Abuse Detection Unit.[12] This pilot program uses data analytics to identify and prosecute health care professionals who are contributing to the prescription opioid epidemic by diverting or dispensing prescription opioids for illegitimate purposes.[13] The data identifies which physicians are writing opioid prescriptions at a rate that far exceeds other

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[7] *Id.*

[8] Attorney General Sessions, Remarks to Law Enforcement About the Opioid Epidemic (Sept. 22, 2017).

[9] Attorney General Sessions, Remarks at the DEA Graduation Ceremony (Jan. 26, 2018).

[10] Attorney General Sessions, Remarks Announcing the Prescription Interdiction and Litigation Task Force (Feb 27, 2018).

[11] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces New Prescription Interdiction and Litigation Task Force (Feb. 27, 2018).

[12] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017).

[13] Jennifer Barrett, *Program Targets Opioid Fraud and Abuse*, PHARMACY TIMES (Aug. 4, 2017); Attorney General Sessions, Remarks at the DEA Graduation Ceremony (Jan. 26, 2018).

physicians. The data also identifies how many of a doctor's patients died within sixty days of receiving an opioid prescription. The data also identifies pharmacies that are dispensing disproportionately large amounts of opioids.[14] As part of the program, the Department also funded twelve experienced Assistant United States Attorneys for a three year term to investigate and prosecute heath care fraud related to prescription opioids. The unit's task is to root out pill mills and prosecute health care professionals who abuse opioid prescriptions.[15] General Sessions warned doctors and pharmacists:

> [T]oday, we are announcing a new effort to target our federal resources against this epidemic. If you are a doctor illegally prescribing opioids for profit or a pharmacist letting these pills walk out the door and onto our streets based on prescriptions you know were obtained under false pretenses, we are coming after you. We will reverse these devastating trends with every tool we have.[16]

"This data analytics team will help us find the tell-tale signs of opioid-related health care fraud by identifying statistical outliers . . . Fraudsters might lie, but the numbers don't."[17] General Sessions added: "With these new resources, we will be better positioned to identify, prosecute, and convict some of the individuals contributing to these tens of thousands of deaths a year. The Department is determined to attack this opioid epidemic, and I believe these resources will make a difference."[18] The new prosecutors "working with the FBI, DEA, the Department of Health and Human Services, as well as our state and local partners, will help us target and prosecute doctors, pharmacies, and medical providers who are exploiting this epidemic to line their pockets."[19]

In September 2017, General Sessions announced grant funding to address the opioid problem:

> [T]oday, I am announcing that we will be awarding nearly $20 million in federal grants to help law enforcement and public health agencies address prescription drug and opioid abuse. This is an urgent problem and we are making it a top priority. I believe that these new resources and new efforts will make a difference, bring more criminals to justice and ultimately save lives. And I'm convinced this is a winnable war.[20]

General Sessions pointed out the important role of partnerships in winning the war:

> But in order to end this crisis, we must work together. Eighty-five percent of all law enforcement officers serve at the state and local level, and your work is essential to our success. Strengthening partnerships between law enforcement officers at all levels is a central theme of my tenure at the DOJ, and I hope you will help me do that.[21]

In November 2017, General Sessions ordered each of the United States Attorneys to designate an Opioid Coordinator in their district.[22] The role of the coordinator is to work with federal, state, and local

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[14] *Id.*

[15] Adora Namigadde & Gabe Rosenberg, *In Columbus Speech, Sessions Announces Program Targeting Opioid Prescribers*, NPR (Aug. 2, 2017).

[16] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017).

[17] Attorney General Sessions, Remarks at "West Virginia on the Rise: Rebuilding the Economy, Rebuilding Lives" (Sept. 21, 2017).

[18] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces Opioid Fraud and Abuse Detection Unit (Aug. 2, 2017).

[19] Attorney General Sessions, Remarks at "West Virginia on the Rise: Rebuilding the Economy, Rebuilding Lives" (Sept. 21, 2017).

[20] Attorney General Sessions, Remarks to Law Enforcement About the Opioid Epidemic (Sept. 22, 2017).

[21] *Id.*

[22] Attorney General Sessions, Remarks at the DEA Graduation Ceremony (Jan. 26, 2018).

law enforcement and prosecutors to identify and prosecute over prescribing and over dispensing cases.[23] General Sessions emphasized the importance of working as a team and the importance of the goal at the DEA graduation ceremony. He urged graduates:

> Let me conclude by making this clear: we are in this together. We support you and embrace your mission, one that represents a top priority of the Department of Justice. Go at your work honorably and with enthusiasm and determination. Be creative. Come up with better ideas. We can defeat this evil presence that is killing our people, destroying our families, and weakening our nation.[24]

In January 2018, General Sessions announced a DEA surge to combat prescription opioid diversion:

> I am announcing today that, over the next 45 days, DEA will surge Special Agents, Diversion Investigators, and Intelligence Research Specialists to focus on pharmacies and prescribers who are dispensing unusual or disproportionate amounts of drugs. DEA collects some 80 million transaction reports every year from manufacturers and distributors of prescription drugs. These reports contain information like distribution figures and inventory. DEA will aggregate these numbers to find patterns, trends, statistical outliers—and put them into targeting packages. That will help us make more arrests, secure more convictions—and ultimately help us reduce the number of prescription drugs available for Americans to get addicted to or overdose from these dangerous drugs.[25]

In February 2018, General Sessions appointed an experienced federal prosecutor to serve as the National Director of Opioid Enforcement and Prevention Efforts at the Department of Justice.[26] He directed her to "help us formulate and implement initiatives, polices, grants, and programs relating to opioids, and coordinate these efforts with law enforcement."[27] He also announced the creation of the Prescription Interdiction and Litigation (PIL) Task Force.[28] The PIL Task force includes senior officials from the offices of the Attorney General, the Deputy Attorney General, the Associate Attorney General, the Executive Office for U.S. Attorneys, the Civil Division, the Criminal Division, and the Drug Enforcement Administration.[29] General Sessions said, "The PIL Task Force will focus in particular on targeting opioid manufacturers and distributors who have contributed to this epidemic. We will use criminal penalties. We will use civil penalties. We will use whatever tools we have to hold people accountable for breaking our laws."[30] General Sessions warned physicians and pharmacists who are breaking the law, "These are not our last steps. We will continue to attack the opioid crisis from every angle. And we will continue to work tirelessly to bring down the number of opioid prescriptions, reduce the number of fatal overdoses, and to protect the American people."[31]

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[23] *Id.*
[24] *Id.*
[25] Attorney General Sessions, Remarks on Efforts to Reduce Violent Crime and Fight the Opioid Crisis, (Jan. 30, 2018).
[26] Attorney General Sessions, Remarks Announcing the Prescription Interdiction and Litigation Task Force (Feb. 27, 2018).
[27] *Id.*
[28] Press Release, U.S. Dep't of Justice, Attorney General Sessions Announces New Prescription Interdiction & Litigation Task Force (Feb. 27, 2018).
[29] *Id.*
[30] Attorney General Sessions, Remarks Announcing the Prescription Interdiction and Litigation Task Force (Feb. 27, 2018).
[31] *Id.*

III. A Primer on Investigating Doctors for Overprescribing Opioids

As AUSAs across the nation join General Sessions in this fight against doctors who illegally prescribe opioids, many find themselves confronting this type of case for the first time. What are the investigative tools they can use to investigate the doctors? How do they tell the bad doctors from those not violating the law? What should they be looking for during the investigation to identify the doctors illegally prescribing opioids? Hopefully, this article will begin to answer some of those questions. It is a primer on these investigations. There are other, more comprehensive, in-depth resources that treat all aspects of working these cases, from identifying the doctor, to investigating his practice, to the indictment, through the trial, and to sentencing,[32] but this article will serve as a starting point for conducting the investigation.

Investigating doctors for illegal opioid distribution is not an easy task. The investigation is often difficult and complex. What follows are the basics—the elements you have to prove, how to identify the doctor who is illegally prescribing opioids, how to build your case inside and outside of the doctor's office, and some issues you may encounter along the way to an indictment.

Physicians who illegally prescribe opioids[33] are typically prosecuted under the same criminal statute as traditional drug dealers[34]—21 U.S.C. § 841(a)(1), which provides, "Except as authorized by this subchapter, it shall be unlawful for any person knowingly or intentionally:—(1) to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance."[35]

Unlike prosecutions against the traditional drug dealer, however, to prosecute an illegally prescribing physician the prosecutor must show that the physician acted outside of the scope of professional practice or without a legitimate medical purpose.[36]

The government must show that the defendant knowingly and intentionally distributed a controlled substance and that in so doing, the defendant acted and intended to act without a legitimate medical purpose and outside the usual course of professional practice.[37] As Benjamin Barron points out in his article, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, "[t]here 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 instruction that include one term but not the other."[38] Barron also points out that, "[i]n the context of medical practice,

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[32] *See* Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115 (Nov. 2016); Benjamin R. Barron, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, 64 U.S. ATT'Y BULL. 65 (Sept. 2016).

[33] Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115, 116 (Nov. 2016) (" . . . the term 'opioid,' which describes any substance, regardless of its precise properties, which produces morphine-like effects through action on opioid receptors [in the brain] . . . Over the years, a number of opioids have been developed by pharmaceutical companies to treat pain, including, but not limited to fentanyl, oxycodone, hydrocodone, and hydromorphone.").

[34] *Id.* at 124.

[35] 21 U.S.C. § 841(a)(1) (2012).

[36] United States v. Moore, 423 U.S. 122, 124, 96 S. Ct. 335, 337, 46 L. Ed. 2d 333 (1975); *See* 21 C.F.R. § 1306.04(a) ("a prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice.").

[37] Benjamin R. Barron, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, 64 U.S. ATT'Y BULL. 65, 66 (Sept. 2016).

[38] *Id.*

‘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.”[39]

The courts engage in a case-by-case analysis of the evidence. Whether the opioids were prescribed outside of the scope of professional practice or without a legitimate medical standard is judged by an objective, not a subjective, standard.[40] The term professional practice means generally accepted medical practice under the prevailing standards of treatment. As Barron writes:

> 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 [citation omitted].’ Thus a defendant’s ‘idiosyncratic view of proper medical practices’ cannot constitute the ‘usual course of professional practice [citations omitted].’[41]

Although it may be relevant to show motive, the government is not required to show that the physician prescribed the opioids out of greed or other malicious motive such as in return for sexual favors.[42]

Although the charge of distribution of a controlled substance may be one the prosecutor is familiar with, the scope and tools of the investigation, and exactly what evidence will prove the charge, may be unfamiliar. First, let’s look at the tools of the investigation.

IV. Tools of the Investigation

A. Agency and Other Records

1. DEA

As you might expect, the DEA plays an integral role in the regulation of physicians who prescribe opioids. In his article*, Overview of the Drug Enforcement Administration Diversion Control Program*, Louis J. Milione summarizes that regulation:

> The CSA [Controlled Substance Act] . . . 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 [citation omitted]. 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 is available for legitimate medical . . . purposes . . . The DCP’s [DEA’s diversion control program] regulatory function is accomplished through routine regulatory inspections, by providing guidance to registrants, and by controlling and/or monitoring the manufacture, distribution, [and] dispensing . . . of controlled substances.[43]

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[39] *Id.*
[40] *Moore*, 423 U.S. at 136, 96 S. Ct. at 343.
[41] Benjamin R. Barron, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, 64 U.S. ATT’Y BULL. 65, 66-67 (Sept. 2016).
[42] *See* United States v. Singh, 54 F.3d 1182, 1188 (4th Cir. 1995).
[43] Louis J. Milione, *Overview of the Drug Enforcement Administration Diversion Control Program*, 64 U.S. ATT’Y BULL. 11 (Sept. 2016).

DCP uses the regulatory process to monitor doctors who possess DEA registration certificates. The doctors are required to keep records of their controlled substance activity.[44] With proper notice, DEA Diversion investigators have the authority to conduct inspections of doctors' offices to review those records.[45] If a doctor refuses inspection, the Diversion Investigator has the authority to obtain an administrative inspection warrant.[46] The DEA Tactical Diversion Squads are the criminal enforcement wing of the DCP.[47] It is the mission of agents assigned to these squads to "combine varied resources and expertise in order to identify, target, investigate, disrupt, and dismantle those individuals or organizations involved in diversion schemes."[48] Diversion squads participate in the purchase of evidence, payment for information, surveillance, undercover operations, and executing search warrants.[49] DEA is the prosecutor's closest partner when working cases against overprescribing doctors.

2. ARCOS

The Automation of Reports and Consolidated Orders System (ARCOS) is an online reporting system which includes reports from all DEA registrants who distribute specific controlled substances, including opioids.[50] ARCOS can be a great source of data, particularly with regard to the volume of controlled substances being dispensed by certain professionals.[51]

3. PDMP

Nearly every state has a prescription drug monitoring program (PDMP). Barron describes the PDMP as "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."[52] "[G]enerally, the data kept . . . includes the drug prescribed (type, strength, and quantity), the prescribing doctor, the patient, and the pharmacy at which the prescription is filled."[53] Barron sets out the use of PDMP records:

> 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).[54]

Some states make even more aggressive use of PDMPs. Tara Kunkel, in her article, *Data-Driven Approaches to Responding to the Opioid Epidemic*, describes Arizona's PDMP:

> 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

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[44] *Id.*
[45] *Id.* at 14.
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.* at 15.
[50] Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115, 125-26 (Nov. 2016).
[51] Benjamin R. Barron, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, 64 U.S. ATT'Y BULL. 65, 69 (Sept. 2016).
[52] *Id.* at 68.
[53] *Id.*
[54] *Id.*

> 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 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 . . . 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 card categorized 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.[55]

As Peña and McNeilly point out in their article, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Health Care Providers*, PDMPs:

> [E]xist in nearly every state, and with the use of administrative subpoenas, investigators can access this data to see what prescriptions are being written, who is writing them, who is receiving them, who is filling them, where they are filling them, how often they are filling them, and how the putative patients are paying for them. Diligent physicians and pharmacists should be checking the PDMP during the course of their practice, so obtaining these records for certain patients can also be a helpful way for law enforcement to get a sense of what the medical professional knew at the time of prescribing, or what he should have known.[56]

4. State Disciplinary Records

On occasion, you will learn that the doctor was disciplined by the state authorities for prescribing opioids illegitimately. This discipline is good evidence that the doctor is on notice that his prescribing behavior is not legitimate.

5. Pharmacy Records

At the overt stage of your investigation, consider subpoenaing the prescription records from the pharmacies the doctor used most frequently. You can obtain a doctor profile from the pharmacies by subpoenaing them using the doctor's DEA registration number. This will tell what the doctor is prescribing, the amounts of controlled substance he is prescribing, and the time lapse between prescriptions. If your subpoena reveals thousands of prescriptions, even if the prescriptions are not tied to specific counts of the indictment, these records may be admissible under Federal Rule of Evidence 404(b) to show knowledge, motive and pattern of conduct.[57] You can also subpoena a pharmacy to provide prescription records for a specific patient.

6. Patient Records

A patient's medical records are usually obtained with either a Rule 41 search warrant or a grand jury subpoena. Care must be taken, however, to comply with the standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in obtaining, using, or disclosing the medical records. It is important to obtain these records and for your expert to review them.

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[55] Tara Kunkel, *Data-Driven Approaches to Responding to the Opioid Epidemic*, 64 U.S. ATT'Y BULL. 79 (Sept. 2016).
[56] Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115, 125 (Nov. 2016).
[57] FED. R. EVID. 404(b).

B. Surveillance/Pole Cameras

Surveillance of the parking lot of the doctor's office can provide valuable information. Pole cameras are especially useful because you can learn the volume of his business. The car tags will tell you if a large number of his patients are from out of state. You can also get a sense for how long the patients are inside the office. Surveillance will also aid the agents in selecting potential cooperating witnesses.

C. Witnesses

Determining which type of evidence to use for the "inside the exam" room evidence is an important decision in these cases. You can use cooperating patients, undercover agents, or both.

1. Cooperators

Cooperating patients or former patients of the doctor can be an invaluable source of information about his practice, but they come with the customary baggage of witnesses who are drug abusers. As Peña and McNeilly point out:

> Drug-seeking witnesses are problematic for a number of reasons, including perception problems and continuing drug-seeking issues. Whenever dealing with drug-seeker witnesses, it is important to remember a prosecutor's discovery obligations pursuant to *Brady* and *Giglio*. These types of witnesses will often continue seeking controlled substances during the pendency of the litigation. Not only should the prosecution inquire of any bad acts from the witness, the prosecution should also obtain a recent criminal history from law enforcement.[58]

Debrief them on how they heard about the doctor, what they told the doctor about their pain during the appointment, the length and extent of the examination they received from the doctor, whether the doctor discussed other treatment options instead of pain medication, whether the doctor conducted any diagnostic tests, how they paid the doctor, and the role of the doctor's staff in prescribing the pain medication. Who suggested the exact opioids they received—them or the doctor? Were they permitted to "phone in" requests for pain medication refills? Were they able to obtain refills before the original prescription ran out?

2. Undercover Agents

If at all possible, you should use undercover officers in your investigation. They avoid the *Brady-Giglio* issues that often accompany cooperating witnesses, they are more reliable as witnesses, and at trial they don't carry the impeachment baggage of a cooperating drug addict. Also, if possible, use multiple undercover officers. That will remove the defense that the doctor simply made a mistake examining this one patient. Barron suggests:

> 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

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[58] Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115, 138 (Nov. 2016).

failing to inquire whether the injury purportedly justifying the original prescription had abated).[59]

DEA will undoubtedly provide an undercover who will know how to conduct themselves in the examination room, but a few things should be kept in mind. The undercover should be careful about what information she provides on the medical history questionnaire she fills out as a new patient. This will be an important document in a later prosecution. Claims of severe or intense pain on the questionnaire will later bring into question what the doctor was treating—the information he obtained during the exam or the information on the questionnaire. During the exam, the undercover should try to obtain pain medication without complaining of a type or severity of pain that would justify the prescription of a controlled substance. All undercover visits should be audio and video recorded.

3. Experts

It is essential that you use a medical expert during your investigation. The expert should be someone who practices in the same area as the doctor and has a working knowledge of and experience with pain management and the various means, including opioids, to control pain. The expert should be very familiar with how to conduct a proper medical examination for a patient complaining of pain, the types of diagnostic tests that should be run before prescribing opioids, the various opioids and what type of pain they are used to treat, how they interact with each other and other medications, and the dangers of prescribing opioids, including addiction and side effects. The expert doctor needs to be able to tell you, based on all of the facts developed in the investigation, whether the doctor's prescription practices fell outside of the course of professional medical practice and whether the prescriptions were written for a legitimate medical purpose.

D. Search Warrants

When the covert stage of the investigation is over and it is time to start the overt stage, you may consider starting that stage with a search warrant. You will want to search for both patient records and business records. The patient records will provide the obvious—dates of patient visits, diagnostic tests, if any, performed, the diagnoses, and the medications prescribed. The business records will show the nature of the payments, the volume of the business, and the amount of income and disbursement. Also, during the execution of the search warrant is the best time to interview the doctor's office staff. Ask them about the flow and volume of patients in the office and the doctor's examination and prescription practices. Did the doctor obtain prior medical records of his patients? Did the doctor refer his patients to pain specialists? Was it the practice of the doctor to send his patients for diagnostic tests before prescribing opioids? How did the patients pay? Did they recommend that the patients fill the prescription at one particular pharmacy? Did the doctor ever prescribe opioids without an office visit? Did they suspect many of the patients were drug addicts and if yes, why?

Peña and McNeilly also recommend interviewing the doctor:

> [T]here is no downside in attempting to obtain a proper interview of the [doctor]. If the [doctor] tells the truth, it will go a long way to understanding the extent of the damage caused and provide powerful evidence in the prosecution of substantive offenses. If the [doctor] makes false statements, those statements are admitted at trial in a different light when they are presented as the basis of a false statements charge rather than exculpatory statements. Caution must be exercised to ensure the [doctor] is not a represented party; and

[59] Benjamin R. Barron, *Strategies for Investigators and Prosecutors in Prescription Drug Diversion Cases*, 64 U.S. ATT'Y BULL. 65, 69 (Sept. 2016).

> that, if there is an issue regarding custodial detention, that the [doctor] is *Mirandized* and that the interview is recorded . . .[60]

V. Evidence to Prove the Charge

No one piece of evidence alone will prove your case. You are looking for a pattern of conduct, not an individual instance of over-prescribing opioids. As you work the investigation and interview patients, former patients, staff, former staff, and if possible, use undercovers, the following are indicators or red flags you may discover that, when grouped together in a sufficient number, will show a pattern of illegal conduct.

The most common way to initially identify the doctor who is illegally prescribing opioids is street intelligence. Check with your local, state, and federal drug units. What are their opioid addict cooperators telling them about where they obtain their opioid prescriptions? Once you identify the suspected doctor, you want to learn about his practice, what happens inside of his waiting room, what happens inside of the examination room, what happens in the lab, and all you can about the prescriptions he writes.

A. The Doctor's Practice

The most direct way to learn about the doctor's practice is surveillance. Pole cameras can prove invaluable in conducting surveillance. Look for an extremely high patient volume for an office of that size. Are there long lines of waiting patients outside the practice's front door? Are there out of state tags on the cars the patients are driving? Are they traveling long distances to visit the doctor? Are the patients' visits brief—in and out? Are there nurses at the practice or only clerical staff? Does the doctor even require an office visit to prescribe an opioid, or can the patient simply call in with a request? Check with the local coroners in the county of the practice and surrounding counties. Has the practice had patient deaths from overdose?

B. Inside the Doctor's Office Waiting Room

By interviewing cooperating witnesses and office staff or by using undercover agents, you can learn what happens inside the doctor's office.

Are patients required to provide a medical history during their first visit? Does the doctor or his staff prepopulate the patient charts with information about the patient's complaints of pain? Does the doctor or his staff write out prescriptions for opioids and place them in the patient's file prior to the office visit? Does the practice even keep patient records, files, or prescription logs? If they do, are they accurate? Who determines what opioid to prescribe—the doctor or a non-medical staff person?

Is it a cash-only practice? Does the doctor charge excessive fees for office visits? Are the patients providing services, such as sex, or trading goods as payment for the opioid prescriptions? Is there a direct correlation between the cost of the office visit and the quantity of opioids the doctor prescribes?

C. Inside the Examination Room

Here is some conduct that should serve as red flags about the examination itself. First, does the doctor even perform a medical examination, or if he does, is it only cursory? Do the patients direct the doctor on what opioids they want prescribed? Does the doctor tell them that he cannot prescribe certain opioids unless the patient complains of specific pain? In other words, does he coach them on their symptoms? Does he fail to warn the patients about the dangers and side effects of the opioids he

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[60] Jamie A. Peña & Peter A. McNeilly, *Investigating and Prosecuting Opioid Diversion and Tampering Cases Involving Medical Professionals and Institutional Healthcare Providers*, 64 U.S. ATT'Y BULL. 115, 136 (Nov. 2016).

prescribes? Does he fail to suggest alternatives to opioids, such as surgery, tens units, physical therapy, or massage therapy? Does he fail to refer them to specialists for their pain? Doctors involved in illegal prescribing do not want other doctors reviewing patient files. Does the doctor ignore obvious signs of opioid addiction in the patient? When the doctor and the patient discuss the prescription, do they use the street names for the drugs?

D. In the Lab

Does the doctor fail to order lab work such as blood work or urine screens? If the blood or urine screen indicates that the patient is taking illegal drugs, does the doctor continue to prescribe the opioids? If the blood or urine work indicates that the patient is not taking the opioids prescribed to him, this is an indication the patient is selling the opioids on the street. Does the doctor continue to write him prescriptions for the opioids?

E. The Prescription

When you review the actual prescriptions and the doctor's prescription practice, several red flags may pop up. Is the doctor prescribing an unusually large number of opioids in a short period of time? Is the doctor prescribing the same amount and dose of opioids for all of his patients? Is he prescribing excessive amounts of opioids in individual prescriptions? Or, in order to avoid creating concerns at the pharmacy, is he limiting the number of dosages in the prescriptions by writing two prescriptions at the same time for the same opioid? Is he prescribing opioids for an unreasonable period of time? Is he increasing the dosages of opioids long after anything in the patient's medical records would support such an increase? Does he frequently prescribe opioids for medications the patient reportedly "lost"? Is he providing refills before the original prescription should have run out? Is the doctor directing the patients to go to specific pharmacies to fill their opioid prescription?

The above are just some of the indicators that a doctor is illegally prescribing opioids. Alone, none of them will make your case. However, several of them grouped together will show a pattern and enable you to prove that a doctor is prescribing outside of the scope of professional practice or without a legitimate medical purpose.

VI. Conclusion

These are important cases, but they can also be difficult and time consuming cases. Hopefully this primer will give prosecutors facing their first illegally prescribing physician case the basics to launch an investigation. Fortunately, within the United States Attorneys' community and the Department of Justice family there are numerous resources to help you further your education beyond the basics outlined here. It

is clear that we are facing an opioid epidemic, and it is equally clear that these prosecutions are one of our most important weapons in the fight against that epidemic. Good luck.

ABOUT THE AUTHOR

❑ **K. Tate Chambers** graduated from the Southern Illinois University School of Law, after which he clerked for United States District Court Judge Richard Mills when Judge Mills was serving on the Illinois Appellate Court. Tate joined the United States Attorney's Office for the Central District of Illinois in 1984 and has served in several capacities, including Associate United States Attorney, Appellate Chief, OCDETF Lead Task Force Attorney, Branch Chief, and in the Coordinator positions for PSN, Violent Crime, Gangs, and Community Outreach. Tate also served as the National PSN Coordinator in EOUSA at Main Justice in Washington, D.C. from 2007 to 2010 and on the Evaluation and Review Staff in D.C. as a Criminal Program Manager from 2010 to 2011. Currently he serves as an Assistant Director of the Office of Legal Education, EOUSA, at the National Advocacy Center in Columbia, South Carolina, where he is the Editor in Chief of the United States Attorneys' Bulletin. Tate is retired from the Illinois Army National Guard where he served in the Judge Advocate General Corps.

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Investigating and Prosecuting "Pill Press" Manufacturing Schemes

Benjamin R. Barron
Assistant United States Attorney
Deputy Chief, OCDETF Section
Central District of California

Michael G. Freedman
Assistant United States Attorney
OCDETF Section
Central District of California

I. Introduction

In August 2017, investigators searching a drug dealer's home seized 4,000 pills bearing the symbol of wholesale Vicodin, as shown below. In fact, as lab testing later confirmed, the pills were counterfeit—they were manufactured in a clandestine lab using fentanyl powder mixed with filler substances. In March 2016, agents in a different case seized thousands of pills falsely labeled as OxyContin, Xanax, Vicodin, and other pharmaceuticals from a house that had been turned into a massive clandestine drug lab. The pills were designed to look like authentic pharmaceuticals, but in fact contained acetylfentanyl, a potent fentanyl analogue.

Figure 1: Seized Counterfeit Pills

As the national drug epidemic has escalated, drug traffickers have implemented innovative methods to profit from addiction. This article will discuss one method that has grown in popularity and danger: manufacturing controlled drugs, often counterfeited to look like commercially available prescription pills, for mass black market sale. Using bulk powder and "pill press" machines,

drug traffickers can produce thousands of counterfeit pills per hour. Example of such machines are shown below.

Figure 2: Examples of Pill Presses

Recently in Los Angeles alone, law enforcement has shut down four pill press operations responsible for disseminating hundreds of thousands of pills throughout the country. The danger posed by these schemes is self-evident. The drugs are typically manufactured using fentanyl or fentanyl analogues, which are exponentially more potent than heroin. The drugs are often created by drug dealers in locations such as storage units or garages—not by trained technicians in sterile environs. What an addict, teenage party-goer, or law enforcement officer may believe is a pill of Vicodin or Xanax may in fact be a far more dangerous substance.

In one such case, the defendants were convicted for their roles in manufacturing thousands of pills from fentanyl analogues and other substances imported from China. The conspirators set up clandestine labs in storage units and residential neighborhoods, which alone put neighbors in substantial risk of harm. By illegally using pill presses, they manufactured tens of thousands of pills designed to look like real pharmaceuticals. The defendants sold bags full of pills to unsuspecting users, and then watched the users' reactions in order to run quality control experiments on their counterfeit drugs.

Although fentanyl and its analogues are the drug of choice in counterfeiting operations, they are not the only drugs sought after in these schemes. For example, recently in Los Angeles investigators shut down a scheme that used a powerful designer benzodiazepine powder to manufacture counterfeit Xanax (alprazolam), spreading dangerous pills to unsuspecting users. Counterfeiters also often create pills that mix substances, such as combining alprazolam with fentanyl—a dangerous cocktail that magnifies the overall risk of addiction or death.

Such black market manufacturing schemes are not always limited to clandestine labs. In another recent case in Los Angeles, Berry and Dalibor Kabov, owners of Global Compounding Pharmacy, were convicted at trial of a massive narcotic diversion scheme. While the Kabovs began their scheme selling oxycodone purchased from the wholesale market, their modus operandi shifted after wholesalers started cutting off sales to the pharmacy. In response, the Kabovs purchased a $20,000 pill press from a Chinese company and acquired enough bulk narcotic powder (oxycodone, hydrocodone, and hydromorphone) to manufacture over 200,000 pills.

This article begins by providing a brief overview of some of the most important areas of law in pill manufacturing schemes. We then present a case study from one of the recent trials mentioned above, which highlights helpful investigative strategies for pill press cases and illustrates some of the common modus operandi in these schemes.

II. The Legal Landscape

A. The DEA Registration Requirement

Under 21 U.S.C. § 841(a)(1) of the Controlled Substances Act ("CSA"), it is illegal to manufacture, distribute, or dispense a controlled drug "[e]xcept as authorized by this subchapter."[1] In the context of diversion cases, this exception refers to the handling of controlled drugs in pharmaceutical or medical contexts, by persons or businesses specially authorized to do so by the Attorney General.[2] This special form of licensure is commonly called a Drug Enforcement Administration ("DEA") registration. Everyone in a controlled drug's chain of supply—manufacturers, wholesalers, pharmacies, doctors, etc.—must operate under a valid DEA registration number.

