

NORTHEASTERN UNIVERSITY
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Editors' Introduction

Now in its 12th year, the Northeastern University Law Review continues to evolve in new and innovative ways. After a successful transition in 2017 from a Law Journal to a Law Review, the Law Review set its sights on promoting collaboration with the professors, centers, and institutes at Northeastern University School of Law (NUSL). In this volume, the Law Review is proud to introduce the result of those successful partnerships. This issue features an exciting collaboration with the NUSL Center for Health Policy and Law, and the next issue will showcase articles from a NUSL professor's work with the Innocence Network Conference.

This issue highlights a range of academic experts in the fields of death penalty law, probate law, and health law and policy. John D. Bessler explores how the death penalty and the indefinite nature of death row in the United States creates a constant threat of death, which can violate the United Nations Convention Against Torture's prohibitions on death threats. Richard F. Storrow conducted a first-of-its-kind 50-state review of succession laws and analyzes how these varying laws may fail to adequately provide for surviving spouses and children.

The rest of this issue showcases the innovative works of health law experts who were selected to present their research at the Center for Health Policy and Law's Annual Health Law Conference on April 12–13, 2018. The theme of the conference, "Diseases of Despair: The Role of Health Policy and Law," examined a trend of increasing mortality among middle-aged white non-Hispanic men and women in the United States due to deaths of despair (death from suicide, chronic substance use, and overdoses). The conference brought together experts, policymakers, and academics to discuss the causes behind such trends, and to explore potential political, policy, and legal responses for addressing broader determinants that affect the physical and mental health of Americans dying from these diseases of despair.

Elisabeth J. Ryan, viewing gun violence through a public health lens, argues that physicians have a duty to discuss gun safety with their patients and to warn of the dangers of their presence in patients' homes. Matthew B. Lawrence analyzes the social consequences of deputizing family members in the voluntary and involuntary treatment of individuals with substance use disorders. Abraham Gutman, Katie Moran-McCabe, and Scott Burriss propose a model of

legal levers that may be utilized in promoting and achieving more equitable housing policies. Nicolas P. Terry delves into the healthcare system, such as the stratification of insurance markets, the instability inherent to Medicaid coverage, and inadequate care in prison, to explain why the healthcare system has not only been slow to respond to, but in some cases has actually perpetuated, the nation's ongoing opioid crisis. Taleed El-Sabawi, analyzing two years of congressional hearing testimony on substance abuse and overdoses, highlights the varying narratives employed by pressure groups and the effects of such narratives on federal drug policy, particularly in the opioid crisis.

In addition to collaborations with the centers and institutes at NUSL, the Law Review hosts an annual symposium to explore a contemporary legal topic. During this year's symposium, titled "Rethinking Borders: Climate Change, Migration, and Human Rights," panelists and attendees explored the interplay between migration, human rights, and climate change, with the goal of developing innovative solutions to the current immigration and refugee crisis. The theme of borders grounded the discussion, focusing on how borders are expressed as natural forms, as well as human-made borders that are manifested in laws and policies. The symposium was generously co-sponsored by the Program on Human Rights and the Global Economy, the NUSL Chapter of the International Refugee Assistance Project, the Raoul Wallenberg Institute of Human Rights and Humanitarian Law, and the Center for Public Interest, Advocacy and Collaboration, all of whom the Law Review graciously thanks for helping bring the symposium to fruition.

The Law Review also continues to grow its online presence by publishing high-caliber student, alumni/ae, and practitioner pieces on two platforms: Extra Legal and the Forum. Extra Legal is the Law Review's online counterpart aimed at publishing legal commentaries that provide practical value by explaining the law, taking bold stances on the state of the law, and posing thoughtful questions on emerging issues. A sampling of its many publications includes: *Tripping Over Power Lines: Heydinger, Epel, and States' Autonomy in Setting Renewable Energy Standards*; *Energy Storage: To Be, or Not To Be . . . What, Exactly? That Is the Real Question*; and *The Constitutionality of Section 23 of Massachusetts's Recreational Marijuana Law*. The Forum is a legal blog dedicated to student, faculty, and practitioner discourse in current legal topics. It provides an opportunity for students to have a clear and unique voice on a topic of their choice, and showcases the wide-ranging expertise of NUSL students. Highlights from

this year's publications include: *Jeff Sessions Further Burdens Domestic Violence Asylum Seekers in Matter of A-B-*; *Twitter Fingers Turn to Eight Figures: SEC v. Elon Musk, Tesla*; and *SCOTUS in Context: A Brief History of the ACCA Before the Court*.

This volume would not have been possible without the tremendous efforts of our Staffers and Senior Staffers. The Editorial Board is extremely proud to see the Law Review's exciting evolution and is confident that the Law Review will continue to grow. We have also received invaluable guidance and support from our dedicated faculty advisor, Associate Dean and Director of Research and Information Services Sarah J. Hooke, for whom we are eternally thankful. Lastly, we would like to thank Dean James R. Hackney and the entire faculty and staff of Northeastern University School of Law for their continued support of the Law Review and its mission.

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Northeastern University Law Review

In Memory of

Brian Patrick Morrissey

Editor-in-Chief, Northeastern University Law Review, 2014–2015

**Taking Psychological Torture Seriously:
The Torturous Nature of Credible Death Threats
and the Collateral Consequences for Capital Punishment**

*By John D. Bessler**

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I. Introduction

The modern definition of *torture* makes clear that torture can be either physical or psychological in nature.¹ The U.N. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which entered into force in 1987² and which the U.S. ratified in 1994, defines torture in just those terms.³ In particular, that convention defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person” for a prohibited purpose, such as to obtain a confession or to punish.⁴ The Inter-American Convention to Prevent and Punish Torture likewise defines torture “to be any act intentionally

1 The OXFORD ENGLISH DICTIONARY (1971) defines torture as “severe or excruciating pain or suffering (of body or mind).” Accord DAVID LUBAN, TORTURE, POWER, AND LAW 116 (2014); WMA Declaration of Tokyo, WORLD MED. ASS’N (Mar. 22, 2017), <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/> (“For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.”). The World Medical Association’s Declaration of Tokyo was originally adopted by the 29th World Medical Assembly in Tokyo, Japan, in October 1975. *Id.*; see also BONITA MEYERSFELD, DOMESTIC VIOLENCE AND INTERNATIONAL LAW 78 (2010) (“The traditional definition of torture contains four elements: severe pain and suffering, whether mental or physical; intent; purpose; and state involvement.”).

2 A total of 163 countries are parties to the convention. United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, December 10, 1984, 1465 U.N.T.S. 85, https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-9&chapter=4&lang=en (listing parties).

3 United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, December 10, 1984, 1465 U.N.T.S. 113 [hereinafter “Convention Against Torture” or “CAT”]; JENNIFER K. ELSEA ET AL., THE TREATMENT OF PRISONERS: LEGAL, MORAL OR CRIMINAL? 211 (Ralph D. McPhee ed., 2006) (noting that the U.S. “signed CAT on April 18, 1988, and ratified the Convention on October 21, 1994, subject to certain declarations, reservations, and understandings”).

4 CAT, *supra* note 3, at art. 1. Cf. Rome Statute of the International Criminal Court art. 7(2)(e), July 17, 1998 (“‘Torture’ means the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control the accused; except that torture shall not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions.”); David Weissbrodt & Cheryl Heilman, *Defining Torture and Cruel, Inhuman, and Degrading Treatment*, 29 L. & INEQ. 343 (2011) (discussing the definition of torture).

performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose.”⁵

Death threats, because of their unlawful and invidious nature⁶ and their potentially coercive effects, normally have significant, adverse legal consequences.⁷ They may result in the evidentiary exclusion of confessions obtained through such means,⁸ amount to persecution,⁹ or lead to civil liability, whether for intentional

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- 5 Organization of American States, Inter-American Convention to Prevent and Punish Torture art. 2, Dec. 9, 1985, O.A.S.T.S. No. 67. “Torture,” that convention continues, “shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.” *Id.* As that convention further provides: “The concept of torture shall not include physical or mental pain or suffering that is inherent in or solely the consequence of lawful measures, provided that they do not include the performance of the acts or use of the methods referred to in this article.” *Id.*
- 6 See *Lacey v. Allstate Indemnity Co.*, No. 2:12-cv-02051-SGC, 2015 WL 875379, at *7 n.7 (N.D. Ala. Mar. 2, 2015) (“‘barbaric means’ included death threats toward the plaintiff and his children”).
- 7 1 ENCYCLOPEDIA OF DEATH AND THE HUMAN EXPERIENCE 553 (Clifton D. Bryant & Dennis L. Peck eds., 2009) (“In general, a death threat is not protected speech if there is intent to follow through with the threat. Other factors are considered in determining an unlawful death threat, such as the context in which the threat occurred and whether the target is fearful of serious harm. The means by which an illegal death threat can be communicated include speech, telecommunications, mail, e-mail, and the Internet.”).
- 8 See *United States v. Jenkins*, 938 F.2d 934, 937 (9th Cir. 1991) (“the beatings and death threats alone were sufficient to make the initial confession coerced”); *id.* at 940 (“the implicit threat of a repetition of the beatings and the fear that the police might make good on their twice-promised death threat were sufficient to render Jenkins’s 2:00 a.m. confession coerced”); *Browner v. State*, 765 S.E.2d 348, 352 (Ga. 2014) (“Physical or mental torture is the type of fear of injury that prevents a confession from being admissible”); DAVID H. KAYE ET AL., *THE NEW WIGMORE: A TREATISE ON EVIDENCE, Expert Evidence* § 8.8.3(5)(ii) (2d ed. 2018) (“A credible death threat is an enormous risk factor for confessions in general—when this factor is present, a confession is much more likely to occur”).
- 9 *Loptyeva v. Sessions*, 704 F. App’x 677, 678 (9th Cir. 2017) (citation omitted) (finding that “a ‘specific and menacing death threat’ from a police official” is “‘strong evidence of persecution’”); *Marcos v. Gonzales*, 410 F.3d 1112, 1119 (9th Cir. 2005) (“Credible death threats . . . can support a finding of past persecution.”); *Corado v. Ashcroft*, 384 F.3d 945, 947–48 (8th Cir. 2004) (a “specific, credible, and immediate” death threat can

infliction of emotional distress (“IIED”),¹⁰ by creating a hostile work environment,¹¹ or otherwise.¹² For example, threats of murder¹³

constitute persecution); *Cordon-Garcia v. INS*, 204 F.3d 985, 991 (9th Cir. 2000) (“threats of violence and death are enough” to establish persecution); *see also* *Singh v. Lynch*, 637 F. App’x 320 (9th Cir. 2016) (“Credible death threats, combined with an actual assassination attempt shortly thereafter, substantially supports a finding of past persecution. Therefore, Singh has unquestionably demonstrated that he suffered past persecution”); *Gutierrez-Vidal v. Holder*, 709 F.3d 728, 732 (8th Cir. 2013) (“Persecution ‘includes the credible threat of death, torture, or injury to one’s person or liberty on account of a protected ground,’ but does not include ‘low-level intimidation and harassment.’” (citing *Matul-Hernandez v. Holder*, 685 F.3d 707, 711 (8th Cir. 2012))); *Mashiri v. Ashcroft*, 383 F.3d 1112, 1120 (9th Cir. 2004) (“Persecution may be emotional or psychological, as well as physical.”); *id.* at 1121 (“Viewed cumulatively, Zakia’s evidence of a death threat, violent physical attacks against her husband and sons, a near-confrontation with a violent mob, vandalism, economic harm and emotional trauma compels a finding of past persecution.”); *Reyes-Guerrero v. INS*, 192 F.3d 1241, 1243 (9th Cir. 1999) (death threats against prosecutor were on account of his political opinion, supporting claim of a well-founded fear of persecution).

- 10 *Bobola v. F/V Expectation*, 204 F. Supp. 3d 382 (D. Mass. 2016) (“[A]llegations involving extreme or outrageous threats, such as death threats, can be sufficient to state a claim for IIED.”); *Denton v. Silver Stream Nursing & Rehab. Ctr.*, 739 A.2d 571, 577 (Pa. Super. Ct. 1999) (holding that death threats by a coworker, who was found to be in possession of a firearm at work, stated an IIED claim).
- 11 *Pryor v. United Air Lines, Inc.*, 791 F.3d 488, 496–97 (4th Cir. 2015) (a death threat left for an airline employee in a secure, restricted space, along with the “ample evidence” that the employee was “subjectively terrified after receiving the threats,” were sufficient to find a hostile work environment); *Allen v. Mich. Dep’t of Corr.*, 165 F.3d 405, 411 (6th Cir. 1999) (holding that a hostile work environment existed where the individual received a threatening letter that contained a death threat; the note was signed by the “KKK” and contained a reference to lynching, a drawing of a stick figure with a noose around its neck). Those making death threats to coworkers are subject to termination of employment. *Stephenson v. Amsted Industries Inc.*, No. 09-CV-12267, 2010 WL 5894939, at *7 (E.D. Mich. Oct. 13, 2010) (“[S]everal courts have held that death threats against coworkers constitute a legitimate nondiscriminatory reason for termination” (citing *Smith v. Leggett Wire Co.*, 220 F.3d 752, 759 (6th Cir. 2000))).
- 12 Death threats—it has been written—“are not ‘acts which merely constitute harassment, disrespectful or disparate treatment, a hostile work environment, humiliating criticism, intimidation, insults or other indignities.’” *Turley v. ISG Lackawanna, Inc.*, 803 F. Supp. 2d 217, 255 (W.D.N.Y. 2011) (quoting *Lydeatte v. Bronx Overall Econ. Dev. Corp.*, No. 00 Civ. 5433, 2001 WL 180055, at *2 (S.D.N.Y. Feb. 22, 2001)).
- 13 *Amouri v. Holder*, 572 F.3d 29, 33 (1st Cir. 2009) (citation omitted) (“To establish persecution, an alien must demonstrate that the harm (whether

or putting a gun to one's head as part of a threat to kill can be compelling evidence of past persecution.¹⁴ Death threats can also lead to the dismissal of a civil case,¹⁵ result in criminal prosecutions and convictions,¹⁶ show consciousness of guilt for an underlying

actual or feared) is more than the sum total of ordinary harassment or mistreatment. We need not probe that point too deeply; this case involves claimed threats of murder—and threats of murder easily qualify as sufficiently severe harm.”); *Lin Un v. Gonzales*, 415 F.3d 205, 210 (1st Cir. 2005) (citing *Aguilar-Solis v. INS*, 168 F.3d 565, 570 (1st Cir. 1999)) (“It seems to us that credible verbal death threats may fall within the meaning of ‘persecution.’ We have indicated that a threat to life could amount to persecution.”).

