



The Opioid Crisis

A Failure of Regulatory Design and Action

by Leo Beletsky and Jeremiah Goulka

The United States is almost three decades deep into the drug overdose crisis. Upwards of 72,000 people died of a drug overdose in 2017 according to the CDC, pushing down overall life expectancy for the third year in a row. The rapid increase in overdose deaths has generated a flood of well-worn policy interventions and media narratives, mostly targeting the health care system and the pharmaceutical industry as the principal culprits. We challenge this narrative by examining the role of America's drug control watchdog—the Drug Enforcement Administration.

Considering the scope of the crisis, it is shocking how little attention has been aimed at the nation's drug regulatory structure itself. The rapid increase in overdose rates should have frequently sparked concerns that Washington has been bungling the response. Overdose is now the leading cause of death for people under 55. (J. Katz and M. Sanger-Katz, "The Numbers Are So Staggering." *Overdose Deaths Set a Record Last Year*, N.Y. Times, Nov. 29, 2018.) It is time for a reckoning.

Structural Origins of the Opioid Crisis

American jurisdictions have been policing "vice" for generations, but the modern structure dates back to Richard Nixon's "Law and Order" response to the "Long Hot Summer." As his senior advisor, John Erlichman, recounted:

The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar Left and black people. . . . We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.

(D. Baum, *Legalize It All: How to Win the War on Drugs*, Harper's Mag., Apr. 2016.)

These were the political goals of the "War on Drugs," and they are the unhappy roots of the regulatory structures created to implement those goals. Nixon's administration ushered in the federal Controlled Substances Act in 1971 and created the Drug Enforcement Agency in 1973. There already were, and have since been, several federal

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institutions involved in shaping drug policy that share some blame—notably the White House Office of Drug Control Policy to the Food and Drug Administration. But the two most influential and problematic structures regulating opioids in both the health care and the black-market spheres have been the Controlled Substances Act and its implementing agency, the DEA.

The enactors of this new regulatory system claimed it was guided by the laudable goals of reducing harms from problematic substance use and of providing increased access to effective treatment for addiction. But when it came time to hire staff and get to work, these goals were mostly forgotten. Public health and addiction science were almost entirely left out of the DEA's expertise, stated mission, and operational goals.

Instead, from the beginning, the DEA has been a law enforcement agency. It is almost exclusively focused on the supply side of the drug trade. It makes arrests and conducts strikes. It deploys intelligence-gathering, undercover, and paramilitary assets to dismantle trafficking operations and disrupt black markets. Its operational metrics involve arrests, prosecutions, and seizures of drugs and cash. (*History*, U.S. Drug Enf't Admin., <https://www.dea.gov/history>.) And it was this agency, not the Food and Drug Administration or some other public-health-minded institution, that got the broad, unparalleled authority over the classification, production, distribution, and dispensing of opioids and other controlled substances.

The First Wave of the Opioid Epidemic (1990s to About 2010): Prescription Drugs

Fast-forward to the 1990s. Until that decade, the medical establishment viewed opioid analgesic medications—pain relievers—as controversial and severely underprescribed them, even in caring for people with terminal and other grave illness. Doctors noticed this care gap and changed course, creating an opportunity for pharmaceutical companies to formulate and market new opioid analgesics. By the late 1990s, manufacturing, marketing, and prescription of opioid painkillers were rapidly increasing. (A. Rosenblum, *Opioids and the Treatment of Chronic Pain*, *Exp. Clin. Psychopharm.*, Oct. 2008.)

While this was good news for pain patients, the pendulum swung too far the other way. Aggressively marketed in ways that misrepresented their addictiveness, opioid analgesics became seriously overprescribed. Pills were widely stolen—“diverted” is the term of art—and then misused, often, as with OxyContin, by snorting or crushing. (B. Meier, *Origins of an Epidemic*, *N.Y. Times*, May 29, 2018.)

With broad patient exposure, widespread misuse, and pervasive mixing of these drugs with other depressants, overdose deaths soared. The drug poisoning death rate doubled between 1990 and 2001 according to the CDC,

from 3.4 to 6.8 per 100,000. (CDC, *Drug Poisoning Deaths in the U.S., 1980–2008*, NCHS Data Brief No. 81, Dec. 2001.) So began the worst drug crisis in American history.

