DRUG-INDUCED HOMICIDE: A HARSH WEAPON IN THE WAR ON DRUGS

Abstract: Drug-induced homicide laws are an increasingly used policy choice by lawmakers and prosecutors in combating the current opioid epidemic. A remnant of the War on Drugs, such laws conform to strict liability principles and have left many friends and family members charged with the murder of their friend or relative that died from an accidental drug overdose. This Note contends that drug-induced homicide laws cause more harm than good and that states should adopt statutes and policies that better align with accepted rationales of punishment as they combat the opioid epidemic.

INTRODUCTION

In 1989, Oklahoma amended its first-degree murder statute to include the distribution of a controlled substance that resulted in the death of another person, creating a drug-induced homicide statute.[1] In 2012, as the opioid epidemic raged, Oklahoma again amended its first-degree murder statute, this time to include synthetic drugs on the list of controlled substances covered under the statute.[2]

On April 22, 2023, Josh Askins was arrested for first-degree murder for the death of his friend, Christopher Drake, in Oklahoma City.[3] Askins and Drake were both were fentanyl addicts.[4] They were making plans to enter a detox facility to help fight their addiction when they pooled their money and

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[1] *See* 1989 Okla. Sess. Laws 800 (adding "unlawful distributing or dispensing of controlled dangerous substances, or trafficking in illegal drugs" to Oklahoma's first-degree murder statute).

[2] *See* 2012 Okla. Sess. Laws 699 (adding "or synthetic controlled substances" and "or manufacturing or attempting to manufacture a controlled dangerous substance" to Oklahoma's first-degree murder statute); *see also National Institute on Drug Abuse (NIDA) Oklahoma Opioid Summary*, NAT'L INST. ON DRUG ABUSE, 2–3 https://nida.nih.gov/sites/default/files/21981-oklahoma-opioid-summary_0.pdf [https://perma.cc/HM2S-FJ89] (Mar. 2019) (showing a steep rise in opioid use and opioid overdose deaths in Oklahoma beginning in 2005).

[3] *See* Miranda Vondale Foster, *OKDPD: Man Arrested for First-Degree Murder After Victim Dies from Fentanyl Overdose*, FOX NEWS, https://okcfox.com/news/local/okcpd-man-arrested-for-first-degree-murder-after-victim-dies-from-fentanyl-overdose-drugs-narcotics-illegal-joshua-askins-christopher-drake-oklahoma-county-detention-center-ocdc-oklahoma-city-police-department-ocpd-crime-homicide-arrest-okc-april-22-2023 [https://perma.cc/6GT5-JT5F] (Apr. 24, 2023) (explaining that Josh Askins was arrested for first-degree murder for the overdose death of Christopher Drake).

[4] *See* Eli Saslow, N.Y. TIMES, *He Tried to Save a Friend. They Charged Him with Murder*, BUFF. NEWS (June 25, 2023), https://buffalonews.com/he-tried-to-save-a-friend-they-charged-him-with-murder/article_dbb1c239-3ae9-5b88-8cd8-cfd632db80bd.html [https://perma.cc/H5HB-LEDA] (showing that the two had grown close in recent weeks through their shared struggles, feelings, and faith).

purchased the dose of fentanyl that killed Drake.[5] Although Askins called 911 and performed CPR on Drake, Askins was still charged for Drake's overdose death.[6] Although Oklahoma does have an overdose Good Samaritan law, it only protects people from prosecution for drug possession or drug paraphernalia possession, not drug-induced homicide.[7] After spending four days in jail, Askins overdosed on fentanyl, something that was easier to obtain behind bars than on the streets.[8] Askins survived the overdose, and prosecutors eventually agreed to a settlement with Askins pleading guilty to first-degree manslaughter, receiving years in prison for Drake's overdose.[9]

Such laws and prosecution lead to unexpected and devasting outcomes for co-users all over America.[10] Part I of this Note discusses drug-induced homicide laws in the context of their origins, the opioid epidemic, and the current legal landscape.[11] Part II evaluates drug-induced homicide laws as a type of felony murder statute.[12] Next, Part II compares the U.S. response to the opioid epidemic to that of other countries, highlighting best-practices and common

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[5] *See id.* (describing how Drake and Askins had contacted a rehab facility that accepts Medicaid and planned to enroll together to detox with the help of medication, and, because they were in withdrawal that morning, decided to get another hit of fentanyl).

[6] *Id.*

[7] *See* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, GOOD SAMARITAN FATAL OVERDOSE PREVENTION AND DRUG INDUCED HOMICIDE: SUMMARY OF STATE LAWS 4, 91 (2022), https://legislativeanalysis.org/wp-content/uploads/2022/12/Good-Samaritan-Fatal-Overdose-Prevention-And-Drug-Induced-Homicide-Summary.pdf [https://perma.cc/6VXG-77B6] (listing the Oklahoma statutes that establish overdose Good Samaritan laws). Good Samaritan laws seek to prevent overdose deaths by providing limited protection from prosecution for those that call for emergency services when someone is overdosing. *See id*. at 3 (providing a description of Good Samaritan laws and explaining that forty-eight states currently have Good Samaritan laws in effect).

[8] The Daily, *He Tried to Save a Friend. They Charged Him with Murder*, N.Y. TIMES (Sept. 22, 2023), https://www.nytimes.com/2023/09/22/podcasts/the-daily/fentanyl-murder.html?showTranscript=1 [https://perma.cc/NBA6-D876] (explaining that within a few days of entering jail, Askins was distressed about Drake's death and took a near-lethal dose of fentanyl).

[9] *Id.*

[10] *See* Jennie M. Miller, *Save a Friend's Life or Risk Your Freedom: The Dilemma Too Many People Face When Witnessing an Overdose*, 34 J.C.R & ECON. DEV. 351, 353–55 (2021) (stating that accidental drug overdose death rates are high and that roughly half of the people illegally using prescription opioids obtained them from a family member or friend). Accordingly, roughly half of the people charged under drug-induced homicide laws are "friends, family, or partners of the victim, who do not sell drugs in any significant manner." *See id.* at 355 (showing that in 2018, The Health in Justice Lab found that drug-induced homicide statutes were not being used to charge the drug-dealers the statutes were designed to target). This leads to co-users and addicts getting sent to prison. *See id.* at 355–65 (describing how drug-induced homicide laws get prosecuted). For example, Caleb Smith, a medical student living in Pennsylvania, purchased Adderall online to help him study for his exams. *Id*. at 365. The pills turned out to be fentanyl, and Smith was ultimately charged for the accidental overdose death of his girlfriend under Pennsylvania's drug-induced homicide statute when she died after taking the pill he gave her. *Id*. Smith died from suicide after being let go from jail. *Id*.

[11] *See infra* notes 16–116 and accompanying text.

[12] *See infra* notes 117–143 and accompanying text.

findings.[13] Part II then evaluates the merits of using insanity pleas and considering addiction in sentencing to ameliorate harsh outcomes for addicts under drug-induced homicide laws.[14] Finally, Part III puts forward recommendations for reform and a greater balance of justice and public health goals.[15]

I. DRUG-INDUCED HOMICIDE LAWS IN CONTEXT

Vital to an exploration and evaluation of drug-induced homicide laws is a discussion that explains the complicated and fraught history of opioids and drug policy in the United States[16] This Part seeks to place drug-induced homicide laws completely in context.[17] Section A explains how drug-induced homicide laws are a product of the War on Drugs.[18] Section B describes the progression and current issues specific to the most recent opioid epidemic.[19] Finally, Section C looks at the legal landscape of drug-induced homicide laws, detailing the legislative, prosecutorial, and judicial aspects of such laws.[20]

A. Origins: The War on Drugs and the Rise of Drug-Induced Homicide Laws

In general, the U.S. has criminalized drug use and focused on supply-side policies.[21] Although, there has been state movement toward the decriminalization of drug use.[22] In 2020, Oregon became the first state to decriminalize the

[13] *See infra* notes 144–228 and accompanying text.
[14] *See infra* notes 229–264 and accompanying text.
[15] *See infra* notes 265–293 and accompanying text.
[16] *See infra* notes 35–47 and accompanying text.
[17] *See infra* notes 16–116 and accompanying text.
[18] *See infra* notes 21–31 and accompanying text.
[19] *See infra* notes 32–52 and accompanying text.
[20] *See infra* notes 53–116 and accompanying text.
[21] *See* Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom*, 62 S.C.L. REV. 261, 262 (2010) (claiming that the U.S. policy approach to drugs has been "dominated by a criminal law enforcement focus that has reposed responsibility largely in the hands of law enforcement officials"). Beginning in 1914 with the Harrison Narcotics Act and followed by the Comprehensive Drug Abuse Prevention and Control Act of 1970, the United States has made drug use illegal. *See id.* at 262 n.8 (listing the two main statutes making drug use illegal); *see also* GARY L. FISHER, RETHINKING OUR WAR ON DRUGS 7 (2006) (showing that between 1996 and 2005, the United States spent almost twice as much on supply-side than on demand-side policies). Supply-side policies refer to measures aimed at combating rising drug use by targeting the supply of drugs, including tighter border control and harsher penalties for drug dealers. *See id.* at 6–7 (explaining that supply-side policies are "divided into three parts: domestic law enforcement, interdiction, and international" where domestic law enforcement entails all efforts to stop the making and distributing of illegal drugs within the United States, interdiction "includes all efforts to stop illegal drugs from entering the United States," and international efforts involve working to stop the production of drugs abroad that may come to the United States, such as working to destroy foreign crop production of poppy fields used to make heroin).
[22] *See* Elliott Davis, Jr., Claire Hansen & Horus Alas, *Where Is Marijuana Legal? A Guide to Marijuana Legalization*, U.S. NEWS & WORLD REP. (Apr. 30, 2024), https://www.usnews.com/news/

personal use and possession of all drugs, imposing just a small fine for the open use of fentanyl.[23] By March 2024, however, Oregon all but overturned this decriminalization due to rising overdose deaths and the negative community impact of open-use drugs.[24]

The origin of America's War on Drugs is largely credited to President Nixon in his address to Congress on June 17, 1971, in which he called for an escalation of policies and laws to curtail growing drug use in America.[25] The War on Drugs was a supply-side response to the rising level of drug use, drug overdoses, and the increase in crime levels perceived to be associated with such expanding drug use.[26] Rising awareness of drug use during the Reagan Presidency led to President Reagan's signing of the Anti-Drug Abuse Act of 1986 that, among other things, established mandatory minimum sentences and differential treatment for crack and powder cocaine.[27] The George H. W. Bush,

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best-states/articles/where-is-marijuana-legal-a-guide-to-marijuana-legalization [https://perma.cc/6BZT-U2FE] (demonstrating that within eleven years of Colorado's and Washington's legalization of recreational marijuana use in 2012, support grew quickly and an additional twenty-three states, plus Washington, D.C. and Guam, legalized marijuana).

[23] Mike Baker, *Oregon Is Recriminalizing Drugs, Dealing Setback to Reform Movement*, N.Y TIMES (Mar. 1, 2024), https://www.nytimes.com/2024/03/01/us/oregon-drug-decriminalization-rollback-measure-110.html [https://perma.cc/CA9U-62A7] (stating that Measure 110, passed in 2020, allowed for small amounts of drugs like "fentanyl, heroin and methamphetamine" to be met with a mere $100 citation, that the accused could bypass by completing a health assessment).

[24] *See id.* (showing that between September 2022 and 2023, drug-related deaths in Oregon rose at the highest rate in the country at about forty-two percent); *see also* Daniel Trotta, *Oregon Governor to Sign Bill Recriminalizing Drug Use*, REUTERS, https://www.reuters.com/world/us/oregon-governor-sign-bill-recriminalizing-drug-use-2024-03-09/ [https://perma.cc/5KXF-6PY7] (Mar. 8, 2024) (showing the intent of Oregon Governor, Tina Kotek, to sign House Bill 4002, that recriminalizes drug possession and use, within 30 days).

[25] ANNE L. FOSTER, WAR ON DRUGS DECLARED 109–10 (2023) (illustrating that even though Nixon did not use the phrase "War on Drugs" in his Special Message to Congress on June 17, 1971, the "mix of treatment emphasis, arbitrary tactics, and harsh punishments in the Nixon approach soon made it clear that the effort was as comprehensive as a war"). Many policies sprang from this speech, including maintaining harsh punishment for drug dealing, increased search rights for police officers investigating drug dealing (including no-knock warrants), and greater power for the Drug Enforcement Agency. *See id.* at 110–11 (listing the various policy outcomes of Nixon's speech on the rising drug crisis).

[26] *See id.* at 109–11 (explaining the basic policies that made up the War on Drugs); *see also* Alex Kreit, *Controlled Substances, Uncontrolled* Law, 6 ALB. GOV'T L. REV. 332, 335 (2013) (stating that prior to the Controlled Substance Act (CSA), federal drug regulation was a collection of criminal, regulatory, and revenue systems). The CSA "prohibits the manufacture, sale, and possession for recreational use of any substance it controls." *Id.* The CSA empowered the Attorney General to decide which drugs were included under the CSA, and the Attorney General in turn delegated that authority to the Drug Enforcement Administration. *See id.* (describing which agency is responsible for scheduling new substances and rescheduling those that are already in the CSA).

[27] *See* FISHER, *supra* note 21, at 5 (explaining that rising public awareness of drug use from such sources as Nancy Reagan's "Just Say No" campaign and the drug-overdose death of a rising NBA star put pressure on President Reagan to act and led to him signing the Anti-Drug Abuse Act of 1986, a law that mandated mandatory minimums for drug crimes and created different penalties for the sale of crack and powder cocaine). Two years later, Reagan signed the Anti-Drug Abuse Act of 1988, creat-

Clinton, and George W. Bush administrations all maintained a push toward supply-side reduction policies.[28]

The 1986 Drug Abuse Act also included a drug-induced homicide law.[29] Along with federal movements toward greater drug regulation, state statutes began to reflect stricter control and harsher punishments for the supply and distribution of drugs.[30] Thus, drug-induced homicide laws are one product of the War on Drugs.[31]

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ing the Office of National Drug Control Policy (ONDCP), and enabling it to develop a national strategy and certify the budgets for federal drug control. *Id.*

[28] *See id.* (stating that William Bennett, George H.W Bush's appointed head of ONDCP, supported viewing drug abuse as socially undesirable and during Bennett's leadership, two-thirds of the ONDCP's budget was "directed toward supply reduction and one-third to prevention and treatment"). Under Clinton, the ONDCP's competencies were expanded to include budget and resource control as well as directing policies for drug control. *Id.* Clinton's appointee to head the ONDCP, Barry R. McCaffrey, authorized and oversaw a $1.3 billion project to end the cultivation of coca in Colombia. *Id.* at 5–6. John Walters, George W. Bush's ONDCP appointed leader, continued the Colombia campaign, fought against some states' fight to "liberalize marijuana laws," and implemented an initiative to increase access to recovery. *See id.* at 6 (explaining George W. Bush-era ONDCP programs).