- 14 *Singh v. Holder*, 585 F. App'x 530, 531 (9th Cir. 2014) (“Singh’s statement that the KLF members held a gun to his head when they threatened him was a particularly important aspect of his claim to consider in assessing whether he had experienced past persecution.”).
- 15 *Kalwasinski v. Ryan*, No. 96-cv-6475, 2007 WL 2743434, at *2 (W.D.N.Y. Sept. 17, 2007) (“Death threats directed at an opposing party and a witness are sufficiently serious to warrant the sanction of dismissal.”); *see also* *Michael v. Boutwell*, 138 F. Supp. 3d 761, 785 (N.D. Miss. 2015) (“When considering whether dispositive relief is an appropriate sanction for witness intimidation, other courts have considered: (1) the nature of the threat; (2) whether the threat is likely to have a chilling effect on testimony; (3) whether the threats ‘are the result not of malice but of mental illness;’ and (4) whether the threats are the only instance of improper litigation conduct.”).
- 16 *United States v. Mann*, No. 99-4115, 2000 WL 372243 (8th Cir. Apr. 12, 2000) (affirming conviction for mailing threatening letter to the President of the United States); *Li v. Shelhamer*, No. 5:12-CV-1435 (LEK/DEP), 2013 WL 4483081, at *1 (N.D.N.Y. Aug. 20, 2013) (following a jury trial, a person was convicted of eleven counts of transmitting death threats in violation of 8 U.S.C. § 875 and sentenced to 114 months in prison); *Baldwin v. Commonwealth*, No. 0740-17-4, 2018 WL 3430995, at *1 (Va. Ct. App. July 17, 2018) (affirming conviction following man’s guilty plea for sending written threat to kill or do bodily harm to woman and her daughter); *State v. Cameron*, No. 48619-9-II, 2017 WL 2365118, at *1 (Wash. Ct. App. May 31, 2017) (affirming conviction for “felony harassment-death threats”); *see also* *Radford v. State*, 538 S.W.3d 894, 895 (Ark. Ct. App. 2018) (citation omitted) (“A person commits the offense of first-degree terroristic threatening if, with the purpose of terrorizing another person, he or she threatens to cause death or serious physical injury to another person.”); *State v. Robb*, 723 N.E.2d 1019, 1034–35 (Ohio 2000) (“Defendant’s threats to kill a guard or cut off a guard’s hand helped prove his intent to kill . . .”).

offense,¹⁷ create a conflict of interest,¹⁸ and lead to aggravated sentences.¹⁹

Because of their severity, credible death threats have been found to be torturous in nature,²⁰ with the Convention Against

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- 17 *United States v. Castleman*, 795 F.3d 904, 915 (8th Cir. 2015) (citations omitted) (“[E]vidence of death threats against witnesses . . . is generally admissible against a criminal defendant to show consciousness of guilt of the crime charged.”); *State v. Diggins*, 836 N.W.2d 349, 357 (Minn. 2013) (citations omitted) (“Evidence of a threat made by the defendant against a witness is relevant to show the defendant’s ‘consciousness of guilt.’”).
- 18 *Locascio v. United States*, 395 F.3d 51, 57 (2d Cir. 2005) (“[N]o one would question that a credible death threat from a co-defendant ordering a lawyer to sacrifice a client’s interests constitutes an actual conflict of interest.”); *People v. Avila*, 119 Cal. Rptr. 3d 657, 663 (Cal. Ct. App. 2011) (“Here, there was a credible death threat resulting in the filing of new criminal charges against appellant. The public defender is both the named victim and a necessary witness at any trial on those charges. The trial court properly concluded that the removal of the public defender and the appointment of conflict counsel was an appropriate way to proceed.”); *State v. Barrett*, No. M2009-02636-CCA-R3-CD, 2012 WL 2870571, at *34 (Tenn. Crim. App., July 13, 2012) (“[E]vidence of the Defendant’s statements about having killed before and his threats to kill other inmates was admissible.”).
- 19 *United States v. Dougherty*, 632 F. App’x 993, 995 (11th Cir. 2015) (“In explaining why an upward variance was warranted in this case, the district court also noted that it had considered the death threats made to bank customers and employees”); *United States v. Sogan*, 388 F. App’x 521, 523 (6th Cir. 2010) (“This court has repeatedly held that notes containing the statement, ‘I have a gun,’ qualify for the enhancement for threats.”); *United States v. Hunn*, 24 F.3d 994, 999 (7th Cir. 1994) (“[T]he district court properly enhanced Hunn’s sentence under U.S.S.G. § 2B3.1(b)(2)(F) for his death-threats made during the bank robbery.”); *Perkins v. State*, 559 N.W.2d 678, 692 (Minn. 1997) (“The sentencing judge found ‘particular cruelty’ in Perkins’ death threats to A.L. and her children”); *State v. Brown*, No. A15-0108, 2016 WL 281072, at *1–2 (Minn. Ct. App. Jan. 25, 2016) (“The PSI identified aggravating factors, including . . . appellant’s threats against her family”); *State v. Jackson*, 596 N.W.2d 262, 267 (Minn. Ct. App. 1999) (finding “multiple aggravating factors,” including holding gun to victim’s head and threatening to kill her, made defendant’s crimes “severe”; “death threats and use of handcuffs, and the psychological impact of his crimes” justified “a double-duration departure from the sentencing guidelines”).
- 20 CONGRESSIONAL RESEARCH SERVICE, 7-5700, R40139, CLOSING THE GUANTANAMO DETENTION CENTER: LEGAL ISSUES 25 (2009) (“In November 2008, a military commission judge ruled that statements made by a detainee to U.S. authorities were tainted by his earlier confession to Afghan police hours before, which had purportedly been made under threat of death. The judge concluded that the coercive effects of the death threats producing the detainee’s first confession had not dissipated by the time of

Torture itself barring the use of any statement made as a result of torture.²¹ The right to be free from torture is a universal, non-derogable right,²² and not even prisoners or heinous offenders can be subjected to torturous treatment or punishment.²³ As both

the second. Subsequently, a federal *habeas* court ruled that ‘every statement made by the detainee since his arrest [was] a product of torture. . . .’ (citing *United States v. Jawad*, D-021 (Nov. 19, 2008)).

- 21 CAT, *supra* note 3, at art. 15 (“Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made.”).
- 22 G.A. Res. 2200 (XXI), International Covenant on Civil and Political Rights, art. 7 (Dec. 16, 1966) [hereinafter “ICCPR”] (“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”); G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 5 (Dec. 10, 1948) [hereinafter “Universal Declaration of Human Rights”] (“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”). *See also* G.A. Res. 3452 (XXX), annex, Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, at art. 3 (Dec. 9, 1975) [hereinafter “Declaration on the Protection of All Persons”] (“No State may permit or tolerate torture or other cruel, inhuman or degrading treatment or punishment. Exceptional circumstances such as a state of war or a threat of war, internal political instability or any other public emergency may not be invoked as a justification of torture or other cruel, inhuman or degrading treatment or punishment.”); ICCPR, *supra*, at art. 4(2) (“No derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16 and 18 may be made under this provision.”); Daniel O’Donnell, *The Obligation to Establish Sentences for Torture that Are Commensurate with the Gravity of the Offense*, 22 *BUFF. HUM. RTS. L. REV.* 95, 96 (2015) (citation omitted) (“The prohibition of torture is *ius cogens*—a peremptory norm that applies to all members of the international community, independently of their treaty obligations. One of the many obligations concerning torture recognized by international law is that of criminalizing torture and making it ‘punishable by appropriate penalties which take into account [the] grave nature’ of this crime.”).
- 23 HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 204 (2003) (“The ICCPR is the most comprehensive international human rights treaty the United States has ratified and it includes provisions explicitly intended to protect prisoners from abuse or mistreatment. Under ICCPR article 7, no one ‘shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.’ The prohibition against such abusive treatment applies to prison authorities, governing both actions against individual prisoners as well as the overall conditions of confinement in which prisoners live.”). *Cf. Roper v. Simmons*, 543 U.S. 551, 560 (2005) (“By protecting even those convicted of heinous crimes, the Eighth Amendment reaffirms the duty of the government to respect the dignity of all persons.”). The Grand Chamber of the European Court of Human Rights has held on multiple occasions

the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights (“ICCPR”) make clear: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”²⁴ While courts have not always found death threats to be credible or to amount to torturous conduct,²⁵ threats that place individuals in great fear can (and often have been found to) constitute acts of mental or psychological torture.²⁶

With credible death threats producing psychological terror already treated as torturous in nature, this article explores what the collateral consequences are for capital prosecutions and death sentences.²⁷ After all, death threats are ordinarily unlawful²⁸ and

that the prohibition against torture makes for no exceptions. *E.g.*, *El-Masri v. Former Yugoslav Republic of Maced.*, App. No. 39630/09, Eur. Ct. H.R. ¶ 195 (2012).

- 24 Universal Declaration of Human Rights, *supra* note 22, at art. 5; ICCPR, *supra* note 22, at art. 7.
- 25 *See Velasco v. Holder*, 436 F. App’x 379, 379 (5th Cir. 2011); *Salan-Espinoza v. Holder*, 446 F. App’x 833, 834 (9th Cir. 2011). A finding of torture requires a case-by-case examination, and factfinders must sort through whether acts, including particular threats, rise to the level of torture or not. Seth Lowry, *Truth Be Told: Truth Serum and Its Role in the War on Terror*, 20 REGENT U. L. REV. 337, 348–50 (2008) (“[C]ourts have opted to analyze torture claims on a case-by-case basis and usually base their decision on the gruesomeness, intensity, or shock value of the treatment alleged . . .”).
- 26 JOHN D. BESSLER, *THE DEATH PENALTY AS TORTURE: FROM THE DARK AGES TO ABOLITION* 218 (2017) (“[T]he Tennessee Supreme Court noted of ‘threats to kill’ that ‘the anticipation of physical harm to one’s self or a loved one constitutes mental torture.’”); *id.* (discussing the interrogation of criminal suspects who were suffocated with plastic bags and had loaded guns pointed at their heads during rounds of Russian roulette).
- 27 *Collateral consequences*—in ordinary parlance—“are the legal disabilities that attach as an operation of law when an individual is convicted of a crime but are not part of the sentence for the crime.” CLAIR A. CRIPE ET AL., *LEGAL ASPECTS OF CORRECTIONS MANAGEMENT* 505 (3d ed. 2013). “Examples of collateral consequences include the denial of government issued licenses or permits, ineligibility for public services and public programs, and the elimination or impairment of civil rights.” *Id.* In this article, the *collateral consequences* terminology is employed in a slightly different manner. It refers here to the consequences flowing from the fact that death threats are already treated by the law as illegal, cruel, and torturous acts.
- 28 Death threats are serious offenses. *E.g.*, 18 U.S.C. § 871 (1994) (“Whoever knowingly and willfully deposits for conveyance in the mail or for a delivery from any post office or by any letter carrier any letter, paper, writing, print, missive, or document containing any threat to take the life of, to kidnap, or to inflict bodily harm upon the President of the United States, the President-elect, the Vice President or other officer next in the order of succession to the office of President of the United States, or the Vice President-elect,

capital charges and death sentences are, at bottom, nothing more than state-sponsored threats of death.²⁹ While the Convention Against Torture has a “lawful sanctions” exception to torture,³⁰ and while the death penalty remains on the books in certain nations and locales at this point in time,³¹ if death threats, because of their immutable characteristics, qualify as acts of torture, then that fact should logically have serious implications for death penalty jurisdictions. The world’s nations, by signing and ratifying the Convention Against Torture, have collectively agreed to prevent and criminalize torture in all forms.³² Indeed, torture has, for decades,

or knowingly and willfully otherwise makes any such threat against the President, President-elect, Vice President or other officer next in the order of succession to the office of President, or Vice President-elect, shall be fined under this title or imprisoned not more than five years, or both.”).