How We Should Have Responded . . . and How We Actually Responded (Wave One)

If the nation's architecture for regulating drugs had been designed in a way that took its publicly-espoused goals seriously—of reducing harms from problematic substance use and providing increased access to effective treatment for addiction—then its agencies would have pursued any number of obvious public health responses to this first wave of overdose deaths. It would have marshaled a calibrated, evidence-based, patient-focused *medical* response. Its leading enforcers would have triggered a rapid course correction in prescribing opioids, especially in combination with other depressants like benzodiazepines. Other sensible approaches would have included concerted efforts to educate patients about overdose risk and making the overdose antidote naloxone more widely available. (L. Beletsky, *Physicians' Knowledge of and Willingness to Prescribe Naloxone*, 84 *J. Urb. Health*, Jan. 2007.) Rather than just prescribing more painkillers, better approaches to pain management would have helped address patients' physical and emotional needs. Most critically, had there been a rapid scaling up in opioid agonist therapy using methadone and buprenorphine, this would have helped stabilize those patients who had developed opioid use disorder (OUD) as a result of exposure to prescription opioids as well as those people who developed OUD as a result of misusing diverted painkillers. Maintenance therapy with these medications slashes opioid overdose risk by 50–80 percent compared to other approaches. (M. Szalavitz, *The Wrong Way to Treat Opioid Addiction*, *N.Y. Times*, Jan. 17, 2018.)

But in these matters, the nation's leading regulatory agency has never been driven by public health. The DEA is a law enforcement agency. Not only does it not share public health attitudes toward drugs and drug users, but it often intentionally gets in the way. And so, when the FDA approved buprenorphine for OUD treatment in 2002, the DEA rescheduled it into a *more* restrictive category of the Controlled Substances Act (CSA)—ignoring an outcry from the medical community. At its own admission, the DEA “did not consider the need to expand narcotic treatment as a specific factor in determining the placement of buprenorphine under the CSA”; instead it obsessed over possible risks of diversion. (B. Andracka-Christon, *America Needs the TREAT Act: Effective Medication for Treating Addiction*, 26 *Health Matrix* 309, 328–30 (2016).)

Being a law enforcement agency, even when the DEA claims to pursue public health goals, the tools it uses are law enforcement tools. There is certainly a role for policing in the health sphere, such as investigating diversion cases,

fraud, and predatory practices by pharmaceutical manufacturers and distributors. But it is hard to calibrate public health goals like well-being, harm reduction, and access to treatment with law enforcement tools and performance metrics like arrests and seizures of drugs or cash. So, when the DEA did embrace one of the recommended public health approaches—a course correction in prescribing opioids—it turned it on its head. Doubling down on its singular focus on suppressing supply, the DEA and its parent, the US Department of Justice, poured federal resources into investigating and prosecuting health care providers for “inappropriate prescribing” of pain medications. (S. Satel, *Doctors Behind Bars: Treating Pain Is Now Risky Business*, N.Y. Times, Oct. 19, 2004.) Several hundred doctors were prosecuted and several thousand prescribing licenses were revoked by the DEA. (M. Hadley, *Are Pain Doctors Wrongly Taking the Blame for the Opioid Crisis?*, Crime Rep., Dec. 12, 2018.)

One way they achieved this was by using federal money to shape state-level policy. DEA and DOJ invested ramping up the investment of funding and law enforcement expertise in state-based prescription drug monitoring programs, 27 of which were established in the first decade of this century. (PDMP TTAC, *Technical Assistance Guide: History of Prescription Drug Monitoring Programs* (Mar. 2018).) While it is true that drug surveillance programs can have benefits leading to better patient care, they were deployed at a time when the DEA and many of the law enforcement agencies it influenced were broadcasting their efforts to arrest and prosecute “pill mill” doctors and pharmacies. It should therefore come as no surprise that by the end of the 2000s, many physicians became wary of prescribing pain medicines at all. The DEA declared victory:

[Controlled prescription drug (CPD)] availability in many areas has been curbed by enforcement and legislative efforts against illicit pill mills and unscrupulous physicians. Implementation of PDMP databases and increased awareness among physicians and the public about the dangers of CPD abuse have helped to reduce CPD availability in some communities.

(DEA, 2014 National Drug Threat Assessment (Nov. 1, 2014).)