[29] TRAVIS LUPICK, LIGHT UP THE NIGHT: AMERICA'S OVERDOSE CRISIS AND THE DRUG USERS FIGHTING FOR SURVIVAL 182–83 (2022) ("At the federal level, the 1986 Drug Abuse Act includes a mandatory minimum of 20 years for such a crime."); *see also* Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207, 3207-2 (1986) (providing a punishment of "not less than 20 years").

[30] *See, e.g.*, 1987 Minn. Laws 373 (adding a drug-induced homicide law to Minnesota's criminal statutes by holding those that cause the death of another by furnishing controlled substances guilty of third-degree murder); 1987 N.J. Laws 422 (adding a drug-induced homicide law by holding distributors of controlled substances strictly liable for the deaths that result from such distribution); 1989 Okla. Sess. Laws 800 (adding a drug-induced homicide law by adding the distribution of a controlled substance under murder in the first degree).

[31] *See* Miller, *supra* note 10, at 354 (describing how drug-induced homicide laws were passed during the 1980s as a part of the War on Drugs to target drug-dealers); *see also, e.g.*, 1993 Ariz. Sess. Laws 1426 (adding a drug-induced homicide law to Arizona's criminal statutes by including deaths that result from "dangerous drug offenses" and narcotics offenses under first degree murder); 1990 Colo. Sess. Laws 1006 (adding a drug-induced homicide law to Colorado's criminal statutes by holding distributors of controlled substances guilty of murder in the first degree for deaths of minors that result from such substances); 1987 Fla. Laws 1637 (adding a drug-induced homicide law to Florida's criminal statutes by including under first degree murder cocaine among the controlled substances that if distributing results in the death of the recipient the perpetrator will be found guilty); 1987 La. Acts 1146 (adding a drug-induced homicide law to Louisiana's criminal statutes by including deaths that result from the distribution of controlled substances under murder in the second degree); 1987 Minn. Laws. 373 (adding a drug-induced homicide law to Minnesota's statutes by including deaths that result from the distribution of controlled substances under murder in the third degree); 1983 Nev. Stat. 510–12 (adding a drug-induced homicide law to Nevada's criminal statutes by including deaths that result from the distribution of controlled substances to minors under murder in the second degree); 1987 N.J. Laws 422 (adding a drug-induced homicide law to New Jersey's criminal statutes by holding distributors of controlled substances strictly liable for the deaths that result from such distribution, implementing a but-for causation requirement); 1979 N.C. Sess. Laws 173 (adding a drug-induced homicide law to North Carolina's criminal statutes by making death resulting from the distribution of a controlled substance murder in the second degree); 1989 Okla. Sess. Laws 800 (adding a drug-induced homicide law to Oklahoma's criminal statutes by adding the distribution of a controlled substance under murder in the first degree); 1989 Tenn. Pub. Acts 1202 (adding a drug-induced homicide law to Tennessee's criminal statutes by making a death that proximately results from the distribution

B. The Current Opioid Epidemic and Rising Overdose Levels

The opioid epidemic in the United States reached new levels of severity in recent years.[32] In 2021 alone, 107,000 people died from a drug overdose.[33] This destructive crisis has deep roots in burgeoning foreign markets for heroin and fentanyl, as well as failures of the U.S. medical system and government regulation.[34]

The current opioid epidemic began in the United States in the mid-1990s with the popularization and eventual near-ubiquity of prescribed opioid pain killers in the U.S. healthcare system.[35] Although the United States initially strictly regulated heroin under the Harrison Narcotics Act of 1914, by the mid-1990s, U.S. medical regulators embraced OxyContin, allowing it to be used for more than just end-of-life care.[36] This over-prescription, urged by Purdue and Johnson

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of a controlled substance murder in the second degree); 1991 W. Va. Acts 465 (adding a drug-induced homicide law to West Virginia's criminal statutes by making the distribution of a controlled substance murder in the first degree); 1987 Wis. Sess. Laws 1836 (adding a drug-induced homicide law to Wisconsin's criminal statutes by making a death that results from the distribution of a controlled substance first-degree reckless homicide).

[32] *See Understanding the Opioid Overdose Epidemic*, CDC, https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html [https://web.archive.org/web/20240404125358/https://www.cdc.gov/opioids/basics/epidemic.html] (Aug. 8, 2023) (showing that overdose deaths were six times higher in 2021 than 1999 and that "overdose deaths increased more than 16% from 2020 to 2021").

[33] *Id.* ("Over 75% of the nearly 107,000 drug overdose deaths in 2021 involved an opioid.").

[34] *See* BETH MACY, DOPESICK: DEALERS, DOCTORS, AND THE DRUG COMPANY THAT ADDICTED AMERICA 27–28 (2018) (describing how "[t]he 1996 introduction of OxyContin coincided with the moment in medical history when doctors, hospitals, and accreditation boards were adopting the notion of pain as 'the fifth vital sign,'" and that this increased opioid prescriptions).

[35] *See id.* at 20–25 (stating that, historically, opioids had been understood to be highly addictive and dangerous for people and had caused terrible social issues around the world). For example, administering opioids to Civil War soldiers led to "[a]n estimated hundred thousand veterans" becoming addicts. *Id.* at 22 (explaining that because it was originally thought that administering morphine by needle was not addictive, doctors during the Civil War administered it freely for pain, creating many addicts). After initially accepting heroin as a safe medicine for pain, the United States highly regulated heroin sale and possession under the Harrison Narcotics Act of 1914. *Id.* at 24–25 (describing how Bayer sold heroin in "cough drops and even baby-soothing syrups" but by 1906 the American Medical Association condemned these uses, explaining heroin was highly addictive). In the mid-1990s, Mortimer, Raymond, and Arthur Sackler, the family-owners of Purdue Pharmaceutical, decided to tweak their "end-of-life painkiller derived from morphine" known as MS Contin and launched OxyContin with the goal of using the medication for purposes other than hospice care. *See id.* at 20 (showing that the Sacklers saw the drug had little more to offer in profits in end-of-life care, so they looked for other uses). They promoted the sale of OxyContin with the help of pain specialist Dr. J. David Haddox who claimed, "If you take the medicine like it is prescribed, the risk of addiction when taking an opioid is one-half of 1 percent." *Id.* at 20–21.

[36] *See id.* at 27 (describing how the recognition and evaluation of patient pain became very important in the mid-1990s as OxyContin entered the scene and the "Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the nonprofit health care and hospital accreditation body, took the idea a step further, approving new mandatory standards for the assessment and treatment of pain"). Purdue responded by intensifying marketing directly to doctors, offering OxyContin as the solution to managing patient pain. *See id.* at 27–28 (stating that Purdue spent hundreds of thousands in marketing

& Johnson, led to prescription misuse.[37] As prescription misuse of opioid painkillers rose, the U.S. government and media highlighted the startlingly high number of opioid prescriptions, leading to a plateau in opioid prescriptions.[38]

Unfortunately, the decline in opioid prescriptions came too late for the many already addicted to opioids.[39] When addicts could no longer access opioid pills, they began buying heroin, causing heroin deaths to double from 2011 to 2014 in comparison to previous years.[40] Heroin did not completely replace opioid pills, however, and overdoses from heroin use did not outstrip opioid pill overdoses.[41] Still, heroin did serve the particularly pernicious function of bringing many prescription abusers into the illicit drug market.[42] This transition exposed opioid pill users to fentanyl, a drug many times more addictive and affordable than their current addiction.[43]

Fentanyl, a Schedule II drug,[44] has played a uniquely horrific role in the current opioid epidemic.[45] Much more potent than heroin and more affordable to make, fentanyl came onto the scene in 2013 and created a sharp rise in opioid overdoses.[46] End-users often unintentionally consume fentanyl because dealers frequently use it instead of opioid pills and lace heroin powder with fentanyl to save money and effort.[47]

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to doctors to capitalize on Purdue's chance to be viewed as the leader in assisting hospitals to meet JCAHO requirements for pain management).

[37] KANT B. PATEL & MARK E. RUSHEFSKY, THE OPIOID EPIDEMIC IN THE UNITED STATES 113–14 (2022) (explaining the wide prescription painkiller abuse, including people taking the drugs not as prescribed or people taking the opioid painkillers prescribed to others).

[38] *See id.* at 114 (indicating that the sale of OxyContin "exceeded $1 billion annually" and that media reports covered the rise in prescription abuse).

[39] *See id.* at 115 (detailing the decline of prescription opioid abuse and rise in heroin deaths).

[40] *Id.*

[41] *Id.*

[42] *See id.* (describing how the drop in opioid prescriptions created an increase in demand for heroin and led to people turning to illegal markets for drugs like fentanyl).

[43] *See id.* (explaining that many pill users were exposed to fentanyl); *see also* Rachel L. Rothberg & Kate Stith, *Fentanyl: A Whole New World?* 46 J.L. MED. & ETHICS 314, 314–16 (2018) (describing just how addictive and potent fentanyl is). Fentanyl and its analogues are substantially more potent that opioids like morphine or heroin but less expensive to make and obtain. *Id.*

[44] *See* Kreit, *supra* note 26, at 336 (explaining that the Controlled Substances Act (CSA) classified illegal drugs into five "schedules" that decrease in regulation from Schedule I to Schedule V). Schedule I drugs are only allowed to be used for research purposes and Schedule II through Schedule V drugs can be prescribed as medicine. *Id*.

[45] *See* Rothberg & Stith, *supra* note 43, at 314–16 (telling how fentanyl flooded the drug market due it is affordability and potency, leading to a rise in overdose deaths). Fentanyl "is fifty times more potent than heroin and one hundred times more so than morphine." *Id.* at 314.

[46] *See id.* at 314–15 (explaining the characteristics and effects of fentanyl on society). Fentanyl has been a contributor to the steep rise in opioid deaths since the early 2010s. *Id.* at 315.

[47] *See id.* at 315–16 (detailing the economics of fentanyl in the drug marketplace and specifically noting that, in Connecticut, the wholesale rate of heroin is tenfold higher than the price of fentanyl and thus if dealers switch fentanyl for heroin, they can make a much larger profit). "When the end product is sold as counterfeit oxycodone pills, the profit margins are even higher, at about $1,000 per gram."

Fentanyl's ability to yield such large profit margins has impacted the decisions of local dealers and led international drug players from Mexico and China to bring more opioids into the United States, including smaller communities and suburbs.[48] Additionally, opioids brought in from China either tend to be fentanyl or have a higher ratio of opioid to cutting-agent or other additive, leading to higher numbers of overdose deaths.[49]

Various U.S. agencies such as the Office of the U.S. Attorney General, the Drug Enforcement Administration (DEA), and Customs and Border Protection have worked to curb the international supply of fentanyl into the United States.[50] 2017 marked the first indictments of traffickers using the dark web to coordinate the movement of fentanyl from China to the United States.[51] Additionally, the DEA has used its emergency scheduling authority—its ability to classify a substance as a dangerous controlled substance under the Controlled Substance Act—to disrupt the international supply of fentanyl by expanding the definition of fentanyl to include all its analogues.[52]

Id. at 316. This means that "each kilogram can result in potentially $10–$20 million dollars in revenue." *Id.*

[48] *See id.* (describing how Mexican cartels have altered their distribution system, taking the drugs to major metropolises, or "hubs," of Atlanta, Chicago, Houston, Los Angeles, or Phoenix, and "go directly from the hubs into smaller markets such as Connecticut," rather than continuing onto cities like Detroit or New York as they usually did). Fentanyl enters the U.S. from China via mail systems like FedEx and without much violence by ordering via the dark web and delivery through mail systems. *See id.* at 316–17 (describing the dangers of the dark web opioid distribution from China).

[49] *See id.* at 317 (stating that Customs and Border Protection reports that opioids they obtain from the United States' Southwest border have a purity of about 7% while the opioids they get from international mail centers have a purity of about 90%).

[50] *See id.* at 317–21 (detailing the efforts of various U.S. agencies to curtail the growing entry of fentanyl into the United States). For example, domestic investigations have led to arrests. *See id.* at 319 (explaining that John Casadei was found by the DEA to be buying drugs from China and that Kyle Peterson was running distribution of these drugs from Connecticut). The United States international efforts have focused on attacking "the fentanyl supply chain." *See id.* at 319–20 (listing various efforts such as seeking to increase "its guidelines penalties for fentanyl trafficking," "lobbying international leaders to crackdown on fentanyl and its analogues," and seeking "to intercept drugs at and in between Ports of Entry through targeting and intelligence-driven strategies").

[51] *See id.* at 319 (telling how although Chinese nationals Jian Zhang and Xiaobing Yan were indicted for using the dark web to sell fentanyl, the two men were not just trafficking in fentanyl but also sold "pill presses, stamps, or dies used to shape fentanyl into pills, directly to customers in cities across the United States").

[52] *See id.* (describing how the DEA enacted an emergency listing "of all fentanyl analogues into Schedule I," under the Controlled Substance Act (CSA)). Prior to the expansion of the definition of fentanyl under Schedule I to include all its analogues, Chinese distributors would avoid the ban on fentanyl by simply altering the fentanyl by a small degree so that the product they made was as effective as fentanyl but not technically fentanyl under the listings of the CSA. *Id*. Essentially, Chinese distributors would slightly alter the drug and then claim the new drug was not listed as illegal. *Id*. As soon as the DEA would make the new fentanyl analogue illegal, the Chinese distributors would again slightly alter the molecule to create a new legal analogue. *Id*. The new listing, however, allows prosecutors "to convict fentanyl-analogue traffickers without having to prove the new analogue is 'intended

C. Drug-Induced Homicide: Current Legal Landscape

In understanding drug-induced homicide laws, it is important to discuss not just the legislators that write the statutes, but the prosecutors that choose how such laws are enforced.[53] This Section evaluates and explains what drug-induced laws generally include and how they work when enforced.[54] Additionally, this Section lays out the legal landscape of drug-induced homicide laws.[55] Subsection 1 looks at current drug-induced homicide laws: where they originated, how they have proliferated, and the variations of such laws.[56] Subsection 2 examines the prosecution of drug-induced homicide laws, including overdose Good Samaritan laws that work in tandem with drug-induced homicide laws.[57] Finally, Subsection 3 discusses the judicial response to drug-induced homicide laws and the impact of judicial interpretation of such statutes.[58]

1. Legislation: Drug-Induced Homicide Laws

Drug-induced homicide laws criminalize the delivery or furnishing of drugs that kill the recipient.[59] Such laws originated during the War on Drugs but were not often used by prosecutors.[60] They have regained significance recently because the opioid epidemic has driven legislatures to update or create these laws and prosecutors to increasingly enforce them.[61] After the initial introduction of drug-induced homicide laws in the late 1980s and early 1990s, legislators passed a second wave of drug-induced homicide statutes in the 2000s that mostly served to expand the types of substances covered by such laws.[62]

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for human consumption' and 'substantially similar' to an already listed substance." *Id*. (quoting 21 U.S.C. §§ 802(32)(A), 813 (2012)).