A DEA registration number thus serves 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 specifically authorizing the manufacture of controlled substances, or who work under a registrant, lack any special protection from criminal liability. Drug dealers manufacturing controlled pills from their garages thus have no legal protection and are criminally liable under 21 U.S.C. § 841(a)(1).[3]

A DEA registration also establishes clear limits on the *scope* of permitted activity. Doctors, pharmacies, etc. typically operate under a DEA registration number allowing those persons or entities to prescribe or dispense controlled drugs; to be protected from criminal liability, they must do so as part of good faith practice.[4] Significantly, to *manufacture* controlled drugs, a separate DEA registration specifically allowing such conduct is required.[5] Thus, for example, the Kabovs manufactured thousands of narcotic pills at a time at Global Compounding Pharmacy, yet they did not operate under a DEA registration for bulk manufacturing. Accordingly, the Kabovs had no lawful authority to do so.

Note the distinction between compounding and manufacturing. Compounding generally refers to instances in which a pharmacy creates an individual dosage of drugs, such as for patients who are allergic to ingredients in commercially available drugs or who need a particular strength not available on the wholesale market. The CSA's definition of the term "manufacturing" expressly exempts compounding (or preparing, packaging, or labeling) drugs, so long as the practitioner doing so acts "in conformity with applicable State or local law" and does so "as an incident to his administration or dispensing of such drug . . . in the course of his professional practice."[6] By contrast, the Kabovs were creating thousands of narcotic pills at a time, conduct that was not "compounding" as a matter of both California law and common sense.

Additionally, pill press schemes typically use materials such as fentanyl powder acquired from international sources, often China. Such offenders are also liable for importing or causing the importation

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[1] 21 U.S.C. § 841(a)(1) (2012).
[2] *See* 21 U.S.C. §§ 822 (2014), 823 (2017).
[3] § 841(a)(1).
[4] *See, e.g.,* United States v. Moore, 423 U.S. 122, 124, 96 S.Ct. 335, 337 (1975); United States v. Feingold, 454 F.3d 1001, 1008 (9th Cir. 2006).
[5] *See* § 823; 21 C.F.R. §§ 1301.11, 1301.13.
[6] *See* 21 U.S.C. § 802(15) (2016).

of such drugs.[7] Here again, even in the medical or pharmacy context, a special form of DEA registration is required to *import* controlled drugs.[8] The Kabovs, for example, were importing bulk controlled drugs from China, yet they did not have a registration specifically authorizing them to do so. For that reason, the Kabovs were also criminally liable for causing the importation of those drugs.

B. Laws Regarding Pill Presses

Federal law also governs the distribution and use of pill press machines and related substances or materials used for manufacturing. On March 31, 2017, a new set of DEA regulations went into effect regarding pill press transactions. Under the regulations, persons or entities that manufacture, distribute, import, or export a pill press, or who broker international transactions, must keep records of transactions for two years and submit electronic reports of transactions to the DEA.[9] Additionally, they "must verify the existence and apparent validity of a business entity" ordering such a machine, and must keep identifying information for any "individuals or cash purchasers."[10] The regulations put sellers or distributors of pill press machines on notice that failure to "adequately prove the identity of the other party to the transaction" may result in "specific penalties . . . for violations of law," and that cash transactions "are suspect and should be handled as such."[11]

The CSA provides multiple criminal tools to combat the trafficking and use of pill press machines in drug trafficking schemes, in addition to liability under § 841(a)(1). It is illegal to possess, manufacture, distribute, export, or import a pill press machine "or any equipment, chemical, product, or material . . . knowing, intending, or having reasonable cause to believe, that it will be used to manufacture a controlled substance or listed chemical" in violation of the CSA.[12] Likewise, failure to provide complete and truthful information in mandatory reports to the DEA is a criminal offense,[13] and violation of those and any other requirements in § 830 also supports steep civil penalties.[14]

C. Other Criminal Charges

Sometimes charges under the CSA are not available in manufacturing schemes. For example, in the recent Xanax counterfeiting scheme noted in the introductory section above, the offenders used a designer benzodiazepine that is not controlled under the CSA.

In those or any other cases involving trademark counterfeiting (e.g., imprinting a pill with a trademarked symbol or replicating a trademarked shape or color), prosecutors can bring charges under the Title 18 anti-counterfeiting statute, which includes heightened penalties where the offense involves any "counterfeit mark on or in connection with" a drug.[15]

Additionally, prosecutors can bring charges under the Food, Drug, and Cosmetic Act ("FDCA"), which applies broadly to all drugs, and thus is not limited only to controlled drugs. The criminal provisions of the FDCA include a variety of charges potentially available in such cases, including charges against the trafficking in misbranded or adulterated drugs, such as for failure to comply with laws

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[7] *See* 21 U.S.C. § 960 (2014); 18 U.S.C. § 2 (2012).
[8] *See* 21 U.S.C. §§ 957, 958 (2012); 21 C.F.R. § 1312.11.
[9] *See* 21 U.S.C. §§ 830(a), (b) (2012); 21 C.F.R. §§ 1300.02, 1310.04, 1310.05.
[10] *See* 21 C.F.R. § 1310.07; *see also* § 830(a)(3).
[11] § 1310.07(d).
[12] 21 U.S.C. §§ 843(a)(6), (7) (2012).
[13] *See* § 843(a)(4).
[14] *See* 21 U.S.C. § 842(a) (2014).
[15] *See* 18 U.S.C. §§ 2320(a), (b)(3) (2016).

regarding safe manufacture and mandatory labeling.[16] The FDCA also includes its own anti-counterfeiting law,[17] and criminalizes unlicensed wholesale distribution.[18]

III. Case Study: United States v. Resnik[19]

Another recent case prosecuted in Los Angeles demonstrates the investigative benefits of focusing on pill presses and provides a helpful case study of the modus operandi of pill press operations.

A. Discovery of the Pill Press

In March 2015, a Customs and Border Patrol ("CBP") officer inspected a package that had arrived at Los Angeles International Airport from China, after recognizing that the Chinese shipper was known to have historically shipped pill machines to the United States in parcels bearing false labels.

The package was labeled as containing a hole puncher, but in fact contained a pill press machine weighing over 200 kilograms. The package listed the co-signee, or buyer of the shipment responsible for receipt, as Gary Resnik, and an address and phone number in Long Beach. Upon determining the nature of the package, the CBP officer contacted the DEA to inquire whether the DEA had received any notice from Resnik relating to the importation of this pill press. The DEA confirmed that no notice had been provided.

Based on these facts, CBP investigated further and uncovered a recent shipment to Resnik labeled as Carboyxmethyl cellulose Sodium to another Long Beach address. This shipment was also from China, and weighed approximately thirty kilograms. Agents determined that Carboyxmethyl cellulose Sodium is used as a disintegrate in pharmaceutical manufacturing.

B. Resulting Investigation

Agents obtained a federal warrant to install a GPS tracker in the pill press package. They watched as an individual later identified as Resnik picked it up and took it to a location in nearby Carson, California. A few weeks later, the GPS tracker indicated that the pill press was moved to a storage unit in Long Beach. Agents then obtained a search warrant for the storage unit.

Inside the storage unit they found evidence of a vast counterfeit pharmaceutical conspiracy. The storage unit was set up as a laboratory with five tabletop pill presses, several forty gallon drums containing chemicals, ventilation equipment, and several plastic bags of white powdery substances and unknown pills. Subsequent testing confirmed massive quantities of acetylfentanyl (one batch alone was over eleven kilograms of acetylfentanyl pills made to look like pharmaceuticals), as well as other highly dangerous controlled substances like alpha-PVP, XLR11, and methylone. The warehouse and evidence

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[16] *See* 21 U.S.C. §§ 331 (2016), 351 (2017), 352 (2016).
[17] *See* § 331(i).
[18] *See* § 331(t), 21 U.S.C. § 353(e) (2016). On opening any investigation into FDCA violations, prosecutors should be mindful of the requirement under USAM § 4-8.200 to "notify and consult with" the Consumer Protection Branch of DOJ's Civil Division.
[19] United States v. Resnik, et al., 16-201-SJO (C.D. Cal. 2016).

were covered in a powdery residue, and one of the agents involved in the search was briefly hospitalized after coming into contact with the powder. A portion of the evidence seized is shown below.

Figure 3: Evidence Seized in *Resnik*

C. Modus Operandi of the Conspiracy

This initial search and seizure that stemmed from the discovery of a pill press in turn led to a lengthy investigation of numerous members of this counterfeit pharmaceutical conspiracy and the identification of another manufacturing location. Ultimately, four defendants were charged in 2016. Three later pleaded guilty, and the fourth was convicted at trial in October 2017. Owing to the massive quantities of acetylfentanyl seized, each defendant either agreed to or faces a base offense level of thirty-eight at sentencing. The first defendant was recently sentenced and received a term of 320 months imprisonment. The evidence uncovered through further investigation and proven at trial, including testimony by a cooperating defendant, reveals additional details about how pill press operations function.

Resnik was the operation's mastermind. Using the internet, he imported from China voluminous quantities of controlled substances such as acetylfentanyl and alpha-PVP, as well as other chemicals to use as binders and dyes. Resnik communicated regularly with Chinese sources who provided expert knowledge on ingredients and quantities. In addition to the pill presses, Resnik and his co-conspirators also used a variety of tools such as pill dyes and hardness testers to make their pills look as real as possible. Over the course of the investigation, agents continued receiving notifications from CBP that shipments were coming from China in the names of Resnik and several of his co-conspirators. Some of the shipments were listed on manifest documents as "toys" or "children's clothing," but others were labelled as "grain mill mixing machine" and "laboratory glassware." As one of the co-conspirators testified at trial, the point of the operation was to make the pills look like the real thing.

After obtaining substances and equipment from China, Resnik directed several other co-conspirators who manufactured tens of thousands of pills per month in the Long Beach storage unit and a house in a residential neighborhood in Los Angeles County. Protecting themselves merely with t-shirts wrapped around their faces, the defendants spent hours mixing chemicals and controlled substances according to Resnik's instructions. The searches uncovered pages of recipe sheets with precise measurements. Furthermore, Resnik employed a color coding system for the bottles of chemicals. This was both, to make the job easier for the manufacturers, and so that Resnik could monitor their work in real time over video cameras he had installed. The lethal drugs imported from China were mixed with

binders and coloring, then pressed in the pill presses, and finally stamped with dyes and labels designed to make them look like legitimate pharmaceuticals.

Once the counterfeit OxyContin, Vicodin, and other drugs were manufactured, the conspirators sold the pills by the bagful on the streets and shipped them to customers across the country. To ensure the quality of the pills, the defendants often watched as customers used the drugs in order to see how the users responded, as well as to determine whether the pills were strong enough or too strong. The defendants sold hundreds of pills at a time at prices ranging from between four to eight dollars per pill. At trial, one of the defendants testified that they earned approximately $300,000 over seven to eight months. During one incident alone, local authorities stopped a customer who had just purchased pills from a defendant, and seized over 4,000 pills containing acetylfentanyl and nearly 500 counterfeit Xanax tablets, some of which are shown below.

Figure 4: Pills Manufactured by Resnik and Seized from Customer

After nearly a year of investigation, on March 15, 2016, agents executed search warrants at each of the four defendants' respective residences, as well as a house next to a preschool that the defendants had been using as their primary lab since the 2015 raid on the Long Beach storage unit. This time a hazmat team was prepared, and went into the house in full protective gear due to the hazardous nature of the drugs involved. Inside the house were many thousands more pills of different sizes and colors, a respirator system, large containers of various powders, and at least four additional pill presses, some of which are shown below.

Figure 5: Evidence Seized in *Resnik*

IV. Conclusion

Counterfeit pharmaceutical operations such as those highlighted in this article will continue to pose a danger throughout the country as long as the national opiate epidemic persists. The operators of these schemes serve as black market manufacturers and distributors of massive amounts of these drugs, cheaply acquired from international sources using narcotics exponentially more powerful than heroin. These offenders are very often responsible for deaths that result from their illegal drugs. Targeting these schemes is an essential part of law enforcement's role in combatting the opiate epidemic. We thank you for your work in this important area and invite you to contact us should you have any questions.

ABOUT THE AUTHORS

❑ **Benjamin R. Barron** has been an Assistant United States Attorney in the Central District of California since 2008, where he serves as Deputy Chief of the district's OCDETF Section. Since 2011, Mr. Barron has coordinated the section's opioid and prescription drug diversion program, including overseeing criminal prosecutions, community outreach efforts, and law enforcement training. Mr. Barron received an EOUSA Director's Award and an OCDETF Director's Award in recognition for this work.

❑ **Michael G. Freedman** has been an Assistant United States Attorney in the Central District of California since 2016 and serves in the district's OCDETF Section.

New Amendments to the U.S. Sentencing Guidelines Concerning Fentanyl and Fentanyl Analogues

Joseph S. Gerbasi
Senior Trial Attorney
Narcotic and Dangerous Drug Section, Criminal Division

I. Introduction

Fentanyl is a Schedule II synthetic opioid developed and currently employed in modern medicine to serve as both an analgesic and an anesthetic. Due to its strong opioid properties—it is approximately 100 times more potent than morphine and fifty times more potent than heroin—fentanyl has become a highly attractive drug of abuse. Abusers can obtain it through diversion from legitimate medical market channels and, more often, readily obtain fentanyl that is illicitly manufactured and distributed. Illicit fentanyl and analogues like carfentanil, which appear to be responsible for much of the current widely publicized opioid overdose epidemic, are often manufactured illicitly in China and sold in the United States as powder or tablets mixed with, or substituted for, heroin or cocaine, as tablets that mimic the appearance of controlled prescription opioids such as oxycodone or hydrocodone, or absorbed onto blotter paper. Many of these drugs are sold online from anonymized "dark net" websites or from overtly operated websites operated by individuals not affiliated with any drug cartel. They are also marketed at the retail level by cells and gangs affiliated with the major transnational criminal organizations that distribute and sell heroin, cocaine, and methamphetamine. The massive volume of international parcel traffic sent through the national mail services and express consignment carriers, often through foreign freight forwarders, combined with the technological and logistical challenges of detection and interdiction, make it difficult for law enforcement to negate this threat wave.

In 2016, drug overdoses led to nearly 64,000 deaths in the United States, or approximately 174 per day. Drug overdoses are now the leading cause of injury-related death in the United States, exceeding those stemming from motor vehicle crashes and firearms. Synthetic opioids, mostly fentanyl and various fentanyl analogues, contributed to more than 20,000 of these reported deaths.[1] This represents a drastic increase from recent years, doubling the number from 2015 and up 540 percent since 2013.[2]

The high potency of fentanyl and fentanyl related compounds, as well as some users' lack of awareness of the presence of fentanyl in adulterated drugs or counterfeit prescription pills, contributes to

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[1] F.B. Ahmad & B. Bastian, *Provisional Counts of Drug Overdose Deaths, as of 8/6/2017*, NATIONAL CENTER FOR HEALTH STATISTICS (2017).
[2] *See* Josh Katz, *The First Count of Fentanyl Deaths in 2016: Up 540% in Three Years*, N.Y. TIMES, Sept. 2, 2017.

high levels of overdose incidents. From 2013 to 2016, the rate of drug overdose deaths due to these synthetic opioids has increased a staggering eighty-eight percent per year.[3] According to the DEA National Forensic Laboratory Information System, reports on fentanyl increased from nearly 5,400 in 2014 to over 14,600 in 2015, and up to 34,000 in 2016.[4] This makes fentanyl the second most reported narcotic analgesic and the seventh most frequently reported drug overall.[5] In response, the Centers for Disease Control (CDC) has released several resources to help heighten public awareness of the crisis: an opioid overdose tip card[6] and a *Get the Facts* infographic[7] highlighting key information on pain management and opioid abuse. Preliminary data show another, albeit smaller, increase in overall drug overdose deaths for 2017. While drug abuse across several controlled substances is trending higher, the abuse of fentanyl and its analogues is responsible for the most severe rise in overdose numbers, thereby creating waves of severe and tragic consequences in wide sectors of the U.S. population.

While fentanyl itself is a Schedule II drug, on February 6, 2018, the DEA used its authority under Section 201 of the Controlled Substances Act (CSA), 21 U.S.C. Section 811(h)(1), to place all non-scheduled fentanyl related substances (defined in the scheduling order) into Schedule I temporarily, on an emergency basis, for two years.[8] Such temporary scheduling can be extended for an additional year if proceedings for permanent scheduling are underway.[9]

II. Summary of Principal Current Sentencing Provisions

Using the scientific name for fentanyl, the CSA establishes mandatory minimum sentences for "N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl] propanamide" and any analogue of that substance.[10] There is a five year mandatory minimum sentence for trafficking *forty or more grams* of fentanyl or *ten or more grams* of an "analogue of fentanyl," and a ten year mandatory minimum sentence for trafficking *400 or more grams* of fentanyl or *100 or more grams* of an analogue of fentanyl.[11]

The Drug Quantity Table ("DQT") in the U.S. Sentencing Guidelines (USSG)[12] delineates Base Offense Levels (BOL) from twelve through thirty-eight for threshold quantities of "fentanyl" and "fentanyl analogue," at severity levels that reflect the mandatory minimum penalty structure. Also, at each BOL, the amount of fentanyl is four times greater than the amount of a fentanyl analogue. The

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[3] *See* Holly Hedegaard, MD, Margaret Warner, PhD, & Arialdi M. Miniño, MPH, *Drug Overdose Deaths in the United States, 1999-2016*, 294 NCHS DATA BRIEF (2017).
[4] *See National Forensic Laboratory Information System 2016 Annual Report,* U.S. DRUG ENFORCEMENT ADMINISTRATION.
[5] *Id.*
[6] *Preventing an Opioid Overdose: Know the Signs. Save a Life.*, CENTERS FOR DISEASE CONTROL AND PREVENTION.
[7] *Opioids for Acute Pain: Get the Facts*, CENTERS FOR DISEASE CONTROL AND PREVENTION.
[8] Schedules of Controlled Substances: Temporary Placement of Fentanyl-Related Substances in Schedule I, 83 FR 5188-01.
[9] 21 U.S.C. § 811(h)(2) (2015).
[10] *See*, *e.g.*, 21 U.S.C. § 841(b)(1)(A)(vi) (2012); 28 C.F.R. § 50.21(d)(4)(vi) (N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl] propanamide is "commonly known as fentanyl").
[11] *See* §§ 841(b)(1)(A)(vi), (b)(1)(B)(vi); 21 U.S.C. §§ 960(b)(1)(F), (b)(2)(F) (2014).
[12] U.S.S.G. § 2D1.1(c) (U.S. Sentencing Comm'n 2016).

guidelines penalty structure (four times as much fentanyl incurs the same sentence as a given quantity of fentanyl analogue) also reflects the statutory penalty scheme. Similarly, the Drug Equivalency Tables ("DET")[13] sets a marijuana equivalency for one gram of fentanyl at 2.5 kilograms of marijuana (a 1:2,500 ratio).[14] The DET sets an equivalency for one gram of alpha-methylfentanyl and 3-methylfentanyl at ten kilograms of marijuana, corresponding with a ratio of 1:10,000. These equivalencies are consistent with the statutory and DQT approaches to fentanyl and fentanyl analogues.

III. Summary of New Sentencing Guidelines Amendments

On April 12, 2018, the U.S. Sentencing Commission voted to adopt and send to Congress several new amendments to the sentencing guidelines for offenses involving fentanyl and fentanyl analogues. These amendments would modify §2D1.1 in three principal ways to more effectively and even-handedly punish some offenders who deal in these substances. The first amendment would add a note to the DQT (to be designated as Note (J)) to define the term "fentanyl analogue." The second amendment would set forth a single equivalency applicable to any fentanyl analogue, making one gram of a fentanyl analogue equivalent to ten kilograms of "converted drug weight" (in effect, the same as the current marijuana equivalency for alpha-methylfentanyl and 3-methylfentanyl). The third and final change to §2D1.1 would establish a specific offense characteristic (at §2D1.1(b)(13)), with a four level increase to the BOL if the defendant knowingly misrepresented or marketed as another substance a mixture or substances containing fentanyl . . . or a fentanyl analogue.[15] These amendments will become effective on November 1, 2018, unless that date is revised or the amendments are modified or disapproved by Congress.

IV. Issues Presented for Federal Prosecutors

As an initial matter, because the guidelines are advisory only, prosecutors can cite upcoming amendments to courts even now as reasons for varying from the guidelines currently in effect.[16]

Federal prosecutors are likely to find these new amendments useful as well-justified steps to better correlate the available punishments associated with fentanyl and fentanyl analogues with the severity of those crimes, particularly in districts that have seen significant numbers of overdose incidents related to these drugs. Prosecutors should be mindful of several aspects of the amendments. First, there is, however, no change to the threshold quantities for mandatory minimum sentences and comparable guidelines sentences for fentanyl. A lethal dose of fentanyl for most individual abusers can be as little as two milligrams, so the current forty and 400 gram threshold (respectively triggering the five and ten year mandatory minimum sentences) represents as many as 20,000 and 200,000 lethal doses. Thus, even cases involving thousands of lethal doses of fentanyl may not satisfy the quantity threshold for the five, let alone ten year mandatory minimum sentences.

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[13] U.S.S.G. § 2D1.1, comment n.8(D) (U.S. Sentencing Comm'n 2016) (used to compare drug quantities with respect to a common referential unit of measurement when calculating the BOL for controlled substances not specifically referenced in the DQT, or when aggregating quantities of multiple controlled substances).

[14] If amended, the DET will be called the "Drug Conversion Tables" and will express equivalencies as grams of "Converted Drug Weight," rather than as grams of marijuana.

[15] Further, the amendments would add the scientific name for fentanyl to the DQT.

[16] *See*, *e.g.*, United States v. Mateos, 623 F.3d 1350, 1368-69 (11th Cir. 2010) (former Justice O'Connor, sitting by designation, holding that forthcoming changes to the guidelines that would more severely punish healthcare fraud inform both the sentencing and reviewing courts on the appropriate sentence in a given case: "[e]ven though the amendment to the guidelines does not apply retroactively to Alvarez, it can still inform our consideration of whether thirty years is a reasonable sentence for her crime . . ."), *cert. denied*, 562 U.S. 1222 (2011).

Second, Note (J) to the DQT will define fentanyl as: "any substance (including any salt, isomer, or salt of isomer thereof), whether a controlled substance or not, that has a chemical structure that is similar to fentanyl (N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl] propanamide)."[17] The Sentencing Commission states that because the current general definition of "analogue" for guidelines purposes[18] incorporates by reference the statutory definition of "controlled substance analogue,"[19] the current guidelines definition may exclude *scheduled* substances from application of USSG §2D1.1's DQT provisions for fentanyl analogue. The clarification is particularly important given the DEA's temporary scheduling of fentanyl related substances.[20]

Finally, the new enhancement at USSG §2D1.1(b)(13) for misrepresenting or marketing a mixture or substance containing fentanyl or a fentanyl analogue as another substance will require that the defendant act "knowingly." The Sentencing Commission states that it "determined that it is appropriate for traffickers who knowingly misrepresent fentanyl or a fentanyl analogue as another substance to receive additional punishment."[21] Sentencing Commission data from the 2016 fiscal year indicates that only sixteen percent of offenders clearly knew they possessed fentanyl, while a majority of fifty-three percent did not know they had fentanyl. For the other thirty-one percent, investigators could not discern if the offender knew that they possessed fentanyl.[22]

Moreover, there may be circumstances in which the offense of conviction does not establish that the defendant knowingly distributed the fentanyl or fentanyl analogue. In such cases, the government would have to establish this fact in addition to the misrepresentation. Particularly with respect to cases involving fentanyl analogues, prosecutors should consider the Supreme Court's decision in *McFadden v. United States*, which held that the knowledge requirement as to a particular substance under 21 U.S.C. § 841 can be established in two ways: by presenting evidence that a defendant knew the substance was

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[17] *Amendments to the Sentencing Guidelines (Preliminary)*, UNITED STATES SENTENCING COMMISSION 119 (n.J) (2018).
[18] U.S.S.G. § 2D1.1, comment n.6 (U.S. Sentencing Comm'n 2016).
[19] 21 U.S.C. § 802(32) (2012).
[20] Prosecutors should keep in mind, however, that the CSA does not define what is meant by an "analogue of N-phenyl-N-[1-(2-phenylethyl)-4-piperidinyl] propanamide" (i.e. analogue of fentanyl) for purposes of 21 U.S.C. §§ 841(b)(1)(A)(vi), (b)(1)(B)(vi) (2012) and 21 U.S.C. §§ 960(b)(1)(F), (b)(2)(F) (2014). Those sections do not explicitly reference Section 802(32) or scheduled substances that share a chemically-similar structure with fentanyl (e.g., furanyl fentanyl). A review of the legislative history is less than instructive as to whether Congress intended to include non-scheduled substances that are chemically and pharmacologically substantially similar to fentanyl in the definition of "analogue of fentanyl," or if Congress intended to include *scheduled* substances that share a chemically similar structure with fentanyl (e.g. furanyl fentanyl).
[21] *Amendments to the Sentencing Guidelines, Policy Statements, and Official Commentary*, UNITED STATES SENTENCING COMMISSION 11 (April 30, 2018).
[22] *Public Data Presentation for Synthetic Cathinones, Synthetic Cannabinoids, and Fentanyl and Fentanyl Analogues Amendments*, UNITED STATES SENTENCING COMMISSION (2018).

controlled, or by presenting evidence the defendant knew the identity of the substance he was distributing.[23]

ABOUT THE AUTHOR

❑ **Joseph S. Gerbasi** has been with the Criminal Division for twenty-one years, first as a trial attorney in the Child Exploitation and Obscenity Section, and now in the Narcotic and Dangerous Drug Section, where he focuses on policy matters, strategic enforcement planning, and interagency counter-narcotics initiatives. He was previously a child abuse and neglect prosecutor with the Office of the District of Columbia Attorney General, and has been a Special Assistant United States Attorney in the District of Columbia and the District of Alaska. He received a B.S. from Boston College in 1986 and a J.D. from the Marshall-Wythe School of Law at the College of William and Mary in 1989. This is his second article for *USABulletin*—he and a co-author contributed an article, titled *The Special Operations Division's National and International Expertise*, to the May, 2006 edition devoted to Gang Prosecutions.

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[23] McFadden v. United States, 135 S. Ct. 2298, 2301, 192 L. Ed. 2d 260 (2015) (holding that the knowledge requirement as to a particular substance under 21 U.S.C. § 841 can be established in two ways: evidence that a defendant knew the substance was controlled; or by evidence the defendant knew the identity of the substance he was distributing). Further, even if the defendant knew the identity of the fentanyl analogue in the mixture or substance, prosecutors may need to prove that the defendant knew the drug was chemically and pharmacologically similar to fentanyl.

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The Medical Examiner's Role in Addressing the Opioid Crisis

Thomas P. Gilson, M.D.
Cuyahoga County Medical Examiner

I. Introduction

The opioid crisis in the United States is a rapidly evolving, steadily worsening crisis that has now persisted for approximately twenty years. The scope of drug overdose mortality and morbidity arising from the crisis is unprecedented in the history of the United States. Starting from a phase involving prescription medications, the crisis has seen transitions to illicit drugs. This initially involved heroin abuse, but has more recently seen fentanyl and fentanyl-like drugs assume increasing prominence.[1] Several sectors of society have responded to the crisis, and these responses have seen the establishment of nontraditional collaborations between previously disparate partners. This paper seeks to characterize the response of the Medical Examiner in Cuyahoga County[2] to the opioid crisis, with emphasis on the roles that can be played by medical examiners in this area, especially in facing the current challenges posed by overdose deaths by fentanyl and the analogues of fentanyl.

The genesis of the opioid crisis in the United States is in the abuse of pharmaceutical opioid pain relievers (OPRs) which were prescribed with increasing frequency in the mid to late 1990's.[3] Within a few years, medical examiners and coroners noticed an increase in mortality associated with abuse of opioid pain relievers.[4] Various responses were implemented in an attempt to reduce the diversion and abuse of prescription opioid pain relievers. These included attempts to address overprescribing (e.g. legislation to address "pill mills"), prosecution of unscrupulous medical practitioners, and reformulation of prescription opioid pain relievers to reduce their abuse potential.[5] As these measures started to take effect, the crisis took an unfortunate turn with a transition to illicit drugs, particularly heroin, becoming adopted by the drug abusing population.[6] This was notable because it represented a transition from the

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[1] Matthew P. Prekupec, MD, Peter A. Mansky, MD & Michael H. Baumann, PhD, *Misuse of Novel Synthetic Opioids: A Deadly New Trend*, J. ADDICTION MED. 256-65 (2017).
[2] Thomas Gilson, MD, Camille Herby, MPH & Claire Naso-Kaspar, *The Cuyahoga County Heroin Epidemic*, ACAD. FORENSIC PATHOLOGY 109-13 (2014). *See also* Thomas P. Gilson, MD, Hugh Shannon & Jaime Freiburger, *The Evolution of the Opiate/Opioid Crisis in Cuyahoga County*, ACAD. FORENSIC PATHOLOGY 41-49 (2017).
[3] Margaret Warner, PhD, Li Hui Chen, MS, PhD & Diane M. Makuc, D.Ph., *Increase in Fatal Poisonings Involving Opioid Analgesics in the United States, 1999-2006*, NCHS DATA BRIEF 1-8 (2009). *See also* Centers for Disease Control and Prevention, *Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008*, MORBIDITY AND MORTALITY WEEKLY REPORT 1476-92 (2011).
[4] Paul Tough, *The Alchemy of OxyContin*, N.Y. TIMES, July 29, 2001.
[5] Hal Johnson, MPH et al., *Decline in Drug Overdose Deaths After State Policy Changes—Florida, 2010-2012*, MORBIDITY AND MORTALITY WEEKLY REPORT 569-74 (2014). *See also* Francesca L. Beaudoin, MD, MS, Geetanjoli N. Banerjee, MPH & Michael J. Mellow, MD, MPH, *State-level and system-level opioid prescribing policies: The impact on provider practices and overdoses, a systematic review*, J. OPIOID MANAGEMENT 109-18 (2016). *See also* Richard C. Dart, MD, PhD, et al., *Do abuse deterrent formulations work?* J. OPIOID MANAGEMENT 365-78 (2017).
[6] Pradip K. Muhuri, Joseph C. Gfroerer & M. Christine Davies, *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY DATA REVIEW (2013).

diversion of a legal medication to the utilization of an illegal narcotic with both law enforcement and public health implications. Law enforcement intervention strategies would now need to focus on criminal importation and sale of illegal substances, and public health officials would need to focus on items like intravenous drug abuse hazards and other unsafe practices associated with illicit drug distribution. As the crisis continued to evolve, additional steps were taken to address the rise of heroin in the drug abusing population. These included stricter enforcement and more frequent prosecution of drug dealers, as well as wider implementation of the opiate antidote, naloxone.[7] As these measures started to impact the heroin phase of the opioid crisis, a disastrous development came in the form of the emergence of fentanyl and the analogues of fentanyl into the drug trade. These drugs are of significantly higher potency than heroin and the prescription OPRs, and as a result, several jurisdictions noted marked increases in mortality.[8]

The medical examiner is in a natural position to address multiple aspects of the opioid crisis and to serve as a bridge in the promotion of nontraditional alliances in combating the epidemic. As a medical doctor, the forensic pathologist/medical examiner is able to liaison with the medical community. As a forensic professional, the medical examiner interacts frequently with law enforcement in a very traditional partnership. Finally, the medical examiner is a sentinel public health official who can provide significant data, support, and collaboration within the public health infrastructure. In addition, in Cuyahoga County the crime laboratory is under the direction of the Medical Examiner, which has served as a useful model in addressing areas of the opioid crisis as well.