The reality was that the DEA’s efforts had not just failed to stop opioid painkiller overdoses—the rate quadrupled between 1999 and 2010—but they had swung the supply pendulum too far back the other way. (R. Paulozzi, *Increases in Heroin Overdose Deaths—28 States, 2010–2012*, MMWR Morb. Wkly. Rep. 849 (Oct. 2014).) By strangling supply, legitimate pain patients were abandoned. Many pain patients were forced to go to different doctors’ offices

for analgesics, which the monitoring systems interpreted as “doctor shopping.” The systems would then flag those patients as “drug seekers,” leading more physicians to shun them in order to protect themselves from getting investigated or sanctioned—and leading patients to avoid going to doctors for their medicine. The end result was a massive, predictable—and predicted—backfiring of the DEA’s efforts. Rather than reducing demand for legitimately prescribed, legitimately produced, and medically-managed opioid painkillers, patients turned to the black market. (L. Beletsky, *Deploying Prescription Drug Monitoring to Address the Overdose Crisis: Ideology Meets Reality*, 15 Ind. Health L. Rev. 139 (2018).)

The Second Wave of the Overdose Crisis (About 2010 to 2014)

Due to the DEA’s efforts, many buyers started shopping on the black market in the first decade of the century. These pain patients now joined illicit users of opioids—many of whom had started by using diverted drugs. What patients found was a bounty of easily purchased pain medications, both stolen and counterfeit. Unfortunately, they also found another opioid that, despite decades of DEA investments in “eradicating” illicit supply chains in the hope of driving up prices, was even easier to find and far cheaper to buy: heroin.

According to the United Nations Office on Drugs and Crime (using 2015 dollars to adjust for inflation), the average street price of a gram of heroin had been steadily falling from a \$472 high in 1992 to \$141 in 2010, and it kept falling through 2013. (UNODC, *World Drug Report 2017*, tbl.8.5.) Lower-grade black tar or South American heroin could be found for far less, in the low \$20s, and, once it was cut into about 20 bags and adulterants were added, it sold on the street for \$10 or less per bag. (P. Weber, *Why Is Heroin So Cheap?*, *The Week*, Feb. 4, 2014.) That was five to eight times cheaper than a black-market OxyContin tablet. (P. Kavilanz, *Prescription Drugs Worth Millions to Dealers*, CNN Money, June 1, 2011.) Consequently, many opioid users—as well as users of other illicit drugs—started injecting heroin. In a 2014 survey of heroin users in treatment for addiction, 94% said they had turned to heroin because prescription opioids were “far more expensive and harder to obtain.” (T. Cicero, *The Changing Face of Heroin Use in the U.S.*, 71 JAMA Psychiatry 821 (2014).)

And in another irony, after years of ignoring reports of people misusing their painkillers by crushing them, thus giving plenty of time for misuse to become rampant, pharmaceutical companies finally changed their formulas to make their painkillers harder to crush—an additional nudge for some people to switch to heroin for ease of use. (B. Meier, *Origins of an Epidemic*, *supra*.)

In rushed the second wave of the opioid crisis. The overdose death rate from heroin tripled from 2010 to 2015. (*Drug Overdose Deaths in the United States 1999–2016*, fig.4, CDC: Nat'l Ctr. for Health Statistics (Dec. 2017), <https://www.cdc.gov/nchs/products/databriefs/db294.htm> [hereinafter CDC, *Drug Overdose Deaths*].) With more people shooting up, outbreaks of injection-related HIV and hepatitis C followed. According to the CDC, between 2010 and 2014, the infection rate for HCV among 18- to 39-year-olds nearly tripled. (CDC, *Persons Who Inject Drugs*, <https://www.cdc.gov/pwid/index.html>.)

How We Should Have Responded . . . and How We Actually Responded (Wave Two)

Again, if the nation's architecture for regulating drugs had been designed to take its espoused public health goals seriously, it would have marshaled a calibrated, evidence-based, patient-focused *medical response*. These would have included the approaches mentioned above, with an even more serious push to make evidence-based drug treatment—including opioid agonist therapy—and the overdose-antidote naloxone more widely available and easily accessed.

Instead, the DEA maintained its intransigence on public health and harm reduction approaches, taking no action to make high-quality, evidence-based methadone or buprenorphine treatment for OUD less hard to find. And it poured more resources into its supply-side enforcement strategies, as if these flawed strategies would finally start working if the DEA could just add enough zeal.