[53] *See, e.g.*, Kaitlin S. Phillips, *From Overdose to Crime Scene: The Incompatibility of Drug-Induced Homicide Statutes with Due Process*, 70 DUKE L.J. 659, 663 (2020) (showing that prosecutors have turned to "previously idle" drug-induced homicide laws to deal with rising overdose deaths).

[54] *See infra* notes 59–108 and accompanying text.

[55] *See infra* notes 59–116 and accompanying text.

[56] *See infra* notes 59–75 and accompanying text.

[57] *See infra* notes 76–108 and accompanying text.

[58] *See infra* notes 109–116 and accompanying text.

[59] *See* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 3–4 (detailing how drug induced homicide laws are "types of laws that establish a specific criminal charge, often manslaughter or murder, for individuals who furnish or deliver controlled substances to another individual who dies as a result").

[60] *See* Phillips, *supra* note 53, at 662–63 (stating that although drug-induced homicide statutes became "prevalent" during the War on Drugs, prosecutions of these statutes were rare).

[61] *See id*. at 663 (highlighting that the opioid epidemic meant prosecutors sharply increased their use of drug-induced homicide laws); *see, e.g.*, 2017 Fla. Laws 1132 (adding new substances covered under Florida's drug-induced homicide law); 2012 Okla. Sess. Laws 699 (updating the state's drug-induced homicide law to include synthetic drugs among other controlled substances listed in the statute).

[62] *See supra* note 31 and accompanying text (listing the various state drug-induced homicide statutes passed during the War on Drugs); *see also* LUPICK, *supra* note 29, at 182–83 (explaining the rise in opioid use in America and drug-induced homicide laws and noting that since fentanyl came on

As of the end of 2022, thirty states have a drug-induced homicide law capable of charging a defendant with crimes ranging from a classified felony to murder.[63] This number represents a trend toward more states having drug-induced homicide laws with nine states initiating drug-induced homicide legislation in 2021 and 2022.[64]

It is important to note that there are a few important hold-out states that have not adopted drug-induced homicide laws, namely California and Oregon.[65] Oregon initiated—but failed—to pass a new drug-induced homicide law.[66] Notably, however, the state has largely focused its efforts on a demand-side approach to the opioid epidemic by signing onto eight class-action law suits against major manufacturers and distributors of opioid drugs.[67] This approach earned Oregon over half a billion dollars that it plans on using to fund addiction recovery programs in its state.[68]

Such drug-induced homicide laws vary in content in a few main ways.[69] First, some states explicitly provide that the use of the controlled substance delivered must be the proximate cause of the death in order for the statute to apply.[70] Second, although the vast majority of state statutes are vague about who may be charged under their provisions, a few are more specific and list selling, manufacturing, or transporting the drug as a required condition for the statute to apply.[71] Third, most states' statutes simply list "controlled substances" or "schedule I" or "schedule II" substances as what must be provided for the statue

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the scene in the mid-2010s, a growing number of states have passed legislation around drug-induced homicide laws).

[63] LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 14.

[64] *See id.* at 15 (detailing the recent trends of drug-induced homicide laws in state legislation). The nine states included "Arizona, California, Florida, Oregon, Pennsylvania, South Carolina, Texas, Washington, and West Virginia," as well as the District of Columbia. *Id.*

[65] *See id.* at 24–25, 93–94 (stating that both California and Oregon proposed but did not pass drug-induced homicide legislation).

[66] *See id.* at 94 (noting that the Oregon bill proposing a drug-induced homicide law that would "establish a new Class A felony" for such action died at the completion of the legislative session).

[67] OR. DEP'T OF JUST., OFF. OF ATT'Y GEN., *Spotlight: Opioid Abuse*, https://www.doj.state.or.us/oregon-department-of-justice/office-of-the-attorney-general/spotlight-opioid-abuse/ [https://perma.cc/CUS5-K35C].

[68] *Id.*

[69] *See* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 14 (showing whether a state has a drug-induced homicide law, if that law offers an affirmative defense, or if that law "applies only to the death of a minor").

[70] *See, e.g.*, FLA. STAT. ANN. § 782.04(1)(a)(3) (West 2024) (requiring a finding that the drugs given to the victim were either "proven to have caused" or were "proven to have been a substantial factor" in the victim's death); VT. STAT. ANN. tit. 18, § 4250(b) (West 2024) (stating that "[t]his section shall apply only if the person's use of the regulated drug is the proximate cause of the person's death").

[71] *See, e.g.*, ARIZ. REV. STAT. ANN. § 13-1105(A)(2) (West 2024) (defining the manufacture and transportation of drugs that results in the death of another qualifies as murder); TEX. PENAL CODE ANN. § 19.02(b)(4) (West 2024) (listing manufacturing and delivering drugs that result in the death of another as murder).

to apply.[72] In contrast, at the time of this Note, others specifically list fentanyl or other synthetic substances.[73] Fourth, two states restrict the drug-induced homicide law to apply only if the victim is under eighteen years of age.[74] Finally, only four states offer affirmative defenses to drug-induced homicide charges.[75]

2. Prosecution of Drug-Induced Homicide Laws

a. Local Prosecution

Cities and states also get to decide who is prosecuted under drug-induced homicide laws.[76] In general, prosecution of drug-induced homicide has risen sharply over the past ten years, with the number of prosecutions in 2018 over fifteen times higher than those in 2008.[77] Roughly half of the charges for drug-induced homicides came from Ohio, Illinois, Wisconsin, and Minnesota.[78] Three states in the Northeast—New York, New Jersey, and Pennsylvania—and three in the South—Tennessee, Louisiana, and North Carolina—however, are where such charges are rising the fastest.[79]

It is unclear why some states have higher levels of prosecutions for drug-induced homicide than others.[80] For example, of the ten states with the highest

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[72] *See, e.g.*, W. VA. CODE § 61-2-1 (West 2024) (defining first-degree murder to include "a felony offense of manufacturing or delivering a controlled substance as defined in article four"); *see also* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 19–122 (showing that Alaska, Arkansas, Colorado, Delaware, Florida, Illinois, Indiana, Georgia, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Nevada, New Jersey, New York, North Dakota, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, West Virginia, Wisconsin, Wyoming, and Washington, D.C all list "controlled substances" or "schedule I" or "schedule II" to describe the drugs delivered in their respective drug-induced homicide statutes).

[73] *See, e.g.*, FLA. STAT. ANN. § 782.04(1)(a)(3) (defining murder to include the "unlawful distribution of" various substances, specifically listing cocaine, opium, methadone, and fentanyl); MISS. CODE ANN. § 41-29-139.1 (West 2024) (repealed effective July 1, 2025) (listing fentanyl).

[74] *See* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 14 (describing how Colorado and Wyoming require victims to be minors under their drug-induced homicide laws).

[75] *See id.* (listing "Delaware, Mississippi, Rhode Island, and Vermont" as states that offer an affirmative defense to a drug-induced homicide laws when the accused made "a good faith effort to promptly seek, provide, or obtain emergency" services when someone they provided drugs to was experiencing an overdose).

[76] *See* Miller, *supra* note 10, at 355 (explaining that who gets charged and convicted depends on how a jurisdiction understands and enforces its statute). For example, Vermont's statute "is narrow, prosecuting only drug-dealers for drug-induced homicide," while Illinois's statute is broader. *Id.*

[77] NE. UNIV. L., CTR. FOR HEALTH POL'Y & L., THE ACTION LAB, DRUG-INDUCED HOMICIDE, https://www.healthinjustice.org/drug-induced-homicide [https://perma.cc/R8E9-FFST] [hereinafter THE ACTION LAB] (using media mentions of drug-induced homicides as a measure for prosecution of drug-induced homicides and showing forty-three mentions in 2008 and 686 in 2018).

[78] LUPICK *supra* note 29, at 187.

[79] *See id.* (showing that New Jersey, New York, and Pennsylvania have the steepest increase in prosecutions and that Louisiana, North Carolina, and Tennessee also seen dramatic increases).

[80] *See id.* (showing the various rates of drug-induced homicide prosecutions by state but failing to give any rationale for the difference in prosecution rates between states).

levels of prosecutions of drug-induced homicide, only one state, Pennsylvania, is among the top ten states with the highest overdose levels.[81]

One explanation for the rise in drug-induced homicide prosecutions is the prosecutors themselves.[82] Prosecutors have begun using drug-induced homicide laws even when they were unused in their states for years.[83] Notably, these drug-induced homicide statutes are generally vague about who may be prosecuted under these laws, usually just listing persons that deliver or distribute controlled substances.[84] Unsurprisingly, the opioid epidemic has increasingly caused prosecutors to treat accidental overdoses as criminal cases.[85] This has left room for prosecutors to charge friends, family, or acquaintances of the deceased for the drug-related death.[86] Facing ever-rising overdose deaths, prosecutors have resorted to using their prosecutorial discretion to charge whoever was the last to handle the drugs before the decedent, usually just a friend or family member.[87]

As a result, half of persons charged under these laws do not distribute drugs in a meaningful or continuous way; a person does not have to be a dealer to be prosecuted.[88] Additionally, due to the ubiquitous nature of cell phones

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[81] *Compare* CDC, NAT'L CTR. FOR HEALTH STATS., *Drug Overdose Mortality by State*, https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm [https://perma.cc/74BL-UJRT] (showing the number of overdose deaths per 100,000 by year for the years 2021, 2020, 2019, 2018, 2017, 2016, 2015, 2014, 2005, and 1999 and showing the top ten states with the highest overdose levels are: Rhode Island (272.7), Tennessee (274.3), New Hampshire (281.9), New Mexico (285.2), Maryland (293.4), Pennsylvania (309), Kentucky (313.7), Delaware (317.7), Ohio (324.5), and West Virginia (478)), *with* THE ACTION LAB, *supra* note 77 (listing states with the highest prosecution level of drug-induced homicide laws as measured by media mentions of prosecutions in ascending order: Michigan, New York, North Carolina, New Jersey, Minnesota, Florida, Illinois, Ohio, Wisconsin, and Pennsylvania).

[82] *See* Phillips, *supra* note 53, at 663 (detailing how with the rising opioid overdose deaths, prosecutors began using long-idle drug-induced homicide statutes and legislatures either revised such statutes or wrote new ones)

[83] *See id.* at 669 (telling how after their initial passing, drug-induced homicide laws went largely unused, even during the 1990s when overdose deaths from prescription opioids increased).

[84] *See* LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 16–122 (showing that various state statutes do not list specifically who may be charged under drug-induced homicide statutes but rather just list those that distribute or deliver controlled substances, meaning they would not have to be doing so in any meaningful way such as a drug dealer).

[85] *See* THE ACTION LAB, *supra* note 77 (explaining that pressure from rising overdose deaths has caused prosecutors to bring more charges for drug-induced homicide).

[86] *See* Miller, *supra* note 10, at 355 (noting that prosecution of close friends or family members often occurs under such statutes).

[87] *See* Phillips, *supra* note 53, at 664 (describing how although drug-induced homicide laws were meant to stop blameworthy, dangerous drug-dealers, prosecutors have used them to target a deceased's close family and friends of the usually because proving chain of events or people responsible for the overdose death can be onerous, leading prosecutors to "focus on the last person to touch the drugs before the deceased consumed them rather than charging the large-scale dealers higher up in the distribution chain").

[88] THE ACTION LAB, *supra* note 77 (showing that fifty percent of drug-induced homicide prosecutions were against "Caretaker/Family/Friend/Partner" rather than a traditional dealer).

and text messages between family members and friends, proving such drug-induced homicides charges is typically easy for prosecutors.[89]

Unfortunately, prosecutions under these old War-on-Drugs-era laws bring with them disparate prosecutions between races with clear gaps in the prosecution of people of color and white people.[90] This is disappointing but unsurprising as drug laws have traditionally been unequally enforced between races in the United States.[91] This racial disparity can be traced to the discretion given to police officers and prosecutors in applying drug-induced homicide laws.[92]

Prosecutors have even instructed law enforcement to treat overdose scenes as homicides to better construct their cases.[93] Additionally, prosecutors are working to increase drug-induced homicide prosecutions by holding national workshops on drug-induced homicide case-building skills.[94]

b. Good Samaritan Fatal Overdose Prevention Laws

The discussion of drug-induced homicide laws prosecutions should also include corresponding overdose Good Samaritan laws.[95] Overdose Good Samaritan laws allow co-users or bystanders to call for help for those experiencing an overdose without fear of facing prosecution for the death of the person overdosing or for their crimes of use or possession.[96]

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[89] *See* LUPICK, *supra* note 29, at 188 (explaining that prosecutors just need to show that drugs were exchanged and that prompts prosecutors to charge close family and friends).

[90] Leo Beletsky, *America's Favorite Antidote: Drug-Inducted Homicide in the Age of the Overdose Crisis*, 4 UTAH L. REV. 833, 839 (2019) (explaining that evidence suggests prosecutors use drug-induced homicide statutes selectively, creating racial disparities in drug-induced homicide charges).

[91] *See generally* MICHELLE ALEXANDER, THE NEW JIM CROW 121–74 (2020) (outlining the history of racial disparity of treatment under federal drug laws between black and white people and explaining that, the perceived "enemy" in the War on Drugs is racially defined). In fact, according to a Human Rights Watch report, African Americans make up 80–90% of prisoners serving time for drug charges in seven states. *Id.* (citing *Incarceration and Race*, HUM. RTS. WATCH, https://www.hrw.org/reports/2000/usa/Rcedrg00-01.htm#P179_32170 [https://perma.cc/E2TP-SZYV]).

[92] *See* Beletsky, *supra* note 90, at 839 (suggesting that prosecutors are responsible for racial disparities in drug-induced homicide charges).

[93] *See* Phillips, *supra* note 53, at 672 (explaining that prosecutors need help in deploying drug-induced homicide laws and accordingly train law enforcement to treat the overdose deaths they find as homicide investigations).

[94] *See* Beletsky, *supra* note 90, at 871 (highlighting that in order to improve drug-induced homicide prosecution, prosecutors have been holding workshops that teach fellow prosecutors how to manage the scene of an overdose death and how to successfully "work up drug-induced homicide charges"). These conferences have prosecutors teach each other the types of skills needed to build successful cases, such as what elements need to be proved and how to recognize an overdose death. *See id.* at 871 n.282 (giving the example of a presentation by Patricia Daugherty, Assistant DA, Milwaukee County, Wisconsin, and Nick Stachula, Detective, West Allis Police Department, at such a conference).

[95] *See* Miller, *supra* note 10, at 355 (explaining that the scope of drug-induced prosecution can vary depending on overdose Good Samaritan statutes and that these statutes, as early as 2007, started providing some immunity to those that called for emergency services when someone was overdosing).

[96] *Id.* at 356.