II. Medical Examiner Intervention Roles and Functions

The principal functions that a medico-legal death investigation (MDI) agency like a medical examiner or coroner office can play in combating the crisis include data acquisition, surveillance, education, strategic planning, and advocacy. Many of these functions find applicability across the roles defined for the medical examiner above (i.e. medical, forensic, and public health). In Cuyahoga County and several other jurisdictions, the MDI system provides a useful data source for mortality associated with the opioid crisis. Death investigation systems are frequently underutilized monitors of public health information in this area. On a very basic level, data is obtained regarding race, gender, and age in the course of a death investigation. In Cuyahoga County, the Medical Examiner undertook a review of overdose deaths in 2012 through 2013 to facilitate a better understanding of the crisis by characterizing overdose fatality victims, with a goal of defining intervention points to decrease mortality. By a thorough examination of information gleaned through death investigation, the Poison Death Review Committee (PDRC) sought to identify additional intervention points to ameliorate the impact of drug abuse within the community. The PDRC included members of the Medical Examiner's Office (from the medical examiner, toxicology and death scene investigation units) as well as stakeholders from law enforcement, corrections, public health, drug addiction treatment, and judicial areas. This systematic study not only identified critical intervention points by a more detailed analysis of the deaths that were occurring, but also initiated partnerships between nontraditional entities that persist to this day. Almost from its inception, the PDRC firmly documented the transition from prescription opioid pain relievers to heroin in Cuyahoga County.[9] The significance of this transition cannot be underestimated from the law enforcement perspective. The implications of a transition from the diversion of legally manufactured prescription medications to illicitly

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[7] Erin L. Winstanley, PhD et al., *Barriers to implementation of opioid overdose prevention programs in Ohio*, SUBSTANCE ABUSE 42-46 (2016).

[8] Thomas P. Gilson, MD, Hugh Shannon & Jaime Freiburger, *The Evolution of the Opiate/Opioid Crisis in Cuyahoga County*, ACAD. FORENSIC PATHOLOGY 41-49 (2017). *See also* Matthew P. Prekupec, MD, Peter A. Mansky, MD & Michael H. Baumann, PhD, *Misuse of Novel Synthetic Opioids: A Deadly New Trend*, J. ADDICTION MED. 256-65 (2017).

[9] Thomas Gilson, MD, Camille Herby, MPH & Claire Naso-Kaspar, *The Cuyahoga County Heroin Epidemic*, ACAD. FORENSIC PATHOLOGY 109-13 (2014).

produced illegal narcotics were of tremendous significance in understanding the opioid epidemic. The responses necessitated by the overprescribing and diversion of prescription narcotics included prosecution of over prescribers in the "pill mill" scenario,[10] as well as the strengthening of prescription drug monitoring programs (PDMP) within the states[11] to identify individuals who were obtaining multiple prescriptions for opioid pain relievers with intent to abuse them and/or divert them for abuse purposes. These measures would not prove effective with the distribution of heroin, which was starting to emerge in our county approximately at this time. Additional findings of the PDRC were the observations that the antidote for opioid overdoses, naloxone, was being underutilized because of the delay in identifying that an overdose had occurred. Our data indicated that seventy-five percent of the overdose deaths occurred in proximity to another individual, but in only twenty-five percent of these deaths was a reversal with naloxone attempted by emergency medical services (EMS). The deeper implication of this finding was that a number of individuals may have benefited from naloxone administration if it was more widely available. This prompted efforts supported by the Medical Examiner in collaboration with other professionals to promote preemptive, wider distribution of naloxone,, initially to the addicts themselves, and subsequently to friends and family members as well as first responders, including law enforcement. It is no small consideration that the support of the Medical Examiner carried credibility both within the medical community as well as with law enforcement.

The PDRC also noted that a significant percentage (approximately sixty-five to seventy percent) of the heroin overdose victims had legal prescriptions for opioid pain relievers. This fact was confirmed in data generated by the Substance Abuse and Mental Health Services Administration (SAMHSA), which showed that most of the heroin abusers in the United States at this time had transitioned from opioid pain relievers to heroin. This finding at both the national and local level suggested a need for education of prescribing physicians, as well as general measures to address the culture of pain treatment in the United States.[12] At our local level, the Medical Examiner was able to collaborate with representatives of the medical community for educational purposes in order to start to address the role of overprescribing of opioid pain relievers in the worsening of the drug epidemic.

A related PDRC observation from the analysis of the Ohio PDMP data for the heroin overdose victims was the identification of frequent "doctor-shopping" on the part of the decedents. In 2013, approximately one third of the individuals who died of a heroin overdose and who had a history of obtaining legal opioid pain relievers, had done so with multiple prescribers over the short lookback (two years or less) available to us. We adopted a traditional definition (provided by the drug addiction treatment professional on the PDRC) of "doctor-shopping", i.e., the use of five or more prescribers within a twelve month period. This finding of prevalent "doctor-shopping" indicated that the state PDMP was inadequately preventing the overprescribing of medication to individuals who had a high likelihood of abusing/diverting these drugs. At the time this observation was made, the PDMP in the state of Ohio was voluntary for participation by physicians and pharmacists. The finding of rampant "doctor-shopping" necessitated a second look at the efficacy of the PDMP, and this resulted in subsequent legislation both to make reporting of narcotic prescribing mandatory, as well as to require a check of the database prior to prescribing narcotics.

The PDRC also noted that drug paraphernalia in some form was present at the scene of death in approximately fifty percent of cases. As both local and federal prosecutors in our jurisdiction increased efforts against drug dealers, it became clear that the traditional scene investigation of a drug overdose death on the part of law enforcement and death investigators was insufficient for prosecution purposes. As

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[10] Melissa C. Mercado-Crespo, PhD et al., *Notes from the Field: Increase in Fentanyl-Related Overdose Deaths—Rhode Island, November 2013-2014*, MORBIDITY AND MORTALITY WEEKLY REPORT 531 (2014).
[11] Jing Wang, MD, PhD & Paul J. Christo, MD, *The Influence of Prescription Monitoring Programs on Chronic Pain Management*, PAIN PHYSICIAN 507-15 (2009).
[12] Deborah Dowell, MD, Tamara M. Haegerich, PhD & Roger Chou, MD, *CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016*, MORBIDITY AND MORTALITY WEEKLY REPORT 1-49 (2016).

the crisis has worsened and the desirability of prosecuting drug distributors has increased, the need for adequate processing of overdose death scenes has been a subject of increased focus. It would be impossible to have law enforcement respond for this level of evidence processing of all death scenes, so initial steps were taken to try to maximize impact through identifying likely potential drug overdose scenes. Based on PDRC findings, the presence of drug paraphernalia at a death scene prompted investigators from the Medical Examiner's Office to notify a newly created law enforcement task force that such a scene would require processing sufficient for possible ensuing prosecution. This practice was subsequently expanded to include the processing of all potential overdose death scenes based not only on the presence of paraphernalia, but also on circumstances suspicious for possible overdose, including a history of drug abuse on the part of the decedent. The Medical Examiner served as a reference point for notification of task forces, as well as prosecutors, when a drug overdose death was reported.

It was also problematic for investigators to wait on toxicology reports before initiating an investigation into a drug overdose death. National accreditation standards require the completion of toxicology testing within sixty days of submission in ninety percent of cases.[13] Adherence to this became increasingly difficult in our jurisdiction as the number of drug overdose deaths increased. Even maintaining compliance with the above national accreditation standard would have proven woefully inadequate in terms of timely response to scene processing and investigation of drug overdose deaths. It became clear that potential scenes of death in drug overdoses needed to be identified more promptly, and the results of toxicology testing, on some level, had to be available much more rapidly to investigators and law enforcement. As a result, in addition to scene notifications to a task force, the reporting of drug screening (prior to definitive confirmation) was shared from the toxicology laboratory to partners in law enforcement and prosecutors' offices. This permitted both more rapid consideration of charges for drug dealers, as well as advisories on unusual trends (e.g. initial fentanyl death clusters, detection of fentanyl analogues) in a closer to "real-time" manner.

An MDI office is a frontline surveillance point in any drug epidemic. By statute, all deaths involving drug use/abuse are reportable to the MDI agency. Detection of trends required diligence on the part of the MDI agency, and efficient responses to these trends require a timely communication and dissemination of this information to other partners. As the Medical Examiner's Office in our county frequently interacts with law enforcement and public health, as well as the medical community, this again is a unique role for timely widespread dissemination of important information. An early difficulty encountered in the larger jurisdiction of the state of Ohio was the inability to recognize evolving trends in opioid overdose deaths due to a lack of specificity in death certification. It was noted that deaths would frequently be certified generally in terms like "opioid toxicity," "drug toxicity," etc., and lack the specificity as to which drugs were specifically involved. This naturally hampered the ability of large scale surveillance organizations like state health departments and the Centers for Disease Control and Prevention (CDC) to identify emerging trends like that described above (i.e. transition from prescription narcotics to heroin). The MDI community needed to collaborate internally[14] to implement a system where more detail was being recorded in a death certificate (e.g. specifically listing the drugs involved in an overdose death). Variations in the training of medical examiners and coroners still present a potential problem in the appropriate certification of overdose deaths.

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[13] NATIONAL ASSOCIATION OF MEDICAL EXAMINERS, INSPECTION AND ACCREDITATION CHECKLIST, STANDARD E.2.H (2014).

[14] Gregory G. Davis, MD, MSPH, *Complete Republication: National Association of Medical Examiners Position Paper: Recommendations for the Investigation, Diagnosis, and Certification of Deaths Related to Opioid Drugs*, J. MED. TOXICOLOGY 100-06 (2014).

Diligent surveillance in our jurisdiction and elsewhere resulted in the identification of the emerging prominence of fentanyl in drug overdose mortality.[15] In Cuyahoga County, episodic fentanyl overdoses had been identified for several years prior to 2014 when a substantial rise was noted in the final months of that year. Periodic outbreaks of fentanyl in multiple jurisdictions had been observed for years prior to the current epidemic of fentanyl abuse and mortality.[16] Within our own jurisdiction in early 2014 the Medical Examiner noted a transient rise in fentanyl deaths in a short period of time and was able to rapidly convey this to law enforcement. They were able to identify a single distribution source and apprehend the individuals responsible for fentanyl distribution.[17] By the end of 2014, it became apparent that fentanyl use was becoming more widespread in the community, both from the death scene investigations as well as from the drug chemistry analysis of narcotics seized in various locations throughout our community. At this time, a question arose to whether the emergence of fentanyl represented illicit manufacture (which the Drug Enforcement Agency had noted in earlier seizures)[18] or the diversion of legal supplies of fentanyl (which was our typical scenario previously). It was fortuitous that the Drug Chemistry laboratory was under the direction of the Medical Examiner's Office at the time that increases in fentanyl mortality were identified. When these increases were noted, immediate cross-referencing with the Drug Chemistry laboratory indicated that the source of fentanyl in the community was from illicit manufacture and illegal distribution and not from diverted legal sources. This kind of collaboration between toxicology and death certificate findings with drug chemistry testing, has been of tremendous benefit to our community. While there are slightly more than 400 crime laboratories in the United States, unfortunately only approximately ten are under the direction of a medical examiner or a coroner, where a toxicology laboratory is usually found.[19] It is imperative in these jurisdictions that lines of communication become established so that information on the emergence of new drugs in either toxicology/mortality or drug seizures is rapidly available and exchanged between these two critical surveillance laboratories.

In the role of educator in the opioid crisis, the medical examiner can assume further vital roles. With regard to the investigation of overdose deaths, the Cuyahoga County Medical Examiner serves as a scientific liaison to both law enforcement and to prosecutors. This can take many forms, including offering guidance on scene safety measures to first responders (e.g. adequate personal protective equipment), as well as the reasonable interpretation of relevant toxicology data in the pursuit of prosecution of drug dealers. The guiding decision in the federal prosecution of drug distributors is the *Burrage* decision.[20] After extensive discussions with prosecutors in our jurisdiction, the need for prosecution became clear to the Medical Examiner, and the ability to address the need in an independent and transparent fashion on the part of the Medical Examiner was made clear to prosecutors.[21] Other educational interventions that the medical examiner can undertake involve the medical community with regard to the impact of prescription opioid pain relievers on the evolution of the drug crisis. The medical examiner can also serve as an informational bridge to law enforcement, prosecutors, and the legal system

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[15] Thomas P. Gilson, MD, Hugh Shannon & Jaime Freiburger, *The Evolution of the Opiate/Opioid Crisis in Cuyahoga County*, ACAD. FORENSIC PATHOLOGY 41-49 (2017).
[16] Johnathan Hibbs, MD, Joshua Perper, MD, LLB & Charles L. Winek, PhD, *An Outbreak of Designer Drug-Related Deaths in Pennsylvania*, J. AM. MED. ASS'N 1011-13 (1991). *See also* J.E. Smialek et al., *A fentanyl epidemic in Maryland 1992*, J. FORENSIC SCI. 159-64 (1994).
[17] Corey Shaffer, *Third fatal fentanyl-laced heroin overdose identified in Cleveland*, CLEVELAND.COM, March 14, 2014.
[18] R. Matthew Gladden, PhD, Pedro Martinez, MPH & Puja Seth, PhD, *Fentanyl Law Enforcement Submissions and Increases in Synthetic Opioid-Involved Overdose Deaths—27 States, 2013-2014*, MORBIDITY AND MORTALITY WEEKLY REPORT 837-43 (2016).
[19] ANSI-ASQ NATIONAL ACCREDITATION BOARD, https://www.anab.org.
[20] Burrage v. United States, 571 U.S. 204, 134 S.Ct. 881, 187 L. Ed. 2d 715 (2014).
[21] Thomas P. Gilson, Carole Rendon & Joseph Pinjuh, *Rules for Establishing Causation in Opiate/Opioid Overdose Prosecutions—The Burrage Decision*, ACAD. FORENSIC PATHOLOGY 87-90 (2017).

in dealing with complex concepts of toxicology, drug potency, and the interpretation of significant trends in the evolution of the drug crisis. Additionally, community leaders in both educational and epidemiological communities may become a point of focus. In looking at the overdose victims in Cuyahoga County with the Medical Examiner's data, it has become apparent that many of the victims (approximately seventy percent) have an education level of a high school diploma or less. Outreach has been made to members of the school and education communities to ensure that this information is made available to them for the purpose of developing strategies for long-term prevention through education in the school systems. It has been an additional finding in our community that the majority of overdose victims had some connection to building or other manual labor trades, and that public health outreach to organized labor was undertaken in an effort to reach these potentially at-risk individuals as well.

Strategic planning from the medical examiner's perspective may take many forms. A very traditional role in strategic planning has been in mass fatality events. In this capacity, the medical examiner serves as a subject matter expert as well as a point of reference for the allocation of resources in response to a mass fatality event. It is entirely reasonable to consider the opioid crisis in the United States as a comparatively slow moving, prolonged mass fatality event. Over the last five years, over 100,000 individuals have died from drug overdoses in the United States.[22] Unlike traditional mass fatality events, which often center around a single natural or manmade disaster, the opioid crisis is a mass fatality event involving the continued abuse of drugs and the introduction of significantly more lethal drugs over the course of the epidemic. In terms of strategic planning, the medical examiner's provision of frontline trend observation data, coupled with the expertise to interpret the significance of these trends, can be invaluable to public health, law enforcement, and medical partners in attempts to collaboratively combat the crisis. The identification of trends to inform public health prevention strategies has also proved critical to an adequate and efficient response. In our jurisdiction, for example, routine drug screening in many emergency departments did not include fentanyl at the time it was becoming the most common drug involved with fatal overdose. It was thus possible to misdiagnose overdose victims and either fail to treat them appropriately or report them to the Medical Examiner for further investigation until this shortcoming in drug screening was addressed. Additionally, the identification of the emergence of fentanyl within the routine cocaine traffic was seen in conjunction with a rise in the number of African Americans who were dying from opioid overdoses. The African American community had been largely passed over in the early phase of the opioid epidemic with prescription pain medication, possibly reflecting disparities in analgesic prescribing.[23] Because of ongoing monitoring and interpretation of drug mortality data, the Medical Examiner in Cuyahoga County was able, early on, to call attention to the rise of a new vulnerable population that had theretofore largely been outside of deleterious effects of opioids and, as a result, to undertake education and intervention efforts.

By integrating the Medical Examiner into the many areas of response to the opioid epidemic, the Medical Examiner in our jurisdiction has been able to advocate for policies that are traditionally outside the scope of forensic pathology practice. The implementation of the naloxone distribution program within our county received strong support from the Medical Examiner's data. Additional interventions, including the development and implementation of educational activities, has also been facilitated in instances by the Medical Examiner's Office.

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[22] *Overdose Death Rates*, NATIONAL INSTITUTE ON DRUG ABUSE (Revised Sept. 2017).

[23] Angela M. Mills et al., *Racial disparity in analgesic treatment for ED patients with abdominal or back pain*, AM. J. EMERGENCY MED. 752-56 (2011). *See also* Joshua H. Tamayo-Sarver, PhD et al., *Racial and Ethnic Disparities in Emergency Department Analgesic Prescription*, AM. J. PUB. HEALTH 2067-73 (2003).

III. Current and Future Challenges: Fentanyl and Fentanyl Analogues

Since its emergence in 2013 to 2014, fentanyl has become the major driver of drug abuse mortality in our jurisdiction[24] and several other locations in the country.[25] Fentanyl is a synthetic opioid with a substantially higher potency than morphine, heroin, and OPRs. It is a Schedule II drug used medically in pain management and anesthesia.[26] In 2016, carfentanil, a potent animal sedative, and several other chemically similar analogues of fentanyl began to appear in the illicit drug trade. These drugs presented, and continue to present, significant challenges to the forensic community.

Because of their higher potency, the analogues of fentanyl are frequently present in low concentrations, which have necessitated increasingly more sensitive methods of analysis to detect them.[27] The instrumentation required for this testing is expensive and may require dedicated personnel for its operation and maintenance. This places major burdens on laboratories, especially in the public sector, to allocate adequate funding to "keep up" with the evolving crisis.

It is also often the case that these new drugs have not been previously encountered in routine drug and toxicology analysis. This presents challenges both in testing as well as in the interpretation of the test results. From a testing standpoint, the identification of a new compound may again require increasingly sophisticated instrumentation, but in addition, there will be a need for reference material to permit testing for drug concentrations, etc. Frequently these standards are not readily available for commercial suppliers. This was the case when carfentanil first appeared in northeast Ohio and reference samples had to be procured from local zoos (where it is employed for large animal sedation/control) to at least permit initial analysis. From an interpretation standpoint, the significance of these drugs may be difficult to know as potency and human toxicity data may be limited or nonexistent. This may also have an impact on the scheduling of these drugs.

The burden of the opioid crisis on MDI agencies has been enormous. With the dramatic escalation in opioid deaths across the nation, several offices have encountered difficulties investigating them. The need for additional staffing for investigations and its strain on budgets is only one part of the problem. While the National Association of Medical Examiners recommends complete autopsy in the investigation of opioid-related deaths,[28] many jurisdictions lack sufficient personnel to comply with this recommendation. An earlier report from the National Academy of Sciences found that the United States lacked an adequate number of forensic pathologists[29] even prior to the marked escalation of drug related mortality, especially in the fentanyl phase of the current drug epidemic. There has been no significant increase in the number of forensic pathology training programs or forensic pathologists since then. Similarly, there are few programs in the United States dedicated to training forensic toxicologists to the

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[24] Thomas P. Gilson, MD, Hugh Shannon & Jaime Freiburger, *The Evolution of the Opiate/Opioid Crisis in Cuyahoga County*, ACAD. FORENSIC PATHOLOGY 41-49 (2017).
[25] Melissa C. Mercado-Crespo, PhD et al., *Notes from the Field: Increase in Fentanyl-Related Overdose Deaths—Rhode Island, November 2013-2014*, MORBIDITY AND MORTALITY WEEKLY REPORT 531 (2014).
[26] RANDALL C. BASELT, DISPOSITION OF TOXIC DRUGS AND CHEMICALS IN MAN 846-49 (10th ed., Biomedical Publications, 2014).
[27] S. Sofalvi et al., *An LC-MS-MS Method for the Analysis of Carfentanil, 3-Methylfentanyl, 2-Furanyl Fentanyl, Acetyl Fentanyl, Fentanyl and Norfentanyl in Postmortem and Impaired-Driving Cases*, J. ANALYTICAL TOXICOLOGY 473-83 (2017). *See also* Marykathryn Tynon Moody et al., *Analysis of fentanyl analogs and novel synthetic opioids in blood, serum/plasma, and urine in forensic casework*, DRUG TESTING AND ANALYSIS (2018).
[28] Gregory G. Davis, MD, MSPH, *Complete Republication: National Association of Medical Examiners Position Paper: Recommendations for the Investigation, Diagnosis, and Certification of Deaths Related to Opioid Drugs*, J. MED. TOXICOLOGY 100-06 (2014).
[29] STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD (National Academies Press, 2009).

doctoral/postdoctoral level. While the need for expensive instrumentation might be addressed with increasing budgets, the shortage of adequately trained forensic personnel cannot. The generation of forensic professionals is time-consuming, and their subsequent training and mentoring is not facilitated by a system already overburdened with casework. The intervention roles and functions discussed above will similarly need to be sacrificed or scaled back in the absence of ample personnel to perform frontline investigations.

IV. Conclusion

The fentanyl/fentanyl analogue phase of the opioid crisis in the United States is the latest evolution of a longstanding problem that has changed over time and presented challenges with each development. The scope of the current problem is huge, and many members of the investigation community are needed to address the challenges. As a multidisciplinary specialist, the medical examiner/coroner can be a critical player in the response by integrating medical, legal, and public health roles. All of these responses will depend on an adequate number of forensic professionals to answer the call to action.

ABOUT THE AUTHOR

❑ **Dr. Thomas P. Gilson** is the Medical Examiner and Crime Laboratory Director in Cuyahoga County, Ohio (metropolitan Cleveland). Prior to his current position, Dr. Gilson served as Chief Medical Examiner for the State of Rhode Island and Deputy Chief Medical Examiner for the City of New York, State of New Hampshire, and State of Connecticut. He is a graduate of the Medical College of Pennsylvania and received his general pathology training at the University of Cincinnati with subspecialty training in forensic pathology at the Office of Chief Medical Examiner for the City of New York. His research interests include the application of forensic pathology to public health issues.

Fentanyl Trafficking Trends in the United States

Kirsten Walters
Supervisory Intelligence Research Specialist
Drug Enforcement Administration, Intelligence Division

Fentanyl is a Controlled Substances Act (CSA) Schedule II synthetic opioid. It is used as an anesthetic, and is also prescribed as a pain reliever to manage breakthrough pain in cancer patients. Its strong opioid properties have made it an attractive drug of abuse for opioid users.

Pharmaceutical fentanyl, available in tablets, liquids, patches, and lozenges is diverted from healthcare facilities, although usually on a small scale. This diversion is typically carried out by individuals with access to the drug who steal it to satisfy a personal addiction or for street level sales. Users can extract the fentanyl gel solution in transdermal patches to smoke or ingest the fentanyl, and intravenous fentanyl solution can be injected directly into the bloodstream.

Fentanyl is also illicitly manufactured in clandestine laboratories in China and, likely, Mexico before being smuggled into the United States and distributed in opioid markets. Illicitly produced fentanyl is typically distributed in a white powder form to be mixed into heroin or other illicit drugs, or pressed into counterfeit opioid prescription pills. Illicitly produced fentanyl is the most common type of fentanyl abused in the United States and is primarily responsible for the current fentanyl crisis.

The threat posed by illicitly produced fentanyl is multifaceted. It originally entered illicit drug markets through heroin; fentanyl in powder form is used as an adulterant and mixed into heroin, oftentimes without heroin users knowing it. It is increasingly more common for fentanyl to be mixed with adulterants and diluents and sold as heroin, with no heroin present in the product. Fentanyl in this form looks just like heroin, is packaged in the same manner as heroin—in baggies or wax envelopes—and displays similar stamps or brands as heroin. Many heroin users have no desire to use fentanyl, although some heroin users will seek it out because of its potency.

Fentanyl was introduced into the prescription pill abuser market when traffickers began taking white powder fentanyl and common diluents and using pill press machines to press it into counterfeit prescription pills that are commonly abused. Often, these pills closely resemble the authentic product they are being sold as, and the users have no idea they are laced with fentanyl.

Figure 1. Counterfeit Oxycodone Tablets Containing Fentanyl

Analysis of seizure data in the early days of the fentanyl crisis revealed a heavy concentration of seizures in the Northeast, where there has historically been a white powder heroin market. However, as abuse of fentanyl became more widespread and expanded to other markets, law enforcement agencies nationwide began to experience increases in seizures of both fentanyl powder products and pills.

While the majority of illicit fentanyl is distributed in heroin-like and pill forms, it has been seen mixed with other opioids and also with cocaine. Traffickers are also experimenting with new preparations, such as on blotter paper, eye droppers, and nasal sprays.

Fentanyl related substances are also available throughout the United States. Fentanyl related substances are substances in the fentanyl chemical family with variations in the chemical structure, which have similar effects on the body as fentanyl. These substances are sometimes substituted for fentanyl by drug traffickers because many of them are not yet controlled.

Carfentanil, which is controlled under Schedule II of the CSA, began to appear in the opioid abuser market in 2016. A fentanyl analog 10,000 times more potent than morphine and the most potent commercially used opioid,[1] carfentanil is used as a tranquilizing agent by veterinarians in zoos and other large wildlife environments for use on elephants and other large mammals. It is not approved for use in humans. There is no evidence that the carfentanil being abused in the United States is diverted from the very small legitimately available supply.

Carfentanil is most commonly encountered in powder form, but it has also been seen in capsule form, tablets, and liquid samples. Since 2016, it has been associated with a number of overdose events, both fatal and nonfatal.

Fentanyl and fentanyl related substances such as carfentanil are purchased on both the open and dark web. New and unique preparations of illicit fentanyl are commonly found on dark web markets.

Fentanyl is transported into the United States in parcel packages directly from China, and is also smuggled across the southwest border. Fentanyl sourced from China is concealed in mail parcels and can be difficult for law enforcement officials to detect. Suppliers in China use freight forwarding companies to present packages for export. The use of multiple freight forwarders and transfers of custody make it difficult for law enforcement to track these packages.[2] Fentanyl is smuggled across the southwest border from Mexico using traditional drug smuggling techniques and is often concealed in hidden automobile compartments.

ABOUT THE AUTHOR

❑ **Kirsten Walters** is a Supervisory Intelligence Research Specialist with the Drug Enforcement Administration (DEA). She is currently employed as the Unit Chief of the Domestic Strategic Intelligence Unit at DEA Headquarters. The Domestic Strategic Intelligence Unit provides senior DEA officials and other United States government policy makers with high priority strategic intelligence analyses on the drug trade in the United States, and assesses the changing dynamics of counter drug situations across the country.

Ms. Walters earned a Criminal Justice degree from Antelope Valley College, and is a California Department of Justice and California State University Certified Crime and Intelligence Analyst. She joined the DEA in 2003, and prior to that worked as a Crime and Intelligence Analyst for the Los Angeles County Sheriff's Department.

[1] *Fentanyl drug profile*, EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION.
[2] *Counterfeit Prescription Pills Containing Fentanyls; A Global Threat*, DEA INTELLIGENCE BRIEF (July 2016).

Homeland Security Investigations, Border Search Authority, and Investigative Approaches to Fentanyl Smuggling

Gregory C. Nevano
Deputy Assistant Director
Illicit Trade, Travel, and Finance Division
United States Immigration and Customs Enforcement
Homeland Security Investigations

I. Introduction

At virtually any time of day throughout the world, Immigration and Customs Enforcement (ICE) Homeland Security Investigations (HSI) Special Agents are hard at work investigating the criminal organizations that are exploiting our nation's borders and threatening our national security and our homeland. Every day, HSI Special Agents are conducting interviews and surveillance, searching vessels at ports of entry, examining incoming shipments at international mail facilities, coordinating highway interdiction stops of vehicles (looking for contraband or dangerous goods), identifying cyber criminals, seizing illegal weapons and technology, and effecting arrests and seizing illicit proceeds.