It expanded international interdiction operations and sent scores of new federal agents to the Mexico border, where the number of seizures approximately doubled between 2009 and 2014. The quantity of heroin seized quintupled between 2008 and 2015. (DEA, 2014 National Drug Threat Assessment, *supra*; DEA, 2016 National Drug Threat Assessment (Nov. 1, 2016).) But overdose deaths did not slow.

The Justice Department also started a push for federal and state prosecutors to treat overdose deaths as homicides. (L. Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, Utah L. Rev. (2019 forthcoming)) Using strict-liability statutes that were passed as acts of political theater during the height of the “drugs and crime” panic over crack cocaine following the overdose death of young basketball star Len Bias, these provisions were ostensibly intended to prosecute major producers and traffickers for deaths caused by their products. (*Id.*) Calling this “political theater” is not hyperbole: The statutes had been passed but almost never used. An analysis by our Health in Justice Action Lab in partnership with Mission LISA identified precisely zero prosecutions under these new laws in the 1980s.

There was only one such prosecution that decade, but it involved California's preexisting felony murder law and the high-profile death of John Belushi. In the 1990s, there were just 13. (*Data Dashboard*, Health in Justice, <https://www.healthinjustice.org/drug-induced-homicide>.)

But the nature of the theater changed at the tail end of the first wave of overdose deaths. Searching for a way to respond, law enforcement leaders and prosecutors dusted off these moribund statutes. They formulated and disseminated this prosecution strategy through conferences and webinars. From 2007 to 2014, prosecutors pursued at least 585 drug-induced homicide cases nationwide. (*Id.*)

As a policy strategy, this backfired. Not only did these prosecutions suffer from the usual absence of deterrent effect seen in drug prosecutions as well as several additional problems that will be described below, they combined with the big increase in seizures of heroin to trigger what has been called the “Iron Law of Prohibition.” (L. Beletsky & C. Davis, *Today's Fentanyl Crisis: Prohibition's Iron Law, Revisited*, 46 Int'l J. Drug Pol'y 156 (2017).) According to fundamental market economics, if you add substantial barriers and costs to an illicit drug supply chain, and you fail to take adequate efforts to reduce demand, the effect is to create direct incentives for traffickers to minimize the volume of trafficked goods while maximizing their potency to maximize profit. This is what happened during Prohibition, when alcohol traffickers discovered it made sense to switch from beer to hard liquor. (*Id.*)

The Third Wave of the Overdose Crisis (2014 to Today)

Enter fentanyl. Fentanyl is a powerful synthetic opioid pain reliever that has been used medically since the 1960s. It can be used safely in extremely controlled, miniscule doses measured in micrograms. An analogy is that a dose the size of a grain of sand—on the order of two milligrams—can kill a person (by suppressing the body's urge to breathe). Compare this to heroin, for which, according to a recent study, the median amount of actual heroin in a median dose bought on the street is 12.0 milligrams. (N. Slam, *Determining the Effective Dose of Street-Level Heroin*, 290 Forensic Sci. Int'l 219 (Sept. 2018).) There are many even stronger analogues of fentanyl; some, like the animal tranquilizer carfentanil, are so powerful that even at microscopic doses, they are not deemed safe for humans.

Unfortunately, fentanyl and its analogues are a perfect fit for the Iron Law of Prohibition. They can be synthesized cheaply and with relative ease. Clandestine manufacturers (often Chinese) produce and distribute them through a variety of channels, including directly to consumers through internet cryptomarkets and indirectly through Mexican drug-trafficking organizations. This makes for good business for traffickers: reducing production and distribution costs while delivering a stronger product.

Some users intentionally buy to use fentanyl, but unfortunately for everyone else, starting around 2014, black-market drug products—particularly heroin and counterfeit pills, but also cocaine, benzodiazepine, and methamphetamine—became increasingly adulterated with fentanyl and its analogues. More and more, what was sold as heroin or prescription painkillers was actually just fentanyl mixed with bulking agents. And because this is a drug that requires but does not often get scientific precision, titrations can be hard to predict. In the span of that single year, from 2014 to 2015, deaths involving opioid synthetics almost doubled, setting the stage for its current role as the principal driver of overdose fatalities nationwide. (CDC, *Drug Overdose Deaths, supra.*)