Overdose Good Samaritan laws are a relatively recent phenomenon.[97] The first overdose Good Samaritan law was passed in 2007, and over half of the current forty-nine Good Samaritan laws in force in the U.S. states and territories took effect after January 2015.[98] Currently, forty-eight states have an overdose Good Samaritan law offering some level of protection for those seeking medical help for an overdose for themselves or another person.[99] Generally, both the overdose victim and the person alerting medical personnel are eligible for protection under overdose Good Samaritan laws, with only five states making the overdose victim ineligible for such protection.[100]

Just as drug-induced homicide laws vary, overdose Good Samaritan laws can vary by how much protection they give to the person that alerts authorities.[101] All overdose Good Samaritan laws offer some protection for drug possession.[102] Beyond that, however, states differ in the kind of protection they offer to the person alerting authorities.[103] For example, some states allow for broad protection—including protections for those with probation or parole violations—while others only allow calling for medical aide to be used as an affirmative defense when charged with possession.[104]

In effect, it is a mix of a state's drug-induced homicide law and overdose Good Samaritan law that determines outcomes for defendants.[105] For example,

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[97] LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 3–4 (describing the advent of overdose Good Samaritan laws).

[98] *Id.*

[99] *See id.* at 3 (noting that "[a]s of December 2022, 48 states and the District of Columbia have Good Samaritan fatal overdose prevention laws. Only Kansas and Wyoming do not have such laws").

[100] *See id*. at 9 (showing that forty-three states offer "[p]rotections for both the overdose victim and the individual seeking medical assistance for another" under their Good Samaritan laws, five states cover only "individuals seeking medical assistance for another," and two states offer no Good Samaritan law).

[101] *See* Miller, *supra* note 10, at 356–57 (explaining that whether Good Samaritan statutes are effective depends on how a jurisdiction applies the statute, listing Illinois as having narrow protection "against possession of specific substances under specific amounts" and as rejecting coverage for drug-induced homicide). Vermont's takes a more fulsome approach, protecting against most drug charges. *Id.* at 357.

[102] LEGIS. ANALYSIS & PUB. POL'Y ASS'N, *supra* note 7, at 5 ("All Good Samaritan fatal overdose prevention laws provide some level of protection for low-level drug possession offenses").

[103] *See id.* at 5–13 (explaining the variations in overdose Good Samaritan laws in the United States). Eighteen states offer "[p]rotection from prosecution but not arrest," twenty-seven states offer "[p]rotection from prosecution and arrest," and three states offer Good Samaritan protection as an affirmative defense or allow preclusion of certain evidence. *Id.* at 5.

[104] *See id.* at 5–7 (detailing how twenty-six states offer protections under overdose Good Samaritan laws for those with probation and parole violations and that Iowa, Texas, and Utah only grant Good Samaritans the affirmative defense of alerting authorities when being charged with possession).

[105] *See* Miller, *supra* note 10, at 355–57 (explaining that both overdose Good Samaritan laws as well as drug-induced homicide laws can be broadly or narrowly applied, and advocating for a narrow application with a broad use of overdose Good Samaritan laws to protect friends and family and promote saving overdose victims); LUPICK, *supra* note 29, at 186–87 (discussing that although overdose

prosecutors can enforce drug-induced homicide laws in such a way that any protection from Good Samaritan laws is nullified.[106] Accordingly, the question of how these two types of laws should work in tandem is important to ensure the best outcomes.[107] Ultimately, the preferred mix depends on whether a state values more prosecutions or saving the lives of those overdosing.[108]

3. How Courts View Drug-Induced Homicide Laws

The U.S. Supreme Court has held that although a state may regulate the circulation of drugs within its borders, it may not criminalize addiction itself.[109] In 1921, in *Whipple v. Martinson*, the Supreme Court held that states have the authority to use their police power to regulate drugs and their sale.[110] In 1962, in *Robinson v. California*, the Supreme Court held criminalizing addiction to be unconstitutional under the Eighth Amendment.[111]

The Supreme Court, however, has distinguished *Robinson* into impotence through subsequent decisions.[112] For example, in 1968, in *Powell v. Texas*, the Supreme Court upheld a law that made public intoxication illegal.[113]

The Supreme Court, however, has not directly addressed the legality of drug-induced homicide laws.[114] In 2012, in *Burrage v. United States*, the Supreme Court ruled on how the federal drug-induced homicide law should be

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Good Samaritan laws are very capable of lowering overdose deaths, their effect can be dampened by drug-induced homicide statutes).

[106] *See* LUPICK, *supra* note 29, at 186–88 ("The increased prosecution of drug-induced homicide completely undermines those laws."). Lindsay LaSalle, a senior attorney at the Drug Policy Alliance, argues that increasing prosecution of drug-induced homicide laws almost makes Good Samaritan laws meaningless. *Id.* at 187.

[107] *See* Miller, *supra* note 10, at 355–57 (advocating for a narrow drug-induced homicide law coupled with a broad overdose Good Samaritan law in order to save more overdose victims).

[108] *See* LUPICK *supra* note 29, at 187 (discussing the interplay between overdose Good Samaritan laws and drug-induced homicide laws). For example, in a state where a Good Samaritan law was enacted, opioid overdose deaths were found to have reduced by 15%. *Id.* Additionally, prosecution of drug-induced homicide laws incentivizes people to use alone, and using alone is a huge risk-factor for overdose death. *Id.*

[109] *See* Robinson v. California, 370 U.S. 660, 666 (1962) (holding that criminalizing addiction itself is unconstitutional).

[110] Whipple v. Martinson, 256 U.S. 41, 45 (1921).

[111] *See Robinson*, 370 U.S. at 666 (holding that a California law that made it a misdemeanor to be addicted to drugs was unconstitutional because punishing addiction—a disease—would constitute cruel and unusual punishment under the Eight Amendment).

[112] *See* Beletsky, *supra* note 90, at 856–57 (explaining that although *Robinson v. California* did establish that criminalizing addiction was not constitutional and that scientific advances show that threats of punishment are not effective against addicts, later rulings allow for laws that punish conduct related to addiction).

[113] Powell v. Texas, 392 U.S. 514, 514 (1968); *see* Beletsky, *supra* note 90, at 857 n.177 (describing how states have been allowed to criminalize the behavior of addicts while not expressly overturning the decision in *Robinson*).

[114] *See, e.g.*, Burrage v. United States, 571 U.S. 204, 218–19 (2014) (ruling on how a drug-induced homicide statute should be interpreted but not commenting on the legality of such a law).

applied, deciding not to comment on whether the law itself was legal.[115] Thus, the courts have not played a large role in the development or enforcement of drug-induced homicide laws.[116]

II. Evaluating Drug-Induced Homicide

As more and more states introduce or resurrect their drug-induced homicide statutes, it is important to find effective ways to evaluate the purposes and outcomes of these laws.[117] This Part evaluates drug-induced homicide laws.[118] Section A discusses drug-induced homicide laws as a type of felony murder.[119] Section B compares the treatment of accidental drug overdoses and policy reactions to rising drug use in Scotland, Canada, and Brazil.[120] Finally, Section C looks at insanity defenses as a possible tool for softening the punishment outcomes for addicts.[121]

A. Assessing Drug-Induced Homicide Laws as Felony Murder Laws

Felony murder laws apply when a perpetrator of a specified felony causes the death of another person during the commission of a listed crime.[122] A remnant of old English law, felony murder laws often do not fit perfectly within the modern felony systems of many states.[123] Additionally, most see felony murder as a type of strict-liability crime, omitting the need to show intent to

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[115] *See id.* (holding that, under 21 U.S.C. § 841(b)(1)(c), the prosecution must establish the drug given by the defendant was a but-for cause of the victim's death not merely a contributing factor); *see also* Beletsky, *supra* note 90, at 834–36 (noting that although the Supreme Court decided on how the prosecution could apply the drug-induced homicide statute, it did not comment on the legality of the provision itself).

[116] *See* Beletsky, *supra* note 90, at 836 (explaining that the Supreme Court's opinion addressing drug-induced homicide statutes did not touch on the prosecution of such statutes or the use of such statutes as a tool to prevent overdose deaths).

[117] *See e.g.*, Miller, *supra* note 10, at 354 (exploring the impact of various combinations of drug-induced homicide and Good Samaritan laws).

[118] *See infra* notes 122–264 and accompanying text.

[119] *See infra* notes 122–143 and accompanying text.

[120] *See infra* notes 144–228 and accompanying text.

[121] *See infra* notes 229–264 and accompanying text.

[122] Model Penal Code § 210.2 cmt. 6 (Am. L. Inst., Proposed Official Draft 1980) ("The classic formulation of the felony-murder doctrine declares that one is guilty of murder if a death results from conduct during the commission or attempted commission of any felony."). Many states incorporated the original felony-murder doctrine into their lawbooks and included that the intent to commit the crime was sufficient intent for murder that resulted during commission of the crime. *Id.*

[123] *See id.* (describing how the use of felony murder was more just under older English law because there were just a handful of felonies and each could be punished with the death penalty). Currently, there is a wide array of felonies, many of which are not serious crimes that necessarily threaten the lives of others. *Id.*

kill.[124] Accordingly, felony murder laws are one of the most controversial laws in the U.S. legal system.[125]

Major critiques of felony murder laws center on the idea that they assign punishment according to the random outcome of events.[126] Specifically, the two main criticisms of felony murder laws are that they are: (1) unconstitutional under the Eighth Amendment because they impose extreme punishment for crimes that lack intent, and (2) unconstitutional under due process because they automatically attribute malicious intent without the usual required proof of fact.[127] Thus, the vast majority of scholars condemn felony murder as an indefensible application of strict liability.[128]

Others find justification for felony murder.[129] This justification, however, requires that these laws be reformed to better reflect the intended purpose of felony murder laws and be more strictly limited their application.[130] Proponents argue that felony murder statutes are justified because of the perpetrator's reasonable expectation of harm and the moral worth of their aims.[131] Ad-

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[124] *See id.* (explaining that these felony murder statutes did not require a prosecutor to prove separate blameworthiness for the death because under these statutes, the homicides were strict liability offenses).

[125] GUYORA BINDER, FELONY MURDER 3 (2012) (noting that felony murder is among the most criticized aspects of the United States' criminal law and nearly all legal scholars condemn its use, finding it without moral defense).

[126] *See id.* at 4 (explaining that it is rare to find a principled argument for felony murder because most feel whether a person is convicted under such laws depends on some type of "morally arbitrary lottery").

[127] *Id.* at 3.

[128] Guyora Binder, *The Culpability of Felony Murder*, 83 NOTRE DAME L. REV. 965, 966 (2008); *see, e.g.*, Jason Tashea, *California Considering End to Felony Murder Rule*, ABA J. (July 5, 2018), https://www.abajournal.com/news/article/california_considering_end_to_felony_murder_rule/ [https://perma.cc/6ZCV-34JP] (reporting that the California legislature would soon vote to amend its criminal statute to end the use of felony murder in the state because, as California State Senator Nancy Skinner explained, bad judgment should not equal to a decision to murder under statute).

[129] *See, e.g.*, BINDER, *supra* note 125, at 9 (arguing that felony murder statutes are justified "[b]ecause the felon's additional malevolent purpose aggravates his culpability for causing death carelessly," and that "[t]o impose a foreseeable risk of death for such a purpose deserves severe punishment because it expresses particularly reprehensible values and shows a commitment to put them into action").

[130] *See id.* at 8–9 (finding justification for felony murder when used under a dual culpability approach to felony murder statutes that require the defendant to both intend a dangerous act and have malicious goals).

[131] *See id.* at 9 (describing how felony murder statutes are justified under a dual culpability that includes both a cognitive and normative aspect). Proponents find that felony murder is justified when both cognitive and normative pillars of the justification are met. *Id.* at 9–10. The cognitive pillar covers the harm the perpetrator could reasonably expect to flow from their actions, and the normative pillar is the moral worth of the perpetrator's purpose in acting. *Id.* Essentially, if a perpetrator meets both pillars, then a murder charge is justified because of the extremely undesirable goals of the accused, mixed with their extreme indifference to life. *Id.* at 10. Additionally, requiring felony murder statutes to include both cognitive and normative aspects keeps the statutes within their proper sphere of application. *See id.* at 10–11 (explaining that a robber that leaves a bank and then while driving

ditionally, proponents point to popular opinion to support the continued existence of felony murder statutes.[132]

Felony murder requires nuanced analysis because it may seem appropriate under some circumstances—such as when an armed robber shoots an innocent bystander during a robbery.[133] The appeal of felony murder, however, can quickly blur as the situation surrounding the crime becomes less directly malicious.[134]

Likewise, evaluating drug-induced homicide statutes under felony murder critiques requires a fine comb because there are many permutations of drug-induced homicide statutes.[135] Drug-induced homicide laws are usually strict liability laws and thus lack a mens rea requirement.[136] These statutes can thus be applied to situations that do not reflect the intended purpose of felony murder statues.[137] Accordingly, some point out that drug-induced homicide laws, like felony murder statutes, fail the basic tenants of criminal law theory.[138]

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carefully strikes and kills a pedestrian would not be held liable under a felony murder statute under this paradigm because the malevolent motive is no longer in place once the robber has left the robbing situation).

[132] *See id.* at 10 (arguing that people tend to support harsher sentences for people that kill while committing felonies rather than just negligent homicide penalties).

[133] *See id.* at 3 (explaining such unintended killings are negligent but negligence does not adequately capture the moral blameworthiness of such killings and negligent homicide is not a sufficiently significant charge). For example, Missouri found a man liable under felony murder when he struck and killed a small child with a car he had stolen seven months prior. *See id.* at 4 (recounting the case of James Colenburg who was found guilty of felony murder based on theft of a car that he had stolen seven months prior to striking and killing a small child). The man was found guilty of felony murder because he committed the felony of stealing the car. *Id.*

[134] *See id.* at 4 (telling the story of a man convicted for felony homicide when he accidentally hit a young boy with a car he had stolen earlier that year).

[135] *See supra* notes 69–75 and accompanying text (listing the ways in which state drug-induced homicide statutes differ); *see also* ARIZ. REV. STAT. ANN. § 13-1105 (West 2024) (defining first degree murder in Arizona to include strict liability only for the deaths of others that result from the manufacture or transportation of drugs). For example, in 2008, in *State v. Moore*, the Court of Appeals of Arizona held a man liable for murder when he shot and killed a man during a drug deal. 189 P.3d 1107, 1110 (Ariz. Ct. App. 2008). Arizona does not include drug possession or dispensing drugs among the drug crimes for which a person may be found culpable for murder in the first degree. *See* ARIZ. REV. STAT. ANN. § 13-3405 (limiting the drug crimes listed to only transportation, importation, or sale of drugs). Thus, Arizona's drug-induced homicide statute limits strict liability to instances in which the perpetrator is engaging in a heightened level of dangerous behavior known to have consequences that more directly affect those around them. *See* BINDER, *supra* note 125, at 10 (arguing that one aspect of culpability under felony murder is a person's cognitive understanding that the situations their actions create are highly dangerous to others, as occurs when trafficking in drugs).