As the only federal investigative agency with combined customs and immigration authority, HSI investigates the widest range of criminal activity in all the law enforcement community. HSI Special Agents are responsible for enforcing more than 400 criminal statutes, including the Immigration and Nationality Act (Title 8), U.S. customs laws (Title 19), general federal crimes (Title 18), and the Controlled Substances Act (Title 21), among many others.

HSI Special Agents utilize their unique authority to identify, interdict, and dismantle the organizations that are responsible for smuggling and supplying deadly opioids—such as illicit fentanyl—to our communities. In 2017, as the fentanyl threat was emerging, HSI made more than 285 fentanyl related arrests and seized more than 2,400 pounds of fentanyl related substances.

To better understand HSI's approaches to fentanyl smuggling investigations, it is valuable to recognize the history of the agency and to highlight the significant border search authority that is unique to HSI Special Agents.

II. History of DHS, ICE, and HSI

The history of the United States Customs Service (USCS) dates to 1789, when customs houses were used as processing points at ports of entry around the country. Customs officials examined, taxed, stamped, and released imported goods while preventing prohibited items from entering the country.

The Immigration Act of 1891 enabled immigration inspectors to inspect passenger manifests, conduct health inspections, and accept or reject immigrants at ports of entry. In 1933, Congress established the U.S. Immigration and Naturalization Service (INS). The Immigration Reform and Control

Act of 1986 expanded INS' responsibilities by allowing it to investigate certain gang, fraud, and human smuggling activities, and to enforce sanctions against employers who hired unlawful aliens.

Following the September 11, 2001 terrorist attacks, and with the passage of the Homeland Security Act of 2002, the Department of Homeland Security (DHS) was created. Twenty-two different federal organizations were combined into a single Department to focus national security efforts on protecting Americans on land, at sea, and in the air. Among the combined agencies were the legacy agencies USCS and INS, which merged their investigative personnel into U.S. Immigration and Customs Enforcement (ICE).

ICE is comprised of two separate operational branches: Homeland Security Investigations (HSI) and Enforcement and Removal Operations (ERO).

HSI is the largest investigative arm of DHS, and it employs criminal investigators (Special Agents) that are responsible for investigating the wide range of domestic and international illicit activities that arise from the movement of people and goods into, within, and outside of the United States. These investigations often touch upon several investigative areas, to include, but not limited to, narcotics, financial crimes, human trafficking and smuggling, intellectual property rights (IPR), counter proliferation, gangs, and cybercrimes such as child exploitation.

ERO enforces the nation's immigration laws. ERO officers (Deportation Officers) identify and apprehend removable aliens, detain these individuals when necessary, and remove them from the United States. ERO officers transport removable aliens from point to point, manage aliens in custody or in an alternative to detention program, provide access to legal resources and representatives of advocacy groups, and remove individuals from the United States who have been ordered to be deported.

A. Border Search Authority

The United States Supreme Court supports the right of the government to conduct searches and seizures at the borders without probable cause or a warrant. This authority protects the United States against the introduction of prohibited, hazardous, or dangerous contraband. Two statutory provisions establish border search authority for HSI Special Agents: Title 19 U.S.C. § 482 allows customs officials to conduct searches of persons, things, vehicles, and mail at the border;[1] and the Immigration and Nationality Act (INA) § 287 gives immigration officers the ability to interrogate, detain, and search individuals and vehicles.[2]

Border searches can also occur in places other than the actual physical border, which can be referred to as the "functional equivalent" of the border, or at the "extended border."

The "functional equivalent" to the border is the first practical detention point after a border crossing. Examples of functional equivalents to the border can include international airports and international mail facilities.

"Extended border" searches occur under circumstances when HSI Special Agents have reasonable certainty of no material change in the person, item, or conveyance since the border crossing, and reasonable suspicion that the person or thing is involved in criminal activity.

HSI Special Agents conduct border, functional equivalent, and extended border searches as part of their investigative approaches as they pursue fentanyl smuggling organizations.

[1] 19 U.S.C. § 482 (2012).
[2] 8 U.S.C. § 1357 (2012).

III. Investigative Approaches to Fentanyl Smuggling

The HSI Illicit Trade, Travel, and Finance Division oversees a wide variety of programs and focused operations that target transnational criminal organizations (TCOs) that exploit America's legitimate trade, travel, and financial systems.

Specifically, it is a mission of the Contraband Smuggling Unit (CSU) to support the HSI field offices in their efforts to identify, disrupt, and dismantle fentanyl smuggling organizations by providing funding, expertise, and coordination. Fentanyl Smuggling Investigations can be initiated at ports of entry, in international mail facilities, in response to overdoses victims, on the internet and dark web, as a result of financial analyses, through interagency coordination, and through human intelligence.

A. Land Border Ports of Entry Investigations

Fentanyl seized at land border ports of entry (POEs) is primarily seen along the United States southern border. HSI Special Agents and Customs and Border Protection (CBP) officers have discovered fentanyl powder and fentanyl tablets concealed in hidden vehicle compartments, on persons, or within their belongings while attempting to enter the U.S. Fentanyl has also been encountered diluted in other drugs, primarily heroin. Fentanyl powder sourced from Mexico is typically in kilogram quantities and purity levels under twelve percent.

HSI Special Agents assigned to ports of entry respond to seizures of illicit substances that are discovered by CBP officers during the course of their examinations for clearance into the United States. HSI Special Agents investigate and gather information for federal criminal prosecution and also work to identify smuggling methods, routes, intended distribution points, and criminal networks associated with the drug seizures.

An emerging fentanyl smuggling trend along the southern border appears to be the use of juveniles as drug carriers. During the last ten days of March 2018, there were six fentanyl seizures at POEs in the San Diego County area where juveniles attempted to smuggle fentanyl into the United States from the Republic of Mexico. Five of the six juvenile narcotics couriers had fentanyl strapped to their bodies. This recent spike in fentanyl smuggling marks a startling new pattern in juvenile narcotics smuggling activity.

B. International Mail Facilities and Express Consignment Carrier

Seizures of fentanyl, fentanyl precursors, and fentanyl analogues have significantly increased at international mail facilities (IMFs) and express consignment carrier hubs (ECCs) over the last two years. Fentanyl seized from these facilities is typically procured for domestic use through online orders from China. The fentanyl seized from IMFs and ECCs is typically unadulterated (ninety-eight percent pure) and is most often found in powder form. Often, new unscheduled fentanyl analogue powders are identified at these locations as China based supply organizations work around drug control laws in their country relating to fentanyl production.

Working with CBP officers, HSI Special Agents take identified fentanyl parcels and pursue federal prosecutions utilizing controlled deliveries and other investigative methods. CBP officers use enhanced analytics to identify shippers and other parts of networks which are then investigated by HSI Special Agents and law enforcement colleagues around the world.

HSI Special Agents have successfully identified U.S. based fentanyl distributors that purchased powder fentanyl online and received shipments through IMFs and ECCs for purposes of pressing the

powder into counterfeit tablets. Special Agents also pursue charges relating to the smuggling of pill presses and other distribution materials under 18 U.S.C. § 545.[3]

For example, in July 2016, HSI intercepted an inbound fentanyl parcel from China that was destined for the Salt Lake City area. As a result, Special Agents identified a regional fentanyl supply organization that was involved in the importation of fentanyl for counterfeit tableting via the dark web. Based on evidence seized during the investigation, agents believe that this organization was responsible for distributing approximately 500,000 counterfeit pills on a monthly basis. At least six leaders of the organization have been federally indicted. During the course of the investigation, agents seized $1.7 million in cash and cryptocurrencies valued at approximately nine million dollars. Special Agents also seized vehicles, silver bars, hundreds of thousands of counterfeit tablets containing fentanyl, and several pill presses.[4]

C. Overdose Investigations

An unfortunate consequence to the heroin and fentanyl epidemic is the number of overdoses (and deaths) that have impacted our communities. HSI Special Agents initiate field investigations into overdoses that occur from illicit opioid use in order to identify and prosecute the domestic and international conspirators associated with the supply chain.

In 2015, HSI Grand Forks, a member of the High Intensity Drug Trafficking Area (HIDTA) taskforce, initiated Operation Denial, which began with the overdose death of an eighteen year old male in Grand Forks, North Dakota. The investigation identified an international fentanyl smuggling organization and has produced twenty-one federal indictments in North Dakota and Portland, Oregon, including the Chinese source of supply, who faces up to life in prison and $12.5 million in fines. The Chinese source of supply has also been designated as an OCDETF Consolidated Priority Organization Target.

In their overdose investigation, HSI Special Agents identified a domestic source of supply operating in Portland, Oregon, and international fentanyl suppliers in Canada and China. The investigation has benefited from federal sentencing enhancements, with some of the identified members of the supply network receiving sentences ranging from twenty years to life. As such, HSI is fully pursuing investigations into overdoses and attributing deaths to smuggling organizations.

HSI has relied on forming partnerships at every level of law enforcement in order to successfully investigate and prosecute those responsible not only in the North Dakota overdose death, but in five other overdose victim cases as well.

D. Financial Investigations

HSI's Illicit Finance and Proceeds of Crime Unit (IFPCU) is a headquarters component tasked with developing investigative techniques and typologies to identify and eliminate vulnerabilities in the U.S. financial systems and to criminally pursue perpetrators of financial and other crimes. The IFPCU enhances cooperation and forges partnerships with domestic and foreign law enforcement, regulatory agencies, and non-governmental bodies.

The IFPCU leverages these partnerships, resources, and trainings to enhance HSI's financial investigations and various Anti-Money Laundering (AML) programs. A significant program that the IFPCU manages is the Illicit Digital Economy Program (IDEP), which oversees cryptocurrency

[3] 18 U.S.C. § 545 (2012).
[4] U.S. v. Shamo, No. 2:16-cr-00631 (D. Utah 2016). Assistant U.S. Attorney Vernon Stejskal and Special Assistant U.S. Attorney Michael Gadd are prosecuting the case. Other investigative agencies include the DEA, IRS Criminal Investigation, FDA Office of Criminal Investigations, and USPIS.

investigations undertaken by HSI. They provide training, equipment, analytical support, and investigative methodologies used in HSI investigations involving cryptocurrencies. The IDEP also cultivates relationships with international police agencies, state and local law enforcement, as well as private industries and academia involved in the cryptocurrency space worldwide.

Operation Dark Net is a successful Arizona based Bitcoin money laundering investigation that identified an individual who offered undercover agents the ability to shield drug proceeds through the laundering of cash for Bitcoin. The subject charged between seven and ten percent as commission for laundering the proceeds without following established "Know Your Customer" requirements. In addition to exchanging narcotics proceeds for Bitcoin, he also purchased narcotics with Bitcoin and provided Bitcoin to individuals who were buying illicit opioids, like fentanyl, via the dark net.

E. Cyber Investigations

The HSI Cyber Crimes Center (C3) brings the full range of ICE cyber investigations, computer forensics, and training assets together in a single location to coordinate global investigations and to provide support to our international field offices who work closely with their host countries in their efforts to combat cyber-enabled crime.

The Cyber Crimes Unit (CCU) within C3 supports field cyber investigations of transnational cybercrime organizations that exploit the convenience and perceived anonymity of the Internet to commit a wide range of criminal activity, to include targeting dark web illicit marketplaces where fentanyl is often sold.

CCU performs an essential role in providing resources to overcome challenges associated with the investigation of dark web marketplaces and in providing investigative and technical requirements necessary to succeed at investigating, disrupting, and dismantling criminal organizations that operate primarily within the cyber domain.

In recognition of the need for specialized skillsets and technology when investigating criminal activity facilitated by these illicit markets, CCU provides a comprehensive training program designed to provide the tools and resources to investigate individuals and organizations responsible for transnational cybercrime, to include fentanyl smuggling.

In addition, successes in dark web investigations often depend significantly on the use of online undercover investigative techniques. CCU provides extensive cyber training, focusing on online undercover investigations and the technical aspects of dark web investigations.

By incorporating a wide array of agency strategies, cyber capabilities, and broad authorities, HSI is at the forefront of cyber investigations to combat online marketplaces that facilitate the purchase and illicit shipment of opioids to the United States.

In April 2017, HSI BEST Upstate South Carolina, HSI Portland, USPIS Greenville, and DEA Greenville identified an organization operating under the dark net, Alpha Bay marketplace vendor name "Peter the Great," which was responsible for several thousand illegal drug transactions. Undercover cyber investigative activity identified "Peter the Great" as the source of supply to an eighteen year old female found dead in her Oregon apartment. Search warrants resulted in the interdiction of 139 parcels that were meant to be sent to customers throughout the United States. The organization concealed their illicit product in over the counter pregnancy test kits. Following arrest, and while awaiting trial, the head of the organization committed suicide.

F. Interagency Coordination

HSI recognizes that no one agency can be successful in the fight against fentanyl on their own. HSI works with federal agencies outside of DHS, often in coordination with state and local partners, in

multijurisdictional investigations utilizing its authority under 19 U.S.C. § 1401(i) to cross-designate other federal, state, and local law enforcement officers to investigate and enforce customs laws.[5]

Interagency examples include the Border Enforcement Security Task Force, National Targeting Center-Investigations, the Special Operations Division, and the Organized Crime Drug Enforcement Task Force.

1. Border Enforcement Security Task Force (BEST)

The primary mission of the Border Enforcement Security Task Force is to combat emerging and existing TCOs by employing a full range of federal, state, local, tribal, and international law enforcement authorities and resources to identify, investigate, disrupt, and dismantle the organizations at every level of operation.

BESTs incorporate personnel from the Department of Homeland Security, Department of Justice, Department of the Treasury, other federal agencies, and more than 100 state, local, and tribal law enforcement agencies.

In response to the fentanyl crisis, HSI has partnered with Customs and Border Protection to establish a BEST in an express consignment carrier facility in Memphis, Tennessee. With the support of the Organized Crime Drug Enforcement Task Force (OCDETF) of the Department of Justice (DOJ), fentanyl analogues and related substances are identified and interdicted while investigative leads are generated.

HSI is collaborating with CBP and the United States Postal Inspectors Service (USPIS) in the development of a more robust, nationwide effort to interdict fentanyl transiting through international and domestic mail. The expansion of BEST at international and express consignment mail facilities places trained investigators at interception locations and is expected to help disrupt the movement of illicit fentanyl via the mail.

2. National Targeting Center-Investigations (NTC-I)

The National Targeting Center-Investigations (NTC-I), which is co-located with CBP's National Targeting Center (NTC), leverages extensive DHS data holdings for targeting purposes in support of HSI-led field investigations. HSI's presence and close collaboration with NTC partners has enhanced the border security continuum by driving the NTC to the forefront of DHS's border security efforts.

NTC-I works closely with NTC, USPIS, and other federal partners to target illicit shipments imported into the United States for interdiction at the international mail and express consignment facilities. These targeted shipments can be based on characteristics and intelligence derived from prior seizures and investigations, which is critical to identifying fentanyl smuggling and trafficking organizations.

3. Special Operations Division

The Drug Enforcement Administration (DEA) Special Operations Division (SOD) is supported by HSI and many other federal agencies. Interagency working groups exploit electronic communications to target international and domestic fentanyl supplying organizations by coordinating and de-conflicting between agencies' field offices. SOD also assists in linking investigations from the street level dealer to the international supply source.

[5] 19 U.S.C. § 1401(i) (2016).

4. Organized Crime Drug Enforcement Task Force (OCDETF)

The Organized Crime Drug Enforcement Task Force (OCDETF) supports multiagency, prosecutor-led investigations by coordinating investigative strategies with funding under various initiatives, including the National Heroin Initiative (NHI). HSI has utilized OCDETF-NHI funding in two ways: to support expansion of its heroin and fentanyl interdiction efforts at ports of entry, and to transform the resultant contraband seizures into coordinated investigations that connect law enforcement agencies and prosecutorial jurisdictions.

IV. Conclusion

As a response to President Trump's declaration of the opioid crisis as a public health emergency, HSI Acting Executive Associate Director Derek N. Benner has said, "We are committed to increasing our enforcement by targeting online sales of opioids, following the money trails, and leveraging our international and local partnerships to take down the opioid smuggling rings and stop this crisis from spreading any further."

The work of HSI Special Agents is vital in the attack against the fentanyl threat. HSI Special Agents will continue to utilize traditional and cutting edge investigative tools as well as their unique statutory authorities to further fentanyl related investigations and disrupt supply chains before the deadly drug even reaches U.S. borders. HSI recognizes that the dismantlement of deadly drug supply chains cannot be successful without the direct and early coordination and support of the United States Attorney's Offices, and looks forward to the development of future significant cases.

ABOUT THE AUTHOR

❑ **Gregory C. Nevano** serves as the Deputy Assistant Director for the Illicit Trade, Travel, and Finance Division, with oversight of nine investigative groups and approximately 125 employees. In this capacity, Mr. Nevano has oversight of all financial, narcotics, document and benefit fraud, criminal gang exploitation, as well several targeting and fusion centers. Prior to this assignment, Mr. Nevano served as the Chief of Staff to the Deputy Director of U.S. Immigration and Customs Enforcement (ICE), who is the chief operating officer for the principal investigative agency in the Department of Homeland Security (DHS). Mr. Nevano assisted the Deputy Director in executing oversight of ICE's day to day operations by leading approximately 20,000 employees in administering operational and mission support to more than 400 domestic and international offices, and by overseeing an annual budget of almost six billion dollars.

Mr. Nevano has held a number of key management positions within ICE Headquarters from 2012 to the present, including the Associate Deputy Assistant Director for the Investigative Services Division, and the Unit Chief for the Asset Forfeiture Unit. Mr. Nevano was assigned as an Assistant Special Agent in Charge (ASAC) in the ICE Boston field office from 2009 until 2012. Prior to becoming an ASAC, Mr. Nevano served as the Group Supervisor of the Narcotics/Violent Gang group from 2006 until 2008, and the Group Supervisor of the Operational Support Group from 2004 until 2006.

From 2001 until 2004, Mr. Nevano was assigned to the FBI Joint Terrorism Task Force (JTTF). In this capacity, Mr. Nevano investigated and prosecuted many terror suspects for immigration fraud violations. Prior to his assignment on the JTTF, Mr. Nevano was a Special Agent with the Immigration and Naturalization Service Boston field office from 1998 until 2002. In this capacity, Mr. Nevano was assigned to the criminal alien squad and served as the prosecuting officer for the office. Mr. Nevano started his federal employment with the U.S. Immigration and Naturalization Service as an Immigration Inspector in Boston, MA, in 1991. He is a graduate of Boston College with a Bachelor of Science in Political Science.

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Hunting in the Dark: A Prosecutor's Guide to the Dark Net and Cryptocurrencies

Matthew J. Cronin
Assistant United States Attorney
Northern District of Ohio

I. Introduction

A young man sits down in front of his computer and within five minutes orders ten grams of carfentanil for approximately $5,000. He anonymously makes the order on a dark net marketplace that he connected to using a TOR browser. He pays for the order using Bitcoin or some other cryptocurrency that remains largely separate from the regulated global financial system. A Chinese laboratory fulfills the order and, within a few days, ships it to the United States. Due to the overwhelming number of packages coming from China, the drug parcel bypasses detection at the border. Shortly thereafter, a postal carrier delivers the drugs to an abandoned home. The young man picks up the carfentanil a short time later. After cutting the carfentanil, he resells it nationwide using the dark net vendor moniker "Cloud9."

Experts estimate that twenty micrograms (twenty millionths of a gram) is a lethal dose of carfentanil for most adults.[1] For five minutes of work, Cloud9 acquired enough drugs to kill—at least in theory—500,000 people. Put another way, this young man ordered more than enough lethal doses of carfentanil to kill every man, woman, and child in a small American city. Using cutting agents, he has enough drugs to increase his profit margin exponentially compared to his initial $5,000 investment. Cloud9 acquired this highly potent and profitable amount of drugs anonymously, inexpensively, and (as he believes it) safely from the comfort of his own home.

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A little over ten years ago, this narrative would be science fiction. Today, this scenario happens every week in many districts across the country. Given their international customer list and access to highly potent drugs, taking down a single dark net target can have the same impact as prosecuting a large multidistrict gang. Despite this immediate and visceral impact on the criminal community, too few prosecutors are taking these cases. This lack of participation is due to law enforcement's unfamiliarity with the underlying technology, the perceived invulnerability of dark net targets due to their use of anonymizing technologies, and uncertainty as to what steps to take in these cases.

This article aims to address these concerns and thus increase prosecutions of dark net targets. First, this article will explain the dark net and cryptocurrencies to a sufficient degree that any prosecutor who reads it could start an investigation. Second, it will describe how dark net targets' reliance on anonymity creates vulnerabilities that skilled prosecutors and agents can exploit. Finally, this article will provide a series of best practices as a general guideline and reference for dark net and cryptocurrency cases.

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[1] *See, e.g.*, *Comparing the lethality and potency of opioid drugs*, THE BOSTON GLOBE (Nov. 15, 2017).

II. Overview of the Relevant Technologies

To investigate and prosecute dark net and cryptocurrency cases, a prosecutor first needs to understand the underlying technologies. While the dark net and cryptocurrencies are relatively new phenomena in the world of law enforcement, they should not intimidate anyone. All that is needed is a basic familiarity with the topic. With that in mind, this article endeavors to provide a simple, jargon-free explanation of the underlying technologies necessary for a prosecutor to make his or her case. It will thus exclude some details that are not immediately relevant to law enforcement operations.

A. The Dark Net

The "clear" or "surface" web is the part of the internet accessible to anyone with a standard browser and that standard web search engines can index. The deep web is the part of the internet whose contents are not indexed by standard web search engines. The dark net or dark web[2] is a part of the deep web that not only cannot be discovered through a traditional search engine, but also has been intentionally hidden and is only accessible through specific software, configurations, or authorization. Think of it like an iceberg. The surface web is above the water line. The deep web is below the water line. The dark net is a small part of the iceberg deep beneath the waves.

One common software used to access the dark net is a TOR (The Onion Router) browser. A TOR browser is designed specifically to facilitate anonymous communication over the internet. Use of the TOR software bounces a user's communications around a distributed network of relay computers. When a user on the TOR network accesses a website, the IP address of a TOR "exit node" (the last computer on the revolving network of relay computers), rather than the user's actual IP address, shows up in the website's IP log.

Dark net marketplaces operate on the dark net. These sites are generally only accessible through the input of specific addresses into a TOR browser. The dark net marketplaces function primarily as black markets, selling or brokering transactions involving drugs, cyber-arms, weapons, counterfeit currency, stolen credit card details, forged documents, victims of human trafficking, child pornography, and other illicit goods. Dark net vendors (also known as distributors or operators) operate on these dark net markets as sellers. They provide detailed information about their wares on these sites, including pricing, quality, and shipping methods. The vendors also list contact information, usually in the form of TOR-based email or encrypted messaging applications.

For prosecutorial purposes, it is essential to note that no one can stumble into a dark net marketplace accidentally. Like a secret criminal club, a person can only get there on purpose and after someone has shown them the way.

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[2] The "dark web" and "dark net" are often used interchangeably. The dark net consists of any overlay network that is accessible only with specific software, configurations, or authorization, often using non-standard communication protocols and ports. The dark web is the World Wide Web content that exists on dark nets. In other words, the dark web are the services and websites running on the dark net. Law enforcement commonly refers to both as the "dark net" or "DarkNet." *See, e.g.*, Press Release, U.S. Dep't of Justice, Attorney General Jeff Sessions Announces Results of J-Code's First Law Enforcement Operation Targeting Opioid Trafficking on the Darknet (Apr. 3, 2018); *A Primer on Dark Net Marketplaces*, FBI (Nov. 1, 2016). This article will therefore do the same.

B. Cryptocurrencies

As of this writing, there are over 1,565 cryptocurrencies available for purchase. These include Bitcoin (BTC),[3] Litecoin (LTC), Ethereum (ETH), and Ripple (XRP). Due to Bitcoin being by far the most commonly used cryptocurrency (on the dark net and otherwise), this article will focus its cryptocurrency analysis on issues relating to Bitcoin.

Bitcoin is often described interchangeably as a digital, virtual, and/or cryptocurrency. All definitions technically apply, but to varying degrees of accuracy. Digital currency is a type of currency only available in digital (rather than physical, such as banknotes) form. It can be centralized or decentralized. An early example of digital currency is e-gold. Virtual currency, as the IRS defines it, is "a digital representation of value that functions as a medium of exchange, a unit of account, and/or a store of value [that] does not have legal tender status in any jurisdiction."[4] One example is World of Warcraft gold.

While these two definitions apply, Bitcoin is first and foremost a cryptocurrency. Cryptocurrency is a decentralized digital currency that uses encryption techniques to both regulate the generation of new units of the currency and verify the transfer of funds.[5] No central bank controls the creation of new currency or verifies transactions as legitimate. Instead, cryptocurrencies put all transactions onto a public ledger called a "blockchain" that records all of the currency's transactions that have ever taken place.[6] Think of it as a giant excel spreadsheet that publicly records all transactions and is available to everyone. Each set of transactions is called a "block," and these transactions are subject to verification before being added to the blockchain. Rather than printing money, cryptocurrencies generate new currency through "mining." Mining occurs when a person (really, a computer network) validates a block of transactions by solving a complex math problem. As a reward, the first miner to solve the math problem (and thus add the block to the blockchain) gets a certain amount of the cryptocurrency.

As a cryptocurrency, bitcoins are units of currency used to store and transmit value among participants on the Bitcoin blockchain. Bitcoin public keys (also known as Bitcoin addresses) are what any blockchain user can see. The public keys are where a person both sends bitcoins and receives bitcoins as payments. Think of it as a P.O. Box for digital money. The public key/address is paired with a Bitcoin private key. The Bitcoin private key is the key that gives the owner(s) access rights to the bitcoins stored in the public key. In other words, a person needs the private key to send and withdraw bitcoins from the public key/address. It acts as the key for the metaphorical P.O. Box. Almost all users combine numerous public and private key combinations in Bitcoin wallets—programs that store the private key data for numerous Bitcoin addresses, allowing users to make Bitcoin transactions from one centralized program. These wallets come in many varieties, including software programs for computers, applications on smartphones, physical "hardware" wallets stored on USB devices, and wallets stored by third parties on the internet.

As a cryptocurrency that relies on a blockchain rather than a central bank to validate transactions, Bitcoin in many ways seems wholly unconnected to the real world and thus unapproachable by law

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[3] Since Bitcoin is both a currency and a protocol, capitalization differs. Accepted practice is to use "Bitcoin" (singular with an uppercase letter B) to label the protocol, software, and community, and "bitcoin" (with a lowercase letter b) to label units of the currency. That practice is adopted here.

[4] *Notice 2014-21*, § 1, INTERNAL REVENUE SERV. (Mar. 25, 2014).

[5] *Cryptocurrency*, OXFORD ENGLISH DICTIONARY.

[6] An in-depth discussion of how cryptocurrencies solve the "double-spending problem" without a central authority through the use of blockchain and cryptographic proofs is beyond the scope of this article. For those interested, there are a number of sources that discuss it in greater detail. Arguably the most succinct and helpful resource is the white paper of "Satoshi Nakamoto," the pseudonym of the person(s) responsible for Bitcoin's creation. Satoshi Nakamoto, *Bitcoin: A Peer-to-Peer Electronic Cash System*, Oct. 2008.

enforcement. That is not the case. First, regulations impose reporting requirements and other controls on individuals and companies transacting in Bitcoin. According to the Treasury Department, Bitcoin exchangers and third-party brokers (such as those on Local Bitcoins) are subject to FinCEN rules. The Commodity Futures Trading Commission (CFTC) has designated Bitcoin as a commodity, subjecting it to the CFTC's jurisdiction.[7] The IRS has ruled that Bitcoin is property that is reportable on income tax returns.[8] Other countries have similar rules, with the list of countries regulating cryptocurrencies rapidly increasing.[9] These regulations both increase the chance of finding useful information relating to the target, and help show criminal intent when a target fails to follow them. Second, if users want to take advantage of their bitcoins' value, they will need to use a Bitcoin exchange. While few vendors accept Bitcoin as payment, there is an entire industry of Bitcoin exchangers (corporate and individual) who buy and sell bitcoin and other cryptocurrencies for a fee. Depending on the host country's regulations, these exchanges have varying degrees of Know Your Customer (KYC) requirements and are subject to legal process. Third, and perhaps most importantly, the entirety of all Bitcoin transactions are preserved and viewable by the public on the blockchain. The importance of this fact is detailed in the section on blockchain analysis below.

III. The Psychology and Vulnerability of Anonymity

Criminals are attracted to the dark net and Bitcoin due to the perceived anonymity that these technologies provide. TOR browsers and other programs limit law enforcement's ability to track IP traffic back to the target. Dark net marketplaces by their very nature are unfriendly to law enforcement. The administrators are anonymous and the servers are generally outside the immediate reach of U.S. legal process. Similarly, cryptocurrency allows users to transact seemingly anonymously, while various tools can further mask a target's trail on the blockchain. The use of these anonymizing technologies gives criminals a sense of invulnerability.

And that is how we get them.

As any experienced investigator will attest, de-anonymizing criminals on the internet is as much a matter of psychology as technology. In these cases, the criminal's perceived anonymity is not only their source of strength, but also ultimately their downfall. Oftentimes, a dark net operator will subconsciously and unwisely transfer their belief that they can act with impunity off the internet and into the real world, where they need to cash out their illicit proceeds and transact their criminal business. For instance, a criminal who sells fentanyl online cannot distribute the product digitally. At a minimum, he has to take the following steps in the real world: (1) obtain fentanyl (usually through an international shipment); (2) distribute fentanyl to a customer (usually through the mail); and (3) exchange his bitcoins for a useable fiat currency through either a company or local exchanger. At each of these steps, a diligent investigative team can and will find the target's true identity. That is because any person will eventually make a mistake, and a person believing that they can act with impunity is exponentially more likely to make a mistake.