We are still in this third wave. Overdose deaths keep rising. According to CDC data, 72,287 people died of drug overdoses in 2017. (*Drug-Poisoning Deaths Involving Heroin: United States, 2000–2013*, CDC: Nat'l Ctr. for Health Statistics (Mar. 2015), [https://www.cdc.gov/nchs/data/databriefs/db190.htm.](https://www.cdc.gov/nchs/data/databriefs/db190.htm)) Nearly 50,000 of these deaths are known to be from opioids, and fentanyl poisoning may have contributed to deaths from other drugs. (*Provisional Drug Overdose Death Counts*, CDC: Nat'l Ctr. for Health Statistics.) There is some hope that this wave is now hitting a plateau, but even if the numbers hold, more Americans are dying of drug overdoses each year than died in the entire Vietnam War. The CDC has found that drug overdose is reducing life expectancy and is now the leading cause of death for people under 55. (Katz and Sanger-Katz, *supra.*)

How We Should Have Responded . . . and How We Actually Responded (Wave Three)

Is anything different this time? Not really. There are some positive steps. The FDA approved a naloxone nasal spray in 2015 (marketed as Narcan), and it is getting increasingly deployed. The DEA has made marginal improvements in its burdens on prescribing buprenorphine, but most of its regulatory hurdles remain in place. So do its auditing and enforcement practices that continue to chill providers' willingness to prescribe maintenance treatment. Accordingly, real care remains hard-to-impossible to access for three-quarters of people living with opioid use disorder and nearly 90 percent of people suffering substance use disorder more generally. (U.S. Dep't Health & Hum. Servs., Off. Surgeon Gen., *Facing Addiction in America: The Surgeon General's Spotlight on Opioids* (2018).)

Meanwhile, misguided approaches like drug-induced homicide prosecutions have proliferated on both the federal and state levels—thanks in no small part to DEA enthusiasm. During the Obama administration, the National Heroin Task Force recommended prioritizing these cases. (R. Goldensohn, *They Shared Drugs. Someone Died. Does That Make Them Killers?*, N.Y. Times, May 25, 2018.) During

the current administration, former Attorney General Jeff Sessions encouraged prosecutors to aggressively use “every lawful tool at their disposal”—including the death penalty—in battling the opioid epidemic. (Memorandum from J. Sessions to U.S. Attorneys, *Guidance on the Use of Capital Punishment in Drug-Related Prosecutions* (Mar. 20, 2018).)

Unfortunately, if the goal of these prosecutions has been to reduce overdose deaths, they are not doing a very good job. Our research, as well as that of the *New York Times* and the Drug Policy Alliance, suggests that of the 2,000 or so such prosecutions that have been brought since 2010, almost none picked off major traffickers. (L. Beletsky, *America's Favorite Antidote, supra.*; R. Goldensohn, *You're Not a Drug Dealer? Here's Why the Police Might Disagree*, N.Y. Times, May 25, 2018.) Instead, they ensnared low-level drug dealers. The majority did not involve “dealers” at all. They caught whoever was last with the overdose decedent: fellow users, friends, and family.

Not only are these prosecutions failing to live up to the laws' espoused goal of targeting major traffickers, when it comes to users, research shows that imprisonment is not an effective deterrent to problematic drug use. (A. Gelb, *The Lack of a Relationship between Drug Imprisonment and Drug Problems*, Pew Charitable Trusts (June 19, 2017).) Part of the concept of addiction is that it is compulsive use despite recognized negative consequences. This is a key reason why public health and harm reduction strategies are more effective.

Another problem is that the move toward treating overdoses as crime scenes to “send a message” to drug dealers is actually sending a message to drug users and their friends and families, dissuading them from calling 911 if they witness an overdose. This undermines the public health-oriented efforts many states are taking to reduce overdose deaths, for example by passing Good Samaritan laws to encourage overdose witnesses to call 911 so that emergency personnel can arrive in time to administer naloxone and stop people from dying.

At the same time, sending people with addiction into jail or prison may be a death sentence. So few detention facilities provide opioid substitution therapy that arrestees with active addictions are forced into the agony of acute withdrawal, often with no treatment. A federal judge has recently opined this to be cruel and unusual punishment, particularly given that even just one week of enforced abstinence in jail can reduce a user's tolerance enough to raise the risk of his or her death by overdose in the first few weeks of reentry by a factor of 140. (See *Pesce v. Coppinger*, No. Civ. 18-11972, Memorandum and Order (D. Mass. Nov. 26, 2018).)

Signs of Hope

Fortunately, more and more local law enforcement agencies have moved beyond the archaic influence of the DEA.