- 29 Proponents of capital punishment frequently ground their defense of it on the idea that the threat of death may deter crime. Glenn M. Bieler, *Death Be Not Proud: A Note on Juvenile Capital Punishment*, 7 N.Y.L. SCH. J. HUM. RTS. 179, 179 (1990) (“Proponents claim the threat of death deters severe criminal behavior.”). In fact, the death penalty has *not* been shown to be a greater deterrent to violent crime than life-without-parole sentences. See NATIONAL RESEARCH COUNCIL OF THE NATIONAL ACADEMIES, *DETERRENCE AND THE DEATH PENALTY* (2012) (reviewing three decades of research and concluding that the research on the effect of capital punishment on homicide is not informative about whether capital punishments decreases, increases or has no effect on homicide rates).
- 30 The definition of *torture* in the Convention Against Torture “does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.” CAT, *supra* note 3, at art. 1(1).
- 31 *Facts About the Death Penalty*, DEATH PENALTY INFORMATION CENTER, <https://deathpenaltyinfo.org/documents/FactSheet.pdf> (last updated Sept. 17, 2018) (listing death penalty and non-death penalty states); *The Death Penalty in 2016: Facts and Figures*, AMNESTY INTERNATIONAL (Apr. 11, 2017), <https://www.amnesty.org/en/latest/news/2017/04/death-penalty-2016-facts-and-figures/> (giving statistics on the death penalty’s use worldwide).
- 32 The Convention Against Torture provides: “Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.” CAT, *supra* note 3, at art. 2(1). “No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.” CAT, *supra* note 3, at art. 2(2). “An order from a superior officer or a public authority may not be invoked as a justification of torture.” CAT, *supra* note 3, at art. 2(3). The Convention Against Torture also provides: “Each State Party shall ensure that all acts of torture are offences under its criminal law. The same shall apply to an attempt to commit torture and to an act by any person which constitutes complicity or participation in torture.” CAT, *supra* note 3, at art. 4(1); *see also*

been universally prohibited by international law and been seen by U.S. courts as a clear violation of the “law of nations.”³³

Although judges seem to have no difficulty identifying and condemning physical torture,³⁴ they have been more reticent to recognize psychological forms of torture, at least in certain contexts.³⁵ This article argues that twenty-first century jurists need, at long last, to take psychological torture seriously. And in the death penalty

CAT *supra* note 3, at art. 4(2) (“Each State Party shall make these offences punishable by appropriate penalties which take into account their grave nature.”). “CAT claims require the adjudicator to consider the possibility of future torture.” *Saleh v. Sessions*, No. 18-3212, 2018 WL 5304812, at *3 (6th Cir. Oct. 25, 2018) (citation omitted); *accord* *Gomez-Domingo v. Sessions*, No. 16-2669, 2018 WL 4492433, at *2 (2d Cir. Sept. 19, 2018) (“The agency must consider ‘all evidence relevant to the possibility of future torture’”) (quoting 8 C.F.R. § 1208.16(c)(3) (2018)); *Bartolome v. Sessions*, 904 F.3d 803, 808 (9th Cir. 2018) (“During the reasonable fear determination, the asylum officer elicits ‘all information relating both to fear of persecution and fear of torture.’”) (quoting *Reasonable Fear of Persecution & Torture Determinations*, INS AOBT 8/6/2008, at *21, 2008 WL 7226112 (Aug. 6, 2008)).

33 *E.g.*, *Filártiga v. Peña-Irala*, 630 F.2d 876, 884–85 (2d Cir. 1980) (“[O]fficial torture is now prohibited by the law of nations. The prohibition is clear and unambiguous, and admits of no distinction between treatment of aliens and citizens [I]nternational law confers fundamental rights upon all people vis-a-vis their own governments. While the ultimate scope of those rights will be a subject for continuing refinement and elaboration, we hold that the right to be free from torture is now among them.”).

34 “One of the reasons physical torture is constitutionally out of the question,” one legal commentator has noted, “is that the constitution protects bodily integrity against invasion and physical torture always involves such an invasion.” JEREMY WALDRON, *TORTURE, TERROR AND TRADE-OFFS: PHILOSOPHY FOR THE WHITE HOUSE* 240 (2010) (citing the work of Seth Kreimer). In 2008, the Nebraska Supreme Court forthrightly declared the electric chair to be unconstitutional and torturous in nature. “[S]ome prisoners will be tortured during electrocutions,” the court ruled, noting that “unconsciousness and death are not instantaneous for many condemned prisoners” and that “[t]hese prisoners will, when electrocuted, consciously suffer the torture that high voltage electric current inflicts on the human body.” *State v. Mata*, 745 N.W.2d 229, 270, 279 (Neb. 2008).

35 Sean Kevin Thompson, *The Legality of the Use of Psychiatric Neuroimaging in Intelligence Interrogation*, 90 CORNELL L. REV. 1601, 1625 (2005) (“Thus far, cases of mental torture tend to be limited to severe forms of mental suffering occasioned by actions such as mock execution or threatened dismemberment or castration.”) (citing War Crimes Documentation Cent., U.S. Dep’t of the Army, Report on Iraqi War Crimes (Desert Shield/Desert Storm) 8 (1992) (unclassified version), reprinted in U.N. SCOR, 48th Sess., at 16–18, U.N. Doc. S/25441 (1993)).

context, that means recognizing capital prosecutions and death sentences for what they are: torturous threats of death.³⁶ Death threats and mock executions, both of which inflict trauma and severe pain and suffering, are already classified as psychological torture,³⁷ and many sources,³⁸ including a U.N. guide to investigating torture,

36 Death threats are made in many contexts for a wide variety of reasons. *E.g.*, U.S. DEP'T OF STATE, 110TH CONGRESS, COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 2007, 568, 2402, 2590, 2593, 2615, 2664, 2666 (Joint Comm. Print 2008) (describing anonymous death threats against journalists, human rights activists and a political cartoonist); SARA SCHATZ, IMPACT OF ORGANIZED CRIME ON MURDER OF LAW ENFORCEMENT PERSONNEL AT THE U.S.-MEXICAN BORDER 83 (2014) (describing death threats by organized crime elements); THE SAGE ENCYCLOPEDIA OF TERRORISM 200 (Gus Martin ed., 2d ed. 2011) (“One of the most famous ‘death’ fatwas in modern times was the 1989 decree issued by the Ayatollah Ruhollah Khomeini, the then leader of the Islamic Republic of Iran, calling for the death of the British writer Salman Rushdie. The fatwa declared that Rushdie should be executed for having insulted Islam in his novel *The Satanic Verses*, published in late 1988.”).

37 *See generally* THE TRAUMA OF PSYCHOLOGICAL TORTURE (Almerindo E. Ojeda ed., 2008). *Accord* 1 TRAUMA PSYCHOLOGY: ISSUES IN VIOLENCE, DISASTER, HEALTH, AND ILLNESS 37 (Elizabeth K. Carll ed., 2007) (“Psychological torture occurs in many forms, some of which are highly subtle, yet quite devastating.”); *id.* (citations omitted) (“*Threats of death and mock executions* convince the victim that he or she could certainly die at the hands of the torturer. Often torturers threaten to arrest, torture, or kill a victim’s family members, including children. Another devastating form of torture is to be *forced to listen to others being tortured* without being able to intervene, or to *witness the torture of others*, including family members and friends.”); Donna E. Arzt, *The Lockerbie “Extradition by Analogy” Agreement: “Exceptional Measure” or Template for Transnational Criminal Justice?*, 18 AM. U. INT’L L. REV. 163, 206 n.143 (2002) (“Forms of psychological torture and ill-treatment include death threats and threats of abuse against the prisoner’s family . . .”).

38 *E.g.*, HANDBOOK OF MULTICULTURAL ASSESSMENT: CLINICAL, PSYCHOLOGICAL, AND EDUCATIONAL APPLICATIONS 168 (Lisa A. Suzuki & Joseph G. Ponterotto eds., 3d ed. 2008) (“Psychological torture may include, among other techniques, humiliation, degradation, death threats, mock executions, being forced to violate taboos, forced confessions, being forced to reveal intimate personal information, and being forced to witness the torture of others, including family members.”). Some of the “more commonly used psychological torture methods” have been listed as follows: “Threats,” “Mock executions,” “Isolation,” “Witnessing torture sessions,” “Sleep deprivation,” “Loud noise,” “Constant exposure to bright light,” “Total sensory deprivation,” “Sexual humiliation,” “Not allowed to wear clothes,” “Constant interrogation,” “Not allowed to wash or to go to toilet,” “Not allowed to be alone in the toilet,” “Excrement abuse.” FORENSIC MEDICINE: CLINICAL AND PATHOLOGICAL ASPECTS 62 (Jason Payne-

list varieties of mental torture (e.g., “Threats of death, harm to family, further torture, imprisonment, mock executions”; “Threats of attack by animals, such as dogs, cats, rats or scorpions”; and “Forcing the victim to witness torture or atrocities being inflicted on others.”).³⁹

Part II of this article describes the illegality of death threats, highlighting how credible death threats are ordinarily treated as criminal, tortious, or torturous acts.⁴⁰ The article then describes the process by which the death penalty is administered, laying out the collateral consequences for capital punishment of credible death threats already being classified as illegal and as unlawful acts of torture. Part III thus details the process by which capital charges are leveled and death sentences are sought, obtained, and carried out. That section reveals that threats to execute offenders are, in effect, nothing more than torturous threats of death, albeit ones made by state actors in a particular context. Finally, Part IV argues that, given the absolute and existing legal prohibition against psychological torture, lawyers and judges should no longer tolerate, or be complicit with, criminal justice systems that make use of death threats of whatever kind or nature. Because death threats are already properly classified as torturous acts in multiple contexts, including

James et al. eds., 2003); *see also id.* (“Sham executions are an ultimate form of psychological torture and they are carried out with the utmost care to make them realistic. The victim is not always relieved when the soldiers fire blanks, but may end up wanting them to end his life.”).

39 Office of the United Nations High Commission for Human Rights (Geneva), Professional Training Series No. 8/Rev. 1, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* p. 29, ¶ 145 (2004).

40 *See, e.g.,* Al Shimari v. CACI Premier Tech., Inc., 300 F. Supp. 3d 758, 781 (E.D. Va. 2018) (citing a 1997 report of the Committee Against Torture concluding that “threats, including death threats,” constitute torture); JORDAN J. PAUST ET AL., INTERNATIONAL CRIMINAL LAW 712, 866 (4th ed. 2013) (discussing the Committee Against Torture’s condemnation of “threats, including death threats,” as “either torture or cruel, inhuman or degrading treatment”). *See also* Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of International Armed Conflicts, art. 75(2)(e), June 8, 1977, 1125 U.N.T.S. 3 (proscribing “[t]hreats to commit” “[m]urder”, “[v]iolence to the life, health, or physical or mental well-being of persons”, “[t]orture”, “[m]utilation”, “humiliating and degrading treatment...and any form of indecent assault”); Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts, art. 4(2)(h), June 8, 1977, 1125 U.N.T.S. 609 (proscribing threats to commit the same and additional conduct).

in the context of torture-murder prosecutions, the use of death threats as part of any crime and punishment regime is inconsistent with human rights principles.⁴¹ The article concludes that the death penalty should be classified under the rubric of torture.

II. The Illegality and Torturous Nature of Threats of Death

A. Existing Legal Protections Against Death Threats Against Individuals

Death threats may be either express or implied.⁴² Public officials sometimes receive illicit death threats,⁴³ but state actors—as history shows—also sometimes make death threats or fail to protect prisoners or others following the making of death threats.⁴⁴ In the latter circumstances, death threats can result in liability for government officials for which there is no qualified immunity.⁴⁵

41 This article provides an in-depth examination of an argument I have explored elsewhere. See generally BESSLER, *THE DEATH PENALTY AS TORTURE*, *supra* note 26.

42 *United States v. Sogan*, 388 F. App'x 521, 523 (6th Cir. 2010).

43 E.g., *Texas Dep't of Criminal Justice v. Levin*, No. 03-15-00044-CV, 2007 WL 2302603, at *5 (Tex. Crim. App. May 25, 2017).

44 Prison officials are legally obligated to protect prisoners from harm. *HANDBOOK ON PRISONS* 575 (Yvonne Jewkes ed., 2013) (“[I]t has long been accepted that the authorities have a duty to protect prisoners against third parties, such as fellow prisoners who might harm them.”).

45 *Santiago v. Blair*, 707 F.3d 984, 993 (8th Cir. 2013) (“[A] reasonable jury could conclude that Clubbs issued the death threats because Santiago had filed and pursued his excessive force grievance. Thus, Clubbs is not entitled to qualified immunity regarding the retaliatory death threats.”); *Irving v. Dormire*, 519 F.3d 441, 449 (8th Cir. 2008) (“We conclude that, when viewed in the light of their retaliatory nature, their objectively credible basis, and their fear-inducing result, the death threats allegedly made by Brigance form the basis of an injury sufficiently serious to implicate the Eighth Amendment.”); *Rodriguez v. Secretary for Dep't of Corr.*, 508 F.3d 611, 617 n.12 (11th Cir. 2007) (“[W]e conclude that the gang-related threats made on Rodriguez’s life, which were explicitly reported to prison officials, present a substantial enough risk of harm to trigger a prison official’s Eighth Amendment duty to act; that is, to take some steps to investigate the likelihood that the reported threat will materialize and to take some steps aimed at reducing the likelihood of the risk.”); *Odom v. S. Carolina Dep't of Corr.*, 349 F.3d 765, 770 (4th Cir. 2003) (inmate-on-inmate assault, preceded by death threats, was sufficiently substantial for Eighth Amendment purposes to survive summary judgment); see also *Wright v. Fry*, No. 1:18-cv-00016-KGB/JTK, 2018 WL 5266845 *1 (E.D. Ark. Oct. 22, 2018) (citations omitted) (“While allegations of verbal threats, taunts, name calling, or the use of offensive language alone do not support claims for use of excessive

For example, in *Jones v. Carroll*,⁴⁶ a former inmate, Charles Jones, brought a section 1983⁴⁷ claim for violation of his civil rights against prison employees, alleging that they failed to protect him from an attack by another inmate, Anibal Melendez. The federal district court determined that a genuine issue of material fact existed as to whether Jones told prison officials about violent threats he received from Melendez, whom had threatened to kill Jones.⁴⁸ In that case, the federal district court ruled that “a reasonable factfinder could conclude, based on plaintiff’s evidence,” that the “State defendants . . . subjectively knew of the substantial risk of harm that Melendez posed to plaintiff based on Melendez’s death threats.”⁴⁹

Death threats are illegal and extremely shocking and outrageous acts,⁵⁰ and they are frequently used by criminals or

force, an exception is recognized “when the state official engaged in a brutal and wanton act of cruelty even though no physical harm was suffered.”); *Irving v. Wells*, No. 1:18-CV-47 JMB, 2018 WL 2868927, at *2 (E.D. Mo. June 11, 2018) (“Although verbal threats are normally insufficient to violate the Constitution, the Eighth Circuit has concluded that death threats . . . may form the basis of an injury sufficiently serious to implicate the Eighth Amendment.”) (citing *Irving*, 519 F.3d at 448–49); *Titus v. Does #10-20*, No. 17-cv-1315-MJR, 2018 WL 558532, at *3 (S.D. Ill. Jan. 25, 2018) (citations omitted) (“Courts must apply an objective standard to determine whether a particular threat, given all the circumstances, may amount to a constitutional violation. The pertinent inquiry is whether a ‘reasonable’ victim would fear for his or her life or safety as a result of the threat; not whether this plaintiff experienced actual fear.”).