[136] *See* Phillips, *supra* note 53, at 665 (explaining that critics seriously scrutinize both the felony murder statute and drug-induced homicide laws for not giving due process); *see also, e.g.*, OKLA. STAT. tit. 21, § 701.7(B) (West 2024) (defining murder in the first degree in Oklahoma to include strict liability for the dispensing of drugs that results in the death of another by defining murder in the first degree "regardless of malice" when that person unlawfully distributes or dispenses a "controlled dangerous substance").

[137] *See, e.g.*, OKLA. STAT. tit. 21, § 701.7(B) (conferring strict liability for those that dispense drugs in Oklahoma that result in the death of another). Under Oklahoma's drug-induced homicide statute, a person may be charged for murder for dispensing a controlled substance, meaning that simp-

There are some drug-induced homicide statutes, however, that better adhere to the intended purposes of felony murder laws such as punishing particularly dangerous and malicious behavior.[139] Additionally, as with felony murder laws, some scholars have supported the use of drug-induced homicide statutes.[140] These proponents require reform of drug-induced homicide statutes to ensure that the laws are applied narrowly and appropriately capture dangerous behavior.[141] In particular, proponents of drug-induced homicide statutes propose a mix of narrow drug-induced homicide statutes that capture blameworthy behavior—such as dealers intentionally adding fentanyl without their clients consent—combined with broad overdose Good Samaritan laws aimed at preventing overdoses and absolving co-users.[142] They argue this mix balances the need to punish bad behavior with the desire to save those dying from overdoses.[143]

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ly sharing with a friend can be treated the same as a drug-dealer distributing a drug. *See supra* notes 3–9 (telling the story of Josh Askins, a man convicted and jailed for the murder of a friend with whom he shared drugs).

[138] *See* Phillips, *supra* note 53, at 664 (highlighting that drug-induced homicide prosecutions persist, even though generally for an injury to constitute a crime it must have been intentionally inflicted and that drug-induced homicide "statutes do not require mens rea").

[139] *See* ARIZ. REV. STAT. ANN. § 13-1105 (defining first degree murder in Arizona to include strict liability only for the deaths of others that result from the manufacture or transportation of drugs). Arizona requires more than drug possession or sharing drugs with friends to be found culpable under murder in the first degree. *See id.* (limiting the drug crimes listed to only the manufacture and transportation of drugs). Thus, Arizona only imposes strict liability for death under its drug-induced homicide statute when the accused's behavior is so dangerous and their intent so bad that strict liability becomes more justified. *See* BINDER, *supra* note 125, at 10–12 (arguing that one reason to feel justified in applying strict liability is because the behavior is known to be very dangerous for others, just as with drug-trafficking). Thus, Arizona's statute better aligns with the purposes of felony murder statutes. *See id.* at 3, 10–12 (advocating for a dual culpability approach to felony murder statutes that requires the defendant to both intend a dangerous act and have malicious goals). This framework could also be used in evaluating drug-induced homicide laws. *See* Miller, *supra note* 10, at 357 (evaluating drug-induced homicide laws and recommending such laws be tailored to only deter the particularly reckless behavior of drug dealers).

[140] *See generally* Miller, *supra* note 10 (advocating for a narrow drug-induced homicide statute and a broad overdose Good Samaritan law to best achieve punishment and policy goals).

[141] *See id.* at 380–81 (proposing an exemplar drug-induced homicide statute that would "target only drug-manufacturers and drug-dealers who *profit* from the sale of the drug"). This proposal attempts to prevent the prosecution of friends or family members that simply dispensed the drug and requires that the drug delivered be the proximate cause of the overdose death. *Id.* at 381–82.

[142] *See id.* at 380–85 (outlining a narrow drug-induced homicide statute that would only be applicable to drug dealers and require the drug dispensed to be the proximate cause of the overdose death as well as a broad Good Samaritan law that prevents prosecution of "*any* drug-related offense" for those that seek help for people who are overdosing) (emphasis added).

[143] *See id.* at 385 (arguing that the proposed model drug-induced homicide statute would ensure only those that deserved prosecution—such as those that make and deal in illegal drugs—were prosecuted under such statutes and Good Samaritan laws would promote seeking medical care for people experiencing an overdose).

B. International Comparisons: How Have Other Counties Dealt with Rising Drug Use and Accidental Overdoses?

Although the United States has especially high rates of opioid addiction and overdose death, there are other countries that struggle with rising addiction levels.[144] This Section compares different countries' approaches to rising drug use and accidental drug overdoses by looking at their (1) current landscape of drug usage and overdoses; (2) general treatment of drug use under criminal statutes, including any demand- and supply-side policies; and (3) the specific treatment of accidental drug overdoses.[145] Subsection 1 evaluates Scotland.[146] Subsection 2 looks at Canada.[147] Subsection 3 assesses Brazil.[148] Finally, Subsection 4 provides a general summation of patterns and insights from the three countries.[149]

1. Scotland Under the United Kingdom

Currently, Scotland has the highest rate of drug-related deaths in Europe, with a recorded 327 fatalities per million in 2020.[150] A recent report from Scottish police lists 900 suspected drug deaths from January 2023 to September 2023, a 13% increase from the previous year.[151] This rise is attributable in part to increasing availability of synthetic opioid drugs.[152]

Accordingly, the Scottish government has sought policies to lower the rising trend of drug deaths.[153] Specifically, it has implemented policies to increase the availability of naloxone (a drug used to counteract opioid overdoses), integrate care for those with addiction and mental health issues, and in-

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[144] Lucas O. Maia, Dimitri Daldegan-Bueno & Benedikt Fischer, *Opioid Use, Regulation, and Harms in Brazil: A Comprehensive Narrative Overview of Available Data and Indicators*, SUBSTANCE ABUSE TREATMENT, PREVENTION, & POL'Y, Jan. 26, 2021, at 1, 2 (noting that North America is the area of highest opioid consumption and opioid availability, reaching about 31,000 defined daily doses per million people per day by the early 2010s).

[145] *See infra* notes 150–228 and accompanying text.

[146] *See infra* notes 150–167 and accompanying text.

[147] *See infra* notes 168–195 and accompanying text.

[148] *See infra* notes 196–217 and accompanying text.

[149] *See infra* notes 218–228 and accompanying text.

[150] *See Scotland Proposes Making All Drug Possession Legal*, REUTERS (July 7, 2023), https://www.reuters.com/world/uk/scotland-proposes-making-all-drug-possession-legal-2023-07-07/ [https://perma.cc/SZQ5-82EW] (July 7, 2023) (outlining the rising rates of drug deaths in Scotland).

[151] *See* SCOTTISH PARLIAMENT, OFFICIAL REPORT: MEETING OF THE PARLIAMENT 19 DECEMBER 2023, at 42 (2023) https://www.parliament.scot/api/sitecore/CustomMedia/OfficialReport?meetingId=15621 [https://perma.cc/6RZT-EL8L] (statement of Elena Whitman) (reporting to Scottish Parliament on rising levels of drug deaths).

[152] *See id.* (noting that Elena Whitham, Scotland's Minister for Drugs and Alcohol, expressed genuine concern that they are seeing more and more synthetic opioids).

[153] *See id.* at 42–43 (listing various policies and initiatives Scotland has adopted to combat rising drug deaths including training pharmacy workers).

crease substance abuse training for pharmacy workers.[154] Additionally, Scotland has moved to legalize drug possession for personal use.[155] These policies represent a clear demand-side strategy.[156]

Scotland, however, is still a part of the United Kingdom (U.K.), meaning that its drug laws fall under the jurisdiction of the U.K.'s Parliament.[157] The U.K. criminalizes drug possession.[158] Thus, currently, the U.K. and Scotland are at odds over the best approach to lower overdose deaths in Scotland.[159]

The U.K. was initially known for its demand-side approach to rising drug deaths in the 1960s and 1970s.[160] By the early 2000s, however, its conservative government moved toward a more supply-side approach, adopting harsher penalties for drug possession and distribution.[161] Although rising drug deaths have led several agencies to urge for more demand-side approaches, such recommendations have not been adopted.[162]

The U.K. does not have a drug-induced homicide law.[163] It is possible, however, for a dealer to be charged under a constructive manslaughter law for the death of their client.[164] To qualify under the charge of manslaughter, the

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[154] *See id.* at 43–44 (detailing the various policy implementations the Scottish government has been working on); *see also* FISHER, *supra* note 21, at 7 (explaining that demand-side policies include preventing drug use and providing treatment for drug addiction).

[155] *See Scotland Proposes Making All Drug Possession Legal*, *supra* note 150 (showing that Scotland's government would like to decriminalize drug possession).

[156] *Supra* note 154 and accompanying text.

[157] *Scotland Proposes Making All Drug Possession Legal*, *supra* note 150.

[158] Misuse of Drugs Act 1971 c. 38, § 5 (Eng.) (making the possession of a controlled drug illegal).

[159] *See Scotland Proposes Making All Drug Possession Legal*, *supra* note 150 (noting that Scotland has requested that the United Kingdom legalize the possession of drugs for personal consumption but the United Kingdom (U.K.) has refused to do so).

[160] *See* Mathieu Doucet & Lindsey Brooke Porter, *What Is the Harm in Addiction? Autonomy, Vulnerability, and the Case for Harm Reduction Drug Policy*, 82 CAMBRIDGE L.J. 265, 267–68 (2023) (describing that the "British method" for heroin addiction treatment included prescribing "injectable heroin" and that the U.K. was the originator of needle-exchange programs and had fifteen such sites by 1987 and roughly 300 by the 1990s).

[161] *See id.* (detailing how during the 1990s and the early 2000s decade, legislators passed a number of acts that served to increasingly combine criminal law and health responses to drugs). The Cameron coalition beginning in 2010 served to move toward a policy of reduction focusing on criminalizing drugs. *Id*.

[162] *See id.* at 268–69 (noting that a 2016 report from the Advisory Council on the Misuse of Drugs proposed a number of measures focused on harm reduction, including "[o]pioid agonist therapy (OAT), a harm reduction strategy that stands in opposition to strict abstinence approach," where patients "take an opioid agonist (substitute)—usually methadone or buprenorphine—under medical supervision, instead of heroin," as well as a "scaling-up of take-home Naloxone provision," but these recommendations were not implemented into the U.K.'s drug strategy).

[163] *See Drugs Penalties*, U.K. GOV'T, https://www.gov.uk/penalties-drug-possession-dealing [https://perma.cc/F85E-GWQG] (outlining current U.K. laws relating to drugs and drug-related charges but not including a drug-induced homicide law).

[164] Nicola Laver, *Can Drug Dealers Be Criminally Liable if a User Dies?*, https://www.claims.co.uk/knowledge-base/types-of-claim/drug-dealers-liability [https://perma.cc/C3F4-CUEY] (explaining that an individual will not be charged for murder if they supplied illegal drugs to someone who

dealer would need to directly administer the drug to their client, otherwise the law considers an individual's choice to take the drug to be free will.[165]

Both the U.K. and Scotland seem to be struggling with rising opioid drug deaths.[166] Both jurisdictions adopted both supply- and demand-side policies attempting to increase addiction recovery and charge drug dealers.[167]

2. Canada

Canada's opioid crisis mirrors that of the United Stated, with rising levels of addiction stemming from legal medical prescription overuse.[168] In fact, Canada ranks just behind the United States in opioid consumption.[169] Canada has experienced over 40,000 opioid-related deaths since 2016.[170]

Historically, Canada has employed a supply-side approach to drug policy, criminalizing drug use.[171] In 1908, Canada passed The Opium Act, its first

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then dies from those drugs). There may be a murder charge if the dealer "supplied to a child; or a deadly batch of heroin mixed with fentanyl is knowingly supplied—leading to the user's death—the dealer could be found guilty of murder." *Id.* "A death following the supply of illegal drugs could lead to a charge of 'constructive' manslaughter (also known as involuntary or 'unlawful act' manslaughter) or gross negligence manslaughter." *Id.*

[165] *See id.* ("[A] typical example of constructive manslaughter is where the drug dealer supplies drugs and actually injects the drug into the victim with the victim's consent, and the victim later dies.").

[166] *See* SCOTTISH PARLIAMENT, *supra* note 151, at 42 (explaining the rising overdose death rates in Scotland); *see also* Doucet & Porter, s*upra* note 160, at 268 (highlighting the sharp rise in deaths from drug overdose since 2010 in the U.K.).

[167] *See supra* notes 150–167 and accompanying text (describing the current laws and policy choices of Scotland and the U.K. and rising levels of drug deaths).

[168] *See* Grant Robertson & Karen Howlett, *How a Little-Known Patent Sparked Canada's Opioid Crisis*, GLOBE & MAIL (Dec. 30, 2016), https://www.theglobeandmail.com/news/investigations/oxycontin/article33448409/ [https://perma.cc/ETK5-699G] (explaining that a Canadian subsidiary of Purdue Pharma obtained a Canadian patent to sell OxyContin, and that under the same assertion as its American counterpart—that OxyContin was not addictive—the Canadian subsidiary sold a substantial amount of pills in Canada, leading to the deaths of thousands).

[169] Klara A. Zierk, *The Real Antidote: A Critical Review of U.S. and Canadian Drug Treatment Courts and a Call for Public Health Prevention Tools as a Solution to the Opioid Epidemic*, 29 IND. INT'L & COMPAR. L. REV. 185, 204 (2019) (noting that "Canada[] has the second highest rate (just over nineteen percent of Canada's entire population) for opioid consumption in the world").

[170] *See Key Findings: Opioid-and-Stimulant-Related Harms in Canada*, GOV'T OF CAN., https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/ [https://perma.cc/Q723-VTPV] (Sept. 13, 2024) (explaining that there were "47,162 apparent opioid toxicity deaths reported between January 2016 and March 2024").

[171] *See* Susan Boyd, *Heroin and the Illegal Drug Overdose Death Epidemic: A History of Missed Opportunities and Resistance*, 91 INT'L J. DRUG POL'Y 1, 2–3 (2021) (noting that beginning in the early 1900s, Canada began a long stretch of criminalizing drug use overseen by the federal Opium and Narcotic Drugs Branch and enforced by the Royal Canadian Mounted Police). The underlying rationale for the criminal approach was rooted in racial, gender, and economic discrimination. *See id.* (detailing how Mackenzie King, the man responsible for the Opium Act, criminalized drug use because of disdain for Chinese immigrants and that the laws were enforced through 1950 with high incarceration rates against those in lower socioeconomic brackets).

criminalization of drug use.[172] Canada remained committed to criminalizing drug use, even during the rise of heroin addiction in the 1950s.[173] In fact, in the 1950s and 1960s, Canada passed some of the harshest drug laws in the Western world, such as laws allowing high levels of incarceration for users and long prison sentences.[174] Finally, by the 1990s Canada began to shift its approach to drug use.[175]

In recent history, Canada has championed strong demand-side drug policies, including harm reduction measures such as injection sites.[176] The first injection site was established in Vancouver in 2003 and is considered a success.[177]

Additionally, since 1998, Canada has had drug courts with the aim of treatment over imprisonment.[178] These courts are available to those charged with nonviolent crimes and addicted to drugs such as cocaine or opioids.[179] They offer progressive treatment programs that provide comprehensive care.[180]

Currently, in Canada, there is a rising trend of prosecutors pursuing drug-induced homicide charges in cases of accidental drug overdose.[181] From 2016 to 2019, Canada has seen a 700% increase in drug-induced homicide prosecutions.[182] These prosecutions are not evenly distributed across provinces, with

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[172] *See id.* at 2 (discussing how King, the Deputy Minister of the Department of Labor in Canada, led both a domestic and international movement to criminalize the use of opium, categorizing its users as immoral).