That mistake is costly. While anonymity is a powerful defense, it is almost invariably the dark net operator's *only* defense. Their entire criminal enterprise exists on a one-legged chair. Once law enforcement takes anonymity away from the target, the reality of what he has done will come crashing down to Earth, with all of the evidence tying him to the crime crashing down right next to him.

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[7] *A CFTC Primer on Virtual Currencies*, COMMODITY FUTURES TRADING COMMISSION (Oct. 17, 2017).
[8] Press Release, IRS, IRS Virtual Currency Guidance: Virtual Currency is Treated as Property for U.S. Federal Tax Purposes; General Rules for Property Transactions Apply (Mar. 25, 2014).
[9] *Digital Currencies: International Actions and Regulations*, PERKINS COIE (Apr. 26, 2018), https://www.perkinscoie.com/en/news-insights/digital-currencies-international-actions-and-regulations.html#United%20States.

De-anonymization, therefore, is the key. With that in mind, the remainder of the article is devoted to prosecutorial tips and best practices for how to both de-anonymize targets and proceed after de-anonymization.

IV. Hunting in the Dark

The dark net is a strange and potentially dangerous place. It seems designed to allow criminals to thrive. Prosecutors and their agents can still achieve significant success, however, if they employ the right techniques. The best practices listed below are a starting point to help prosecutors make their case and avoid any pitfalls in the process.

A. Be Careful with Your Filings, the Enemy is Watching

The first thing a prosecutor must know is that while you are looking for your targets, your targets are looking back at you. In one of my earlier dark net cases, an agent filed a complaint affidavit in another district to arrest a dark net fentanyl vendor. Within a few hours, the story had hit the DeepDotWeb, a clear web news site and forum for dark net market enthusiasts. On the site, various users were dissecting the complaint, with a focus on one law enforcement "technique" in particular.

Thankfully, the DeepDotWeb focused on a throwaway line rather than an actual technique. Others have not been so lucky. In other cases, agents and prosecutors have revealed critical sources and methods. As a result, the entire dark net community changed payment options, delivery methods, and communication systems. These changes were never to law enforcement's benefit.

These mistakes are instructive. Unlike almost any other criminal community, dark net operators are not only intelligent, but also highly interested in our methods. They regularly check ECF filings and keep abreast of all dark net-related cases internationally. As a group, they will change their techniques at the slightest hint that their current methods endanger them.

The dark net's interest in prosecutorial techniques influenced the writing of this article. Readers may notice that some sections of this article are highly generalized. That is because, while the U.S. Attorney's Bulletin's readership is primarily federal prosecutors, it is open to the public. There is no doubt that this article will ultimately be featured on the DeepDotWeb, Reddit, Dread, or some other dark net discussion group.

Just as this article avoids revealing sensitive sources and methods, federal prosecutors and agents must do so in their filings. List companies that responded to subpoenas or search warrants only as "Third Party Providers," or similar terminology. Avoid any specific references to law enforcement techniques unless absolutely necessary. Remember that search warrants and complaints only require probable cause. Resist the urge to provide information if it is more than what is needed to meet this standard and survive subsequent legal challenges. Failure to do so can endanger law enforcement operations far beyond the scope of your case.

B. Those Who Live by Anonymity, Die by Anonymity

Dark net operators rely heavily on the powerful shield of anonymity that the dark net and cryptocurrencies provide them. Use their greatest asset against them. Just as agents cannot immediately identify a dark net target, the dark net target cannot identify an agent. Cloaked in the same anonymous technology, a well-trained federal agent can infiltrate any dark net criminal community. Operating undercover on the dark net, agents are able to generate tremendous amounts of information about their targets, potentially becoming a target's valued customer or even a "friend." That is especially true when an undercover agent gains access to an account with significant criminal transaction history (and thus digital street cred) or, even better, has longstanding ties to the target.

One advantage of dark net undercover operations is that they can come together quickly. Undercover operations in the real world can take months of planning, development of sources, and careful coordination, not to mention posing a risk of harm. Subject to the investigative agency's approval, a successful dark net undercover operation, on the other hand, can come together in a matter of hours and poses little to no risk to the participants.

Combined with controlled buys and other investigative techniques, the undercover operations provide critical means of developing the necessary information to de-anonymize the dark net operator. For instance, an anonymous undercover agent is able to generate some of the best evidence in the case simply through a review of the dark net vendor's account page. Just as a seller on Amazon or eBay has reviews with descriptions of purchased products, the public facing account page of any reputable vendor will include detailed information about prior transactions. The review page alone can be sufficient to put substantial drug weight mandatory minimum sentences or other enhancements onto a dark net target. While these reviews are falsifiable, the fact that the vendor has not challenged them is strong evidence of their veracity. Moreover, defenses relating to user attribution rarely succeed. A dark net vendor may claim that someone else was using the account up until recently. That defense did not work for the Dread Pirate Roberts.[10] It is unlikely to work for others. Absent strong evidence supporting the defense, a jury usually discounts it.

While anonymity offers easy access to undercover operations, it also poses some risk for "blue on blue" activity. With that in mind, it is essential for agents to de-conflict and be aware of which accounts are hostile or friendly. Otherwise, agents may find themselves investigating fellow law enforcement and risk breaking both of their covers.

C. Active Prosecutorial Engagement and Bringing Agencies Together

Prosecutors need to be engaged in a dark net investigation from the start. There are two primary reasons for requiring greater prosecutorial engagement. First, dark net investigations routinely require the skillsets and resources of multiple federal law enforcement agencies. To be clear, each agency can perform a variety of law enforcement functions, and certain agents have developed multiple specialties. That said, while agencies have some overlapping abilities, they have also organically specialized over time. FBI has strong cyber and blockchain analysis abilities. HSI has unique visibility on international targets, travel, and shipments. DEA labs offer unique drug data. Postal has unparalleled ability to monitor and seize parcels, as well as manipulate shipping data. The IRS provides strong financial analysis. Depending on the target, prosecutors will require skills and resources housed in different agencies. In my cases, for instance, we have created an informal task force with agents from a number of agencies who team up with each other, depending on the needs of the investigation. A prosecutor who has worked with each of these agencies on numerous occasions has a unique vantage point to see what resources the case needs and what agencies can best provide them at any given time.

Second, dark net investigations are in many ways the Wild West of law enforcement, where agents have minimal formal training on how to proceed in the many strange scenarios that can come up. In these situations, it is essential that agents have ready access to a prosecutor who can offer them advice on the best legal process to obtain evidence and help them avoid potential legal pitfalls that they may not notice otherwise.

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[10] United States v. Ulbricht, 858 F.3d 71, 98 (2d Cir. 2017) ("His principal defense strategy at trial—more of an effort at mitigation than outright denial of his guilt of the conspiracy and other charges in the indictment—was to admit his role at the beginning and end of the site's operation, but to contend that he sold Silk Road to someone else in 2011 and abandoned his role as its administrator, only to be lured back by the successor DPR near the end of its operation to take the blame for operating the site.") *id.* at 89-90; ("After deliberating for about three and a half hours, the jury returned a guilty verdict on all seven counts in the Indictment.") *id.* at 91-92.

D. Where Does the Target Touch the Real World?

With the understanding that this article cannot go into exacting details about investigative methods for the reasons described above, investigators should first and foremost consider where the target has to interact with the real world. What is the vendor selling? If it is a physical item like fentanyl, then there are numerous points where an investigative team can narrow down the geographic scope of the search. If it is digital, like child pornography or corporate information, then there are databases and other methods that can help narrow down the means by which the target acquired the illicit digital goods. Furthermore, dark net targets are humans, and humans always revert to routine. Once you get a sense of how they operate, you can often find an identifying pattern based on a few data points.

None of the dark net operators are charitable operations. The focus of any investigation therefore should be on how the target accepts payments for its illicit wares and then cashes out these payments. If the target does not use cryptocurrency, then there are numerous conventional financial investigation techniques available to you. For targets using a cryptocurrency like Bitcoin, there are other steps to de-anonymize them, including blockchain analysis.

E. Finding Your Target on the Blockchain

Criminals believe that cryptocurrency is anonymous. That is only partially correct. While no one needs to reveal their identity to open a Bitcoin wallet and transact in bitcoins, all transactions are recorded and available to the public on the blockchain. Reviewing criminally related transactions on the blockchain offers similar insight into a criminal organization as a review of financial services data. There are many ways to perform this analysis, including through companies that offer specialized software that identifies and tracks blockchain transactions. These products not only simplify the analysis, but actively work to overcome various tools that dark net marketplace operators use to increase their anonymity on the blockchain. Federal law enforcement agencies have contracts allowing them to use this blockchain analysis software.

Blockchain analysis can result in extraordinary results. Depending on the target's level of sophistication, it can reveal the identity of the target, suppliers, co-conspirators, and customers. At a minimum, successful blockchain analysis from a dark net marketplace controlled buy will:
(a) de-anonymize whoever was receiving the proceeds from the illicit transactions; and (b) tie that de-anonymized person to the dark net marketplace account from which the agent ordered the illicit goods. The de-anonymized target, finding the stiff penalties of the entire operation placed solely on his shoulders, often has a strong incentive to cooperate against any potential co-conspirators.

While blockchain analysis is powerful, a novice should not attempt it. Generally, agents require specialized training to be able to use the programs effectively. Performing improper blockchain analysis can result in something far worse than a dead end in an investigation: it can result in the wrong lead. Investigative teams can subsequently lose months chasing the wrong target based on inaccurate blockchain analysis.

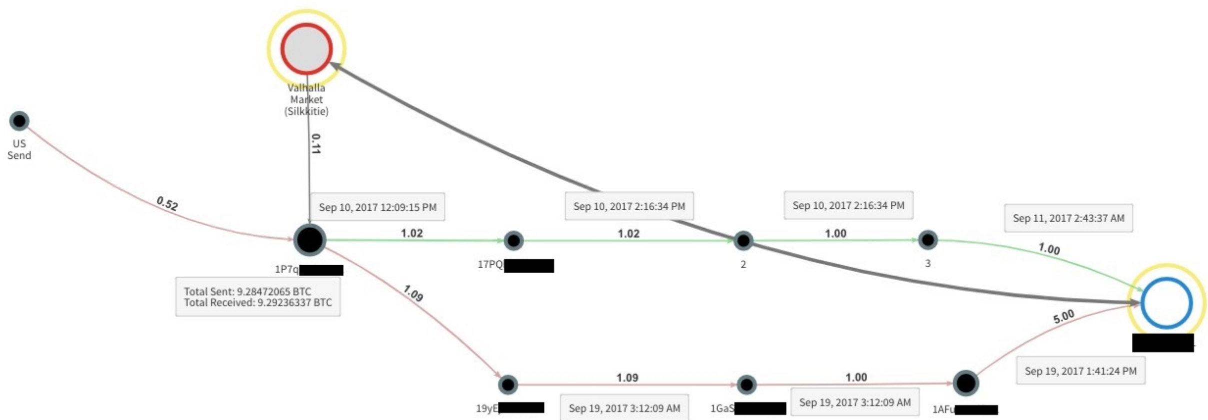


Figure 1. Successful Blockchain Analysis

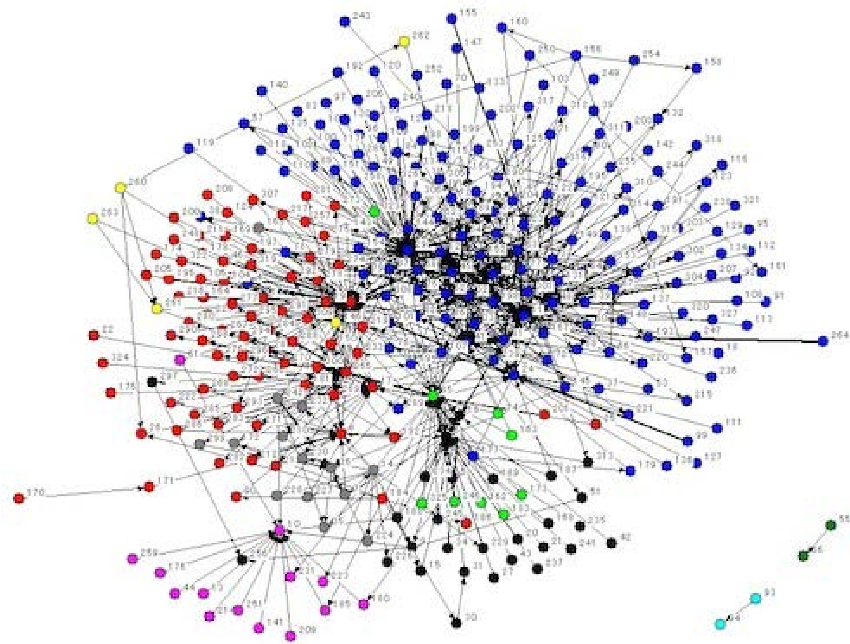


Figure 2. Unsuccessful Blockchain Analysis

The figures above demonstrate the value of blockchain analysis and the dangers of improper analysis. Figure 1 is a successful blockchain analysis showing a fentanyl controlled buy traveling through a series of temporary wallets before ending up at a Third Party Provider that can identify the target. Note that the target also had money coming in from his criminal activity on Valhalla, another dark net market. Figure 2, on the other hand, shows the dangers of an unsuccessful chain analysis, highlighting the amount of potential wrong paths that an unwitting agent could mistakenly take. Thus, while prosecutors should

strongly consider using blockchain analysis in their cryptocurrency cases, they should only do so with a properly trained agent.

F. Subpoenas, Search Warrants, and Title III Orders to Electronic and Digital Providers

There are also many conventional means of identifying dark net targets. If the target slips up and reveals a personal account, a subpoena for identifying information alone can be sufficient. Unfortunately, prosecutors are rarely that lucky. For more sophisticated operators, law enforcement still has a variety of tools at its disposal. If agents can connect a target's pseudonym to an email or social media account, preservation letters followed by search warrants can provide the lead needed to reveal his identity.

Many criminals now prefer applications that do not store historical data and thus prevent acquisition of evidence through search warrants. Corporate non-retention policies or software designed to purge historical data, however, generally will still allow for acquisition of contemporaneous data pursuant to a Title III order. Electronic Title III interceptions are not nearly as onerous as phone interceptions, requiring significantly fewer agents to monitor the wire. They are also entirely manageable to obtain. So long as agents have established probable cause tying a crime to the underlying account or server, it should be easy to establish necessity, since there are no other known feasible means to get the evidence.

G. Rule 41 Premises and Device Search Warrants and Seizing Cryptocurrencies

Due to the fact that the underlying technologies are both novel and quickly evolving, Rule 41 premises search warrants pose some unique challenges when dealing with dark net targets. It is essential that prosecutors inform both the agents (to make sure that they find the evidence) and the judge (to make sure that the agents have permission to seize the evidence) about what they may find there.

While a guide for Rule 41 search warrants could be an article in and of itself, here are a few best practices that are unique to these types of cases. First, there are numerous applications and programs relating to the dark net, anonymous communications, and cryptocurrencies. It is essential to find these applications, as they provide circumstantial evidence tying the target to the dark net and the underlying account. It is always a better practice to have the right to seize all electronic devices on the premises and then, as appropriate, obtain supplemental search warrants granting your agents the ability to image and search these devices. Depending on the sophistication of the target, agencies should consider having a dark net specialist review the imaged material later on to uncover hidden evidence.

Second, in addition to having permission to seize all digital, virtual, and cryptocurrencies in your warrant, make sure that your agents know their agency's cryptocurrency seizure policy and have a plan in place to quickly seize and secure any cryptocurrency before they enter the premises. While every agency policy is different, most require immediate transfer of all accessible funds to a law enforcement wallet. Failure to properly seize cryptocurrency can lead to damaging results. Remember that any person with a private key can access the cryptocurrency affiliated with the public key. That means that any co-conspirator with access to the internet and knowledge of the private key could take the unsecured cryptocurrency, even months after the agents "secured" it. This scenario highlights the importance of agents knowing what to do before they encounter any cryptocurrency.

Third, in order to seize the cryptocurrency, agents need to locate the wallet generation seed or the private key. The wallet generation seed is a string of randomly generated words (usually ten to twenty words long) that allow a person to fully recreate and access their wallet, even if they forgot their private key. For private keys, look for a string of characters. Bitcoin private keys are a 256-bit number normally represented in fifty-one to fifty-two characters. Figures 3 and 4, below, are examples of wallet seeds and private keys, respectively.

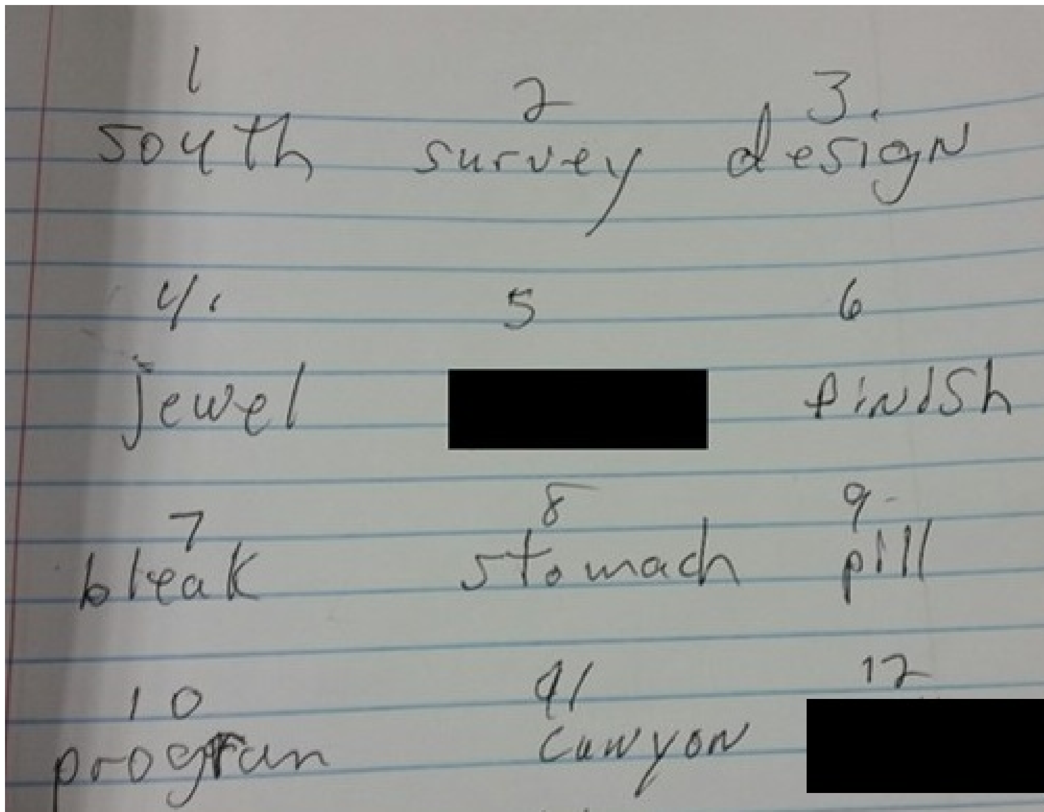
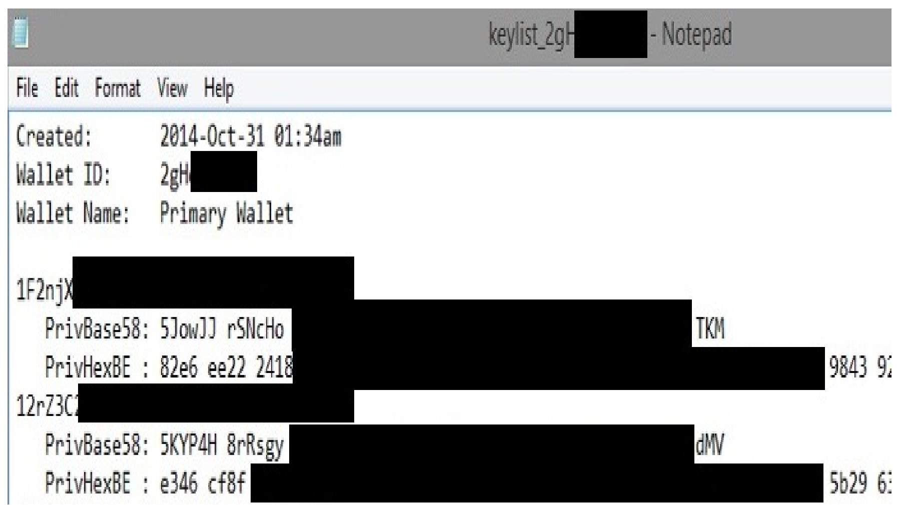


Figure 3. Example of a Handwritten Wallet Seed



keylist_2gH - Notepad

File Edit Format View Help

```
Created:        2014-Oct-31 01:34am
Wallet ID:      2gH
Wallet Name:    Primary Wallet

1F2njX
   PrivBase58: 5JowJJ rSNcHo TKM
   PrivHexBE : 82e6 ee22 2418 9843 9
12rZ3C
   PrivBase58: 5KYP4H 8rRsgy dMV
   PrivHexBE : e346 cf8f 5b29 6
```

Figure 4. Example of a Text File Containing Private Keys Associated with a Wallet

Both wallet seeds and private keys can be stored in numerous locations electronically and in the real world. These include keys handwritten on a piece of paper, saved in a wallet file or directory, stored within the wallet client, saved in a text or PDF file, printed as text or QR codes, stored on smartphone applications, saved within hardware wallets, and hidden within image data. It is essential that agents both

know where to look and have extensive permissions to search in these types of locations for ultimate seizure. It is also essential that agents prioritize this information when interviewing any targets.

Finally, expect the unexpected when executing a search warrant. The dark net offers ready access to many illegal activities without immediate consequences. Once users go onto the dark net to acquire or sell one item, it is common for them to move on to other illegal activity. These can include drugs, credit card data, child pornography, and the like. In one of our recent cases, we had a dark net target who went from child pornography to fentanyl. The agents should know that, as soon as they encounter evidence of crimes outside the scope of the warrant, they should immediately desist and acquire a supplemental warrant from the judge.

H. Detain the Defendants

Prosecutors should strongly consider moving to detain dark net defendants. First, many types of offenses involved in dark net usage, particularly drugs and child porn, readily demonstrate the danger to the community. Second, the means by which dark net operators commit their crimes—through fully anonymized, untraceable technology—makes it infeasible for pretrial services to properly monitor their activities. All they need is $100 to get a used smart phone, and no one is the wiser. Third, there is a real risk that the criminal still has funds somewhere on the blockchain or evidence stored online that they could access if released. There is no reliable way to recover those funds or evidence later on.

Finally, there is at least anecdotal evidence that pretrial release poses a risk to the dark net defendant himself. In several of my cases, dark net defendants were released on bond in either another district or a foreign country. In all but one case, the targets committed or attempted to commit suicide. There are a number of potential reasons why that is the case. Many dark net targets describe their conduct as if they lived two wholly separate lives. Having these two lives collide in such a dramatic fashion can lead to a lot of emotional turmoil. Furthermore, the targets often have no criminal history. Facing down a federal indictment that carries stiff mandatory minimums or other penalties in their first encounter with the justice system can often lead to despair. A dark net defendant released on bond thus poses a risk to the community, the investigation, and potentially even to himself, making detention the best option.

I. Explaining Your Case to the Jury

If the prosecutor and agents successfully investigated the target to the point of de-anonymization, they likely have strong evidence of guilt. Every defendant has a right to a jury trial, however, and some choose to exercise it in spite of their low probability of success. In these situations, the greatest risk to the prosecution is the jury shutting down due to the perceived complexity of the case. In particular, dark net and cryptocurrency prosecutors should understand that the underlying technology employed in the dark net and cryptocurrencies is novel and exotic to the average citizen.

Prosecutors are agents of order. Our role is to make sure that everything is clear and understandable to the court and jury. Defense counsel are oftentimes agents of chaos, who try to sow confusion and thus, reasonable doubt. One way to sow confusion is to make a technology that is central to the case seem foreign and incomprehensible. To combat this tactic, prosecutors should do what humanity has done for millennia when explaining seemingly complicated ideas: operate by analogy. Make everything simple and easy to understand by associating it with concepts from everyday life. Here are some simple examples: a dark net marketplace is like Amazon for criminal conduct. A dark net marketplace is like a secret criminal club, you can only get there on purpose and after someone has shown you the way. A bitcoin private key is like a key to a safety deposit box filled with digital money. While there may be more nuances that you can explain to the jury later, relating the underlying technologies to everyday life not only allows the jury to understand your case but also preemptively undercuts your opponent's defense.

J. Use Law Enforcement Resources

Oftentimes, when a dark net investigation has stalled out, it is because a prosecutor or an agent failed to take advantage of the incredible resources at their disposal. It is common and understandable for prosecutors and their agents to think of themselves as the entirety of their team. That is not the case. If the need arises, prosecutors have the vast resources of U.S. law enforcement and its global partners at their disposal. Leverage the incredible knowledge and hard work of the men and women working in this field. Each agency has specialists who can provide assistance on particular tasks. There are also multi-agency organizations, such as Special Operations Division, the National Targeting Center, OCDETF Fusion Center, and the National Cyber Investigative Joint Task Force, who each provide incredible investigative work product. Recall that law enforcement has already seized numerous dark net market servers and that—if the target is worth the effort—the information stored therein may prove vital to the investigation. In addition, make sure to reach out to experts in the field. They are almost always willing to offer advice.

Finally, know that a target operating in another country is not necessarily the end of the case. The United States has agreements in place around the world to secure cooperation from foreign law enforcement. If needed, work through the appropriate channels to secure the evidence and/or assistance that you require.

V. Conclusion—Cloud9 Revisited

The young man using the moniker Cloud9 sits down in front of his computer and within five minutes orders ten grams of carfentanil for approximately $5,000. He anonymously makes the order on a dark net marketplace that he connected to using a TOR browser and pays for it using Bitcoin. He believes himself secure. He is wrong.

Federal agents were investigating Cloud9 after his drugs caused a carfentanil overdose in another state. Earlier, they made a series of controlled buys, using the dark net's anonymity against Cloud9. Using various techniques, they isolated his likely location to a section of a city. The blockchain analysis from the controlled buys came back a short time later, with subsequent subpoena returns providing detailed financial information. This information confirmed that Cloud9 is James Smith, who lives in that same city. Surveillance identified the mailer that Cloud9/Smith uses in an attempt to insulate himself from scrutiny as John Doe, one of Smith's college friends. Doe leaves Smith's home when mailing the drug parcels. Social media and returns from search warrants on online accounts confirmed that Smith and Doe know each other and have ties to the dark net drug trade.

At the culmination of the investigation, the prosecutor obtains search warrants for Smith's home and complaints on both Smith and Doe. In the last controlled buy, agents approach Doe as he puts the carfentanil in the mailbox. Confronted with evidence and with his anonymity shattered, Doe implicates Smith and provides information about the Cloud9 account. Simultaneously, agents execute a search warrant on Smith's home, seizing carfentanil and various electronic devices. Computer forensics and other information tie Smith to the Cloud9 account. The drug weight established from the Cloud9 account's review page alone is sufficient for a mandatory minimum of ten years imprisonment. Postal records and other evidence gained from the search tie Smith and Cloud9 to the overdoses. Smith thus faces a mandatory minimum of twenty years to life imprisonment for dealing carfentanil that was the but-for cause of the victims' deaths. The prosecutor charges Smith for the overdose deaths. For the first time, the families of the victims have some small sense of justice.

While some of the technology and techniques are new, any prosecutor can successfully take down dark net targets with a little hard work and determination. Criminals will only increase their use of the dark net and cryptocurrencies over time, making a basic understanding of these technologies essential for numerous types of federal prosecutions in the years to come. Armed with this information, a federal

prosecutor can strip dark net targets of their anonymity and force their actions into the light of day. It is in this light that we will achieve justice.

ABOUT THE AUTHOR

❑ **Matthew J. Cronin** is an Assistant United States Attorney in the Northern District of Ohio. His practice focuses on prosecuting transnational, cryptocurrency, dark net, and money laundering crimes. Mr. Cronin has trained federal prosecutors, U.S. and foreign law enforcement, and business leaders on a variety of topics, including the dark net, anonymizing technologies, cryptocurrencies, and computer intrusions. Prior to joining the Department of Justice, Mr. Cronin practiced as an attorney at Latham & Watkins LLP.

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The Role of Community Outreach in the Opioid Crisis: Maintaining Hope in the Face of Rising Overdose Deaths

Joseph M. Pinjuh
Attorney-Advisor
Field Programs and Operations
OCDETF Executive Office

I. Introduction

We have all heard the often repeated statement, "We will not be able to arrest our way out of the current Opioid Crisis." A true statement, but what does it mean exactly? More to the point, what does it mean for the average Assistant United States Attorney grappling with this epic crisis? After all, we are federal prosecutors charged with enforcing the laws of the United States. Beyond those weighty and time consuming duties, what else should/could we be doing to help? The answer to that question is complicated at best and varies by individual, but the main gist of that aforementioned statement is that we cannot battle this crisis alone using only the typical tools in our prosecutorial arsenal. We must involve the community, build lasting coalitions, and take the message of prevention, education, and hope directly to the community.

II. Building a Lasting Coalition

As overdose deaths from prescription pills were mounting across the nation, the State of Ohio was hit particularly hard. The Ohio Department of Health reported that from 1999 to 2013, drug overdose deaths in Ohio increased a staggering 413 percent.[1] According to the Ohio Board of Pharmacy, in 2010 there was an average of sixty-seven doses of prescription opioids dispensed for *every* Ohio resident.[2] By 2014, that number climbed to seventy-two doses. In 2012, then U.S. Attorney for the Northern District of Ohio, Steve Dettelbach, decided to partner with the Cleveland Clinic to host a Prescription Pill Summit aimed at educating prescribers of the dangers of over-prescribing opioids and the connection to heroin abuse and addiction. Some members of the U.S. Attorney's Office questioned whether the medical community would be a receptive audience, much less a willing partner. However, Steve's commitment never wavered, and in May of 2012 we presented the Summit at the Cleveland Clinic in front of approximately 250 doctors, physician's assistants, and nurse practitioners. That day was the beginning of a wonderful and continuing partnership with the entire medical community in the greater Cleveland, Ohio, area.