46 *Jones v. Carroll*, 628 F. Supp. 2d 551 (D. Del. 2009).

47 Title 42 U.S.C. § 1983 (2017) allows prisoners to seek redress for the deprivation, under color of state law, of rights guaranteed by the U.S. Constitution or federal laws. *Perry v. Garcia*, No. 09cv622 LAB (RBB), 2010 WL 3633042, at *12 (S.D. Cal. July 16, 2010); *Norton v. Garro*, 957 F. Supp. 1067, 1070 (E.D. Wis. 1997); *Webb v. Hopkins*, No. 88 CV 2501, 1989 WL 15814, at *1 (E.D.N.Y. Feb. 9, 1989).

48 *Jones*, 628 F. Supp. 2d at 553–55.

49 *Id.* at 560. As that court further ruled: “The court finds that the failure to protect an inmate from another inmate who had issued continuing death threats poses an objective risk of excessive harm to the threatened inmate.” *Id.* at 560 n.9.

50 *E.g.*, *Neumeyer v. Wawanesa General Ins. Co.*, No. 14cv181-MMA (RBB), 2015 WL 1924981, at *24 (S.D. Cal. Apr. 24, 2015) (“death threats constitute criminal behavior”); *Baird v. Gotbaum*, 662 F.3d 1246, 1249 (D.C. Cir. 2011) (“Of course death threats are extreme . . .”); *see also* CAL. PENAL CODE § 422 (2011) (making death threats a crime); U.S.S.G. § 2B3.1(b) (2)(F) (2016) (providing for the upward adjustment of a defendant’s base offense level for robbery by two levels “if a threat of death was made”); *United States v. Fontanez*, No. 17-13944, 2018 WL 3239249, at *2 n.3

totalitarian or repressive regimes for illicit purposes.⁵¹ Death threats, it has been held, are completely unjustified and unjustifiable,⁵² and because of their nature, they can themselves be evidence of aggressive or murderous intent.⁵³ The seriousness of death threats is even reflected in the application of evidentiary rules. As the U.S. Court of Appeals for the Second Circuit emphasized in a recent case:

It is long settled that the admissibility of death threats made by a defendant is evaluated in accordance with the ordinary principles of Federal Rule of Evidence 403. At the same time, the potential for unfair prejudice is so great that Rule 403's balancing test permits admission of death threat evidence only if there is clear need for the evidence and it serves an important purpose.⁵⁴

As the Second Circuit ruled in that case: “It is hard to deem harmless the erroneous admission of death threat evidence. In this instance, the evidence was toxic.”⁵⁵

(11th Cir. June 3, 2018) (noting that the defendant “received a two-level enhancement for making a threat of death” pursuant to U.S.S.G. § 2B3.1(b)(2)(F) (2016)).

51 STEPHEN J. MOREWITZ, *DEATH THREATS AND VIOLENCE: NEW RESEARCH AND CLINICAL PERSPECTIVES* 101 (2008) (citation omitted).

52 *See Schanze v. Schanze*, No. A15-0231, 2015 WL 8548626, at *3 n.2 (Minn. Ct. App. Dec. 14, 2015) (“We categorically reject Daniel’s argument that the harm threatened was not imminent because it was contingent on Danielle having an extramarital affair. To adopt this argument could be read to suggest that an extramarital affair somehow justifies death threats. The unfortunate occurrence of an extramarital affair does not ever justify death threats.”).

53 *Hernandez v. Stainer*, No. 1:11-cv-00489-AWI-JLT, 2013 WL 5773041, at *16 (E.D. Cal. Oct. 24, 2013) (“[W]here both perpetrators made death threats against the victims, each assisting the other in what appears to be a highly coordinated assault, and where the shooting does not appear to have been either an accident or impulse by Ramirez, but rather part of a jointly understood and planned strategy of attack, the evidence is certainly sufficient to support a finding by reasonable jurors that Petitioner shared the same homicidal mind state as Ramirez.”); *People v. Gamble*, 899 N.Y.S.2d 207, 209 (N.Y. App. Div. 2010) (“Defendant’s pattern of aggressive conduct toward the victims, including specific death threats and menacing with a handgun, was highly probative of motive and intent . . .”).

54 *United States v. Morgan*, 786 F.3d 227, 229 (2d Cir. 2015) (citation omitted).

55 *Id.* at 234. *See also United States v. Tarantino*, No. 08-CR-0655 (JS), 2012

Death threats are not constitutionally protected speech.⁵⁶ “[T]he First Amendment,” the U.S. Supreme Court has ruled, “permits a State to ban a ‘true threat.’”⁵⁷ As the Supreme Court has explained: “[T]rue threats’ encompass those statements where the speaker means to communicate a serious expression of an intent to commit an act of unlawful violence to a particular individual or group of individuals.”⁵⁸ “Intimidation in the constitutionally proscribable sense of the word,” the Court emphasized, “is a type of true threat, where a speaker directs a threat to a person or group of persons with the intent of placing the victim in fear of bodily harm or death.”⁵⁹ Thus, the constitutional rights of someone making a true threat are not violated if an adverse action (e.g., a criminal prosecution or the termination of employment) follows the making of that threat.⁶⁰

WL 1458197, at *4 (E.D.N.Y. Apr. 27, 2012) (citations omitted) (“Death threats, like other evidence, are subject to the usual Rule 403 balancing test. Nevertheless, courts are mindful that ‘the potential prejudice from death threats may be great’ and may tend to ‘exclude death threats more frequently than other evidence.’”).

56 United States v. Walker, 665 F.3d 212, 227 (1st Cir. 2011) (“The law is crystal clear that threats are not constitutionally protected speech.”). See Santiago v. Blair, 707 F.3d 984, 992 (8th Cir. 2013) (“[A] reasonable jury could find that threats of death, issued by a correctional officer tasked with guarding a prisoner’s segregated cell, would chill a prisoner of ordinary firmness from engaging in the prison grievance process”); Van Deelen v. Johnson, 497 F.3d 1151, 1157 (10th Cir. 2007) (“[A]llegations of physical and verbal intimidation, including a threat by a deputy sheriff to shoot him if he brought any more tax appeals, would surely suffice under our precedents to chill a person of ordinary firmness from continuing to seek redress for (allegedly) unfair property tax assessments.”).

57 Virginia v. Black, 538 U.S. 343, 359 (2003) (quoting Watts v. United States, 394 U.S. 705, 708 (1969) (per curiam)).

58 *Id.*

59 *Id.* at 360; see also Baumgartner v. Eppinger, No. 1:10CV2810, 2013 WL 5563913, at *17 (N.D. Ohio, Sept. 27, 2013) (citations omitted) (“The Seventh Circuit, in a case involving 18 U.S.C. § 876, stated that, in order for the government to establish a ‘true threat,’ it must demonstrate that a reasonable person would foresee that the statement at issue would be interpreted by the recipient as ‘a serious expression of an intention to inflict bodily harm upon,’ or to kill, that person. The court emphasized the importance of the context of the statement in determining whether it was a true threat or merely political hyperbole.”).

60 See, e.g., Smith v. N.Y.C. Dep’t of Educ., 109 A.D.3d 701, 702–03 (N.Y. App. Div. 2013) (holding that disciplinary proceeding and ultimate discipline imposed against tenured teacher, that is, termination of employment, did not violate teacher’s right to free speech under the First Amendment, where teacher’s death threats against initial arbitrator in a prior disciplinary

That is because it is improper to threaten someone with death. The Supreme Court, in fact, has made clear that a victim's fear, if reasonable or grounded in reality, mandates that threatening speech lose its First Amendment protection.⁶¹

B. Death Threats, Persecution, and the U.S. Constitution's Eighth Amendment

The U.S. Constitution's Eighth Amendment imposes a duty on prison officials "to protect prisoners from violence at the hands of

proceeding were true threats not entitled to First Amendment protection, and they did not implicate matters of public concern); *Misiak v. Boeing*, No. C09-0716-JCC, 2010 WL 55857, at *4–5 (W.D. Wash. Jan. 5, 2010) ("The state courts neither misinterpreted nor misapplied Supreme Court authority in determining that prohibiting inmates from making death threats is related to the legitimate penological interest of protecting correctional officers."). A person subjected to a plausible and imminent threat of serious injury or death is entitled to the law's protection—a principle that, as a general matter, applies equally to inmates. *Valdez v. City of New York*, No. 11 Civ. 05194(PAC)(DF), 2013 WL 8642169, at *11 (S.D.N.Y. Sept. 3, 2013) ("[C]ourts have consistently required plaintiffs in inmate-safety cases to allege that they either suffered a physical injury or were subject to an imminent threat of serious physical injury in circumstances making the threat plausible."). Of course, an inmate is legally protected from harm only if the threat is real. *See Chalif v. Spitzer*, No. 9:05-CV-1355 (LEK/DEP), 2008 WL 1848650, at *9 (N.D.N.Y. Apr. 23, 2008) (finding no substantial risk of serious harm where plaintiff alleged that he was "subjected to psychological torture by imminent threat of death" but complaint did not include "any incident[] whereby he was assaulted by any fellow inmates, or that such an assault was threatened and imminent"). *See also Richardson v. Castro*, No. 97-CV-3772 (SJ), 1998 WL 205414, at *5 (E.D.N.Y. Apr. 24, 1998) (citation omitted) ("[V]erbal threats do not violate the constitution 'unless accompanied by physical force or the present ability to effectuate the threat.'").

61 Joshua Azriel, *First Amendment Implications for E-Mail Threats: Are There Any Free Speech Protections?*, 23 J. MARSHALL J. COMPUTER & INFO. L. 845, 846 (2005) (citation omitted) ("The U.S. Supreme Court recently decided a case where the victim's fear mandates that threatening speech lose its First Amendment protection. The Court, in a 6-3 decision, ruled that cross burning is not protected speech when it is used to intimidate an individual or a group of people. The salient part of the Court's ruling is that intimidation is a true threat, and a prohibition on intimidating threats protects people from a fear of violence. The Court stated that the speaker does not actually have to carry out the threat for it to be illegal. This follows the reasoning of several lower court decisions that use a reasonable person standard to determine the efficacy of a threat.").

other prisoners”⁶² and prison guards.⁶³ The Eighth Amendment, in fact, has already been found to protect inmates from death threats.⁶⁴ One federal district court articulated the applicable standard: “Courts must apply an objective standard to determine whether a particular threat of death or harm, given all the circumstances, may amount to a constitutional violation.”⁶⁵ “The pertinent inquiry,” that court stressed, “is whether a ‘reasonable’ victim would fear for his or her life as a result of the threat; not whether this plaintiff experienced actual fear.”⁶⁶ In that case, the court observed that “repeated threats to beat and kill Plaintiff and to have officers at his next prison ‘get’ him” may have “violated Plaintiff’s constitutional rights.”⁶⁷ “These actions,” the court concluded, taking note of how the inmate was forced to strip and spread his buttocks for an inordinate length of time, were calculated “to strike fear into Plaintiff, to humiliate him, and to emphasize that the Defendants had the power to harm and

62 Farmer v. Brennan, 511 U.S. 825, 833 (1994) (citation omitted).

63 See Hudson v. McMillian, 503 U.S. 1 (1992) (a correctional officer’s use of excessive physical force against a prisoner may, in appropriate circumstances, constitute a cruel and unusual punishment even though the prison does not suffer either “significant injury” or “serious injury”); McClanahan v. Butler, No. 16-cv-340-SMY, 2016 WL 4154910, at *2 (S.D. Ill. Aug. 5, 2016) (“The intentional use of excessive force by prison guards against an inmate without penological justification constitutes cruel and unusual punishment in violation of the Eighth Amendment and is actionable under § 1983.”); see also 42 U.S.C. § 1997e(e) (2012) (“No Federal civil action may be brought by a prisoner confined in a jail, prison or other correctional facility for mental or emotional injury suffered while in custody without a prior showing of physical injury. . . .”); Johnson v. Bradford, 72 F. App’x 98, 99 (5th Cir. 2003) (“Johnson’s challenge to the defendants’ alleged death threats does not present a claim of physical injury and therefore fails to state an excessive force claim.”).

64 Dobbey v. Ill. Dep’t of Corr., 574 F.3d 443, 445 (7th Cir. 2009) (citations omitted) (“[A] threat, which is how the plaintiff interpreted the incident, can rise to the level of cruel and unusual punishment.”); *id.* (“‘Mental torture is not an oxymoron, and has been held or assumed in a number of prisoner cases to be actionable as cruel and unusual punishment,’ . . . — imagine falsely informing a prisoner that he has been sentenced to death.”); Lamon v. Brown, No. 12-cv-1176-JPG-DGW, 2013 WL 6508490, at *2 (S.D. Ill. Dec. 12, 2013) (citation omitted) (“[T]hreats or mental torture can rise to the level of cruel and unusual punishment.”).

65 Bardo v. Stolworthy, No. 15-cv-1193-JPG, 2015 WL 7713710, at *8 (S.D. Ill. Nov. 30, 2015) (citing Dobbey v. Ill. Dep’t of Corr., 574 F.3d 443, 445 (7th Cir. 2009)).