[173] *See id.* at 3–4 (explaining that many traveled from Canada to the U.K. to receive legal medical treatment for heroin addiction).

[174] *See id.* at 5 ("By the 1950s and early 1960s, Canada had enacted some of the most punitive laws of any western nation.").

[175] *See id.* at 6–7 (detailing that harm reduction centers were set up in Vancouver).

[176] *See* J.J. Larkins, *A Site to See: Lessons from Canada and Australia for Implementing Government-Sanctioned Overdose Prevention Sites in the United* States, 37 TEMP. INT'L & COMPAR. L.J. 81, 110 (2022) (highlighting that Canada opened its first legal overdose prevention site (OPS), Insite, in 2003 in Vancouver after "the Health Minister granted an exemption to Insite under section 56 of the Controlled Drugs and Substances Act"); *see also* Evelyn L.A. Jackson, Note, *Safe Injection Facilities: Reconsidering American Drug Policy*, 63 B.C. L. REV. 1467, 1476 (2022) ("Harm reduction is a humanitarian approach to drug policy that aspires to help dependent drug users without trying to limit their use.").

[177] *See* Larkins, *supra* note 176 (explaining that by 2020, there were thirty-nine OPSs in Canada receiving roughly three thousand daily visits and that these OPSs "attended to fifteen thousand overdoses and drug-related emergencies between 2017 and 2019").

[178] *See* Zierk, s*upra* note 169, at 212–13 (giving an overview of Canada's drug court system).

[179] *See id.* at 212 (explaining that in 1997 experts from law enforcement, legal aid, and public health came together to create a drug court that provided a path for non-violent offenders who are addicts of illegal drugs to avoid jail and obtain treatment).

[180] *See id.* at 213 (noting that participants in Canada's drug courts receive outpatient treatment and case management support).

[181] *See W5: Death Penalty, Part Two*, CTV News (Nov. 26, 2021), https://www.ctvnews.ca/video?clipId=2331308 [https://perma.cc/8LLP-D4UE] (explaining that prosecutors are pursing more drug-induced homicide charges and there is a rise in drug-induced homicide prosecutions in Canada).

[182] *See id.* (giving the following number of charges for manslaughter and criminal negligence in overdose deaths in Canada by year: 9 in 2016, 12 in 2017, 7 in 2018, 65 in 2019, and 31 in 2020).

Ontario producing nearly half.[183] Additionally, although most of these prosecutions represent charges against local drug dealers, a few include a friend or family member that unknowingly supplied the decedent with lethal drugs.[184]

Canada has an overdose Good Samaritan law.[185] Passed in 2017, the federal statute was a part of a broader effort to combat rising overdoses.[186] Both the federal and provincial governments are raising public awareness of the Good Samaritan statute to prevent overdose deaths.[187] The statute's protections are minimal, however, and only shield the Good Samaritan from prosecution for crimes of possession.[188]

Canada's drug-induced homicide statutes range from criminal negligence to manslaughter.[189] To charge a defendant for drug-induced homicide under manslaughter, a defendant must fulfill the requirements for manslaughter under Canadian law.[190] Canada's manslaughter statute has an actus reus of committing "an objectively dangerous unlawful act, *which causes* death."[191] The mens rea requirement has two parts: (1) "the intent to commit the underlying unlawful act;" and (2) "the objective foreseeability of the risk of bodily harm which

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[183] *See W5: Death Penalty, Part One*, CTV NEWS (Nov. 26, 2021), https://www.ctvnews.ca/video/c2331306-w5--death-penalty--part-one [https://perma.cc/J7RB-MHVM] (giving the following numbers for Ontario's prosecution of drug-induced homicide laws: 2 in 2016, 5 in 2017, 5 in 2018, 28 in 2019, and 23 in 2020, and showing that Ontario represented 28 of the 65 prosecutions in 2019).

[184] Marg. Bruineman, *Woman's Fatal Overdose Led to Friend's Conviction for Manslaughter*, MIDLANDTODAY, (Apr. 5, 2021), https://www.midlandtoday.ca/local-news/womans-fatal-overdose-led-to-friends-conviction-for-manslaughter-3604792 [https://perma.cc/8CXP-7735] (describing how Robert Rodgers was charged and convicted of manslaughter after he brought what he thought was cocaine—but turned out to be a powerful opioid—to a gathering of friends). His friend, Darci-Lynn Beers, mother to a young toddler, died after the group ingested the drugs. *See id.* (explaining the details of Beer's death that led to Rodgers' conviction).

[185] *See About the Good Samaritan Drug Overdose Act*, GOV'T OF CAN., https://www.canada.ca/en/health-canada/services/opioids/about-good-samaritan-drug-overdose-act.html [https://perma.cc/K6WY-EHGU] (Aug. 6, 2024) (outlining the Good Samaritan law Canada passed in 2017 that was a part of Canada's harm reduction strategy).

[186] *See id.* (explaining that the Good Samaritan law follows the public health focus that Canada has adopted for substance use).

[187] *See id.* (promoting the use of the Good Samaritan statute); *see also W5: Death Penalty, Part One*, s*upra* note 183 (explaining that Ontario police launched a campaign to raise awareness of the Good Samaritan statute).

[188] *See* GOV'T OF CAN., *supra* note 185 (highlighting that although the Good Samaritan law does protect against crimes of possession for both the one experiencing the overdose and a co-user, it does not protect against other crimes related to drugs). For example, in Ontario, although the police promote knowledge of the Overdose Good Samaritan statute to curb overdose deaths, the statute will not protect against drug-induced homicide charges. *See W5: Death Penalty, Part One*, s*upra* note 183 (noting that Good Samaritan statutes are very limited in protections offered in Canada).

[189] *See W5: Death Penalty, Part One*, s*upra* note 183 (listing both manslaughter and negligence as charges used to prosecute drug-induced homicides).

[190] *See* R. v. Haas (2016), 326 Man. R. 2d 302, paras. 72–73 (Can. Man. C.A.) (finding the defendant guilty under Canada's manslaughter statute for giving a woman sixteen morphine pills in one night, leading to her death).

[191] *Id.* at para. 32 (emphasis added).

is neither trivial nor transitory, in the context of the dangerous act."[192] In terms of causation, the Canadian Supreme Court has guided courts to concentrate on the defendant's moral responsibility rather than the victim's autonomy.[193] For example, in 2016, in *R v. Haas*, the Manitoba Court of Appeal found a forty-seven year-old man guilty of manslaughter where he gave the victim, a twenty year-old female, sixteen morphine pills in one evening, causing an overdose death.[194] The court refused the defendant's argument that the victim's choice to consume the pills served as an intervening superseding cause, breaking the causation needed to prove manslaughter.[195]

3. Brazil

Brazil struggles with rising cocaine addiction and overdose deaths.[196] The rising numbers of cocaine addicts have caused increased violence in Brazil.[197] Additionally, given its proximity to major cocaine-producing countries, Brazil finds itself battling not just domestic drug use, but also drug trafficking.[198]

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[192] *Id.*

[193] *See id.* at para. 61 ("The Supreme Court of Canada has directed that the determination of causation is to focus on the accused person's moral responsibility as opposed to the autonomy of the victim and the victim's choices.").

[194] *Id.*

[195] *See id.* at paras. 62–64 (explaining that the chain of causation for manslaughter can be broken in the case of an intervening cause). The court held that the victim's voluntary ingestion of the morphine pills was not an intervening cause in this case because the circumstances showed the defendant's morally blameworthy behavior. *See id.* at para. 63 (holding that given the facts of the case, the trial court did not err in using the "but-for" test to factor in things such as "the victim's "age, her lack of knowledge of the pills given to her and the fact that she never left the accused's apartment"). A court also found a 41-year-old guilty of manslaughter when he motivated a young teenager at his party to use drugs, showing her how to increase the drug's potency. *See id*. at para. 56 (citing R. v. C.W. (2006), 209 O.A.C. 1 (Can. Ont. C.A.)) (holding that the actions gave rise to morally blameworthy behavior that caused the death of another).

[196] *See* Paula Miraglia, *Drugs and Drug Trafficking in Brazil: Trends and Policies*, BROOKINGS INST. 4 (2016), https://www.brookings.edu/wp-content/uploads/2016/07/Miraglia-Brazil-final.pdf [https://perma.cc/QJ9B-9D54] (highlighting that cocaine use has sharply increased in the last ten years with cocaine use among the population "estimated at 1.75 percent").

[197] *See* Mauricio Savarese, *Drug Abuse Is Soaring in Sao Paulo's Downtown. Users, Residents and Shop Owners Are All Suffering*, ASSOCIATED PRESS (June 25, 2023), https://apnews.com/article/sao-paulo-crackland-downtown-drugs-4804b8e6672c3fcf1a856dd987bff594 [https://perma.cc/ADT7-FDZ2] (describing how a large number of cocaine addicts have gathered in Sao Paulo in a downtown area of the city now known as "Crackland," and that this movement has created increased incidents of violence for shop keepers and locals).

[198] *See* Miraglia, *supra* note 196, at 3 (explaining that because it borders Peru, Bolivia, and Colombia—the primary origins of cocaine—Brazil has become the major transit point for moving cocaine to Europe). General trends over the last decade have made Brazil a major player in the cocaine trade and brought rising cocaine consumption to Brazil domestically. *Id*.

Non-medical use of opioids is less common in South America compared to North America.[199] Although opioid use in Brazil has been steadily increasing,[200] Brazil's opioid use is small in comparison to other G-20 countries.[201] In the context of Latin America, however, Brazil's opioid use is moderate.[202] In fact, opioids are difficult to come by in Brazil because of the strict regulation on opioid use, even within medical contexts.[203]

Deaths resulting from opioid addiction are rare in Brazil, making up only 0.1% of addiction deaths from 2001 to 2007.[204] Brazil schedules opioids as narcotics.[205] As such, Brazil has restrictions on which types of medical professionals may dispense opioids and how pharmacists may dispense prescribed opioid medications.[206]

Brazil criminalizes drug use.[207] Although Brazilian drug policy is largely based on the United Nations International Drug Control Conventions, it has contributed to mass incarceration.[208] In fact, in terms of absolute numbers, Brazil ranks fourth in the world in incarcerations, with its prison population doubling in the last decade.[209]

In 2006, Brazil adopted measures to differentiate the treatment of drug users from drug traffickers.[210] Under the law, drug users receive lighter sentences, typically avoiding jail.[211] The law, however, did not initially include

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[199] *See* Maia, *supra* note 144, at 2 (noting that the "prevalence of non-medical opioid use in South America was estimated to be 0.1–0.2% from 2015 to 2017, in comparison to approximately 4% reported in North America").

[200] *See id.* at 3 (showing that opioid use levels were 172 defined daily doses per million people per day in 2000–2002, rising to 384 in 2009–2011 and 512 in 2016–2018).

[201] *See id.* (noting that Brazil's "opioid consumption remains significantly smaller (<5%)" than other G-20 countries).

[202] *See id.* (explaining that Brazil ranks middle-of-the-pack in Latin America for opioid consumption, consuming less than Chile and Argentina but more than Peru and Bolivia).

[203] *See id.* at 6 (arguing that Brazil should loosen regulations and allow more use of opioids for pain management).

[204] *See id.* (showing that of the "44,326 deaths associated with psychoactive substance-related disorders," opioids played a role in just 24).

[205] *See id.* at 4 (illustrating that "[o]pioid analgesics are scheduled as 'narcotic substances'" that also include "morphine, buprenorphine, pethidine, methadone, hydrocodone, oxycodone, fentanyl, and others," that these types of narcotics are "permitted only in special concentrations," and that Brazil divides them into strong and weak opioids).

[206] *See id.* (explaining that "[o]nly medical physicians and dental surgeons are permitted to prescribe scheduled opioids, based on a special registration from the local health surveillance service" and that pharmacists cannot take emergency prescriptions over the telephone for opioids).

[207] *See* Miraglia, *supra* note 196, at 7 (noting that the penal code is the main tool Brazil uses in its "War on Drugs").

[208] *See id.* (describing how Brazil based its drug policy on UN policy, adopting "tough on crime" national legislation along with a "weakening of civil liberties" that has led to mass incarceration.

[209] *Id.*

[210] *Id.* at 1.

[211] Isabela Cruz, *Supreme Court and Congress in Tug-of-War Over Cannabis Decriminalization*, BRAZILIAN REP., https://brazilian.report/power/2024/03/24/tug-of-war-cannabis-drugs-decriminalization/

objective criteria to determine whether the accused was a drug user or a drug trafficker.[212] Unfortunately, the resulting discretion given to local police and judges created disparate outcomes based on race and socioeconomic status.[213] In June 2024, however, Brazil's Supreme Court decided that the law will have objective criteria, holding that a person found with forty grams or less of marijuana would be considered a drug user.[214]

In Brazil, if authorities can prove the defendant caused the outcome, accidental overdoses may be charged under negligent homicide.[215] Negligent homicide, or culpable homicide, applies when there was no intent to kill.[216] Negligent homicide results in lower penalties than intentional homicide.[217]

4. Key Insights from Country Comparison

The United States has proportionately more addicts that other countries.[218] Additionally, as discussed in Part I, these addicts were created during

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[https://perma.cc/UU4U-9SG4] (Mar. 24, 2024) (explaining that a law passed in 2006 provides that drug-dealers can receive jail time as a sentence, but drug-users may only receive community service or education courses).

[212] *See* Miraglia, *supra* note 196, at 8 (noting that the judge could "take into account the nature of the substance seized and the conduct and previous record of the supposed user" and that this vague criterion allowed for police discretion).

[213] *See id.* at 1 (highlighting that the justice system's discriminatory culture along with authorities substantial discretion to label conduct as trafficking has led to a pattern of addicts serving jail time); *see also* Cruz, *supra* note 211 (explaining that although it is not certain that someone arrested for just a minor amount of marijuana will face arrest, studies show that being a person of color, younger, and having a lower socioeconomic status increases the likelihood a person will serve jail time). For example, "[a] survey by the Brazilian Jurimetrics Association shows that, in São Paulo, people with a university degree are only considered drug dealers if they are caught with at least 49 grams of cannabis on average—while just over 32 grams is enough to put an illiterate person behind bars." *Id.*

[214] *See* Alexia Massoud, *User or Dealer? That Is the Question*, BRAZILIAN REP. (June 27, 2024), https://brazilian.report/cartoons/2024/06/27/user-or-dealer-that-is-the-question/ [https://perma.cc/QS6B-DKN5] (explaining that Brazil's Supreme Court made possession of up to forty grams of marijuana for personal use legal, establishing an objective criterion between drug user and drug dealer).