After the Pill Summit, AUSAs were regular speakers at continuing medical education courses and various hospital conferences throughout the district, discussing the dangers of over-prescribing, the widespread diversion of prescription opioids, and the critical need to use the Ohio Automated RX Reporting System to screen for patients engaging in doctor shopping. We even started appearing at local schools to talk about the dangers of prescription drug abuse. Local coaches, especially football coaches, invited us to talk to their teams about injuries and the dangers of prescription drug addiction. One of our

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[1] *2013 Ohio Drug Overdose Data: General Findings*, OHIO DEPARTMENT OF HEALTH.
[2] *Ohio Automated Rx Reporting, State Statistics*, OHIO STATE BOARD OF PHARMACY.

early successes was placing twenty-four hour anonymous prescription drop-boxes in every city in the county. Warning audiences of the dangers lurking in their own medicine cabinets, we told them that if they remembered only one thing from our talk, remember to go home and check their medicine cabinets for unused prescription opioids and safely dispose of them. Soon, the drop-boxes were overflowing. Around the same time, the DEA brought a Diversion Squad to the district, and prosecutions against corrupt doctors and pill mills increased significantly. However, just as we were making inroads in the fight against the illegal diversion of prescription opioids, heroin made a deadly comeback.

In the State of Ohio, heroin overdose deaths tripled from 2012 to 2016, and fentanyl overdose deaths increased by eighty percent from 2014 to 2016.[3] It was again time to turn to our new partners and seek answers to halting this new deadly crisis. When U.S. Attorney Dettelbach suggested that we reach out to the Cleveland Clinic, University Hospitals, and MetroHealth to convene a Heroin Summit modeled after the successful Pill Summit, some members of the office, myself included, were openly skeptical. After all, the medical community had some skin in the game for the diversion of illegal prescription drugs. However, would the medical community be as receptive discussing a deadly street drug like heroin and the connection between prescription opioid addiction and heroin abuse? Thankfully, I could not have been more wrong.

In November of 2013 the partnership convened an historic Heroin Summit at the Cleveland Clinic. Among the more than 750 attendees were doctors, nurses, pharmacists, treatment professionals, educators, federal and state prosecutors, federal, state and local law enforcement, judges, individuals in recovery, clergy, and a host of other community members and government officials who wanted to make a difference. What grew out of that Summit was the District's Community Action Plan broken down into four subcommittees: Law Enforcement, Healthcare Policy, Treatment, and Education/Prevention. To continue the momentum from the Summit, the U.S. Attorney's Task Force on Heroin and Opioids was formed. The four aforementioned subcommittees report at the quarterly meetings held in the U.S. Attorney's Office about successes, challenges, and news specific to their particular subject matter.

III. Recognizing the Value of Community Outreach

One of the missions of the Education/Prevention subcommittee is community outreach beyond just the high school setting. The challenges associated with conducting widespread community outreach were more complicated than we assumed. First, we had to find willing audiences, and then we needed willing and informed speakers. Initially, some schools and communities resisted our outreach efforts, refusing to admit there was a drug problem in their school or town. The rising overdose deaths rates soon dispelled that reluctance. However, convincing the speakers was another issue entirely.

Most AUSAs think nothing of facing an angry judge or difficult jury; however, speaking in front of 600 bored high school students or at a parents' forum is a different ball game entirely. Additionally, many of the outreach events were either after hours or on weekends. Fostering and maintaining buy-in from AUSA speakers is an ongoing challenge. Thankfully, we have more than enough dedicated folks ready to answer the call. Moreover, because of the great community partnerships we fostered, we had plenty of volunteer speakers from the medical, treatment, and law enforcement communities. After a few months, we were doing an outreach event almost every week.

The outreach program was committed to reaching different and diverse audiences. We did plenty of school presentations from fifth through twelfth grade, and we also targeted local colleges. The events ranged from auditoriums filled with 800 or more students to health class sessions with twenty students. We participated in group viewing sessions of the *Chasing the Dragon* video with parents and/or students, and we provided question and answer sessions afterwards. We also targeted the building trade unions in

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[3] Rose A. Rudd, et al., *Increases in Drug and Opioid Overdose Deaths—United States, 2000-2014*, MORBIDITY AND MORTALITY WEEKLY REPORT 1378-82 (2016).

the area because of the high rates of addiction among their members. Soon, area mayors were reaching out to our Committee asking us to participate in town hall meetings addressing the opioid crisis. One of the more interesting forums was school board meetings discussing the need for drug testing in public area high schools.

The success of the outreach was due in large part to the quality and willingness of the speakers. Thanks to the community partnerships formed over the last five years, speakers included Special Agents in Charge (SACs) and Assistant Special Agents in Charge (ASACs) from the FBI and DEA, renowned local doctors, treatment specialists, health board leaders, county judges, local police chiefs, parents who lost a child to overdose, and recovering addicts. Some of the most powerful presentations came from recovering addicts, not much older than the school audiences we addressed. Their message of hope and faith amid the mounting overdose deaths resonated the loudest among our audiences.

Staying relevant meant finding new partners and constantly adjusting and updating PowerPoint presentations and other materials. One of the truly great partners is Robby's Voice, a nonprofit started by parents who lost their son to an overdose. Hearing Rob Brandt describe the pain and hopelessness of losing his son to a heroin overdose is heart wrenching. To see how he has turned that grief into a lifelong mission to raise awareness about drug addiction is inspirational. The Department of Justice was keenly aware of our efforts, and in 2016 our group won the Attorney General's Award for Outstanding Contributions to Community Partnerships for Public Safety. By 2018, our outreach program had reached over 91,000 people, and yet the overdoses continued to mount.

IV. Maintaining Belief in the Value of the Message

As the horrible statistics of overdose deaths mounted, burnout for our speakers, first responders, and investigators was becoming a real issue. People were losing hope. The arrival of fentanyl and related analogues only made the carnage worse. According to the Cuyahoga County Medical Examiner's Office, thirty-seven residents of Cuyahoga County (the greater Cleveland, Ohio area) died of a fentanyl overdose in 2014. By 2016, that number had climbed to 399. The preliminary numbers for 2017 are over 477.[4] When combined with heroin and other drugs, the county was experiencing over two overdose deaths per day.

The Law Enforcement subcommittee of the U.S. Attorney's Task Force on Heroin and Opioids initiated a text alert system every time someone in the county died from an overdose. The text alerts always spiked on the weekends and darkened everyone's mood. It was a particularly brutal weekend in the early spring of 2017, with eight overdose deaths in a forty-eight hour span. Sadly, Carfentanil had arrived with a vengeance. The following week, I had another school talk scheduled. That week in the office, a grizzled Task Force Officer asked me why I bothered "wasting my time" doing all the community outreach. Hope and motivation ebbing slowly away, I gathered my materials and drove to the school. I thought I gave a good presentation, but secretly wondered if even one of the 450 students in attendance was listening.

I ended my presentation that day by asking the audience to raise their hands if they had at least one good friend. Not surprisingly, everyone raised their hands. I then asked them to keep their hands raised if they considered themselves a good friend, and again, all hands stayed raised. I then asked them to keep their hands raised if they knew that their friend was suffering from a drug addiction that no one else knew about, would they tell someone like a parent, teacher, counselor or coach. Sadly, seventy-five percent of the raised hands went down. I finished by telling those who put their hands down that "the next time someone asks you if you are a good friend, don't raise your hand, because you are not a good friend." I told them that being a good friend means more than going to the funeral and expressing your condolences to the parents. Depressed and beaten, I was packing up my things to leave when a student

[4] *Cuyahoga County Medical Examiner's Office Report* (Jan. 25, 2018).

came up to me and said she knew someone who was struggling with an addiction and she wanted to be a good friend and get them some help. Thankfully, the school's guidance counselor was still in the auditorium, and I was able to put the two together quickly. I also had my answer—indeed someone *was* listening!

I walked out of the school that day a little taller than when I walked in and with my faith and hope completely restored. When I got back to the office, I saw that same Task Force Officer. He asked me, "How many of those kids actually listened to what you were saying today?" Gleefully, I responded, "Maybe just one, but one was more than enough!"

V. Conclusion

Hope and faith are complicated and fragile feelings. They often materialize where and when you least expect. Sometimes they are restored in unpredictable ways when you need them most. Success in community outreach cannot simply be measured in whether the number of overdose deaths increased or decreased. As a speaker, you never know how many people you actually reached, or who said "no" to drugs at a party because of your talk. If you reach just *one* person, your talk was a success. It remains true that we will never arrest our way out of this crisis. We will win this battle one life saved at a time. Hope and faith in tow, are you ready to help? Someone's life may just be depending on it!

ABOUT THE AUTHOR

❑ **Joseph M. Pinjuh** has served as an Assistant United States Attorney in the United States Attorney's Office for the Northern District of Ohio (NDOH) from 1998 to present. In October 2010, he was appointed as Chief of the Organized Crime Drug Enforcement Task Force (OCDETF) and Narcotics Unit, NDOH. In 2018, he was detailed to the OCDETF Executive Office in Washington, DC, to serve as the Attorney-Advisor to Field Programs and Operations. His areas of specialization or expertise include: Title III prosecutions; complex, multi-defendant narcotics prosecutions; community based gang prosecutions; and community outreach. He graduated *cum laude* from Syracuse University in 1988 with a dual Bachelors of Arts degree in English and Political Science, and obtained his Juris Doctorate in 1992 from Vanderbilt University School of Law. He was a Captain in the United States Air Force Judge Advocate General's Corps via direct Presidential appointment from 1992 to 1998. He was the recipient of the Federal Bar Association's 1999 Younger Outstanding Federal Attorney Award, OCDETF National Mission Award for 2012 and 2016; and the Attorney General's Award for Outstanding Contributions to Community Partnerships and Public Safety in Northern Ohio for 2016. He is admitted to practice in Tennessee and Ohio, and serves as a guest lecturer in the Cleveland Marshal School of Law trial advocacy course and at Case Western Reserve Law School's Criminal Practice Seminar. He has been an instructor for the United States Department of Justice's National Advocacy Center, and also served as a Juvenile Court Magistrate in Strongsville, Ohio, from 1999 to 2008.

Prescription Drug Abuse and Illicit Substance Use: A Crisis in Indian Country

Leslie A. Hagen
National Indian Country Training Coordinator
Executive Office for United States Attorneys

"Having survived numerous wars, famine, disease epidemics, the violent breakup of their territories and the consequent legal struggle to achieve sovereignty, the tribe now faced an existential crisis—one that had been brewing in the shadows long before anyone grasped its impact or could organize a response. No longer a discrete series of isolated incidences, opioid addiction had taken on a genuine sense of urgency."[1]

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In October 2016, Rory Wheeler, an EMS worker for, and a member of, the Seneca Nation of Indians in New York, rushed to the scene of a crisis call. Sadly, it was too late; a young woman on the Cattaraugus Indian Reservation had overdosed and was pronounced dead at the scene.

Wheeler reported seeing the woman's mother hysterical and screaming over the body. Three hours later, Wheeler's pager went off again. This call, too, resulted in another young woman being pronounced dead from an overdose. Both women were Seneca tribal members in their early twenties. Even more tragic, both woman left behind young children.

For Wheeler, just nineteen years of age at that time, the deaths of two fellow tribal members from his small community in the same day was a game changer. "That was the moment that I knew we were in trouble," says Wheeler. "That was the day that changed my life, when I began to realize that the issue of opiates was serious in our community and that we had to do something."[2]

I. The Problem

One only needs to open any newspaper or turn on the nightly news and it is starkly evident that the United States is in the midst of an opioid crisis. The misuse and abuse of these drugs is killing thousands, devastating families, wreaking havoc on hospital emergency rooms, and endangering the lives of first responders.

On April 11, 2018, Christina Nolan, United States Attorney for the District of Vermont, testified on the dangers of fentanyl before the Senate Subcommittee on Crime and Terrorism. She said, in part, the following:

> It would be impossible to overstate the impact of the opioid crisis currently gripping our nation. Drug overdoses, suffered by family, friends, neighbors, and colleagues, are now the leading cause of injury-related death in the United States, eclipsing deaths from motor vehicle crashes or firearms. According to the Centers for Disease Control and Prevention (CDC), there were nearly 64,000 overdose deaths in 2016, or approximately 174 per day,

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[1] Suzette Brewer, *Tribes lead the battle to combat a national opioid crisis*, HIGH COUNTRY NEWS (May 9, 2018).
[2] *Id.*

> over 42,249 (66 percent) of these deaths involved opioids, and the sharp increase in drug overdose deaths between 2015 to 2016 was fueled by a surge in fentanyl and fentanyl analogue (synthetic opioids) involved overdoses. Researchers at the CDC recently examined opioid overdose deaths in Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Rhode Island, West Virginia, and Wisconsin, and found that over half of the victims tested positive for fentanyl. We expect 2017 statistics will show that fentanyl and other illicit synthetic opioids were the primary catalyst for fatal overdoses in 2017.[3]

While many in America are now becoming aware of the devastation caused by illicit drugs and the misuse of prescription drugs, Indian country and tribal communities have experienced this reality for many years. In 2016, American Indians and Alaska Natives had the second highest rate of opioid overdose deaths of any race—an estimated fourteen fatalities per 100,000 people.[4] The death rate among white people is 17.5 per 100,000; 10.3 for black Americans; 6.1 for Hispanics, and 1.5 for Asians and Pacific Islanders, according to the most recent data from the Centers for Disease Control and Prevention (CDC).[5]

On March 14, 2018, Christopher M. Jones, PharmD., M.P.H., the Director for the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health and Substance Use Policy Laboratory, testified at a hearing titled "Opioids in Indian Country: Beyond the Crisis to Healing the Community" held by the Senate Committee on Indian Affairs. He testified that in 2016 according to SAMHSA's National Survey on Drug Use and Health, "over 11 million Americans misused prescription opioids, nearly 1 million used heroin, and 2.1 million had an opioid use disorder due to prescription opioids or heroin."[6] He testified further that this same survey tool determined that 5.2 percent (72,000) of American Indian/Alaska Native (AIAN) aged eighteen and older reported misusing a prescription drug in the past year.[7] Additionally, four percent (56,000) of AIAN aged eighteen or older reported misusing a prescription pain reliever in the previous year.[8]

At that same March 2018 Senate Committee hearing, Dr. Michael Toedt, Chief Medical Officer for the Indian Health Service (IHS) testified about the dire consequences of the opioid crisis in Native communities. Dr. Toedt said that "the Centers for Disease Control and Prevention (CDC) reported that American Indians and Alaska Natives had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015 compared to other racial and ethnic groups."[9] During the 1999 to 2015 time period, deaths rose more than 500 percent among the AIAN population.[10]

But the numbers don't tell the full story. For Native Americans, the underreporting is far greater than that of other groups, perhaps as high as thirty percent, according to Robert Anderson, the CDC's

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[3] Christina Nolan, U.S. Attorney of the Dist. of Vt., Testimony on the Dangers of Fentanyl Before the S. Subcomm. on Crime and Terrorism (Apr. 11, 2018).
[4] Rachel Roubein, *The 'forgotten people' of the opioid epidemic*, THE HILL (May 10, 2018).
[5] *Id*.
[6] *Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community Before the S. Comm. on Indian Affairs*, 115th Cong. 1 (2018) (testimony of Christopher M. Jones, Dir. for the Nat'l Mental Health and Substance Use Policy Lab).
[7] *Id*.
[8] *Id*.
[9] *Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community Before the S. Comm. on Indian Affairs*, 115th Cong. 3 (2018) (statement of Michael E. Toedt, Chief Medical Officer for Indian Health Service).
[10] *Id*.

chief for its mortality statistics branch.[11] Additionally, according to Dr. Toedt, due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AIAN may be underestimated by up to thirty-five percent.[12] The National Congress of American Indians in a June 2017 Research Policy Update for Tribal Leaders highlighted that "from 2006 to 2012, 77 percent of AI/AN drug overdose deaths across Idaho, Oregon, and Washington were from prescription opioids."[13]

One example of a tribe struggling with the opioid crises is the Yurok Tribe, the largest federally recognized tribe in California, with more than 6100 enrolled tribal members. Its reservation is located in the counties of Humboldt and Del Norte in Northern California. According to the Tribe, the Yurok Reservation is located in one of the nation's hardest hit regions by the opioid crisis.[14] In a lawsuit recently filed by the Yurok tribe, the tribe outlines the opioid crisis's impact on children. The pleadings list the significant impact that opioid abuse has caused in tribal communities:

- Between 2009 and 2012, American Indian women were 8.7 times more likely to be diagnosed with maternal opiate dependence or abuse during pregnancy. Accordingly, many tribal infants suffer from withdrawal and Neonatal Abstinence Syndrome (NAS).[15]
- Babies suffering from NAS may be separated from their families and placed into the custody of tribal child welfare, or receive other governmental services so they can be provided medical treatment and protection from parents struggling with addiction.[16]
- Many NAS infants have short and long term developmental issues that prevent them from meeting basic developmental milestones. In addition, many of these children suffer from vision and digestive issues that prevent them from attending school with their peers. These disabilities can last a lifetime.[17]

The Yurok Tribe has researched and documented the extent of the opioid problem and its effects on their people. For example, the tribe reports that prescribing rates for Humboldt and Del Norte are consistently higher than the prescription rate for the State of California. In 2013, the average number of five milligram Vicodin prescribed *per resident* that year for Del Norte residents was enough to give every person (including children) in the county more than one dose a day for the entire year.[18] The Yurok Tribe alleges in pleadings that "almost 30% of residents were prescribed opioids at least once in 2016 based on the number of *unique* patients receiving opioids."[19] A total of 314,730 opioid pills were dispensed by the sole DEA registered provider in the area; this translates to ninety pills per person. The heavy use of opioids by the Yurok people has resulted in an uptick in nonprescription opioid use, like heroin. The tribe has also experienced an influx of synthetic fentanyl products that have been trafficked by Mexican cartels operating in Northern California. Because violent crime goes hand in glove with substance abuse, the tribe has seen an increase in the commission of major crimes involving opioid use, such as human trafficking.[20]

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[11] Rachel Roubein, *The 'forgotten people' of the opioid epidemic*, THE HILL (May 10, 2018).
[12] *Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community Before the S. Comm. on Indian Affairs*, 115th Cong. 3 (2018) (statement of Michael E. Toedt, Chief Medical Officer for Indian Health Service).
[13] *Responding to the Opioid Crisis: An Update for Tribal Leaders*, NAT'L CONG. AM. INDIANS 1 (June 2017).
[14] Complaint, The Yurok Tribe v. Purdue Pharam L.P., No. 3.18-cv-1566, 6-7 (Mar. 12, 2018).
[15] *Id*. at 26.
[16] *Id*.
[17] *Id.* at 27.
[18] *Id.*
[19] *Id.* at 28.
[20] *Id.*

II. Department of Justice's Commitment to Fighting Violent Crime and Working Together with American Indians and Alaska Natives

The scope of prescription drug abuse and the use of illicit substances in tribal communities demands the federal government's attention. The Department of Justice recognizes the United States' unique legal relationship with federally recognized Indian tribes. The United States Constitution, treaties, federal statutes, executive orders, and court decisions establish and define the unique legal and political relationship that exists between the United States and Indian tribes. In December 2014, the Attorney General issued guidelines stating principles for working with federally recognized Indian tribes. These guidelines apply to all Department personnel working in Indian country. The overarching principles as directed by the Attorney General are the following:

- "The Department of Justice honors and strives to act in accordance with the general trust relationship between the United States and tribes."
- "The Department of Justice is committed to furthering the government-to-government relationship with each tribe, which forms the heart of our federal Indian policy."
- "The Department of Justice respects and supports tribes' authority to exercise their inherent sovereign powers, including powers over both their citizens and their territory."
- "The Department of Justice promotes and pursues the objectives of the United Nations Declaration on the Rights of Indigenous Peoples."
- "The Department of Justice is committed to tribal self-determination, tribal autonomy, tribal nation-building, and the long-term goal of maximizing tribal control over governmental institutions in tribal communities, because tribal problems generally are best addressed by tribal solutions, including solutions informed by tribal traditions and custom."[21]

The Attorney General's guidelines for working with federally recognized tribes also addresses Department efforts concerning law enforcement and the administration of justice in tribal communities, which are priorities for USAOs and the FBI:

- "The Department of Justice is committed to helping protect all Native Americans from violence, takes seriously its role in enforcing federal criminal laws that apply in Indian Country, and recognizes that, absent the Department's action, some serious crimes might go unaddressed."
- "The Department of Justice prioritizes helping protect Native American women and children from violence and exposure to violence, and works with tribes to hold perpetrators accountable, to protect victims, and to reduce the incidence of domestic violence, sexual assault, and child abuse and neglect in tribal communities."[22]

[21] Memorandum from the Att'y. Gen, on Guidelines Stating Principles for Working with Federally Recognized Indian Tribes to Heads of Dep't Components for all U.S. Attorneys, at 1 (Dec. 3, 2014).
[22] *Id.* at 3.

III. Prosecution and Interdiction Efforts

"Indian country is unique in many ways, but at the core it is not unique in that the people in Indian country are seeking what we all seek. They seek, and they deserve, a good quality of life, including decent jobs, educational opportunities, the well-being of their children and freedom from substance and alcohol addictions."[23]

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The above quote is from the 2007 testimony of Matthew Mead, then United States Attorney for the District of Wyoming. Mead had been asked to testify in front of the Senate Committee on Indian Affairs at an "Oversight Hearing on Law Enforcement in Indian Country." Mead went on to say that "it is often hard to address issues relating to quality of life, when personal security and law enforcement concerns are not sufficiently addressed in a manner where citizens feel safe."[24]

The trafficking of prescription painkillers is nothing new in Indian country. In April 2006, U.S. Attorney Mead testified in front of the same Senate Committee regarding a large drug trafficking organization operating on the Wind River Indian Reservation. Mead detailed how the Drug Enforcement Administration (DEA) and the Bureau of Indian Affairs (BIA) had initiated an investigation into the Goodman Drug Trafficking Organization (Goodman DTO), a family-run organization based on the reservation.[25] Mead testified that the Goodman DTO was responsible for "distributing methamphetamine, cocaine, marijuana and diverted prescription painkillers, such as Oxycodone (OxyContin), Hydrocodone (Vicodin), and Proxyphene (Darvocet),"[26] to individuals living on the reservation and in the surrounding county. Law enforcement estimated that the Goodman DTO distributed at least one pound of methamphetamine each month to its clientele on the reservation and that it served approximately twenty to fifty drug customers each day. The year-long investigation ended with law enforcement executing nineteen arrest warrants and twenty-eight search warrants on the reservation and surrounding areas.[27] Eventually twenty-five defendants, including a tribal court judge, were convicted.

In 2006, Mead also testified about how one Mexican drug trafficking organization, led by Jesus Martin Sagaste-Cruz of Mexico, targeted Indian country based on a 'business model' it developed. The 'business plan' involved selling methamphetamine not only on the Wind River Indian Reservation, but also other Indian reservations in South Dakota and Nebraska. During the course of the investigation, law enforcement learned that the members of the drug ring created the 'business plan' after reading a newspaper article about how liquor stores in Whiteclay, Nebraska, were selling huge quantities of alcohol to members of the Oglala Sioux Tribe living on the Pine Ridge Indian Reservation, a reservation where alcohol is prohibited. The article said that millions of dollars' worth of beer and malt liquor were sold each year in this very small and remote town and that sales sharply increased each month shortly after per-capita checks were mailed.[28]

Drug ring members surmised that if people addicted to alcohol were given free methamphetamines, they would quickly become addicted to the drug.[29] The Mexican drug pushers also

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[23] *Oversight Hearing on Law Enforcement in Indian Country Before the S. Comm. on Indian Affairs*, 110th Cong. 1 (2007) (statement of Matthew H. Mead, U.S. Attorney for the Dist. of Wyo.).
[24] *Id.*
[25] *Hearing on Combating Methamphetamine in Indian Country Before the S. Comm. On Indian Affairs*, 109th Cong. 8-9 (2006) (statement of Matthew H. Mead, U.S. Attorney for the Dist. of Wyo.).
[26] *Id.* at 8.
[27] *Id.*
[28] *Id.*
[29] *Id.* at 9.

assumed that they could easily blend into a tribal community.[30] The Sagaste-Cruz organization planned to distribute the methamphetamine to 'customers' who would then become dealers to support their own drug addiction. To further their 'business plan', members of the drug ring moved to communities close to the targeted reservations. Members of the Sagaste-Cruz organization then deliberately set out to develop intimate relationships with female tribal members.[31] These women were provided free samples of methamphetamines. Some of these individuals became lower level distributors of the drug. All of them told law enforcement that they started out as recreational users and became severely addicted. To support their habit, they became dealers and distributors. They frequently employed the same recruiting tactic used against them, providing free samples of the drug to foster addiction.[32]

Mead testified that the key to breaking open the case and stopping the flow of methamphetamines onto the reservation was coordination among law enforcement. In Indian country, several police departments and federal law enforcement agencies may simultaneously have jurisdiction to investigate a case. In Wyoming, the sharing of information and resources led to the understanding that they were dealing with a large, well organized criminal enterprise and not just an addiction issue on the Wind River Reservation.[33] In 2005, a jury convicted Jesus Martin Sagaste-Cruz of Mexico of conspiracy to distribute methamphetamine. He was also found guilty of distributing in excess of 100 pounds of methamphetamine on the Wind River Indian Reservation and several other communities in Wyoming and Utah. At that time, that quantity of methamphetamine had a street value of between $4.5 and $6.6 million. Sagaste-Cruz received a life prison term.[34]

In his 2007 testimony, Mead importantly noted that it is "a basic responsibility of any government to provide a security level that enables citizens to make their lives better."[35] This is especially true in Indian country, where the Department of Justice has a unique relationship with federally recognized tribes. "As one aspect of this relationship, in much of Indian Country, the Justice Department alone has the authority to seek a conviction that carries an appropriate potential sentence when a serious crime has been committed."[36] Accordingly, the Department's role as the primary prosecutor of serious crimes makes its responsibility to citizens in Indian country unique and mandatory. Per a memorandum from the Deputy Attorney General to the United States Attorney's Offices with Indian country responsibility, "public safety in tribal communities is a top priority for the Department of Justice."[37]

Another example of a significant drug trafficking investigation in Indian country was led by the U.S. Attorney's Office for the District of New Mexico. Some of the defendants in this case also were Mexican nationals, and the case emphasizes the need for interagency collaboration to work successfully in Indian country. The case, dubbed "Operation Crystal Snow", was the result of a multi-agency investigation that included the following: Homeland Security Investigations (HSI), the HIDTA Region II Narcotics Task Force with assistance from the Farmington office of the FBI, U.S. Marshals Service, BIA's Division of Drug Enforcement, Shiprock office of the Navajo Nation Division of Public Safety, New Mexico State Police, San Juan County Sheriff's Office, Farmington Police Department, and New Mexico National Guard. The investigation was launched following an increase in methamphetamine trafficking in the Shiprock area of the Navajo Nation. The investigation identified eight defendants, who

[30] *Id.* at 9-10.
[31] *Id.*
[32] *Id.*
[33] *Id.* at 10.
[34] *Id.* at 9.
[35] *Law Enforcement in Indian Country: Hearing Before the Committee on Indian Affairs*, 110th Cong. 18 (2007) (statement of Matthew H. Mead, U.S. Attorney for the Dist. of Wyo.).
[36] Memorandum from David W. Ogden, Deputy Att'y Gen. on Indian Country Law Enforcement Initiative to U.S. Attorneys with Districts Containing Indian Country (Jan. 11, 2010).
[37] *Id.*

were charged in a series of indictments following a number of undercover drug purchases by law enforcement. Seized during the arrests and the execution of two search warrants were more than two and a half pounds of methamphetamine, ten firearms, and a vehicle.[38]

Improving public safety and the fair administration of justice in tribal communities is a top priority for the current Department of Justice. On February 28, 2017, U.S. Attorney General Sessions announced the formation of the U.S. Department of Justice Task Force on Crime Reduction and Public Safety. The Task Force was formed pursuant to the President's Executive Order on a Task Force on Crime Reduction and Public Safety and is chaired by the Deputy Attorney General, Rod Rosenstein. Task Force members include the Director of the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), the Administrator of the Drug Enforcement Administration (DEA), the Director of the FBI, and the Director of the U.S. Marshals Service (USMS).

Attorney General Sessions said the following:

> On my first day in office, I called in the heads of the four major law enforcement agencies to discuss this plan. Violent crime is on the rise, and we must always remember that crimes are committed against real people. The creation of this task force is a critical step toward confronting this crisis vigorously, effectively and immediately.
>
> The task force is central to the Attorney General's commitment to combatting illegal immigration and violent crime, such as drug trafficking, gang violence and gun crimes, and to restoring public safety to all of the nation's communities.
>
> The task force is charged with developing strategies to reduce crime; identifying deficiencies in existing laws and policies that have made them less effective in reducing crime and proposing new legislation and policies to improve public safety and reduce crime; evaluating the availability and adequacy of crime-related data and identifying measures to improve it; and conducting any other relevant studies. In conducting its work, the task force will consult with federal, state, tribal and local law enforcement, law enforcement organizations and victims' and community advocacy organizations, among others, to learn about successful local efforts and how they can best be supported at the federal level.[39]

Violent crime in Indian country and drug trafficking are certainly two of the important public safety issues addressed by the task force. In April 2017, the Executive Office for United States Attorneys (EOUSA) organized the Violent Crime in Indian Country Subcommittee. EOUSA's Native American Issues Coordinator chairs this Subcommittee, which is part of the larger Task Force on Crime Reduction and Public Safety.