66 *Id.*

67 *Id.*

kill him.”⁶⁸

American jurists have long classified verbal threats as potentially violative of the Eighth Amendment if accompanied by extreme psychological torment or harm.⁶⁹ For instance, in *Babcock v. White*,⁷⁰ the Seventh Circuit held that “the Constitution does not countenance psychological torture merely because it fails to inflict physical injury.”⁷¹ Likewise, in *Northington v. Jackson*,⁷² an inmate, Craig Northington, filed a civil rights action against sheriff’s deputies, corrections officers, and a county sheriff’s department alleging that law enforcement officers stopped him on his way from the Denver County Jail to his community placement worksite.⁷³ In that case, Northington alleged that a captain put a revolver to his head and threatened to kill him.⁷⁴ In its analysis, the Tenth Circuit, noting that Northington “alleged psychological injury as a result of the alleged death threat,”⁷⁵ explicitly ruled: “Under these circumstances, if true, it could be ‘malicious and sadistic’ for a corrections officer to place a revolver to a prisoner’s head and threaten to pull the trigger.”⁷⁶ “Mr. Northington’s allegations, accepted as true, may state a violation of

68 *Id.*

69 *Cummings v. Harrison*, 695 F. Supp. 2d 1263, 1272 (N.D. Fla. 2010); *see also id.* at 1273 (“[D]espite the general principle that verbal threats are insufficient to state a claim, some cases have recognized that verbal threats to kill an inmate do present an Eighth Amendment claim.”). In *Cummings*, the court ruled: “The threats as presented in Plaintiff’s affidavit reveal sufficient psychological harm to survive. This is especially true as the verbal threats are alleged to have been continuing and combined with physical assaults.” *Id.*; *see also Gomez v. Bironde*, No. 91-15731, 1992 WL 153007, at *2 (9th Cir. July 6, 1992) (“Gomez’s allegations of excessive force combined with death threats arguably state a[n] [E]ighth [A]mendment claim.”); *Johnson v. Glick*, 481 F.2d 1028, 1029–30, 1033 (2d Cir. 1973) (finding that a prisoner stated an Eighth Amendment claim by alleging that an officer struck him and threatened to kill him), *cert. denied*, 414 U.S. 1033 (1973); *cf. United States v. Gore*, 592 F.3d 489, 491–92 (4th Cir. 2010) (the government “concedes that some minimal right of self-defense must be available to inmates charged under 18 U.S.C. § 111 because disabling an inmate entirely from protecting himself from wanton, unlawful aggression threatening death or serious bodily injury would violate the Eighth Amendment’s prohibition of cruel and unusual punishments”).

70 *Babcock v. White*, 102 F.3d 267 (7th Cir. 1996).

71 *Id.* at 273.

72 *Northington v. Jackson*, 973 F.2d 1518 (10th Cir. 1992).

73 *Id.* at 1520, 1522.

74 *Id.* at 1522.

75 *Id.* at 1524.

76 *Id.*

the Eighth Amendment,” the Tenth Circuit determined.⁷⁷

In immigration and asylum cases, prior death threats are used to establish past persecution or a well-founded fear of future persecution.⁷⁸ For instance, in *Hernandez-Avalos v. Lynch*,⁷⁹ the Fourth Circuit held that a native and citizen of El Salvador, Maydai

77 *Id.* at 1525. In its ruling, the Tenth Circuit distinguished *Collins v. Cundy*, 603 F.2d 825 (10th Cir. 1979), in which the Tenth Circuit had previously ruled that a sheriff’s “idle threat to hang a prisoner” did not give rise to a section 1983 claim. *Northington*, 973 F.2d at 1524 (citing *Collins*, 603 F.2d at 827); *see also* *Clark v. Ellis*, No. 4-11-cv-00135-KGB-JTK, 2012 WL 3595973, at *4 (E.D. Ark. May 24, 2012) (citations omitted) (“[M]ere verbal threats made by a state-actor do not constitute a § 1983 claim [T]he constitution does not protect against all intrusions on one’s peace of mind. Fear of emotional injury which results solely from verbal harassment or idle threats is generally not sufficient to constitute an invasion of an identified liberty interest.”).

78 Death threats are a frequent staple of persecution claims. *E.g.*, *Tairou v. Whitaker*, No. 17-1404, 2018 WL 6252780, at *4 (4th Cir. Nov. 30, 2018) (“Because Tairou received multiple, explicit threats of death both during and after the village gathering, the BIA’s conclusion as to past harm contravenes our express and repeated holding that the ‘threat of death’ qualifies as persecution.”); *Loptyeva v. Sessions*, 704 F. App’x 677, 681 (9th Cir. 2017) (citation omitted) (“[W]hile ‘death threats alone can constitute persecution,’ the context in which the threat is made ultimately determines its persecutory impact[.]”); *Godoy v. Holder*, 434 F. App’x 634, 635 (9th Cir. 2011) (citations omitted) (“[D]eath threats, when combined with other factors present here (including the murders of family members and physical confrontations with persecutors), may constitute persecution.”); *Ramirez-Recinos v. U.S. Att’y Gen.*, 406 F. App’x 457, 459 (11th Cir. 2010) (“[W]e upheld a persecution claim where an alien received numerous death threats, was dragged by her hair out of her car and beaten, had her groundskeeper tortured and killed by attackers looking for her, and was further kidnapped and beaten.”); *Kumar v. Gonzales*, 444 F.3d 1043, 1055 (9th Cir. 2006) (holding that threats to kill individual if he returned to India “require a finding that he has met his burden of showing a well-founded fear of future persecution”); *Lim v. INS*, 224 F.3d 929, 936 (9th Cir. 2000) (“[M]enacing death threats can constitute a primary part of a past persecution claim, particularly where those threats are combined with confrontation or other mistreatment.”); *Sackie v. Ashcroft*, 270 F. Supp. 2d 596, 602 (E.D. Pa. 2003) (“Given Mr. Sackie’s undisputed and uncontroverted testimony that he was threatened with imminent death on numerous occasions, frequently given mind altering substances and suffered cuts to his back and arms, we must find that he has met his burden of proving that he was tortured in his native country.”). *Cf.* *Pabon v. U.S. Att’y Gen.*, 704 F. App’x 903, 907 (11th Cir. 2017) (“Being intentionally shot at is sufficiently extreme to establish persecution, even if the attack is unsuccessful, and there is no strict physical harm requirement to establish persecution.”).

79 *Hernandez-Avalos v. Lynch*, 784 F.3d 944 (4th Cir. 2015).

Hernandez-Avalos (“Hernandez”), had sufficiently proven past persecution and a well-founded fear of future persecution based on a gang’s death threats.⁸⁰ In 2007, members of the Mara 18 gang had killed the cousin of Hernandez’s husband for refusing to join the gang.⁸¹ Hernandez had not witnessed the murder, but she later identified the body and took it home for burial.⁸² After that burial, gang members had come to her home and threatened to kill her if she fingered the gang members responsible for the murder.⁸³ Within a few months, Hernandez was threatened with death again when Mara 18 gang members returned to her home and put a gun to her head after she told them her 12-year-old son would not join the gang.⁸⁴ After Hernandez was similarly threatened with death yet a third time by gang members, she fled to the United States with the help of a smuggler.⁸⁵

In *Hernandez-Avalos*, the Fourth Circuit took note of the death threats, emphasizing that its jurisprudence made clear that “the threat of death qualifies as persecution.”⁸⁶ “Because Hernandez credibly testified that she received death threats from Mara 18,” the Fourth Circuit determined, “she has proven that she has a well-founded fear of future persecution were she to return to El Salvador.”⁸⁷ “[I]n this case,” the Fourth Circuit stressed, “Mara 18 threatened Hernandez in order to recruit her son into their ranks, but they also threatened Hernandez, rather than another person, because of her family connection to her son.”⁸⁸ Acknowledging the corruption and the power of gangs within Salvadoran prisons and El Salvador’s judicial system,⁸⁹ and finding that Hernandez had established her eligibility for asylum, the Fourth Circuit concluded that Hernandez’s credible testimony “is legally sufficient under the circumstances present here to establish that the Salvadoran authorities are unable or unwilling to protect her from the gang members who threatened her.”⁹⁰ In

80 *Id.* at 946–53.

81 *Id.* at 947.

82 *Id.*

83 *Id.*

84 *Id.*

85 *Id.*

86 *Id.* at 949.

87 *Id.*

88 *Id.* at 950.

89 *Id.* at 952–53.

90 *Id.* at 953.

reality, death threats have long been a problem in El Salvador,⁹¹ as they have been in many other countries.⁹²

American courts have wrestled on more than one occasion with cases involving death threats made against inmates. For example, in *Chandler v. D.C. Department of Corrections*,⁹³ a threat was made against an inmate's life and the inmate alleged it had caused him "psychological damage" and that his fear that the threat would be carried out caused him to suffer "[n]ightmares and [to] wak[e] up in a frantic sweat."⁹⁴ In that case, the U.S. Court of Appeals for the District of Columbia began its analysis by stating: "We note at the outset that verbal threats, without more, may be sufficient to state a cause of action under the Eighth Amendment."⁹⁵ The Court of Appeals then concluded that, "[d]epending on the gravity of the fear," "the credibility of the threat," and the targeted person's "psychological condition," a death threat "could have caused more than de minimis harm and therefore could have been sufficient to state a claim of excessive use of force."⁹⁶ "These issues," the Court of Appeals ruled, reversing the district court's dismissal of

91 See, e.g., LAWRENCE MICHAEL LADUTKE, FREEDOM IN EXPRESSION IN EL SALVADOR: THE STRUGGLE FOR HUMAN RIGHTS AND DEMOCRACY 58 (2004); THOMAS L. PEARCY, THE HISTORY OF CENTRAL AMERICA 110 (2006).

92 HUMAN RIGHTS IN DEVELOPING COUNTRIES: YEARBOOK 1997 196–97 (Hugo Stokke et al. eds.) (discussing death threats in Guatemala); SILVIO WAISBORD, WATCHDOG JOURNALISM IN SOUTH AMERICA: NEWS, ACCOUNTABILITY, AND DEMOCRACY 60 (2000) (discussing death threats in South America against journalists).

93 *Chandler v. D.C. Dep't of Corr.*, 145 F.3d 1355 (D.C. Cir. 1998).

94 *Id.* at 1359.

95 *Id.* at 1360. In support of that proposition, the U.S. Court of Appeals for the District of Columbia cited Justice Harry Blackmun's concurrence in *Hudson v. McMillian*, 503 U.S. 1 (1992). In that concurrence, Justice Blackmun observed: "It is not hard to imagine inflictions of psychological harm—without corresponding physical harm—that might prove to be cruel and unusual punishment. . . . [T]he Eighth Amendment prohibits the unnecessary and wanton infliction of 'pain,' rather than 'injury.' 'Pain' in its ordinary meaning surely includes a notion of psychological harm." *Id.* at 16 (Blackmun, J., concurring); see also *id.* at 17 (Blackmun, J., concurring) ("Psychological pain often may be clinically diagnosed and quantified through well-established methods, as in the ordinary tort context where damages for pain and suffering are regularly awarded."). The U.S. Supreme Court, in a recent Eighth Amendment case, has itself found that "it is proper to consider . . . psychiatric and professional studies." *Hall v. Florida*, 134 S. Ct. 1986, 1993 (2014).

96 *Chandler*, 145 F.3d at 1361.

the inmate's Eighth Amendment claim, "cannot be resolved without more factual development."⁹⁷

Similarly, in *Burton v. Livingston*,⁹⁸ an inmate alleged that an officer pointed a gun at him and threatened to shoot him. The officer allegedly asked the inmate to "run" so he could "blow" the inmate's "Goddamn brains out."⁹⁹ In that case, the officer reportedly used racial epithets and, through his words, tried "to scare" the inmate into running, potentially allowing the officer to shoot the inmate in the back and then later falsely claim that the inmate was trying to escape.¹⁰⁰ As the Eighth Circuit described the lawsuit's allegations: "The complaint states that Sgt. Livingston pointed a lethal weapon at the prisoner, cocked it, and threatened him with instant death. This incident occurred immediately after the prisoner had given testimony against another guard in a § 1983 action."¹⁰¹ Faced with those allegations, the Eighth Circuit ruled: "The complaint describes in plain words a wanton act of cruelty which, if it occurred, was brutal despite the fact that it resulted in no measurable physical injury to the prisoner."¹⁰² "The day has passed," the Eighth Circuit held, "when an inmate must show a court the scars of torture in order to make out a complaint under § 1983."¹⁰³ As the Eighth Circuit emphasized: "We hold that a prisoner retains at least the right to be free from the terror of instant and unexpected death at the whim of his allegedly bigoted custodians."¹⁰⁴

97 *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 843 (1994)). As the Court of Appeals stressed: "[T]he risk that Corporal Brooks's threat might be carried out, if left unaddressed (a matter upon which the district court made no findings), could amount to 'a sufficiently substantial "risk of serious damage to [Chandler's] future health"' to be actionable as an unconstitutional condition of confinement." *Id.* (quoting *Farmer*, 511 U.S. at 843).

98 *Burton v. Livingston*, 791 F.2d 97, 99–100 (8th Cir. 1986).

99 *Id.* at 99.