[215] *See* E-mail from Ademar Borges de Sousa Filho, Professor of Pub. L., Instituto Brasileiro de Ensino, Desenvolvimento e Pesquisa (IDP) [Brazilian Institute of Teaching, Development and Research], to author (Feb. 23, 2024, 08:58 EST) (on file with author) ("[I]nstances of accidental overdose may result in a charge of negligent homicide, with penalties lower than those for intentional homicide. This is applicable when it is proven that the co-user caused the outcome through recklessness, negligence, or malpractice.").

[216] *Five-Year-Old's Fatal Plunge Provokes Hard Questions About Brazil's Racism*, THE GUARDIAN (June 12, 2020), https://www.theguardian.com/world/2020/jun/12/brazil-black-boy-fall-death-racism [https://perma.cc/Y7KZ-LSCT] (detailing how Sarí Hacker was charged with negligent or culpable homicide when she allowed the five-year-old boy she was watching go up to the ninth floor of the apartment complex in which she lived and fall to his death).

[217] *See* E-mail from Ademar Borges de Sousa Filho to author, *supra* note 215 (noting that negligent homicide carries lower penalties than intentional homicide).

[218] *See* Maia, s*upra* note 144, at 2 (noting that between 2016 and 2018, "North America alone still accounted for about 60% of the world's total opioid consumption").

the 1990s and early 2000s through governmental and medical policies.[219] Canada mirrors this story.[220]

Furthermore, this comparison illustrates that opioid addiction is a difficult social problem to address.[221] Under supply-side approaches, there is a pattern of disparate treatment of drug users stemming from wealth inequalities and racism.[222] A tendency toward over-incarceration in both the United States and Brazil speaks to this phenomenon.[223]

Additionally, the U.K.'s treatment of accidental overdoses adds an important layer of consideration in criminalizing accidental overdoses.[224] Specifically, the U.K. treatment holds consenting adults accountable for their own outcomes while only holding distributors accountable when they use deceit or perform the actual injection or ingestion.[225]

Canada's treatment of accidental overdoses also lends some interesting insight.[226] First, to convict a person for an accidental drug overdose, Canada requires proof that the accused (1) committed an intentional, dangerous bad act, and (2) could reasonably foresee that the act would cause substantial harm.[227] Further, to determine whether the accused's act caused the overdose, Canada considers the moral blameworthiness of the accused's actions and circumstances such as the victim's age, situation, and general ability to voluntarily act for themselves.[228]

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[219] *See supra* notes 35–43 and accompanying text (detailing how pharmaceutical companies created opioid addiction and, after addicts could no longer get opioids through legal prescription, they turned to prescription misuse and illegal drugs such as heroin and later fentanyl).

[220] *See supra* notes 167–169 and accompanying text (detailing how a Canadian subsidiary of Purdue Pharma obtained a patent and authorization to sell Oxycontin in Canada, leading to rising opioid addiction in Canada that mirrored that in the United States).

[221] *See supra* notes 150–156, 168–177 and accompanying text (detailing the struggles of Scotland and Canada to combat opioid addiction).

[222] *See supra* notes 91, 213 and accompanying text (highlighting how supply-side policies in the United States and Brazil have led to disparate treatment among different races).

[223] *See supra* notes 91, 208–213 and accompanying text (explaining the racial disparity and over-incarceration issues in the United States and Brazil).

[224] *See supra* notes 163–165 and accompanying text (describing the U.K approach to accidental drug overdoses).

[225] *See supra* notes 163–165 and accompanying text (explaining that for an accused to be held liable for an accidental drug overdose, they would have had to actually inject the drug into the victim or otherwise cause the victim to ingest the drug).

[226] *See supra* notes 189–195 and accompanying text (detailing Canada's manslaughter statute that applies to accidental drug overdoses where the accused has committed an intentional bad act and could reasonably foresee substantial harm would result).

[227] *See* R. v. Haas (2016), 326 Man. R. 2d 302, para. 32 (Can. Man. C.A.) (giving the elements required in Canada to prove manslaughter in an accidental drug overdose).

[228] *See supra* notes 193–195 and accompanying text (listing the additional considerations a Court applies when evaluating manslaughter charges).

C. Room for Mercy: Can Insanity Pleas or Sentencing Consideration Offer Mitigated Justice for Addicts?

Some have argued that addicts should be treated differently under the law due to their impaired physical and mental abilities.[229] This Section explores how addicts might receive differential treatment under drug-induced homicide laws.[230] First, this Section looks at insanity pleas generally.[231] Next, this Section discusses how intoxication has been applied to insanity defenses.[232] Then, this Section discusses how opioid addiction may be included as a disease of the mind under the insanity defense.[233] Finally, this Section examines how courts may account for addiction in sentencing.[234]

The affirmative defense of insanity stems from Roman law and is controversial.[235] The insanity defense was developed to cover crimes committed by those who either (1) were not able to control their actions or (2) were not aware of the actual circumstances surrounding their actions or the outcomes they created.[236] Accordingly, the question of guilt is not just about what the person did but who they are and why they did it.[237]

Determinations of insanity within the legal system have focused on identifying the observable indicators for insanity rather than why a person was insane.[238] There are two main versions of the insanity plea: (1) the Model Penal

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[229] *See, e.g.*, Leslie E. Scott, *Substance Use Disorder's (SUD) Impact on Criminal Decision-Making and Role in Federal Sentencing Jurisprudence: Arguing for Culpability-Based SUD Mitigation*, 19 OHIO ST. J. CRIM. L. 471, 510 (2022) (arguing that the United States Sentencing Commission (USSC) Guidelines, section 5K2.13, should include consideration for addiction because substance use disorders (SUDs) cause changes in the brain that diminish decision-making abilities).

[230] *See infra* notes 235–264 and accompanying text.

[231] *See infra* notes 235–243 and accompanying text.

[232] *See infra* notes 244–249 and accompanying text.

[233] *See infra* notes 250–261 and accompanying text.

[234] *See infra* notes 262–264 and accompanying text.

[235] *See* Gabriel Hallevy, *The Shadows of Normality: Legal Insanity Under Modern Criminal Law* ("Under Roman law, it was not acceptable to impose criminal liability upon the mentally ill, and in certain circumstances of public dangers, mentally ill persons were held in public custody."), *in* THE INSANITY DEFENSE: MULTIDISCIPLINARY VIEWS ON ITS HISTORY, TRENDS, AND CONTROVERSIES 97, 98 (Mark D. White ed., 2017) [hereinafter THE INSANITY DEFENSE]; Mark D. White, *Introduction in* THE INSANITY DEFENSE, *supra*, at ix, ix (explaining that although most people would agree that if a person commits a crime and does not understand they are doing something wrong or cannot resist the bad conduct, they should not be punished, the insanity defense can seem "profoundly unjust" to many people).

[236] WILLIAM J. WINSLADE, THE INSANITY PLEA 9 (1983) (explaining that when using the insanity defense, the question at trial is, "'did the man mean to fire the gun and cause the injury?' or 'could he or did he choose to fire the gun?'").

[237] *See id.* at 7–8 (1983) (explaining how a person is judged by the jury and the court after committing a crime and pointing out that factfinders are interested in the defendant's state of mind and justifications as well as circumstantial evidence).

[238] *See* Hallevy, *supra* note 235, at 98 (highlighting that the legal determination of insanity did not necessitate understanding why a person was insane, just a recognition of the resulting symptoms of insanity to decide an offender's criminal liability).

Code (MPC) standard, promulgated by the American Law Institute; and (2) the federal standard for the insanity defense.[239] The MPC version is more inclusive and allows an insanity defense where the accused "lacked substantial capacity" to either understand their conduct was wrong or to control their conduct.[240] The federal version demands a higher standard for the application of the insanity defense, requiring the accused's complete inability to understand whether ones actions are right or wrong or the nature of their conduct.[241] Currently, twenty-nine states employ the federal standard while fifteen states use the MPC version of the insanity defense.[242] Five states no longer allow any insanity defense.[243]

Generally, states do not allow the insanity defense—including temporary insanity—to be used when the defendant's insanity is the result of intoxication because intoxication so often accompanies crime.[244] The exceptions to this rule generally center around the intoxication being an indirect trigger of an underlying mental or physical condition.[245] For example, in 1840, in *State v. Dillahunt*,

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[239] JOSHUA DRESSLER & STEPHEN P. GARVEY, CRIMINAL LAW: CASES AND MATERIALS 658 (9th ed. 2022).

[240] *See id.* at 654–57 (detailing the evolution of the insanity defense). Contemporary origins stem from the *M'Naghten* Rule that resulted from an attempted assassination of British Prime Minister in 1843 and established two elements of the insanity defense: (1) that the person was suffering under a defect of the mind such that (2) he did not understand the nature of his conduct or that his conduct was wrong. *Id.* at 655. The *M'Naghten* Rule was criticized for requiring a complete lack of mental capacity. *See id.* (explaining that critiques centered on requiring psychiatrists to find a defendant had no ability to reason or understand when experience usually showed that there is a range of mental incapacitation). Next came the "irresistible impulse" test that broadened the determination of insanity to include not just cognitive parts of the defendant's conduct but also volitional aspects as well. *See id.* at 656 (describing how the irresistible impulse test inquires if the defendant completely lacks control over their own mind). The "irresistible impulse" addition was then further expanded by the "product test." *See id.* (telling how the "product test" came from *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954), and tested for insanity by determining if the defendant's conduct was the result of a problem with the defendant's mind). Then, in 1985, the American Law Institute promulgated a Model Penal Code (MPC) version of the insanity defense test that does not hold a defendant responsible when "as a result of mental disease or defect, the defendant lacked substantial capacity" either to (1) "appreciate the criminality (wrongfulness) of his conduct" or (2) "conform his conduct to the requirements of law." MODEL PENAL CODE § 4.01 cmt. 3 (AM. L. INST., Proposed Official Draft 1985). The MPC version of the insanity defense does not require "complete impairment of ability to know or to control." *Id.*

[241] *See* DRESSLER & GARVEY, *supra* note 239, at 658 & n.n (quoting 18 U.S.C. § 17 (2006)) (explaining that the federal standard is a based on the *M'Naghten* Rule where the defendant lacks the mental capacity to appreciate why their acts are wrongful).

[242] *See id.* at 659 (listing the number of states adopting the MPC version of the insanity defense).

[243] *See id.* (detailing how after the John Hinckley was acquitted due to insanity for after trying to kill President Reagan, states reverted to a stricter and narrower standard for the insanity defense).

[244] Russell D. Covey, *The Temporary Insanity Defense*, *in* THE INSANITY DEFENSE, *supra* note 235, at 32–33 (explaining that criminal law historically did not allow defendants to plead insanity when they had voluntarily consumed the drugs or alcohol that impaired them because of how often intoxication and crime are found together).

[245] *See id.* (holding an accused to be insane when the accused consumed a substance that triggered intoxication but an underlying medical condition triggered by the intoxication, not the toxication it-

the Court of General Sessions of Delaware acquitted a man of his crimes because the man's extreme withdrawal symptoms from alcohol did not allow him to know that his conduct was unlawful or immoral.[246] Additionally, in *People v. Freeman*, in 1943, the Court of Appeal of California reversed a negligent homicide conviction where the defendant claimed his underlying epilepsy condition—that was triggered by consuming alcohol—left him unconscious and caused the death of the victim.[247]

Fentanyl addiction is particularly pernicious and withdrawal from fentanyl can cause nausea, muscle and/or bone pain, tachycardia, hypertension, and even heart failure.[248] Thus, fentanyl withdrawal may be a type of underlying physical condition that could allow the accused to use the insanity defense just as the accused in *Dillahunt* used extreme alcohol withdrawal.[249]

Additionally, some believe that pathological intoxication qualifies as a disease of the mind and thus should be covered under the insanity defense.[250] That idea centers on defining pathological intoxication as a mental disease that leads to an inability to comprehend right and wrong or control one's conduct.[251] Essentially, proponents argue that pathological intoxication should be

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self, caused the bad conduct). For example, if drinking triggers withdrawal symptoms or an underlying mental or physical condition, the temporary insanity defense is available. *Id.*

[246] *See* State v. Dillahunt, 3 Del. (3. Harr.) 551, 553 (1840) (allowing a plea of temporary insanity due to "a frenzy of drunkenness" because the withdrawal symptoms the defendant suffered included intense hallucinations that made it so the defendant did not comprehend what he was doing).

[247] *See* People v. Freeman 142 P.2d 435, 439–40 (Cal. Dist. Ct. App. 1943) (ruling the defendant not negligent due to his epilepsy condition).

[248] Adrienne Webster, *Fentanyl Withdrawal Symptoms, Timeline, and Detox Treatment*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/withdrawal-timelines-treatments/fentanyl [https://perma.cc/6VKT-673Y] (July 19, 2024) (listing symptoms of fentanyl withdrawal as: "[d]iarrhea and vomiting"; "[n]ausea"; "[t]achycardia (increased heart rate)"; "[m]uscle or bone pain"; "[h]ypertension (high blood pressure)"; "[i]nsomnia"; "[a]nxiety"; "[i]creased body temperature"; "[s]weating"; and "[c]hills," and explaining that "[w]hile typically not life-threatening, fentanyl withdrawal can be extremely uncomfortable" and "[i]n some cases, complications from opioid withdrawal can occur," such as severe dehydration that may lead to heart failure).

[249] *See Dillahunt*, 3 Del. at 553 (allowing the insanity defense when the accused suffered from extreme alcohol withdrawal); *see also supra* note 5 and accompanying text (telling how Askins, later charged with murder for the overdose of his friend, had sought another hit of fentanyl due to the pain he was experiencing from fentanyl withdrawal).

[250] LAWRENCE P. TIFFANY & MARY TIFFANY, THE LEGAL DEFENSE OF PATHOLOGICAL INTOXICATION, WITH RELATED ISSUES OF TEMPORARY AND SELF-INFLICTED INSANITY 206–07 (1990) (explaining that although courts rarely address the question of whether pathological intoxication is a disease of the mind under an insanity defense directly, pathological intoxication fits under such an umbrella term). "[D]isease of the mind" is not a medical term but rather a legal term that encompasses a range of medical concepts. *See id.* at 208–12 (highlighting that courts sometimes use medical terminology in their definition of mental disease, but psychiatry is a social science and there is no "authoritative or generally accepted medical definition of mental disease").