Currently, there are 573 federally recognized tribes in the United States.[40] According to the Bureau of Indian Affairs, "[a]pproximately 56.2 million acres are held in trust by the United States for various Indian tribes and individuals."[41] In addition, the Bureau states the following:

> There are approximately 326 Indian land areas in the U.S. administered as federal Indian reservations (i.e., reservations, pueblos, rancherias, missions, villages, communities, etc.). The largest [such land area] is the 16 million-acre Navajo Nation Reservation located in

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[38] Press Release, U.S. Dep't of Justice, Eight San Juan County Residents Facing Federal Charges Arising Out of Methamphetamine Trafficking on Navajo Reservation (May 12, 2016).
[39] Press Release, U.S. Dep't of Justice, Office of Pub. Affairs, Att'y Gen. Announces Crime Reduction and Public Safety Task Force (Feb. 28, 2017).
[40] *Frequently Asked Questions*, U.S. DEP'T INTERIOR, BUREAU INDIAN AFF. (last visited May 15, 2018).
[41] *Id.*

Arizona, New Mexico, and Utah. The smallest is a 1.32-acre parcel in California where the Pit River Tribe's cemetery is located. Many of the smaller reservations are less than 1,000 acres.[42]

Approximately, 5.2 million people in the United States identify as Native American, "either alone or in combination with one or more other races," per the 2010 Census.[43] Of this group, 2.9 million, or 0.9 percent of the total U.S. population, identify as only Native American.[44] In 2010, more than 1.1 million Native Americans resided on tribal land.[45]

The two main federal statutes governing federal criminal jurisdiction in Indian country are 18 U.S.C. § 1152[46] and § 1153.[47] Section 1153, known as the Major Crimes Act, gives the federal government jurisdiction to prosecute certain enumerated offenses such as murder, manslaughter, rape, aggravated assault, and child sexual abuse, when they are committed by Indians in Indian country.[48] Section 1152, known as the General Crimes Act, gives the federal government exclusive jurisdiction to prosecute all crimes committed by non-Indians against Indian victims in Indian country.[49] Section 1152 also grants the federal government jurisdiction to prosecute minor crimes by Indians against non-Indians, although that jurisdiction is shared with tribes and provides that the federal government may not prosecute an Indian who has been punished by the local tribe.[50]

To protect tribal self-government, section 1152 specifically excludes minor crimes involving Indians when the crimes fall under exclusive tribal jurisdiction.[51] The federal government also has jurisdiction to prosecute federal crimes of general application, such as drug and financial crimes, when they occur in Indian country, unless a specific treaty or statutory provision provides otherwise. On a limited number of reservations, the federal criminal responsibilities under sections 1152 and 1153 have been ceded to the States under "Public Law 280" or other federal laws.

The United States Constitution, treaties, federal statutes, executive orders, and court decisions establish and define the unique legal and political relationship that exists between the United States and Indian tribes. The FBI and the USAOs are two of many federal law enforcement agencies with responsibility for investigating and prosecuting crimes that occur in Indian country. FBI jurisdiction for the investigation of federal violations in Indian country is statutorily derived from 28 U.S.C. § 533, pursuant to which the FBI was given investigative authority by the Attorney General.[52] In addition to the FBI, the Department of the Interior's Bureau of Indian Affairs (BIA) plays a significant role in enforcing federal law, including the investigation and presentation for prosecution of cases involving violations of 18 U.S.C. §§ 1152 and 1153.

It must be emphasized that the General Crimes Act and Major Crimes Act deal only with the application of federal enclave law to Indians and have no bearing on federal laws of general applicability that make actions criminal wherever committed, regardless of the status of the defendant or the location of the crime. Drug offenses under federal law, like those found in Title 21 of the United States Code, fall

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[42] *Id.*
[43] Tina Norris, Paula L. Vines & Elizabeth M. Hoeffel, *The American Indian and Alaska Native Population: 2010*, U.S. CENSUS BUREAU, 1 (2012).
[44] *Id.* at 3.
[45] *Id.* at 13.
[46] 18 U.S.C. § 1152 (2012).
[47] 18 U.S.C. § 1153 (2013).
[48] § 1153(a).
[49] § 1152.
[50] § 1152.
[51] § 1152.
[52] 28 U.S.C. § 533 (2012).

into the category of general federal applicability crimes. Consequently, the U.S. Attorney's office will have jurisdiction over these offenses if the violation occurs in Indian country regardless of the Indian or non-Indian status of the defendant.

On April 11, 2018, just two weeks after U.S. Secretary of the Interior Ryan Zinke announced the formation of a new Joint Task Force (JTF) to combat the opioid crisis in Indian country, the JTF's first raid seized forty-nine pounds of methamphetamine with a street value of $2.5 million, and more than $20,000 worth of marijuana, plus smaller amounts of heroin and other narcotics.[53] The raid was led by Interior's JTF with partnership from the Pueblo tribes and New Mexico law enforcement officials. This operation ran from April 3 to April 7, 2018, and was conducted at the following Pueblos around Albuquerque, New Mexico: Laguna, Sandia, Cochiti, San Ildefonso, Santa Ana, Santa Clara, Picuris, Santo Domingo, Pojoaque, Nambe, San Felipe, Tesuque, and Ohkay Owingeh. The JTF conducted 304 traffic stops and ninety-three vehicle searches, issued 129 traffic citations, and arrested eleven subjects for drug possession. The JTF consisted of agents and officers from the Bureau of Indian Affairs (BIA) and their K-9 unit, Office of Justice Services, Division of Drug Enforcement, BIA District-IV Indian Country High Intensity Drug Trafficking Area Task Force, New Mexico State Police (NMSP) and their K-9 unit, NMSP Investigation Bureau's Regional Narcotic Task Force, and the Department of Homeland Security Task Force.[54]

Not surprisingly, where there are drugs, there is violent crime. On May 10, 2018, the U.S. Attorney's Office for the District of Arizona announced the sentencing of three defendants, each members of the Navajo Nation, for their roles in a RICO conspiracy and participation in the violent Red Skin Kingz (RSK) gang. The three defendants received either a ten, thirty, and fifty year prison term. RSK operated on the eastern side of the Navajo Nation in the District of Arizona. RSK is responsible for at least three murders, attempted murder, aggravated assaults, carjacking, kidnapping, sexual assault, and drug trafficking. In December 2014, one of the defendants and another RSK member shot and killed two men and then transported their bodies to a remote "wash" on the Navajo Reservation. The bodies were dismembered, burned, and buried to conceal the murders. Three days after these murders, two of the three defendants shot and killed another victim immediately after a drug transaction. The defendants took the victim's body to a remote sheep camp on the Navajo Reservation, where they dismembered and burned the victim's body. Cruelly, they forced the victim's girlfriend to watch their acts of depravity.[55]

Yet another example of a significant law enforcement operation in Indian country occurred on May 31, 2018. The Department of Interior (DOI) announced that it seized nearly 10,000 fentanyl pills and other drugs during a weeklong operation on tribal land in Arizona. The sting also netted forty-eight pounds of methamphetamine, 863 pounds of marijuana, $30,000 in cash, and resulted in eighty-six arrests. The street value of all the drugs seized was nearly $4.8 million. DOI said its opioid reduction task force conducted the operation on the Tohono O'odham and Gila River reservations from May 15 to May 26 with the assistance of tribal police and other law enforcement authorities.[56]

Another multijurisdictional law enforcement effort is led by the FBI. The FBI's Indian Country Program (FBIIC) currently has 141 Special Agents in over twenty Field Offices primarily working violent crime matters on a reactive basis. Due to the high volume of violent crimes and limited resources within FBIIC, Safe Trails Task Forces (STTF) are a critical component to combat violent crimes, drugs, gangs, and gaming violations. Agents rely heavily on Task Force Officers (TFOs) within FBIIC to support the

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[53] Press Release, U.S. Dep't of the Interior, In First Raid, New Opioid Task Force Seizes $2.5 Million worth of Meth and $22,000 in Marijuana, Heroin and Other Narcotics (Apr. 11, 2018).
[54] *Id.* at 1-2.
[55] Press Release, U.S. Dep't of Justice, RSK Gang Members Sentenced to Lengthy Prison Terms for Conspiracy to Commit Acts of Racketeering, Including Murder, Kidnapping, Drug Trafficking, and Other Offenses (May 10, 2018).
[56] *Feds Seize Thousands of Fentanyl Pills in Indian Country*, U.S. NEWS (May 13, 2018).

heavy caseload. Due to the extreme rural nature of FBIIC, Tribal TFOs provide invaluable assistance and intelligence related to the location of the crime scenes, identity of suspects and victims, and location of suspects. Because other federal agencies have limited presence within FBIIC, STTFs offer one of the only task force options to tribes. STTFs strengthen law enforcement capabilities and continuity through training, increased coordination, and deputation of officers.

The FBI operates seventeen STTFs spread across the nation with the possibility of adding more STTFs in the near future. Currently, there are approximately ninety full time TFOs from state, local, Tribal, and federal agencies on the seventeen STTFs. STTFs make a considerable impact upon the overall Indian country work being completed by the FBI. For instance, in 2017 approximately forty percent of the 453 arrests made by the FBI in Indian country were made by STTFs.

The full list of current STTFs is as follows:

1. AQ New Mexico STTF
2. DE Straits Area STTF
3. DE Upper Peninsula STTF
4. LV Nevada STTF
5. MP Headwaters STTF
6. MP Missouri River STTF
7. MP Northern Plains STTF
8. OC Oklahoma STTF
9. MM Florida STTF
10. MW Menominee STTF
11. PD Warm Springs STTF
12. PX Eastern AZ STTF
13. PX Northern Arizona STTF
14. PX Southern Arizona STTF
15. PX Truxton Canyon STTF
16. SE Northeast Washington STTF
17. SE Salish STTF

IV. The Tribal Law and Order Act

In July 2010, the Tribal Law and Order Act (TLOA) was signed into law as Title II of Public Law 111-211. The purpose of the TLOA is to help the federal government and tribal governments better address the unique public safety challenges that confront tribal communities. TLOA amended many existing federal statutes that impacted criminal justice and social services in tribal communities. A number of those legislative amendments link directly to tribal and federal efforts to curb illicit substances and prescription drug abuse.

A. Assumption of Concurrent Federal Criminal Jurisdiction

Section 221(b) of TLOA, now codified at 18 U.S.C. 1162(d),[57] permits an Indian tribe with Indian country subject to state criminal jurisdiction under Public Law 280[58] to request that the United States accept concurrent jurisdiction to prosecute violations of the General Crimes Act (18 U.S.C. § 1152) and the Major Crimes Act (18 U.S.C. § 1153) within that tribe's Indian country.[59]

[57] 18 U.S.C. § 1162(d) (2012).
[58] UNITED STATES STATUTES AT LARGE, 83 Cong. Ch. 505, August 15, 1953, 67 Stat. 588.
[59] U.S. Assumption of Concurrent Federal Criminal Jurisdiction; Hoopa Valley Tribe, 81 Fed. Reg. 90,870 (Dec. 15, 2016).

PL 280 tribes requested this provision be included in the statute because they believed that the response from state criminal justice professionals was waning, and less than needed to protect the community from violent crime.[60]

The Department published final regulations on December 6, 2011, which established the framework and procedures for a mandatory Public Law 280 tribe to request the assumption of concurrent federal criminal jurisdiction within the Indian country of the tribe that is subject to Public Law 280.[61] Among other provisions, the regulations provide that upon acceptance of a tribal request, the Office of Tribal Justice shall publish notice of the consent in the Federal Register.[62]

At a 2012 hearing before the Indian Law and Order Commission (also created under TLOA), the Director for the Office of Tribal Justice (OTJ) testified about the process for a tribe requesting assumption of concurrent federal criminal jurisdiction:

> The chief executive officer of a tribe formally submits a request for concurrent federal criminal jurisdiction to OTJ. That request must explain why the assumption of concurrent federal criminal jurisdiction will improve public safety and criminal law enforcement and reduce crime in the Indian Country of the requesting tribe. OTJ provides notice of that request in the Federal Register. OTJ will also seek comments on the request from federal law enforcement. In addition, notice of the request will be provided directly to state and local government and law enforcement. After receiving the request, OTJ will hold a formal consultation with the Tribe.[63]

The Hoopa Valley Tribe, located in California, requested in 2012 that the United States assume concurrent Federal jurisdiction to prosecute violations of the General Crimes Act and the Major Crimes Act within the Indian country of the tribe. According to Bryon Nelson, Jr., the Hoopa Valley Tribal Vice-Chair during 2013 testimony in front of the Testimony to the House Appropriations Subcommittee, the BIA was providing only enough funding to cover hiring and staffing for one to two officers.[64] The Tribe then funded ten officers; these officers are often the first and only responders to calls on the Reservation. Mr. Nelson testified that Hoopa Valley has the largest reservation in the state and that the number of officers working the reservation were not enough to meet the public safety needs of the community. Nelson said that the Tribe was facing significant and unique policing challenges due to rampant illegal drug trafficking and marijuana related crime in the area.[65] Granting of the Tribe's request would allow the United States to assume concurrent criminal jurisdiction over offenses within the Indian country of the tribe without eliminating or affecting the state's existing criminal jurisdiction. The Tribe's request was granted on November 18, 2016. It was to take effect no later than November 18, 2017.[66]

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[60] *Id.*
[61] Assumption of Concurrent Federal Criminal Jurisdiction in Certain Areas of Indian Country, 76 Fed. Reg. 76,037 (Dec. 6, 2011) (codified at 28 C.F.R. § 50.25).
[62] *Id.* at 76,043.
[63] *Hearing Before the Indian Law and Order Comm'n*, (2012) (testimony of Tracy Toulou, Dir. of the Office of Tribal Justice).
[64] *Hearing Regarding the Fiscal Year 2014 HIS and BIA Budget Request Before the H. Appropriations Subcomm. on Interior, Environment, and Related Agencies*, 113th Cong. 4 (2013) (testimony of Mr. Byron Nelson, Jr., Tribal Vice-Chairman, Hoopa Valley Tribe).
[65] *Id.*
[66] U.S. Assumption of Concurrent Federal Criminal Jurisdiction; Hoopa Valley Tribe, 81 Fed. Reg. 90,870 (Dec. 15, 2016).

B. Prescription Drug Monitoring Programs

Passage of TLOA included an amendment to the Indian Health Care Improvement Act (25 U.S.C. § 1680q(b)(2)).[67] This amendment required that the Attorney General submit to the Senate Committee on Indian Affairs and the House Committee on Natural Resources a report that, in part, addresses the capacity of Federal and tribal agencies to carry data collection and analysis and information exchanges as described in the Act.

Beginning in FY 2002, Congress appropriated funding to the U.S. Department of Justice to support the Harold Rogers Prescription Drug Monitoring Program (HRPDMP).[68] Prescription drug monitoring programs (PDMPs) help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented prescription monitoring programs have the capability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files, a time consuming and invasive process.

The purpose of the HRPDMP is to enhance the capacity of regulator and law enforcement agencies to collect and analyze controlled substance prescription data. The program focuses on providing help for states that seek to establish and enhance prescription drug monitoring. Program objectives include:

- Building a data collection and analysis system at the state level;
- Enhancing existing programs' ability to analyze and use collected data;
- Increasing the usage of PDMP data among authorized users within the states;
- Facilitating the exchange of collected controlled substance prescription data among states; and
- Assessing the efficiency and effectiveness of the programs funded under the initiative.

PDMPs continue to be an important effort in addressing opioid addiction in tribal communities. The Indian Health Service (IHS) has a PDMP policy, which is intended to strengthen the monitoring and deterrence of prescription misuse and diversion. This is accomplished because IHS providers are required to check state PDMP databases prior to prescribing opioids for more than seven days. According to the Chief Medical Officer for IHS, Dr. Toedt, the "IHS has partnered with all states where IHS federal facilities are located and has successfully connected with 17 out of the 18 state PDMP databases, allowing access for 82 of the 83 IHS facilities offering pharmaceutical services."[69] Dr. Toedt also testified that the IHS PDMP policy requires that practitioners conduct peer reviews of prescriber activity. Additionally, per IHS policy, pharmacies must report opioid prescribing data to state PDMPs; this step exceeds what is currently required by law.[70]

C. IASA Interdepartmental Coordinating Committee

TLOA also amended the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986 (Public Law 99-570). The amendment required that the Secretary of Health and Human Services (HHS), the Secretary of the Department of the Interior (DOI), and the Attorney General develop and enter

[67] 25 U.S.C. § 1680q(b)(2) (2012).
[68] *FY17 Comprehensive Opioid Abuse Site-Based Program Awards*, BUREAU OF JUSTICE ASSISTANCE (2017).
[69] *Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community Before the S. Comm. on Indian Affairs*, 115th Cong. 4 (2018) (statement of Michael E. Toedt, Chief Medical Officer for Indian Health Service).
[70] *Id.*

into a Memorandum of Agreement (MOA) to create and implement a coordinated effort for the prevention and treatment of alcohol and substance abuse at the local level. The initial MOA was signed by cabinet level officials from HHS, DOI and the Attorney General in July 2011. A second MOA was signed in December 2016.[71] The MOA established the IASA Interdepartmental Coordinating Committee, which includes representatives from HHS, DOI, DOJ, and other federal agencies.[72] The coordinating committee is the mechanism by which the agencies meet the MOA's terms. The coordinating committee uses the MOA for policy direction, goal setting, and authority.[73]

Additionally, the TLOA amendments also requested that leadership from HHS, DOI and the Department of Justice do the following:

1. Determine the scope of the alcohol and substance abuse problems faced by Tribes;
2. Identify the resources and programs of each agency that would be relevant to a coordinated effort to combat alcohol and substance abuse among AIAN; and
3. Coordinate existing agency programs with those established under TLOA.[74]

A number of Department components are active participants on the IASA Interdepartmental Coordinating Committee. Projects like TAP training and the DEA Take Back events, both described more fully in this document, are just two of many efforts in which IASA Interdepartmental Coordinating Committee and Department employees have been active participants.

V. Prevention and Training Efforts

The Department of Justice’s efforts in eradicating prescription drug abuse and illicit substance use is multifaceted. U.S. Attorney’s Offices like the District of New Mexico have partnered with a local university to develop an initiative targeting heroin and opioids. The Department has funded Healing to Wellness Courts (similar to drug courts) in tribal communities. The Department also manages the National Indian Country Training Initiative, an effort focused on criminal justice and social service professionals working in Indian country and with tribal communities. The hope is that these efforts will, in part, reduce the number of drug crimes and violent crimes committed as a result of drug use. If there is an offense that occurs, training will work to ensure an appropriate response to the victim and the community. This next section outlines a few of these innovative efforts working to make tribal communities drug free communities.

A. HOPE Initiative

The Heroin and Opioid Prevention and Education (HOPE) Initiative was launched in January 2015 by the University of New Mexico Health Sciences Center and the New Mexico U.S. Attorney’s Office in response to the national opioid epidemic, which has had a disproportionately devastating impact on New Mexico. Opioid addiction has taken a toll on public safety, public health, and the economic viability of our communities. Working in partnership with the DEA are the Bernalillo County Opioid Accountability Initiative, Healing Addiction in our Community (HAC), Albuquerque Public Schools, and other community stakeholders. HOPE’s principal goals are to protect our communities from the dangers associated with heroin and opioid painkillers and to reduce the number of opioid related deaths in New Mexico.

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[71] Memorandum of Agreement between HHS, DOI, and DOJ on Indian Alcohol and Substance Abuse (Dec. 6, 2016).
[72] *Id.* at 5.
[73] *Id.* at 6.
[74] *Id.* at 2-3.

The HOPE Initiative is comprised of five components: (1) prevention and education; (2) treatment; (3) law enforcement; (4) reentry; and (5) strategic planning.[75] HOPE's law enforcement component is led by the Organized Crime Section of the U.S. Attorney's Office and the DEA in conjunction with their federal, state, local, and tribal law enforcement partners. Targeting members of major heroin and opioid trafficking organizations for investigation and prosecution is a priority of the HOPE Initiative. Learn more about the New Mexico HOPE Initiative at http://www.HopeInitiativeNM.org.

A recent example of a case brought by the HOPE Initiative is the prosecution of Stetson Holliday. Holliday, age twenty-three, pled guilty on May 17, 2018, to a prescription drug trafficking charge.

The DEA arrested Holliday on January 16, 2018, on a criminal complaint charging him with distributing prescription drugs. According to the criminal complaint, Holliday distributed approximately ten Xanax (alprazolam) tablets to an undercover DEA Special Agent.

Holliday was charged with distributing a Schedule IV controlled substance, alprazolam. Holliday pled guilty to the indictment without the benefit of a plea agreement. At sentencing, he faces a maximum penalty of five years in federal prison. This case was investigated by the Albuquerque office of the DEA and is being prosecuted by Assistant U.S. Attorney Peter J. Eicker as part of the New Mexico HOPE Initiative.[76]

B. "Take Back" Event in Indian Country

Twice a year, the DEA hosts the National Prescription Drug Take Back Day; this effort addresses a crucial public safety and public health issue. According to the 2015 National Survey on Drug Use and Health, 6.4 million Americans abused controlled prescription drugs.[77] The study shows that a majority of abused prescription drugs were obtained from family and friends, often from the home medicine cabinet. The DEA's Take Back Day events provide an opportunity for Americans to prevent drug addiction and overdose deaths. Each year, events are scheduled in October and April.

For the October 2017 event, there was a significant interagency partnership with the DEA to increase the number of tribal drop sites. The DEA worked with its tribal law enforcement partners to set up 115 collection sites on tribal lands. Opioid addiction impacts tribal communities just as it does all parts of American society.[78] "By partnering with FBI, BIA, and tribal law enforcement, the DEA was able to greatly expand tribal participation in the Take Back program. DEA remains committed to supporting public safety in American Indian and Alaska Native communities."[79]

A record-setting 912,305 pounds—456 tons—of potentially dangerous, expired, unused, and unwanted prescription drugs for disposal were collected at more than 5,300 collection sites. The DEA reports that this amount is almost six tons more than was collected at the April 2017 event. According to the DEA, 1,507 pounds of drugs were collected at the tribal locations. The total amount of prescription drugs collected by DEA from the fall of 2010 to the fall of 2017 is 9,015,668 pounds, or 4,508 tons.[80]

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[75] HOPE INITIATIVE NEW MEXICO, http://www.hopeinitiativenm.org/ (last visited June, 18, 2018).
[76] Press Release, U.S. Dep't of Justice, Albuquerque Man Pleads Guilty to Federal Prescription Drug Trafficking Charge (May 17, 2018).
[77] *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables*, SAMHSA 178 (Sept. 8, 2016).
[78] Press Release, U.S. Dep't of Justice, Drug Enforcement Admin. Collects Record Number of Unused Pills as Part of its 14th Prescription Drug Take Back Day (Nov. 7, 2017).
[79] *Id.*
[80] *Id.*

C. Healing to Wellness Courts

The Department's Bureau of Justice Assistance (BJA) supports Tribal Healing to Wellness Court through the Adult Drug Court Discretionary Grant Program (ADCDGP). The ADCDGP provides financial and technical assistance to states, state courts, local courts, units of local government, and Indian tribal governments to develop and implement drug courts and veterans' treatment courts. These courts effectively integrate evidence-based substance abuse treatment, mandatory drug testing, sanctions and incentives, and transitional services in judicially supervised court settings with jurisdiction over offenders to reduce recidivism, substance abuse, and prevent overdoses.[81] The ADCDGP is one of several BJA strategies to address the opioid crisis.

Through the ADCDGP, BJA has a cooperative agreement with the Tribal Law and Policy Institute (TLPI). TLPI is a 100 percent Native American operated nonprofit corporation organized to design and deliver education, research, training, and technical assistance programs which promote the enhancement of justice in Indian country and the health, well-being, and culture of Native peoples. As a BJA training and technical assistance (TTA) Provider, TLPI's role is to provide intensive training and technical assistance to BJA funded Tribal Healing to Wellness Courts.[82] Services include, but are not limited to the following:

- Review Policies and Procedures, Participant Handbook, roles and responsibilities, etc.
- Assess compliance with Tribal Key Components and Drug Court Standards
- Train on various Wellness Court topics
- Assist in planning and implementation

Additional information concerning TLPI's efforts concerning Healing to Wellness Courts can be found online at http://www.wellnesscourts.org/.

Healing to Wellness Courts have been successful in Indian country because they incorporate an Indian person's traditions and culture. These courts focus on healing the defendant and not just meting out punishment. While one may think of Healing to Wellness programs as only successful in tribal communities, even state courts in areas with large Indian populations have begun to use the model because it works. For example, on May 18, 2018, the Second Judicial District in Albuquerque, New Mexico, announced that it has started a new specialty court; this effort incorporates traditional Native American customs and medically assisted substance abuse treatment into a court-ordered treatment program.[83] Defendants will be ordered to attend the program following their plea of guilty to a criminal offense. The new program in Albuquerque is a forty-eight week recovery program. Participants will be required to attend regular meetings with probation officers, maintain regular appearances in front of an assigned judge, participate in an individualized treatment program, and attend twelve-step and sponsor meetings. Participants will also be required to either maintain full time employment or perform community service.[84] Chief District Judge Nash in a statement said, "Our specialty courts have proven highly successful at reducing recidivism among target populations by employing treatment techniques that get to the root cause of the behavior that is bringing certain individuals into the criminal justice system."[85] The court also remarked that drug and Healing to Wellness courts are more cost effective than is long term incarceration.[86]

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[81] *Drug Court Discretionary Grant Program*, BUREAU OF JUSTICE ASSISTANCE (last visited June 18, 2018).
[82] *Tribal Healing to Wellness Courts*, TRIBAL LAW AND POLICY INSTITUTE (last visited June 18, 2018).
[83] Ryan Boetel, *Specialty court to include Native American customs*, ALBUQUERQUE JOURNAL, May 18, 2018.
[84] *Id.*
[85] *Id.*
[86] *Id.*

D. Department of Justice Indian Country Training Resources

In July 2010, the Department's Executive Office for United States Attorneys (EOUSA) launched the National Indian Country Training Initiative (NICTI) to ensure that Department prosecutors, as well as state and tribal criminal justice personnel, receive the training and support needed to address the particular challenges relevant to Indian country prosecutions. The Department's NICTI Coordinator leads this training effort, which is based at the National Advocacy Center (NAC) in Columbia, SC. Since its inception, the NICTI has delivered just shy of 100 residential training courses at the NAC and in the field. In addition, the Coordinator has delivered hundreds of presentations for other federal agencies, tribes, and tribal organizations held around the country. The NICTI has reached all United States Attorneys' Offices with Indian country responsibility and over 300 tribal, federal, and state agencies. In addition to live training, the NICTI issues written publications and serves as faculty for other federal agency trainings, webinars, tribally hosted conferences, and technical assistance providers serving Indian country. Importantly, the Department's Office of Legal Education covers the costs of travel and lodging for tribal attendees at classes sponsored by the NICTI. This allows many tribal criminal justice and social service professionals to receive cutting edge training from national experts at no cost to the student or tribe.

Since its inception, the NICTI has sponsored solely, or in partnership with other federal agencies or departments, a number of trainings that directly address proper investigation and prosecution techniques for drug related offenses. For example, the NICTI has partnered with the FBI a couple of times to sponsor a class titled "Investigation and Prosecution of Indian Country Criminal Enterprises." This training was for federal and tribal investigators and prosecutors who work criminal enterprise—primarily gang and drug—cases in Indian country. The training covered applicable federal statutes, an overview of gangs in Indian country, ground and air surveillance techniques, utilizing technical equipment, source development, undercover operations, OCDETF Fusion Centers, Project Pinpoint, and an overview of the FBI's Safe Trails Task Force program.

In June and September 2018, the NICTI will partner with the FBI, BIA, and DEA to develop and deliver a training titled "Investigative Techniques Related to the Enforcement of Illicit Drug Trafficking in Indian Country." This training is designed for federal, state, and tribal law enforcement and prosecutors who investigate and prosecute drug cases in Indian country. In addition, this training will include an overview of the drug problem in Indian country; illicit drug identification and handling of methamphetamines, heroin, and fentanyl; FBI Safe Trails Task Forces; evidence collection; prosecution considerations for drug cases on tribal lands; safeguarding first responders; disposal of drug evidence under EPA, OSHA, and DOT Standards; NIBIN Resources; Prescription Drug Monitoring Programs; NARCAN Use; and El Paso Intelligence Center Resources.

Trainings that strengthen investigation and prosecution skills concerning drug cases are extremely important and must be frequently offered. This is especially true in Indian country where in many places there are very high turnover rates of police and prosecutors. However, in addition to traditional criminal justice trainings, the problem of drug trafficking and prescription drug abuse demands that social service professionals, tribal leadership, community members, and mental health professionals also receive training about the important role they play in resolving the scourge of drugs in a community. Accordingly, the NICTI has partnered with the National Alliance on Drug Endangered Children (National DEC)[87] to deliver multiple trainings for and in Indian country. National DEC is a national nonprofit whose mission is to break multigenerational cycles of abuse and neglect of children. National DEC defines a drug endangered child as one at risk of suffering physical or emotional harm as a result of illegal drug use, possession, manufacturing, cultivation, or distribution.[88] The training is designed for teams of stakeholders from the tribal community, and it "focuses on the formation of community-based

[87] *Our Programs*, NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN (last visited June 18, 2018).
[88] *The Problem*, NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN (last visited June 18, 2018).

partnerships that encourage agency personnel from across multiple disciplines to coordinate their mutual interests, resources and responsibilities."[89]

In 2017 and 2018, the NICTI, together with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Bureau of Justice Assistance (BJA), worked together to host a yearly training titled "Tribal Action Plan Development Workshop: A Tribal Law and Order Act Training Initiative." The Tribal Action Plan (TAP) Training Initiative was established in direct response to the Tribal Law and Order Act of 2010. Section 241 of TLOA, codified at 25 U.S.C. § 2412, says that "The governing body of any Indian tribe may, at its discretion, adopt a resolution for the establishment of a Tribal Action Plan to coordinate available resources and programs" in an effort to combat alcohol and substance abuse among its members.[90] A TAP is a valuable strategic plan developed by community stakeholders to address issues of drug and alcohol abuse in the community. TAPs support the principle of tribal self-determination and provide tribes the opportunity to take a proactive role in the fight against alcohol and substance misuse in their communities. The workshop at the National Advocacy Center is designed to provide core teams of five representatives per tribe with the necessary tools and guidance to develop a TAPTribe. The TAP training is a popular one. Each time the class is offered there is a waiting list of tribes hoping to attend. To date, the tribes listed below have received TAP training at the DOJ's National Advocacy Center via the NICTI and are working on their strategic plan to combat drugs and alcohol. It is important to note that additional tribes may have received TAP training from another federal agency.