100 *Id.*

101 *Id.* at 100. "Apparently," the Eighth Circuit reported, "another guard who was present took the threat seriously enough to step between the prisoner and Sgt. Livingston." *Id.*

102 *Id.*

103 *Id.*

104 *Id.* The Eighth Circuit further ruled: "So far as we can tell at this early stage of the case, the guard's conduct was not motivated by the necessity of correcting a rebellious inmate or by legitimate concerns for institutional security. Neither is it an instance of rough language which resulted only in bruised feelings." *Id.* "This is rather," the Eighth Circuit emphasized, "a complaint that a prison guard, without provocation, and for the apparent purpose of retaliating against the prisoner's exercise of his rights in

The case of *Hudspeth v. Figgins*¹⁰⁵ is also illustrative. In that case, a prisoner, James Hudspeth, sued two prison guards who had allegedly impaired his right of access to the courts, with one correctional officer reportedly threatening to transfer Hudspeth to a work detail where the inmate, per the threat, would be shot by “accident.”¹⁰⁶ In that case, the Fourth Circuit ruled: “A threat of physical harm to a prisoner if he persists in his pursuit of judicial relief is as impermissible as a more direct means of restricting the right of access to the courts.”¹⁰⁷ “It is enough,” the Fourth Circuit explained, pointing out that the inmate need not have actually succumbed to the threat, “that the threat was intended to impose a limitation upon the prisoner’s right of access to the court and was reasonably calculated to have that effect.”¹⁰⁸ If Hudspeth was intentionally placed “in fear for his life if he pressed his court actions,” the Fourth Circuit added, “that would inflict such suffering as to amount to unconstitutional punishment.”¹⁰⁹ “The life of a prisoner is a dreary one of suffering,” it concluded, “but the Constitution prohibits the infliction upon a prisoner of unnecessary suffering which is inconsistent with contemporary standards of decency.”¹¹⁰

petitioning a federal court for redress, terrorized him with threats of death.” *Id.* at 100–01. “Under the circumstances of this incident,” the Eighth Circuit concluded, “the guard’s actions, if proved, were a violation of Mr. Burton’s rights under the First Amendment and under the Due Process and Equal Protection Clauses of the Fourteenth Amendment.” *Id.* at 101; *see also* *Shamsud’Diyn v. Moyer*, No. ELH-17-3271, 2018 WL 3022660, at *9 (D. Md. June 18, 2018) (“[A] ‘complaint that a prison guard, without provocation, and for the apparent purpose of retaliating against the prisoner’s exercise of his rights in petitioning a federal court for redress, terrorizing him with threats of death,’ would be sufficient to state a claim.”) (quoting *Burton*, 791 F.2d at 100–01)); *Mehinovic v. Vuckovic*, 198 F. Supp. 2d 1322, 1346 (N.D. Ga. 2002) (“Mental torture consists of ‘prolonged mental harm caused by or resulting from: the intentional infliction or threatened infliction of severe physical pain or suffering; . . . the threat of imminent death; or the threat that another person will imminently be subjected to death, [or] severe physical pain or suffering.’ As set out above, plaintiffs noted in their testimony that they feared that they would be killed by Vuckovic during the beatings he inflicted or during games of ‘Russian roulette.’ Each plaintiff continues to suffer long-term psychological harm as a result of the ordeals they suffered at the hands of defendant and others.”).

105 *Hudspeth v. Figgins*, 584 F.2d 1345 (4th Cir. 1978).

106 *Id.* at 1347.

107 *Id.* at 1348.

108 *Id.*

109 *Id.*

110 *Id.* The U.S. Supreme Court has been using the “evolving standards of

A provision of federal law put in place as part of the Prison Litigation Reform Act¹¹¹ regulates the ability of inmates to bring claims for compensatory damages for prison conditions that relate to an inmate's mental health. According to the provision of that law now codified at 42 U.S.C. § 1997e(e):

No Federal civil action may be brought by a prisoner confined in a jail, prison, or other correctional facility, for mental or emotional injury suffered while in custody without a prior showing of physical injury or the commission of a sexual act (as defined in section 2246 of Title 18).¹¹²

But that law plainly does not allow government actors to psychologically torture prisoners with impunity.¹¹³ As the Seventh Circuit wrote in rejecting the Attorney General's contention that 42 U.S.C. § 1997e(e) makes a showing of *physical injury* a filing prerequisite for every civil rights lawsuit involving mental or emotional injury: "This contention if taken to its logical extreme would give prison officials free reign to maliciously and sadistically inflict psychological torture on prisoners, so long as they take care not to inflict any physical injury in the process."¹¹⁴

decency" test since 1958 to gauge what violates the Eighth Amendment's Cruel and Unusual Punishments Clause. *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (determining that the Eighth Amendment "must draw its meaning from the evolving standards of decency that mark the progress of a maturing society").

111 42 U.S.C. § 1997e (2013).

112 *Id.* § 1997e(e).

113 *Scarver v. Litscher*, 371 F. Supp. 2d 986, 997–98 (W.D. Wis. 2005) (citation omitted) ("A plaintiff who has suffered psychological torture but not physical injury may still obtain nominal or punitive damages.").

114 *Calhoun v. DeTella*, 319 F.3d 936, 940 (7th Cir. 2003). As the Seventh Circuit determined in that case: "As we have observed before and reemphasize here, '[i]t would be a serious mistake to interpret section 1997e(e) to require a showing of physical injury in all prisoner civil rights suits.' On several occasions we have explained that § 1997e(e) may limit the relief available to prisoners who cannot allege a physical injury, but it does not bar their lawsuits altogether. As its title suggests, § 1997e(e) is a 'limitation on recovery.' Accordingly, physical injury is merely a predicate for an award of damages for mental or emotional injury, not a filing prerequisite for the federal civil action itself." *Id.*; see also *id.* at 941 ("Although § 1997e(e) would bar recovery of compensatory damages 'for' mental and emotional injuries suffered, the statute is inapplicable to awards of nominal or punitive

As a general matter, the Eighth Amendment thus ordinarily protects inmates from harm, further requiring that they be clothed, fed, sheltered, and provided with adequate health care.¹¹⁵ “The Eighth Amendment,” as one federal district court put it, “requires the government ‘to provide medical care for those whom it is punishing by incarceration.’”¹¹⁶ And the Eighth Amendment has long been read to require the provision of mental health services for inmates¹¹⁷ and to bar torture.¹¹⁸ For example, in *Estelle v. Gamble*,¹¹⁹ the U.S. Supreme Court determined that “the primary concern of the drafters” of the Eighth Amendment was “to proscribe ‘torture[s]’ and other ‘barbar[ous]’ methods of punishment.”¹²⁰ In that 1976 decision, the Supreme Court went on to declare: “Our more recent cases, however, have held that Amendment proscribes more than

damages for the Eighth Amendment violation itself.”).

- 115 *Brown v. Plata*, 563 U.S. 493, 510 (2011) (“Prisoners are dependent on the State for food, clothing, and necessary medical care.”); *id.* at 511 (“If government fails to fulfill this obligation, the courts have a responsibility to remedy the resulting Eighth Amendment violation.”); *id.* at 538 (“Establishing the population at which the State could begin to provide constitutionally adequate medical and mental health care, and the appropriate time frame within which to achieve the necessary reduction, requires a degree a judgment.”); *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (citations omitted) (“[P]rison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must ‘take reasonable measures to guarantee the safety of the inmates’ . . .”).
- 116 *Scarver*, 371 F. Supp. 2d at 998 (quoting *Snipes v. DeTella*, 95 F.3d 586, 590 (7th Cir. 1996)).
- 117 *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987) (citations omitted) (“Courts have repeatedly held that treatment of a psychiatric or psychological condition may present a ‘serious medical need’ under the *Estelle* formulation.”); *King v. Litscher*, No. 17-CV-201-JPS, 2017 WL 4334133, at *3 (E.D. Wis. Sept. 28, 2017) (“It is well settled that the Eighth Amendment protects the mental health of prisoners no less than their physical health.”); *Green v. Grams*, No. 10-cv-745-slc, 2011 WL 5151520, at *3 (W.D. Wis. Oct. 28, 2011) (same).
- 118 *Estelle v. Gamble*, 429 U.S. 97, 102 (1976) (noting that “the primary concern of the drafters” of the Eighth Amendment “was to proscribe ‘torture[s]’ and other ‘barbar[ous]’ methods of punishment”); *see also* *Taylor v. Crawford*, 487 F.3d 1072, 1082 (8th Cir. 2007) (“The Eighth Amendment prohibits the unnecessary and wanton infliction of pain through torture, barbarous methods, or methods resulting in a lingering death.”); *Snipes v. DeTella*, 95 F.3d 586, 590 (7th Cir. 1996) (“[R]ecent Supreme Court decisions have held that the Eighth Amendment proscribes more than just ‘physically barbarous punishments.’”).
- 119 *Estelle v. Gamble*, 429 U.S. 97 (1976).
- 120 *Id.* at 102.

physically barbarous punishments.”¹²¹ “We therefore conclude,” the Court held, “that deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ proscribed by the Eighth Amendment.”¹²²

A failure to provide adequate psychiatric and mental health care services to inmates is deliberately indifferent to their serious medical needs and thus constitutes an Eighth Amendment

121 *Id.* As the Court in *Estelle v. Gamble* put it: “The Amendment embodies ‘broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . . ,’ *Jackson v. Bishop*, 404 F.2d 571, 579 (8th Cir. 1968), against which we must evaluate penal measures. Thus, we have held repugnant to the Eighth Amendment punishments which are incompatible with ‘the evolving standards of decency that mark the progress of a maturing society.’” *Id.* In *Jackson v. Bishop*, the Eighth Circuit—in an opinion authored by then - Judge Harry Blackmun—concluded in 1968: “[W]e have no difficulty in reaching the conclusion that the use of the strap in the penitentiaries of Arkansas is punishment which, in this last third of the 20th century, runs afoul of the Eighth Amendment; that the strap’s use, irrespective of any precautionary conditions which may be imposed, offends contemporary concepts of decency and human dignity and precepts of civilization which we profess to possess; and that it also violates those standards of good conscience and fundamental fairness enunciated by this court” *Jackson*, 404 F.2d at 579.

122 *Estelle*, 429 U.S. at 104–05 (citation omitted); *see also id.* (“This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a cause of action under § 1983.”).

violation.¹²³ As the Second Circuit put it in *Langley v. Coughlin*,¹²⁴ “the basic legal principle is clear and well established . . . that when incarceration deprives a person of reasonably necessary medical care (including psychiatric or mental health care) which would be available to him or her if not incarcerated, the prison authorities must provide such surrogate care.”¹²⁵ In 2011, the U.S. Supreme Court itself considered an Eighth Amendment case involving prison overcrowding and inadequate provision of services. In that case, the Supreme Court emphasized: “For years the medical and mental health care provided by California’s prisons has fallen short of minimum constitutional requirements and has failed to meet prisoners’ basic health needs. Needless suffering and death have been the well-documented result.”¹²⁶ The Court stressed that California prisoners “with serious mental illness do not receive minimal, adequate care,” with suicidal inmates held “for prolonged periods in telephone-booth-sized cages without toilets.”¹²⁷

123 *Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986) (citing *Hoptowitz v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982)); *see also* *Kothmann v. Rosario*, 558 F. App’x 907, 910 (11th Cir. 2014) (citation omitted) (“A correctional system’s deliberate indifference to a prisoner’s serious medical needs, including ‘psychiatric or mental health needs,’ violates the Eighth Amendment.”); *Thomas v. Farley*, 31 F.3d 557, 559 (7th Cir. 1994) (“Mental torture is not an oxymoron, and has been held or assumed in a number of prisoner cases, such as *Joseph v. Brierton*, 739 F.2d 1244 (7th Cir. 1984); *Jordan v. Gardner*, 986 F.2d 1521, 1525–26 (9th Cir. 1993), and *Northington v. Jackson*, 973 F.2d 1518, 1524 (10th Cir. 1992), to be actionable as cruel and unusual punishment.”); *Green v. Wilson*, No. PWG-15-3866, 2018 WL 3629970, at *5 (D. Md. July 31, 2018) (holding that the Eighth Amendment does not recognize “any distinction between the right to medical care for physical ills and its psychological and psychiatric counterparts”); *Bentz v. Mulholland*, No. 18-cv-1064-DRH, 2018 WL 2735483, at *9 (S.D. Ill. June 7, 2018) (holding that when harassment by prison officials is “accompanied by actions which suggest that the harassment is persistent or results in pain (either physical or psychological),” such “verbal harassment may support an Eighth Amendment claim”); *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1256 n.81 (M.D. Ala. 2017) (“ADOC’s failure to provide mental-health and correctional staffing sufficient to operate a minimally adequate mental-health system is in itself an unreasonable response under the deliberate-indifference standard.”); *Henderson v. S. Carolina Dep’t of Corr.*, C/A No.: 4:17-287-BHH-TER, 2017 WL 2199020, at *5 (D. S.C. Apr. 25, 2017) (citation omitted) (“Claims regarding mental health treatment fall under a claim for deliberate indifference to medical care.”).

124 *Langley v. Coughlin*, 888 F.2d 252 (2d Cir. 1989).

125 *Id.* at 254.

126 *Brown v. Plata*, 563 U.S. 493, 501 (2011).

127 *Id.* at 503.

Prisoners, like non-incarcerated human beings, have both physical and psychological needs. “Serious medical needs” in the prison context encompasses “conditions that are life-threatening or that carry risks of permanent serious impairment if left untreated, those that result in needless pain and suffering when treatment is withheld and those that have been diagnosed by a physician as mandating treatment.”¹²⁸ Suicide is but one objectively serious harm that prison officials must guard against,¹²⁹ and it has been specifically held that, in the prison context, “[t]he Eighth Amendment protects inmates’ mental health as well as their physical health.”¹³⁰ An inmate can therefore state a claim for deliberate indifference by alleging that “his ‘pleas’ for psychological treatment were ‘ignored,’”¹³¹ with one U.S. magistrate judge allowing an inmate’s complaint to proceed past a motion to dismiss where the inmate alleged a deliberate indifference to his serious medical needs that resulted “in increased pain, potentially life threatening spikes in blood pressure, dizzy spells, anxiety, and other psychological trauma.”¹³²

In the immigration context, case law makes clear that “credible, specific threats can amount to persecution if they are severe enough.”¹³³ “[T]hreats of murder,” the First Circuit has explained, “fit squarely within this rubric.”¹³⁴ Although the Immigration

128 *Scarver v. Litscher*, 371 F. Supp. 2d 986, 999 (W.D. Wis. 2005).

129 *Id.*; *see also* *Whitney v. City of St. Louis*, 887 F.3d 857, 860 (8th Cir. 2018) (“The Eighth Amendment prohibits jail officials from acting with deliberate indifference towards risks of suicide.”); *Mullin v. Balicki*, 875 F.3d 140, 158 (3d Cir. 2017) (noting that a “vulnerability-to-suicide claim . . . is simply a more specific articulation of the Eighth Amendment rule that prison officials must not be deliberately indifferent to a prisoner’s serious medical needs”).