[251] *See id.* at 208 (suggesting that where the defendant's behavior signals they may have pathological intoxication, this should be used to determine insanity, even where it is not understood exactly what is causing the pathological reaction).

included as a disease of the mind even though the addiction stemmed originally from choosing to drink alcohol or take drugs.[252]

Substance use disorders (SUDs) may fit under a disease of the mind.[253] SUDs have a recognized comorbidity with psychiatric disorders.[254] Additionally, the American Psychiatric Association's most recent publication on diagnosing mental disorders demands certain symptoms to merit an SUD diagnosis.[255] Furthermore, an SUD impacts primary brain paths, including those affecting motivation and control.[256] SUDs can also cause physical changes in the brain that affect reasoning and decision-making.[257] These physical changes continue overtime, leading to reduced activity in the part of the brain required for judgment and self-control.[258] Additionally, opioid addiction is classified as a chronically relapsing condition, meaning that users have high rates of return to use after receiving treatment.[259] All this presents circumstances that may explain why addicts struggle with judgment and self-control.[260] Thus, SUDs can lead to a lack of cognition and voluntariness such that it may fit under an insanity defense.[261]

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[252] *See id.* at 214 (arguing for the inclusion of pathological intoxication under a disease of the mind, stating that the law "does not punish one whose brain tumor caused a convulsion that led to an accident" because "those whose conduct is determined by the laws of nature" are not normally deemed worthy of punishment and that the law has always allowed disease as an excuse for wrongdoing as long as the defendant did not create the disease). "To insist, however, in all cases, that some underlying mental or physical defect be precisely identified as the 'cause' of the aberrant behavior is too blunt an instrument for the setting of day-to-day social policies as meted out in a courtroom." *Id.*

[253] *See* DRESSLER & GARVEY, *supra* note 239, at 658 n.n (quoting 18 U.S.C. § 17 (2006)) (explaining that the federal standard for the insanity defense applies where, because of mental disease, the accused could not appreciate the wrongness of their conduct); *see also* TIFFANY & TIFFANY, *supra* note 250, at 209–12 (noting that there is no authoritative definition of mental disease).

[254] Danielle E. Ramo & Sandra A. Brown, *Classes of Substance Abuse Relapse Situations: A Comparison of Adolescents and Adults*, 22 PSYCH. ADDICTIVE BEHAVS. 372, 373 (2008) ("The co-occurrence of SUDs and other Axis I psychiatric disorders has been well documented in adults and youth.") (citation omitted).

[255] *See* Scott, *supra* note 229, at 481 (explaining that the fifth edition American Psychiatric Association's handbook for diagnosis puts forth physical, behavioral, and cognitive symptoms for SUD).

[256] *See id.* at 482 (explaining that SUD is a brain disease "because it involves 'acute and chronic' functional changes to at least four primary brain circuits: reward, motivation/drive, memory/learning, and control").

[257] *See id.* (highlighting that "[b]rain-imaging studies of people with SUD show physical changes (referred to as 'neuroadaptations') in these brain circuits, which are 'critical to judgment, decision-making, learning and memory, and behavior control").

[258] *See id.* at 483–84 (explaining the process by which the prefrontal cortex—the part of the brain "necessary for judgment, planning, and self-regulation"—sees reduced activity over time).

[259] *See id.* at 480 (noting that experts understand SUD causes chronic relapses and leads addicts to use drugs even though it causes serious social and health problems).

[260] *Id.*

[261] *See* MODEL PENAL CODE § 4.01 cmt. 3 (AM. L. INST., Proposed Official Draft 1985). (explaining that the MPC insanity defense does not hold a defendant liable when "as a result of mental disease or defect, the defendant lacked substantial capacity" either to (1) "appreciate the criminality (wrongfulness) of his conduct" or (2) "conform his conduct to the requirements of law"); *see also* Scott,

Currently, federal sentencing guidelines do not allow for reduced sentencing for diminished capacity where the diminished capacity stemmed from drug addiction.[262] Accordingly, some have called for SUDs to be included as mitigating factors in sentencing to reflect the diminished self-control and decision-making capacity of addicts.[263] Others contend, however, that such mitigation is not only unnecessary but could be harmful because addiction and crime are so correlated, and addiction makes committing crime more likely.[264]

III. WHERE WE LAND WITH DRUG-INDUCED HOMICIDE LAWS

In putting forth policy recommendations for the treatment of accidental drug overdoses, context is important.[265] First, the high number of opioid addicts in the United States mainly stems from bad medical policies endorsed by the U.S. government and corporate greed of pharmaceutical companies.[266] Second, the opioid crisis was further exacerbated by the introduction of fentanyl—a drug so powerful and cheap that international drug cartels have brought an increasing supply into the United States, including areas not traditionally exposed to such harsh drugs.[267] Third, opioid addiction is a persistent condition that has proven essentially resistant to treatment.[268] Fourth, SUDs leave addicts with lowered ability to choose right from wrong and control their actions—the two criteria necessary for an insanity defense.[269] Although this does not necessarily mean SUDs qualify for complete coverage under the insanity defense, it does at the very least give strong reason to include addiction as a consideration

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supra note 229, at 483–84 (explaining that SUDs can leave addicts with decreased judgment and self-control).

[262] *See* Scott, *supra* note 229, at 501 (noting that section 5K2.13 of the USSC Guidelines, does not allow a judge to "depart below the applicable guideline range if . . . the significantly reduced mental capacity was caused by the voluntary use of drugs or other intoxicants") (alteration in original).

[263] *See id.* at 510 (telling how addiction as a disease explains why the addict is less culpable than another defendant whose crime has no connection to addiction).

[264] *See id.* at 501 (noting that the USSC discourages judges' use of "drug/alcohol dependence or abuse" as a factor when mitigating sentences for crimes).

[265] *See supra* notes 34–47 and accompanying text (explaining that the U.S. rise in opioid addiction stemmed from over-prescription of Oxycontin and similar opioid drugs). An increasing amount of fentanyl has entered the United States because it is both cheap and potent. *See supra* notes 48–52 and accompanying text (noting that fentanyl has entered the United States from foreign sources such as China through the dark web).

[266] *See supra* notes 35–43 and accompanying text (highlighting that Johnson & Johnson and Purdue Pharma greatly contributed to rising use of opioids in the United States).

[267] *See supra* notes 39–52 and accompanying text (explaining the increase of fentanyl in the United States and the economic impetus that led to drug cartels bringing fentanyl into more suburban U.S. areas).

[268] *See supra* notes 258–259 and accompanying text (discussing how opioid addiction is a chronically relapsing condition where addicts usually relapse within eighteen months of treatment).

[269] *See supra* notes 256–261 and accompanying text (noting that SUDs leads to lowered ability to control one's actions as well as decreased capacity to make judgments and that the insanity defense requires a showing of decreased capacity to control and understand the correctness of one's actions).

in sentencing decisions.[270] Accordingly, addicts facing drug-induced homicide charges should be allowed to present evidence of their addiction and receive consequences that best meet the goals of punishment.[271]

Rising drug overdoses are the hallmark of the opioid epidemic and prosecutors and legislatures feel pressure to demonstrate strong reactions.[272] Charging co-addicts for accidental drug overdoses, however, is both ineffective and possibly unconstitutional.[273] To combat the opioid epidemic more effectively, the United States should adopt an array of both demand- and supply-side policies that focus on harm reduction and equity.[274]

The United States should adopt effective demand-side policies.[275] First, the United States should aim for a greater presence of safe injection sites coupled with investment in treatment programs.[276] Additionally, courts should account for addiction when issuing sentences and be allowed to consider opioid addiction under an insanity plea.[277] Even though such demand-side policies can be expensive, such measures represent a more just and outcome.[278]

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[270] *See supra* notes 259–261 and accompanying text (discussing why an addict's decreased capacity for judgment should be included as a consideration in sentencing).

[271] *See supra* notes 251, 261–264 and accompanying text (explaining that although SUDs cause diminished reasoning ability and self-control, current federal sentencing guidelines do not allow consideration of addiction in sentencing); *see also* Russell L. Christopher, *Deterring Retributivism: The Injustice of Just Punishment*, 96 NW. U. L. REV. 843, 846–48 (2002) (explaining that retributivism justifies punishment based on the idea that "the punished deserve it" and that consequentialism justifies punishment because of deterrence, incapacitation, and rehabilitation). Retributivism is "circular or empty" because it relies solely on desert to justify punishment. *See* Christopher, *supra*, at 975 (explaining the limits of retributivism).

[272] *See* THE ACTION LAB, *supra* note 77 (noting that prosecutors are increasingly treating accidental drug overdoses as homicides even though there is no evidence these prosecutions curtail drug sales).

[273] *See id*. (saying that prosecutions of drug-induced homicide laws have not curtailed illegal drug sales); *see also supra* notes 126–138 accompanying text (describing that drug-induced homicide laws that lack mens rea and charge the accused with murder arguably violate constitutional guarantees against cruel punishment and guarantees of due process).

[274] *See infra* notes 275–282 and accompanying text (listing proposed supply- and demand-side policies).

[275] *See supra* notes 267–268 and accompanying text (explaining there are outside forces such as international fentanyl trade that have caused rising overdose deaths and that opioid addiction is resistant to treatment).

[276] *See supra* notes 176–177 and accompanying text (discussing the success of Canada's safe injection sites); *see also* The Daily, *Oregon Decriminalized Drugs. Voters Now Regret It*, N.Y. TIMES (Mar. 12, 2024), https://www.nytimes.com/2024/03/12/podcasts/the-daily/oregon-drugs.html? [https://perma.cc/U7FE-BM5K] (showing how Oregon failed to invest money into addiction recovery programs due to Covid and thus these harm reduction measures were not effective).

[277] *See supra* notes 262–264 and accompanying text (listing the reasons that drug addiction should be considered in sentencing).

[278] *See supra* notes 266–271 and accompanying text (noting the factors that have contributed to the rise in overdose deaths and why addicts should not be the sole party held responsible).

Some supply-side policies will also be necessary.[279] Full decriminalization of drug use is not recommended because open use creates a worrisome drop in community safety.[280] Canada's drug courts, however, provide a promising model where drug use charges flow through a separate judicial system aimed at connecting addicts with recovery programs.[281] Additionally, the United States should implement policies and laws that focus on reducing the flow of opioids into the United States from international sources.[282]

Drug-induced homicide laws do have their place in combating rising opioid deaths.[283] These statutes, however, should be narrowly tailored to capture only the pernicious behavior of drug-dealers that cut more innocuous drugs with fentanyl to increase demand for their business.[284] Accordingly, adopting some aspects of U.K. and Canadian law can be of use.[285] The United States should implement Canada's requirement that causality in drug-induced homicide laws must include an assessment of the accused's morally blameworthy behavior.[286] Additionally, a presumption of the victim's voluntariness in ingesting the drugs that resulted in overdose—such as in the U.K. system—would be helpful in ensuring drug-induced homicide statutes reach only those truly deserving of punishment.[287]

Further, where adopted, the prosecution of drug-induced homicide laws should be overseen by an external body to ensure the laws are not enforced inequitably by race or socioeconomic status.[288] Finally, these laws should be

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[279] *See supra* notes 48–52 and accompanying text (explaining that U.S. agencies are working to curtail the foreign sources that have brought an increased amount of fentanyl into the country).

[280] *See supra* note 196–198 and accompanying text (detailing how a movement toward harm-reduction rather than criminal consequences for cocaine use has led to decreased community safety); *see also* The Daily, *supra* note 276 (explaining that after Oregon decriminalized drug use, a "sense of lawlessness" was created and there was a lot of open use on city streets that made the community feel unsafe).

[281] *See supra* notes 178–180 (discussing how Canada drug courts treat drug use charges differently and work with focus on addiction recovery rather than jail sentences).

[282] *See supra* notes 48–52 and accompanying text (highlighting that foreign sources have brought an increased amount of fentanyl into the United States and that U.S. agencies are working to curtail that).

[283] *See supra* notes 139–141 and accompanying text (explaining that where drug-induced homicide laws serve to charge dealers who intentionally engage in dangerous reckless activities that are reasonably foreseeable to cause great harm, they better align with the justifications for felony murder laws).

[284] *See supra* notes 142–143 and accompanying text (discussing how drug-induced homicide laws should be written to only capture particularly dangerous dealer behavior that causes death).

[285] *See supra* notes 224–228 and accompanying text (showing how U.K. and Canada laws have additional criteria in order to find the accused liable for accidental drug overdoses).

[286] *See supra* notes 193–195, 228 and accompanying text (explaining that Canada considers the moral blameworthiness of the accused when determining causation for manslaughter).

[287] *See supra* notes 224–225 and accompanying text (discussing how the U.K. considers the voluntariness of the victim in taking the drugs that led to the overdose).

[288] *See supra* notes 90–91 and accompanying text (highlighting the racial disparity in prosecutions of drug crimes in the United States); *see also supra* note 213 and accompanying text (noting that racial disparity has occurred in the enforcement of drug crimes in Brazil).

coupled with broad Good Samaritan laws that promote life-saving care for overdoses.[289]

Ironically, one solution to the opioid epidemic may be found in allowing the use of currently illegal drugs to aid in addiction recovery.[290] Recent small studies have shown that ibogaine, a psychedelic, taken during therapeutic treatment sessions is a successful method for curing addiction to both crack cocaine and fentanyl.[291] Ibogaine both assuages opioid withdrawal and gives its users a desire to stay clean.[292] These research results have spurred some states to invest in further ibogaine research, as well as the federal government to reevaluate allowing testing psychedelic drugs for addiction recovery.[293]

CONCLUSION

The current opioid crisis in the United States has left policymakers struggling to cope with rising overdose deaths and skyrocketing costs of caring for addicts within communities. These trends, though extreme, do not merit reactionary retributive policy choices like broad drug-induced homicide laws. Drug-induced homicide laws and the rising prosecution levels under such statutes have mostly led to the incarceration of addicts and friends or family that did not know the deadly nature of the drug they supplied for the decedent. Ultimately, these laws do not achieve their goal of deterrence and simply offer placating sentiments of retribution to those who have lost a loved one to the opioid crisis.

What is really required to combat rising overdose levels are harm reduction measures funded in large part by those most culpable for the opioid addiction rates in the United States and systems to stem increasing fentanyl availability from international sources.

SHANDA N. STEPP

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[289] *See supra* notes 95–106 and accompanying text (explaining that Good Samaritan laws can lower overdose death rates).

[290] *See* Andrew Jacobs, *Powerful Psychedelic Gains Renewed Attention as a Treatment for Opioid Addiction*, N.Y. TIMES (Mar. 5, 2024) https://www.nytimes.com/2024/03/05/health/ibogaine-psychedelic-opioid-addiction.html?smid=nytcore-ios-share&referringSource=articleShare [https://perma.cc/8H6E-MGVY] (stating that ibogaine studies have found positive findings on the usefulness of psychedelic drugs in addiction recovery).

[291] *See id.* (finding that "between a third and two-thirds of the people who were addicted to opioids or crack cocaine and were treated with the compound in therapeutic setting were effectively cured of their habits, many after just a single session").

[292] *See id.* (explaining that ibogaine serves the dual purposes of making opioid withdrawal more tolerable and providing patients with a strong desire to stay sober).

[293] *See id.* (listing Kentucky and Ohio as states that have proposals to use money from opioid settlements to fund trials testing ibogaine therapy and explaining that federal drug researchers seem to be willing to again allow testing ibogaine after regulators stopped testing over concern for "the drug's cardiac risks").