Many are working to connect users with services, treatment, and even overdose reversal. They are joining the vast majority of the public that since 2014 has wished government efforts to end the opioid epidemic would focus on treatment rather than punishment. (Pew Research Ctr., *America's New Drug Policy Landscape* (Apr. 2, 2014).)

On a policy front, sensible policies are being deployed at the state and local levels—ever the laboratories of public health innovation. For instance, opioid overdoses are declining in Rhode Island, where effective treatment is now available to people behind bars. (G. Lopez, *How America's Prisons Are Fueling the Opioid Crisis*, *Vox* (Mar. 26, 2018).) Massachusetts is pilot testing similar treatment in its jails and has radically expanded access to the overdose-antidote naloxone and to drop-in centers that help people struggling with addiction. Maryland and the District of Columbia are no longer treating the inexpensive kits and test strips that can quickly determine whether street drugs are dangerously contaminated as prosecutable drug paraphernalia. These approaches are signs of hope, though it should be noted they are far from cutting-edge elsewhere in the world. Indeed, they are often standard operating procedure, with well-documented evidence of effectiveness in countries that have ended their overdose crises. (*Opinion: States Show the Way on the Opioid Epidemic*, *N.Y. Times*, Apr. 24, 2018.)

One such strategy that feels alien to mainstream American culture—but has support from many key state and local law enforcement leaders and prominent health organizations—is to open safe consumption spaces. Also known as safe injection facilities, these operations are an element of what is known as *harm reduction* services, meaning that they meet drug users where they are, try to keep them safe, and help find treatment for people who want it. These facilities provide an indoor place to inject, sanitary syringes to prevent blood-borne disease transmission, equipment to test the user's drugs for contaminants, advice on how to access treatment and other services, and a medical professional to administer naloxone in case of an overdose. Studies suggest these facilities reduce deaths and crime while increasing the number of users seeking treatment, and so cities like Seattle, San Francisco, Philadelphia, Boston, New York City, Denver, Ithaca, and more are actively considering opening them. (G. Lopez, *A Big New Review of the Evidence Finds That Prescription Heroin Works*, *Vox*, Dec. 6, 2018.) Unsurprisingly, DEA/DOJ's response was to intimidate. The Justice Department took to the pages of the *New York Times* to threaten to prosecute anyone who works at one of these safe consumption spaces. (*Opinion: Fight Drug Abuse, Don't Subsidize It*, *N.Y. Times*, Aug. 27, 2018.)

Even less mainstream to American culture is the concept of prescription heroin, but a recent RAND Corporation report indicates it has a strong research base and could be enormously useful in treating people whose addictions have been resistant to present treatment interventions. (B. Kilmer et al., RAND Corp., *Considering Heroin-Assisted Treatment and Supervised Drug Consumption Sites in the United States* (2018).)

To End the Epidemic, We Need a New System

As the saying goes, no good crisis should go to waste. The current public health emergency presents an urgent need to rethink how our nation regulates drugs. The DEA's policies and strategies, and the Controlled Substance Act itself, have fueled black-market opioid use, in turn developing fertile ground for deadly fentanyl and its analogues to poison the black-market supply—all feeding the ongoing and growing overdose crisis. And they have consistently and energetically hindered solutions from being implemented and scaled up.

As another saying goes, law enforcement cannot arrest our way out of this crisis. As people and organizations perform to their metrics, the DEA's primary metrics—arrests, prosecutions, and drug and cash seizures—have failed our citizens. The DEA and the legal architecture around it must be fundamentally changed if we as a nation hope to correct this current health crisis. We should stop spending billions of taxpayer dollars every year blocking proven solutions and making the problems worse. (And we have not even touched on how the DEA's War on Drugs strategies have fed violence and catalyzed mass incarceration at home while triggering widespread human rights abuses, political and economic upheaval, and environmental degradation abroad.) (See L. Beletsky, *Sequester the Drug War*, *Huff. Post*, May 31, 2013.)

We propose that our nation needs to take the major step of reimagining how we regulate drugs. Let us envision a science-driven drug policy that advances life, liberty, and the pursuit of happiness. We should strive to bring all of our policy and treatment tools to bear in ending this epidemic of overdose deaths and substance use disorders. We need to listen to law enforcement leaders who see evidence-based treatment and other harm reduction strategies as the solutions to these crises. We need to clear the roadblocks. We need to fund solutions and deploy them to the people and communities that need them. The DEA has had 45 years to win its War on Drugs. It is time for a reckoning. ■