130 *Scarver*, 371 F. Supp. 2d at 1000 (citing *Calhoun v. DeTella*, 319 F.3d 936, 940 (7th Cir. 2003); *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987)).

131 *Antonelli v. Sheahan*, 81 F.3d 1422, 1432 (7th Cir. 1996); *see also* *Harris v. Billington*, No. 12-cv-437-wmc, 2015 WL 1893240, at *14 (W.D. Wis. Apr. 24, 2015) (holding that a delay in treatment “can, under certain circumstances, constitute deliberate indifference”).

132 *Davis v. Hyden*, No. A02-214 CV (JKS), 2005 WL 3116641, at *1, 5 (D. Alaska Nov. 21, 2005).

133 *Javed v. Holder*, 715 F.3d 391, 395–96 (1st Cir. 2013); *see also* *Barreto v. U.S. Att’y Gen.*, 392 F. App’x 689, 691 (11th Cir. 2010) (“[W]e have held that a minor beating, a detention of 11 hours, and a credible death threat by a person who had the immediate ability to act on it constituted persecution.”).

134 *Javed*, 715 F.3d at 396 (quoting *López de Hincapié v. Gonzales*, 494 F.3d 213, 217 (1st Cir. 2007)); *see also* *Sumschi v. U.S. Att’y Gen.*, 677 F. App’x 579, 581 (11th Cir. 2017) (quoting *De Santamaria v. U.S. Att’y Gen.*,

and Nationality Act (“INA”)¹³⁵ contains no statutory definition of “persecution,”¹³⁶ that term has been interpreted to cover a “threat of death, torture, or injury to one’s person”¹³⁷ or—as another court put it—“severe humanitarian mistreatment, such as ‘death threats, involuntary confinement, torture, and other severe affronts to the life or freedom of the applicant.’”¹³⁸ As the Ninth Circuit ruled in 1996: “There is no question that persistent death threats and assaults on one’s life, family, and business rise to the level of persecution.”¹³⁹ More recently, the Ninth Circuit summarized its prior case law as follows: “In several cases, we have found that where the applicant was the target of repeated beatings, death threats, and expressions of hatred, a finding of persecution is compelled.”¹⁴⁰

525 F.3d 999, 1009–10 (11th Cir. 2008)) (“[W]e previously concluded that the record compelled a finding that an alien was persecuted when she received repeated death threats over the course of two years and was dragged from her vehicle by her hair, was traumatized by the torture and murder of a family groundskeeper who refused to reveal her whereabouts, and was kidnapped and beaten.”); *Sanchez Jimenez v. Att’y Gen.*, 492 F.3d 1223, 1233 (11th Cir. 2007) (finding that past persecution included death threats, attempted kidnapping, and armed men shooting at the petitioner in a moving car); *Lobo v. Holder*, 684 F.3d 11, 18 (1st Cir. 2012) (citations omitted) (“[C]redible verbal death threats may fall within the meaning of ‘persecution[.]’ . . . only when the threats are so ‘menacing as to cause significant actual suffering or harm.’”); *Andriasian v. INS*, 180 F.3d 1033, 1042 (9th Cir. 1999) (“[T]he warning that the Andriasians would be killed if they did not leave Azerbaijan immediately—which was made all the more credible by the fact that the Azeri thugs who issued the threat had just murdered Mr. Andriasian’s neighbor in cold blood—would by itself be sufficient to establish past persecution.”).

135 Under the INA, “the Attorney General has discretion to grant asylum to a noncitizen who is unable or unwilling to return to his home country ‘because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.’” *née Joseph v. Sessions*, No. 17-1403, 2018 WL 3549714, at *2 (4th Cir. Mar. 20, 2018) (citations omitted).

136 *Id.* at *3.

137 *Id.*; *Yan Zhang v. Sessions*, 681 F. App’x 554, 559 (8th Cir. 2017) (citations omitted); *but see Jimenez v. Att’y Gen.*, 737 Fed. Appx. 117, 118 (3d Cir. 2018) (“To meet the legal definition of torture, the threat of harm must be ‘by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.’”) (quoting 8 C.F.R. § 1208.18(a)(1) (2018)).

138 *Huang v. Att’y Gen. of U.S.*, 620 F.3d 372, 380 (3d Cir. 2010) (quoting *Gomez-Zuluaga v. Att’y Gen.*, 527 F.3d 330, 341 (3d Cir. 2008)).

139 *Singh v. INS*, 94 F.3d 1353, 1360 (9th Cir. 1996).

140 *Marzbanian v. Holder*, 597 F. App’x 947, 949 (9th Cir. 2015). The U.N.

While menacing threats can constitute persecution, empty or unsubstantiated threats unsupported by evidence of danger do not meet the standard for a persecution claim.¹⁴¹ For example, it has been held that “mere threats, such as anonymous death threats through the telephone, without more, do not rise to the level of persecution.”¹⁴² But it is clear, as the Eleventh Circuit has stated, that “[a] credible death threat by a person who has the immediate ability to act on it constitutes persecution regardless of whether the threat is successfully carried out.”¹⁴³ “We are more likely to conclude,” the Eleventh Circuit has observed, “that the record compels a finding of past persecution when an applicant faced imminent and credible death threats.”¹⁴⁴ “We are also more likely to conclude,” the Eleventh Circuit has stressed, “that the record compels a finding

Human Rights Committee has itself determined, in a different context, that States cannot ignore “known threats to the life of persons under their jurisdiction, just because he or she is not arrested or otherwise detained.” *INTERNATIONAL HUMAN RIGHTS LAW* 270 (Daniel Moeckli et al. eds., 2d ed. 2014) (citing *Delgado Páez v. Columbia*, CCPR/C/39/D/195/1985 (12 July 1990), para. 5.5). The Human Rights Committee has thus “found violations of the right to security where there was a failure to investigate credible death threats.” *Id.*

- 141 *Lemus-Arita v. Sessions*, 854 F.3d 476, 481 (8th Cir. 2017) (citations omitted) (“a threat that is ‘exaggerated, nonspecific, or lacking in immediacy may be insufficient’”; “[t]hreats alone constitute persecution in only a small category of cases, and only when the threats are so menacing as to cause significant actual suffering or harm”); *Hernandez-Lima v. Lynch*, 836 F.3d 109, 114 (1st Cir. 2016) (citations omitted) (“Death threats rise to the level of persecution only when ‘so menacing as to cause significant actual suffering or harm.’ Evidence that such threats were entirely empty ‘plainly supports [a] determination’ that they did not meet that standard.”); *Vera v. Holder*, 425 F. App’x 604, 605 (9th Cir. 2011) (citations omitted) (“Only in ‘extreme cases’ involving ‘repeated and especially menacing death threats’ have we held such threats establish past persecution.”).
- 142 *Cordero v. U.S. Att’y Gen.*, 374 F. App’x 882, 887 n.1 (11th Cir. 2010).
- 143 *Diallo v. U.S. Att’y Gen.*, 596 F.3d 1329, 1333–34 (11th Cir. 2010). Credible death threats can and do result in criminal prosecutions. *E.g.*, *United States v. Stewart*, 420 F.3d 1007 (9th Cir. 2005); *United States v. Polson*, 154 F. Supp. 2d 1230, 1231, 1234 (S.D. Ohio 2001). “In general, whether a communication constitutes a ‘threat’ within the purview of 18 U.S.C. § 876 is a question of fact for the jury so long as a reasonable recipient, familiar with the context of the communication, could interpret it as a threat.” *Id.* at 1235; *see also* *State v. January*, No. 75170-1-I, 2017 WL 5127889, at *3 (Wash. Ct. App. Nov. 6, 2017) (“The nature of a threat depends on all the facts and circumstances and is not limited to a literal translation of the words spoken.”).
- 144 *Gutierrez-Granda v. U.S. Att’y Gen.*, 386 F. App’x 848, 851 (11th Cir. 2010).

of past persecution when the applicant has suffered physical injury along with death threats.”¹⁴⁵ “A specific threat of harm to an asylum applicant,” a guide produced by the American Immigration Lawyers Association observes, “is usually sufficient to demonstrate a well-founded fear of persecution.”¹⁴⁶

C. *The Torturous and Coercive Nature of Threats of Death*

Death threats and threats of physical harm not only induce fear¹⁴⁷ and suffice for purposes of inmates setting forth legitimate section 1983 claims,¹⁴⁸ but they can also, in particular circumstances, terrorize¹⁴⁹ and constitute acts of torture, that is, the extreme or aggravated form of cruelty.¹⁵⁰ In *Death Threats and Violence: New*

145 *Id.*

146 REGINA GERMAIN, AILA’S ASYLUM PRIMER: A PRACTICAL GUIDE TO U.S. ASYLUM LAW AND PROCEDURE 68 (2005). That standard for making out a claim of a well-founded fear of persecution has been laid out in a number of cases. *E.g.*, *Dong Ming Wu v. U.S. Att’y Gen.*, 270 F. App’x 211, 214 (3d Cir. 2008) (citations omitted) (noting that a well-founded fear of persecution “encompasses ‘threats to life, confinement, torture, and economic restrictions so severe that they constitute a threat to life or freedom,’ including forced sterilization”); *accord Yu v. U.S. Att’y Gen.*, 513 F.3d 346, 348 (3d Cir. 2008).

147 *Fortson v. Eppinger*, No.: 1:15 CV 2078, 2017 WL 603086, at *6 (N.D. Ohio Feb. 15, 2017) (“[T]he jury was well aware that both women were extremely reluctant to testify. The record reveals that Andee Caver was afraid to testify because she had received death threats”); *see also* Kenneth L. Karst, *Threats and Meanings: How the Facts Govern First Amendment Doctrine*, 58 STAN. L. REV. 1337, 1341–44 (2006) (“Death threats are particularly harmful, for they trigger short-term fear and long-term anxiety.”).

148 *McKenney v. Farrinton*, 2:16-cv-00630-JAW, 2017 WL 825280, at *5 (D. Me., Mar. 2, 2017) (citations omitted) (“Several circuit courts of appeals have held that . . . threats can constitute the necessary adverse action. . . . [A] verbal insult alone does not constitute adverse action. Death threats and threats of serious physical harm, however, generally suffice.”); *see also* *Dixon v. Groeger*, 2:16-cv-00178 NT, 2016 WL 4532066, at *2, *4 (D. Me., Aug. 29, 2016) (“[D]eath threats and threats of serious physical harm generally suffice.”).

149 *In re Chiquita Brands Int’l, Inc.*, 190 F. Supp. 3d 1100, 1104 (S.D. Fla. 2016) (“AUC was a violent terrorist organization which had unleashed a systematic campaign of terror—death threats, extrajudicial killings, torture, rape, kidnappings, forced disappearances and looting—against vast swathes of the Colombian civilian population”).

150 *Azadeh v. Government of Islamic Republic of Iran*, No. 1:16-cv-1467 (KBJ), 2018 WL 4232913, at *11 (D. D.C. Sept. 5, 2018) (noting that “torture” is a label “usually reserved for extreme, deliberate and unusually cruel practices”). *See also* MICHAEL JOHN GARCIA, CONG. RESEARCH SERV., RL32438, U.N. CONVENTION AGAINST TORTURE (CAT): OVERVIEW

Research and Clinical Perspectives, Stephen Morewitz, citing a 2006 study and noting the prevalence of death threats varies by context and the underlying motivations for them, emphasizes: “Death threats are a prevalent form of psychological torture. Based on a study of 69 refugees who were torture survivors, Olsen et al. (2006) discovered that death threats were the most prevalent method of torture.”¹⁵¹ As Morewitz notes: “They are prevalent in domestic violence episodes, in time of war, and especially during periods of racial and ethnic conflicts and political instability.”¹⁵² Though death threats are often coupled with physical abuse and beatings,¹⁵³ threats of death—all by themselves—can thus be torturous, as the legal classification of mock executions as acts of psychological torture makes crystal clear.¹⁵⁴

AND APPLICATION TO INTERROGATION TECHNIQUES 18 (2009) (“U.S. courts and administrative bodies have found that severe beatings, maiming, sexual assault, rape, and (in certain circumstances) death threats may constitute ‘torture’ for purposes of either CAT or TVPA”); Declaration on the Protection of All Persons, *supra* note 22, at art. 1(2) (“Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment.”). Threats made in interrogation settings have sometimes been described as constituting “psychological torture.” *Crowe v. County of San Diego*, 608 F.3d 406, 432 (9th Cir. 2010).

- 151 STEPHEN J. MOREWITZ, *DEATH THREATS AND VIOLENCE: NEW RESEARCH AND CLINICAL PERSPECTIVES* 5 (2008); *see also id.* at 99 (“Death threat victims can suffer severe impairment in their occupational functioning. They are at increased risk of suffering severe anxiety, depression, and other stress-related health problems and may be at risk for engaging in suicidal behaviors.”).
- 152 MOREWITZ, *supra* note 151, at 6. Threats to kill or threats of harm are prohibited by international human rights law and international humanitarian law. *See, e.g.*, Jordan J. Paust, *Human Rights on the Battlefield*, 47 *GEO. WASH. INT’L L. REV.* 509, 540–41 (2015) (“[T]he following unlawful interrogation tactics are absolutely prohibited under both human rights law and the laws of war: (1) torture that occurs from the use of waterboarding or related forms of inducement of suffocation, (2) the cold cell and related forms of inducement of hypothermia, (3) rape and other forms of sexual violence as an interrogation tactic or other form of conduct during war, (4) threats to kill the detainee and/or others, and (5) use of snarling dogs against naked persons in order to induce intense fear or terror.”).
- 153 *E.g.*, *Abebe-Jiri v. Negewo*, No. 1:90-CV-2010-GET, 1993 WL 814304, at *1 (N.D. Ga., Aug. 20, 1993) (describing the “interrogation and torture” of a woman in the presence of several men, where she was “told to take off her clothes,” where her “arms and legs were then bound and she was whipped with a wire on her legs and her back,” and where she was “repeatedly threatened with death if she did not reveal the location of a gun”).
- 154 GARY D. SOLIS, *THE LAW OF ARMED CONFLICT: INTERNATIONAL*

III. The Nature of Capital Prosecutions

A. Threats of Death in Penal Systems

Threats have long been used in penal systems and by judges, as the history of capital and corporal punishments demonstrates.¹⁵⁵ In colonial times, a common punishment was to make an offender sit on the gallows with a noose around the neck.¹⁵⁶ For example, in colonial Massachusetts, in an effort to curtail stealing, a 1736

HUMANITARIAN LAW IN WAR 668 (2d ed. 2016) (“The U.N. Human Rights Committee and the Inter-American Commission on Human Rights consider mock executions torture.”); *see also* TORTURE AND ITS CONSEQUENCES: CURRENT TREATMENT APPROACHES 204 (Metin Başoğlu ed. 1992) (“Sham executions are a well-known and frequently reported form of torture (e.g., Allodi & Cowgill, 1982; Benfeldt-Zachrisson, 1985; Goldfeld *et al.*, 1988).”). Sometimes the detainee is subject to a prolonged threat of execution.”); *id.* at 475 (“Commonly used psychological methods of torture include . . . threats of torture to self or relatives and sham executions.”).