2017 Class

- Ak-Chin Indian Community
- Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation
- Chickasaw Nation
- Delaware Nation
- Ho-Chunk Nation of Wisconsin
- Hopi Tribe
- Oneida Nation
- Pueblo of Jemez
- Pueblo of Santa Clara
- Sac and Fox Nation
- Saginaw Chippewa Tribe of Michigan
- Seminole Nation of Oklahoma
- Snoqualmie Tribe
- Wampanoag Tribe of Gay Head Aquinnah
- Yakama Nation

[89] *Our Solution*, NATIONAL ALLIANCE FOR DRUG ENDANGERED CHILDREN (last visited June 18, 2018).
[90] 25 U.S.C. § 2412(a) (2012).

2018 Class

- Bad River Tribe
- Bay Mills Indian Community
- Eastern Band of Cherokee Indians
- Fallon Paiute-Shoshone Tribe
- Fort Peck Tribes
- Hopland Band of Pomo Indians
- Hualapai Tribe
- Little River Band of Ottawa Indians
- Makah Indian Tribe
- Nisqually Indian Tribe
- Pueblo of Cochiti
- Pueblo of Isleta
- Saginaw Chippewa Indian Tribe
- San Carlos Apache Tribe
- Sokaogon Chippewa Community
- Tohono O'odham Nation
- Tribal Tech, LLC
- Yurok Tribe

The NICTI will continue to partner with the Department, other federal agencies, and tribal training and technical assistance providers to develop and deliver state-of-the-art training that will address the many facets of preventing, investigating, and prosecuting prescription drug abuse, illicit drug use and trafficking, and alcohol facilitated crimes like sexual assault.

VI. Conclusion

A May 10, 2018 article published in *The Hill* is titled "the forgotten people of the opioid epidemic."[91] The article recounts a recent ceremony to mourn lost loved ones attended by members of the Seneca Nation and others from surrounding communities. To remember those who had passed, there was a bell rung and lantern lit. The deceased had lost their life to opioids. According to one person in attendance, "that bell would just not stop ringing."[92] AIAN communities have been some of the hardest hit during the opioid crisis. Before the opioid crisis, there were significant issues in some tribal communities with marijuana, heroin, and methamphetamines, and some traffickers like Jesus Martin Sagaste-Cruz specifically targeted Indian country for these reasons.

The response of law enforcement and the criminal justice system to the drug crisis is critically necessary. Traffickers must be apprehended and held responsible for the poison they spread in tribal communities. But, as the saying goes, "we can't arrest ourselves out of the drug problem." Therefore, the Department must and will continue to be involved in prevention efforts, Take Back events, training, etc.

Tribes, too, are taking action. Nearly two dozen federally recognized tribes have filed lawsuits against drug companies over the nation's opioid epidemic. These suits seek to recoup costs for social services and other programs the tribes funded as a means of treating record high addiction rates among Native Americans. The tribes argue that the drug companies undertook a misleading and aggressive

[91] Rachel Roubein, *The 'forgotten people' of the opioid epidemic*, THE HILL (May 10, 2018).
[92] *Id.*

marketing effort that downplayed the addictive nature of prescription opioids. A federal judge in Ohio is overseeing the suits filed by Tribes as well as those filed by cities, counties and states.[93]

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"What I've learned is that these people didn't ask for this. They got hooked because we're flooded with pills, and they can't stop, and then they're in the back of the ambulance with me. It's heartbreaking what this has done to our people. But we are hopeful that the efforts to seek justice will be successful, so that we can begin to heal and restore our communities."[94]

ABOUT THE AUTHOR

❑ **Leslie A. Hagen** serves as the Department of Justice's first National Indian Country Training Coordinator. In this position, she is responsible for planning, developing, and coordinating training in a broad range of matters relating to the administration of justice in Indian country. Previously, Ms. Hagen served as the Native American Issues Coordinator for the Executive Office for United States Attorneys. In that capacity, she served as EOUSA's principal legal advisor on all matters pertaining to Native American issues, provided management support to the United States Attorneys' Offices, and coordinated and resolved legal issues. She also served as a liaison and technical assistance provider to Department of Justice components and the Attorney General's Advisory Committee on Native American Issues. Ms. Hagen started with the Department of Justice as an Assistant United States Attorney in the Western District of Michigan. As an AUSA, she was assigned to Violent Crime in Indian Country and handled federal prosecutions and training on issues of domestic violence, sexual assault, child abuse, and human trafficking affecting the eleven federally recognized tribes in the Western District of Michigan.

[93] Eric Heisig, *Native American tribes fight to not be forgotten in massive opioid litigation*, CLEVELAND.COM, May 30, 2018.
[94] Suzette Brewer, *Tribes lead the battle to combat a national opioid crisis*, HIGH COUNTRY NEWS, May 9, 2018.

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Public Safety and Public Health Efforts to Combat the Opioid Epidemic

Naomi Adaniya
Policy Analyst
Criminal Division, Fraud Section, Health Care Fraud Unit

I. Introduction

As of 2016, overdose deaths from illicitly manufactured, synthetic opioids such as fentanyl—thirty to fifty times more potent than heroin[1] and fifty to one hundred times more potent than morphine[2]—outpace overdose deaths from prescription opioids. According to a research letter published in the *Journal of the American Medical Association*, which analyzed death certificates from the National Vital Statistics System, forty-six percent of the 42,249 opioid overdose deaths which occurred in 2016 involved synthetic opioids. This percentage represents a nearly threefold increase over that reported in 2010 (fourteen percent).[3] Conversely, only forty percent of those deaths involved prescription opioids.[4]

While staggering, this percentage likely *underrepresents* the true scale of synthetic opioids' devastation, due to limitations in state level, postmortem testing, which may not include fentanyl analogs such as acetylfentanyl, furanylfentanyl, and carfentanil.[5] This rise in the abuse of synthetic opioids results in part from a corresponding decrease in legitimate opioid prescribing. Historically, the opioid epidemic began medically, with approximately eighty percent of eventual heroin users abusing prescription opioids initially.[6] Nevertheless, in 2012, the introduction of federal and state initiatives began to level opioid prescribing;[7] concurrently, from 2012 to 2014, the number of opioid overdose deaths involving fentanyl doubled, from 2,628 to 5,544.[8] In addition, opioid-inclusive toxicology reports confirm this shift from abusing only prescription opioid to abusing multiple drugs, including prescription and synthetic opioids, as well as potentiator drugs that intensify the effects of the opioids.

Generally, illicit drug manufacturers (traffickers) sell fentanyl not as a pure product but mixed with less potent, though more expensive, drugs such as heroin. Though it packs a more powerful high

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[1] *FAQ's- Fentanyl and Fentanyl-Related Substances*, U.S. DRUG ENFORCEMENT ADMINISTRATION, https://www.dea.gov/druginfo/fentanyl-faq.shtml.
[2] Julie K. O'Donnell, PhD. et al, *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700—10 States, July-December 2016*, MORBIDITY AND MORTALITY WEEKLY REPORT 1197 (2017).
[3] *Nearly half of opioid-related overdose deaths involve fentanyl*, NATIONAL INSTITUTE ON DRUG ABUSE (2018).
[4] Christopher M. Jones, PharmD, MPH et al, *Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, 2010-2016*, J. AM. MED. ASS'N (2018).
[5] Julie K. O'Donnell, PhD. et al, *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700—10 States, July-December 2016*, MORBIDITY AND MORTALITY WEEKLY REPORT 1201 (2017).
[6] Wilson M. Compton, MD, *Research on the Use and Misuse of Fentanyl and Other Synthetic Opioids*, NATIONAL INSTITUTE ON DRUG ABUSE (2017).
[7] *Id.*
[8] Richard G. Frank, PhD & Harold A. Pollack, PhD, *Addressing the Fentanyl Threat to Public Health*, NEW ENG. J. MED. 605 (2017).

than heroin, fentanyl costs significantly less to produce, at a price of $3,500 per kilogram (versus $65,000 per kilogram).[9] Given the greater potential for profit, sellers continue to cut their product—whether heroin, methylenedioxymethamphetamine (MDMA), or even benzodiazepines like Xanax—with fentanyl. According to a Centers for Disease Control and Prevention (CDC) report, approximately forty-one percent of the 7,100 heroin related deaths recorded between 2012 and 2014 involved fentanyl.[10] Regionally, this practice is particularly widespread in the eastern United States, where dealers often cut white powder heroin with fentanyl.[11] Correspondingly, the CDC found the highest rates of fentanyl overdose in the Northeast, with much of New England—including Maine, Massachusetts, New Hampshire, and Rhode Island—reporting a full sixty to ninety percent of opioid overdose deaths in those states involving fentanyl.[12] Among these opioid overdose deaths, non-Hispanic white men aged twenty-five to forty-four had the greatest representation.[13] Ultimately, this cutting of purer, weaker drugs with synthetic opioids has resulted in a sharp rise in fatal overdoses as dealers with little grasp on appropriate dosing sell mislabeled fentanyl to unsuspecting users.

II. Opioid Epidemic

Although this *USA Bulletin* focuses on fentanyl, a synthetic opioid, the opioid epidemic itself appeared in three waves, each defined by a different class of opioid. According to Rita Noonan, a leader in the CDC's Division of Unintentional Injury Prevention, the first wave of the opioid epidemic saw increases in deaths involving prescription opioids starting in 1999.[14] The second wave reported increases in heroin involved deaths starting in 2010. Since 2013, this current wave has seen an increase in deaths involving synthetic opioids like illicitly manufactured fentanyl.

Though the opioid epidemic keeps evolving, prescription opioid misuse continues to presage opioid use disorder. In 2015, nearly half of opioid related deaths involved prescription opioids.[15] Generally, individuals suffering from opioid use disorder obtain the drugs first from a valid prescription, written by a healthcare professional for either themselves or a friend or relative.[16] As the epidemic continues to expand, prescription opioids and treatment for opioid use disorder place an increasingly substantial burden on both public and private healthcare insurers.

According to a recent Kaiser Family Foundation report, spending on opioid addiction and overdose treatment by large employer health plans has increased each year in the last decade, from $278 million (2006) to $2.627 billion (2016).[17] A similar burden has been placed on government healthcare programs, including Medicare and Medicaid. In 2016, Medicare, a federal healthcare program, was projected to spend $696 billion and provide healthcare coverage to over fifty-seven million beneficiaries;

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[9] *Id.*
[10] *Id.*
[11] R. Matthew Gladden, PhD, Pedro Martinez, MPH, & Puja Seth, PhD, *Fentanyl Law Enforcement Submissions and Increases in Synthetic Opioid-Involved Overdose Deaths—27 States, 2013-2014*, MORBIDITY AND MORTALITY WEEKLY REPORT (2016).
[12] Julie K. O'Donnell, PhD. et al, *Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700—10 States, July-December 2016*, MORBIDITY AND MORTALITY WEEKLY REPORT (2017).
[13] *Id.*
[14] Rita Noonan, PhD, *Rural America in Crisis: The Changing Opioid Overdose Epidemic*, PUBLIC HEALTH MATTERS BLOG (Nov. 28, 2017), https://blogs.cdc.gov/publichealthmatters/2017/11/opioids/.
[15] *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (2017).
[16] Jeanette M. Tetrault & Jenna L. Butner, *Non-Medical Prescription Opioid Use and Prescription Opioid Use Disorder: A Review*, 88 YALE J. BIOLOGY AND MED. 228 (2015).
[17] *Spending on opioid addiction and overdose treatment has increased each year in the last decade*, HENRY J. KAISER FAMILY FOUNDATION (2018).

Medicaid, a federal-state healthcare program, was estimated to cost $575.9 billion to cover approximately 72.2 million people. Medicaid covers inpatient and outpatient addiction treatment services, medication-assisted treatment (MAT), and other services for health conditions either associated with or independent from opioid addiction.[18] In FY 2013, Medicaid spent approximately $9.4 billion on care for people with opioid addiction.[19] Due to the programs' size and complexity, the U.S. Government Accountability Office (GAO) has designated both Medicare and Medicaid as high risk for their vulnerability to fraud, waste, abuse, and mismanagement. This vulnerability extends to these programs' response to the opioid epidemic. In November 2017, the GAO urged CMS to provide greater oversight of opioid prescriptions.[20]

Government health care program beneficiaries, who misuse prescription opioids and develop opioid use disorder, interact with the health care system in a variety of ways. To obtain prescription opioids directly, in a practice known as doctor or pharmacy shopping, individuals may seek care from multiple medical professionals (physicians, physician assistants, and nurse practitioners) or use multiple pharmacies to fill prescriptions. In 2016, one in three Medicare Part D beneficiaries received an opioid prescription, and almost 500,000 beneficiaries received high amounts of opioids.[21] Drug overdoses often necessitate visits to emergency rooms or hospitalization. At the other end of the spectrum, beneficiaries also seek to use their health insurance coverage to pay for substance abuse treatment.

Government healthcare programs are also vulnerable to fraudulent healthcare providers or entities. Fraudulent medical professionals may ask patients for additional cash payments. In lieu of a cash payment, a fraudulent provider may require patients to undergo medically unnecessary treatments to secure a prescription for an opioid or potentiator drug and increase the providers' Medicare or Medicaid billing. Fraudulent providers may also receive kickbacks for referrals from entities such as drug testing laboratories or pharmacies. In recognition of the burden the opioid epidemic was placing on Medicare and Medicaid, CMS published their Opioid Misuse Strategy in January 2017.[22]

The impact of the opioid epidemic calls for a coordinated government response. As the September 2016 *USA Bulletin* discusses, the response requires public safety and public health opioid strategies to be integrated and complimentary.[23] Joint initiatives capitalize on the expertise of each sector to find or prove public health oriented tasks are relevant to public safety and vice versa. In the first example, a goal of capturing real time fatal and non-fatal overdose data—a task perhaps best aligned with Department of Health Vital Statistics Sections—provides valuable, timely information to help better direct public safety officials. In the second example, successfully investigating and prosecuting those contributing to the opioid epidemic—a goal most would task as a public safety responsibility—is facilitated only when public safety and public health agencies work together.

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[18] Julia Zur, *Medicaid's Role in Addressing the Opioid Epidemic,* HENRY J. KAISER FAMILY FOUNDATION (2017).

[19] Katherine Young & Julia Zur, *Medicaid and the Opioid Epidemic: Enrollment, Spending, and the Implications of Proposed Policy Changes*, HENRY J. KAISER FAMILY FOUNDATION (2017).

[20] *Prescription Opioids: Medicare Needs to Expand Oversight Efforts to Reduce the Risk of Harm*, U.S. GOVERNMENT ACCOUNTABILITY OFFICE (2017).

[21] *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*, OFFICE OF INSPECTOR GENERAL (July 2017).

[22] *Centers for Medicare & Medicaid Services (CMS) Opioid Misuse Strategy 2016*, CENTERS FOR MEDICARE & MEDICAID SERVICES (2017).

[23] David J. Hickton & Soo C. Song, *Integrating Public Safety and Public Health to Reduce Overdose Deaths*, 64 U.S. ATT'Y BULL. 3 (Sept. 2016).

III. ODMAP

Seeing the need for real time opioid overdoses data, the Washington/Baltimore High Intensity Drug Trafficking Area (W/B HIDTA) developed ODMAP in 2016.[24] ODMAP is a free, web based application, capable of being used in the field on any mobile device, that compiles street level data with digital mapping tools to help public health officials, first responders, and police departments respond to and track fatal and non-fatal overdoses in real time.[25] According to Jeff Beeson, Deputy Director and Chief of Staff of the W/B HIDTA, ODMAP finds patterns and links in overdose data that enables the HIDTA to notify public health officials to anticipate overdoses eight to ten hours before they occur—an overdose early warning system.

Though simple in design to minimize data collection challenges, ODMAP is revolutionary for two reasons. This tool and its predictive abilities are strengthened as ODMAP implementation proliferates, and the information collected by first responders (police, fire, and EMS) is utilized by both public safety and public health officials. Public health officials benefit from more accurate, real time reporting of overdoses and naloxone administrations. The data is vital not only for designing and implementing interventions but also to enable communities to secure government and nonprofit grant applications. Public safety officials use ODMAP data to better respond to anticipated overdose surges. In addition, police have access to more data, including victim's date of birth and overdose history; witness information; overdose drug (fentanyl, oxycodone, other narcotic); any drugs found at the scene; even photographs of drugs' packaging.[26]

The W/B HIDTA quickly demonstrated the power and utility of ODMAP. In 2017, public health and public safety officials from the CDC National Center for Injury Prevention and Control (NCIPC) and the W/B HIDTA secured funding from the Department of Health and Human Services' Ignite Accelerator, the Department's internal innovation startup program, to integrate ODMAP with regional and local EMS and dispatch systems, in order to supplement data entered by first responders.[27] Realizing the importance of analyzing ODMAP data, the partnership between NCPIC and W/B HIDTA continues with analysts from both agencies working collaboratively to allow ODMAP to achieve its full overdose prevention potential, monitoring data in real time across jurisdictions.

IV. Health Care Fraud and Abuse Control Program

Without a doubt, public safety or law enforcement officials play a role in combatting the opioid epidemic by investigating and prosecuting civil and criminal cases. As previously discussed, the impact of the opioid epidemic on government health programs is especially concerning and necessitates a collective response by public safety and public health agencies. There is no better example of the success this type of partnership yields than the Health Care Fraud and Abuse Control (HCFAC) Program.

Established by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA), the HCFAC Program is under the joint direction of the Attorney General and the Secretary of Health and Human Services (HHS). To operationalize the Program, DOJ and HHS created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The Medicare Fraud Strike Force (MFSF) teams are a key component of HEAT.

Strike Forces are comprised of interagency teams, including but not limited to: federal prosecutors from the DOJ Criminal Division Fraud Section Health Care Fraud Unit, Assistant

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[24] Robbie Gonzalez, *This App Maps Opioid Overdoses in Real Time*, WIRED (2017).
[25] *ODMAP FAQs*, HIGH INTENSITY DRUG TRAFFICKING AREA, http://www.hidta.org/odmap-faqs/.
[26] Robbie Gonzalez, *This App Maps Opioid Overdoses in Real Time*, WIRED (2017).
[27] Kevin McTigue & Will Yang, *Fall 2017 HHS Ignite Accelerator: Selecting the Teams*, IDEALAB (2017), https://www.hhs.gov/idealab/2017/08/08/fall-2017-hhs-ignite-accelerator-selecting-the-teams/.

United States Attorneys, and special agents from both the FBI and HHS Office of Inspector General (HHS OIG). These partners engage additional support from agencies such as the Drug Enforcement Administration (DEA), the Internal Revenue Service (IRS), Secret Service, Medicaid Fraud Control Units (MFCU), and Prescription (Drug) Monitoring Programs (PDMP or PMP). They also provide mutual advanced data analytic assistance through internal data analysis groups including the DOJ Criminal Division's Health Care Fraud Data Analytics Team and HHS OIG's Consolidated Data Analysis Center (CDAC).

The HCFAC Program has a historical rate of return between four and six dollars for each dollar spent on the Program. Since its inception, Strike Force prosecutors have filed more than 1,750 cases, charging more than 3,700 defendants who collectively billed the Medicare program over fourteen billion dollars; 2,331 defendants pleaded guilty and 315 others were convicted in jury trials; and 2,117 defendants were sentenced to imprisonment for an average term of approximately fifty months. Based on the success of these efforts and increased appropriated funding for the HCFAC Program from Congress and the Administration, DOJ and HHS operate Strike Force operations to a total of nine areas in the United States: Los Angeles, California; Miami and Tampa, Florida; Chicago, Illinois; Brooklyn, New York; Detroit, Michigan; Southern Louisiana; and Dallas and Houston, Texas.

The key to the Strike Forces' success has been the integration of public safety (DOJ) and public health (HHS) partners since inception. The strength of this relationship is evident when executing the largest ever healthcare fraud enforcement action. In June 2018, the DOJ Criminal Division Fraud Section Health Care Fraud Unit led and coordinated the 2018 National Health Care Fraud and Opioid Takedown, which resulted in charges against 601 individuals in fifty-eight federal districts, including 165 doctors, nurses, pharmacists, and other licensed medical professionals, for their alleged participation in healthcare fraud and opioid related schemes involving more than $2 billion in false billings. Of those charged, 162 defendants were charged for their roles in opioid related fraud schemes. The opioid epidemic impacts beneficiaries and providers across the care continuum. The 2018 Takedown builds on the success of last year's effort that resulted in charges against 120 defendants for their roles in opioid related fraud schemes.

In the Eastern District of Michigan, eighteen defendants, including nine physicians, were charged as part of an investigation into an over $300 million health care fraud scheme that involved a network of Michigan and Ohio pain clinics, laboratories, and other medical providers. Charges include health care fraud, wire fraud, conspiracy to defraud the United States, payment or receipt of kickbacks, and money laundering. The scheme included prescribing medically unnecessary controlled substances, some of which were sold on the street, and billing Medicare for medically unnecessary services, including injections that resulted in patient harm.

In a Southern District of Florida case, the owner and operator of a purported addiction treatment center and home for recovering addicts, along with one other individual, were charged in a scheme involving the submission of over fifty-eight million dollars in fraudulent medical insurance claims for purported drug treatment services. The allegations include actively recruiting addicted patients to move to South Florida so that the coconspirators could bill insurance companies for fraudulent treatment and testing, in return for which the coconspirators offered kickbacks to patients in the form of gift cards, free airline travel, trips to casinos and strip clubs, and drugs.

In a Southern District of Texas case, a Houston-based physician and owner of a pain management clinic were convicted of one count of conspiracy to unlawfully distribute controlled substances and three counts of unlawfully distributing and dispensing controlled substances. A federal jury found them guilty for their roles in running an illegal pill mill that provided tens of thousands of unlawful prescriptions for

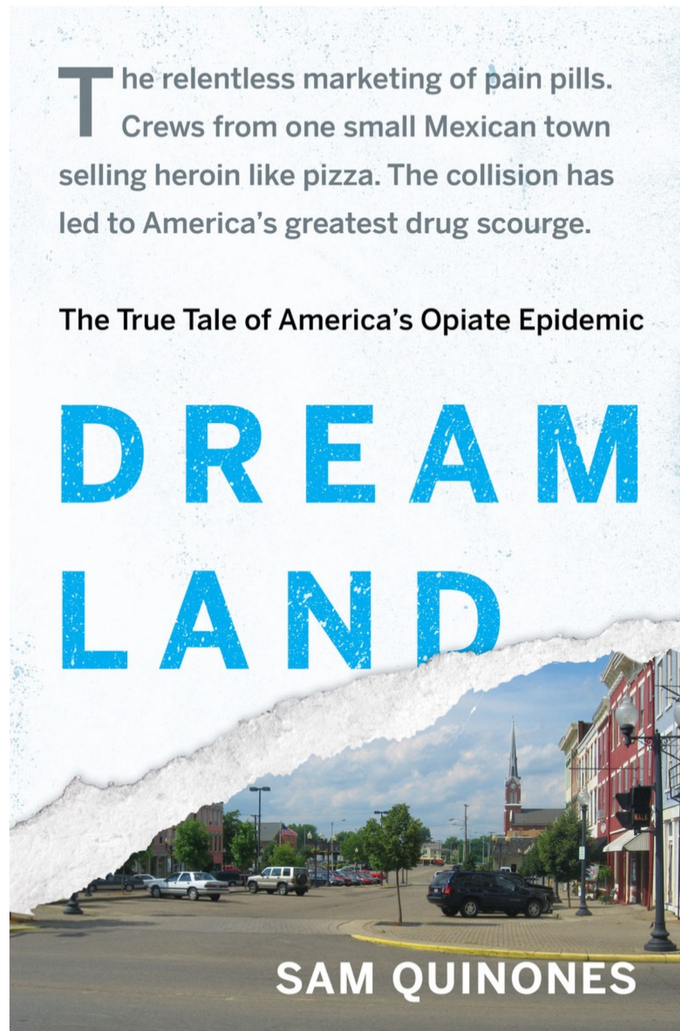
millions of doses of opioids and other controlled substances. Trial evidence showed that the defendants charged approximately $300 for each prescription and required payment in cash.

ABOUT THE AUTHOR

❑ **Naomi Adaniya**, MPH, PhD, is a Policy Analyst in the United States Department of Justice Criminal Division. She serves as the Director of the Health Care Fraud Data Analytics Team and leads the Department's Opioid Fraud and Abuse Detection Unit, a pilot program to utilize data to help combat the devastating opioid crisis that is ravaging families and communities across America. In both capacities, Dr. Adaniya and her team are responsible for supporting health care fraud and opioid related investigations and prosecutions across the country. In recognition of her work, Dr. Adaniya received the 2017 Attorney General's Award for Fraud Detection. Dr. Adaniya graduated from The Ohio State University with a Masters and Doctorate in Public Health and a second Masters in Geography. She received her Bachelors of Science in Economics from the University of Pennsylvania, Wharton School.

Book Review of *Dreamland: The True Tale of America's Opiate Epidemic*[1]

Mary Beth Pfister
Assistant Director of Curriculum and Faculty Development
National Advocacy Center



Last summer, while visiting family in my father's hometown of Portsmouth, Ohio, my uncle gave me a book called *Dreamland*. He said it painted a graphic picture of the town's decline from its former glory days when a local employer built a football field-sized pool by that name in the town center. It sounded like a good read for one interested in this particular small town, but it turned out to be the book I have most often recommended to others since then. *Dreamland* is both a compelling read and an insightful and well researched explanation of the current opioid crisis in America.

Dreamland describes the confluence of events that created this crisis by telling the stories of both those responsible and those affected. Journalist Sam Quinones describes how pain management became a major focus among some doctors and big pharma in the 1990s, and how big pharma, through its aggressive marketing of the new wonder drug OxyContin, convinced the medical community that it could prescribe time-released painkillers containing opiates liberally without causing addiction. Although the basis for this position was paper thin, more and more legitimate and well-intentioned physicians who were eager to help patients with chronic pain began prescribing higher doses of opiate painkillers for longer periods of time. The insurance industry encouraged this approach with its practice of reimbursing for prescriptions but not for alternative pain treatments. Even patients who initially were properly prescribed opiate painkillers eventually required higher and higher doses to achieve the same effect. This opened the door for less than legitimate prescribers to open pain clinics and profit greatly from what was often no more than legalized drug dealing of OxyContin and Vicodin, with patient visits lasting five minutes or less. Collectively, these events and others chronicled in the book led to an

[1] SAM QUINONES, DREAMLAND: THE TRUE TALE OF AMERICA'S OPIATE EPIDEMIC (Bloomsbury Press, 2015).

unprecedented demand and market for prescription painkillers containing opiates, the same substance present in heroin.

Meanwhile, resourceful residents of Xalisco, a small town in Mexico, were developing a new entrepreneurial model for selling heroin in the United States. Ambitious dealers avoided big cities with their gangs, violence, and competition in favor of smaller communities where they sold to middle and upper class customers who had exhausted their prescription supplies of opiates but not their newfound dependence on them. These dealers sold black tar heroin, an inexpensive and potent version of the drug, and recruited clean cut young men from the same hometown to make deliveries on demand. This "pizza delivery" model, with its polite and prompt delivery drivers, who neither used the product nor carried weapons, helped the dealers expand into previously untapped suburban and rural markets. These new customers did not have to travel to rough neighborhoods or spend big dollars to acquire illegal opiates, which made the product more available and attractive.

Although the details Quinones provides about the opiate providers are fascinating, even more interesting (and heartbreaking) are the stories of those who became victims of the opioid epidemic. The author paints a vivid picture of families who watched loved ones become addicted to prescription painkillers, often appropriately prescribed and taken at first, and then, unbelievably, to heroin. He talks with caring and involved parents who were unable to save their children and with residents of small communities who were unable to halt their decline, as increased demand for opiates led to increased crime. Their experiences illustrate both how strong the hold of opiates can be and how destructive. Their stories also help the reader understand how this crisis became so widespread before it became widely recognized as a problem, because addiction and overdoses were so underreported.

Dreamland was been named a "best book of the year" by many publications when it was first published, including The Boston Globe, Slate, The Guardian, and Amazon. Anyone who has wondered how in the world this crisis developed should read it.

ABOUT THE AUTHOR

❑ **Mary Beth Pfister** is Assistant Director for Curriculum and Faculty Development at the National Advocacy Center, where she has developed training for the Department of Justice since 2008. She previously served as a criminal Assistant United States Attorney in the District of Arizona. Before joining the Department, she was an equity partner at a law firm in Phoenix. She earned her J.D. from Harvard Law School.

Note from the Editor in Chief . . .

There is little doubt that opioid addiction and fentanyl abuse are among the most serious problems we face in the Department of Justice today. Our sincere thanks to Joe Pinjuh (OCDETF) and Seth Adam Meinero (EOUSA) for spearheading this issue addressing these topics. We also are grateful to the authors who took time away from their busy practices to share their knowledge and experience with the U.S. Attorneys' community and the Department family. As Director James A. Crowell IV noted in the Introduction to this issue, "We are facing the deadliest drug crisis in American history. Confronting the Nation's opioid epidemic is one of the Department of Justice's highest and most pressing priorities." This issue of the Bulletin will undoubtedly serve as a valuable tool in addressing that crisis.

Thank you,

K. Tate Chambers