155 *E.g.*, John D. Bessler, *The Anomaly of Executions: The Cruel and Unusual Punishments Clause in the 21st Century*, 2 BRIT. J. AM. LEG. STUDIES 297 (2013) (describing the history of capital punishment and corporal punishments in the United States). Of course, making threats *against* judges is a criminal offense. *E.g.*, 18 U.S.C. § 115 (2012) (making it a crime to threaten “to assault, kidnap, or murder . . . a United States judge”); JUDICIAL INDEPENDENCE IN TRANSITION 1248 (Anja Seibert-Fohr ed., 2012) (“Violence or threats made to judges or those close to them is a criminal offence.”); *Life Under Death Threats: Dangers Faced by Judges, Prosecutors*, NPR, (Apr. 1, 2013), <http://www.npr.org/2013/04/01/175938445/the-dangers-facing-judges-and-prosecutors> (“In 2012, 1,370 threats were made against federal judges.”).

156 JEANNINE MARIE DELOMBARD, *IN THE SHADOW OF THE GALLOWES: RACE, CRIME, AND AMERICAN CIVIL IDENTITY* 341 n.31 (2012) (noting that a man was found guilty of attempted rape and sentenced “to sit on gallows”); DANIEL ALLEN HEARN, *LEGAL EXECUTIONS IN NEW ENGLAND: A COMPREHENSIVE REFERENCE, 1623–1960*, at 117 (1999). As one source notes, citing a newspaper story from 1752: “At the Court of Assize, at Springfield, the 2d Tuesday of September last, Daniel Bailey and Mary Rainer, of a Place adjoining to Sheffield in that county, were convicted of Adultery, and were sentenced to suffer the Penalty of the Law therefor, viz. to sit on the Gallows with a Rope about their Necks, for the Space of an Hour; to be whipt forty Stripes each, and to wear for ever after a Capital A, two Inches long, and proportionable in bigness, cut out in Cloth of a contrary Colour to their Cloaths, and sewed upon their upper Garments, either upon the outside of the arm, or on the back.” GEORGE FRANCIS DOW, *EVERY DAY LIFE IN THE MASSACHUSETTS BAY COLONY* 214 n.* (1988) (citing *Boston Evening-Post*, Oct. 9, 1752).

law subjected thieves to increasing penalties—and escalating threats of death—for each offense.¹⁵⁷ A first-time offender was to be fined or whipped; a second offense required the thief to pay tremble damages, sit upon the gallows platform for an hour with a rope around his neck, and then to receive up to thirty stripes at the whipping post; and, finally, to be hanged for a third offense.¹⁵⁸ “The colonists’ rationale,” one historian notes, “was clear: anyone impervious to the fine and the whip, who did not mend his ways after an hour with a noose about him, was uncontrollable and therefore had to be executed.”¹⁵⁹ The punishment of sitting on the gallows continued to exist in Massachusetts after the Revolutionary War,¹⁶⁰ though it eventually passed from the scene along with the corporal punishments of branding, whipping, ear cropping, and standing in the pillory.¹⁶¹

Living under a threat of death, the evidence shows, is a deeply depressing experience, especially when one is confined in prison—and particularly when one is confined in isolation on death row with all that entails.¹⁶² “Most significantly for the offender,”

157 THE CHARTERS AND GENERAL LAWS OF THE COLONY AND PROVINCE OF MASSACHUSETTS BAY 509 (1814).

158 *Id.* at 509–10.

159 DAVID J. ROTHMAN, *THE DISCOVERY OF THE ASYLUM: SOCIAL ORDER AND DISORDER IN THE NEW REPUBLIC* 52 (rev. ed. 2017).

160 1 THE PERPETUAL LAWS OF THE COMMONWEALTH OF MASSACHUSETTS, FROM THE ESTABLISHMENT OF ITS CONSTITUTION, IN THE YEAR 1780, TO THE END OF THE YEAR 1800, at 351 (Boston, I. Thomas & E.T. Andrews 1801) (reprinting a 1786 law that provided for the following punishment: “to sit on the gallows with a rope round his neck for the space of one hour”); 1 THE GENERAL LAWS OF MASSACHUSETTS, FROM THE ADOPTION OF THE CONSTITUTION, TO FEBRUARY, 1822, at 65, 183, 185 (Boston, Wells & Lily and Cummings & Hillard 1823) (referencing 1782 and 1785 Massachusetts laws providing for the punishment of “sitting on the gallows, with a rope about the neck,” “sitting on the gallows with a rope about his neck,” and “sitting on the gallows the space of one hour, with a rope about his neck”); ANDREW DUNLAP, *A SPEECH DELIVERED BEFORE THE MUNICIPAL COURT OF THE CITY OF BOSTON, IN DEFENCE OF ABNER KNEELAND, ON AN INDICTMENT FOR BLASPHEMY* 2, 44 (Boston, 1834) (referencing the punishment of “sitting on the gallows, with a rope about the neck”).

161 PROCEEDINGS OF THE AMERICAN ANTIQUARIAN SOCIETY, AT THE SEMI-ANNUAL MEETING, HELD IN BOSTON, APRIL 28, 1875, at 69–70 (Worcester, Charles Hamilton, Paladium Office 1875).

162 HANDBOOK OF CORRECTIONAL MENTAL HEALTH 467 (Charles L. Scott 2d ed., 2010) (“Treating psychiatrists may encounter death row inmates experiencing overwhelming fear, helplessness, recurrent depression, and

Carol and Jordan Steiker write in *Courting Death: The Supreme Court and Capital Punishment*, “extended death row incarceration presents special problems of cruelty, especially given the prevailing harsh conditions of death row confinement.” “Condemned inmates,” they explain, “now face multiple punishments: lengthy incarceration in solitary-style conditions; the anguish of perpetually living under a sentence of death; and actual execution.”¹⁶³ It is a dreary existence, with death row inmates using the phrase “Dead Man Walking”—the expression popularized by Sister Helen Prejean’s book of the same name¹⁶⁴—to refer to the condemned before execution.¹⁶⁵ In the late-nineteenth-century case of *In re Medley*,¹⁶⁶ the U.S. Supreme Court itself emphasized that “when a prisoner sentenced by a court to death is confined in the penitentiary awaiting the execution of the sentence, one of the most horrible feelings to which he can be subjected during that time is the uncertainty during the whole of it.”¹⁶⁷

The process of state-sanctioned killing begins with a prosecutor’s notice of intent to seek the death penalty. Under federal law, the prosecutor advises the defendant and the court “a reasonable time before trial,” or before the acceptance of a plea, of the government’s intention to seek the death penalty.¹⁶⁸ The

self-mutilation.”); *id.* (“Another phenomenon not uncommonly seen on death row is an inmate who voluntarily waives appeals in an effort to hasten the execution. The motivations of these so-called volunteers may be rooted in depression, resentment, or simple demoralization.”); *see also* Smith v. Mahoney, 611 F.3d 978, 999 (9th Cir. 2010) (Fletcher, J., dissenting) (“At the time of the arraignment, he was deeply depressed because he had been in solitary confinement for some time and subjected to harsh living conditions. He had received death threats from Native American inmates and believed that he would be killed in prison.”). The issue of “volunteers” has been discussed at length elsewhere. *E.g.*, John H. Blume, *Killing the Willing: “Volunteers,” Suicide and Competency*, 103 MICH. L. REV. 939 (2005); C. Lee Harrington, *A Community Divided: Defense Attorneys and the Ethics of Death Row Volunteering*, 25 LAW & SOC. INQUIRY 849 (2000).

163 CAROL S. STEIKER & JORDAN M. STEIKER, *COURTING DEATH: THE SUPREME COURT AND CAPITAL PUNISHMENT* 207 (2016).

164 HELEN PREJEAN, *DEAD MAN WALKING: AN EYEWITNESS ACCOUNT OF THE DEATH PENALTY IN THE UNITED STATES* (1993).

165 DAVID W. NEUBAUER & HENRY F. FRADELLA, *AMERICA’S COURTS AND THE CRIMINAL JUSTICE SYSTEM* 386 (10th ed. 2011).

166 *In re Medley*, 134 U.S. 160 (1890).

167 *Id.* at 172.

168 Charles Doyle Sr., *The Death Penalty: Capital Punishment Legislation in the 110th Congress*, in *CAPITAL PUNISHMENT UPDATE* 8 (Lorraine V. Coyne ed.,

U.S. Department of Justice has a death penalty protocol whereby a local U.S. attorney cannot seek the death penalty without prior authorization from the Attorney General of the United States. Per that protocol, U.S. attorneys are required to submit to the Department of Justice's Capital Case Unit of the Criminal Division all cases involving a charge for which the death penalty is a legally authorized sanction, regardless of whether the U.S. attorney recommends seeking the death penalty. After the Capital Case Unit reviews the case and prepares an initial analysis and recommendation, the Attorney General's Capital Case Review Committee, composed of senior Justice Department lawyers, meets with the U.S. attorney and defense counsel, reviews all documents submitted by the parties, and makes its recommendation to the Attorney General. The Attorney General then makes the final decision regarding whether to seek the death penalty.¹⁶⁹

Part and parcel of torture is instilling the fear of death or bodily harm,¹⁷⁰ and capital charges backed by the resources of federal, state, or local prosecutors—ones designed to take a person's life—certainly cannot be taken lightly by those facing such charges.¹⁷¹ In fact, threats of bodily harm or death, the U.N. Human

2007).

169 SAMUEL WALKER ET AL., *THE COLOR OF JUSTICE: RACE, ETHNICITY, AND CRIME IN AMERICA* 388 (6th ed. 2016).

170 On the practice of torture in prior centuries, one commentator writes: "Often, the intent was to instill the fear of death, as in the use of water torture." *THE TORTURE DEBATE IN AMERICA* 4 (Karen J. Greenberg ed., 2006). Instilling intense fear remains the goal of modern torture techniques. KERIM YILDIZ & JULIET MCDERMOTT, *TORTURE IN TURKEY: THE ONGOING PRACTICE OF TORTURE AND ILL-TREATMENT* 105 (2004); *see also id.* at 39 ("[T]orture terrorizes. The body in pain winces; it trembles. The muscles themselves register fear. This, too, is rooted in pain's biological function of impelling us in the most urgent way possible to escape from the source of pain—for that impulse is indistinguishable from panic. U.S. interrogators have used the technique of "waterboarding" to break the will of detainees. They are strapped to a board and immersed repeatedly in water, just short of drowning. As anyone knows who has ever come close to drowning or suffocating, the oxygen-starved brain sends panic-signals that overwhelm everything else.").

171 Neuroscientists have noted that psychological torture—sometimes called "no-touch" torture—releases stress hormones by creating intense fear. ARMIN KRISHNAN, *MILITARY NEUROSCIENCE AND THE COMING AGE OF NEUROWARFARE* 200 (2017); *see also* Diarmuid Cunniffe, *The Worst Scars Are in the Mind: Deconstructing Psychological Torture*, 7 *ICL J.* 1, 14–16 (2013) (discussing how threats induce fear, can weaken resistance and "break the will of detainees," "are a particularly cruel form of psychological suffering,"

Rights Committee has determined, can constitute psychological torture. For instance, in *Estrella v. Uruguay*, a concert pianist—an Argentine national, Miguel Angel Estrella, then living in France—filed a communication with the Human Rights Committee about his detention in a Uruguayan prison. Estrella’s communication asserted that, in December 1977, he was subjected to torture after armed individuals in civilian clothes broke into his house, threatened him with death, and he was punched and kicked, had his feet and hands bound, and was blindfolded and hooded.¹⁷² The alleged psychological torture he was subjected to was said to consist “chiefly in threats of torture or violence to relatives or friends, or of dispatch to Argentina to be executed,” and “in threats of making us witness the torture of friends.” “For hours upon end,” Estrella asserted of his tormentors, “they put me through a mock amputation with an electric saw, telling me: ‘we are going to do the same to you as Victor Jara’”—a reference to a well-known Chilean singer and guitarist who was found dead, with his hands completely smashed, at the end of September 1973 in a stadium in Santiago, Chile. On March 25, 1982, the Human Rights Committee decided that Estrella “was subjected to severe physical and psychological torture, including the threat that the author’s hands would be cut off by an electric saw, in an effort to force him to admit subversive activity.”¹⁷³

and how “[t]he sensation of fear or exposure to life-threatening situations and fear of death is, in psychological and psychiatric terms, described as a major ‘stressor’”).

172 *Estrella v. Uruguay*, Communication No. 74/1980, U.N. Doc. CCPR/C/OP/2 at 93 (1990), <http://hrlibrary.umn.edu/undocs/newscans/74-1980.html>. “The alleged physical torture consisted of electric shocks, beatings with rubber truncheons, kicks and punches, hanging him up with his hands tied behind his back, pushing him into water until he nearly drowned, and making him stand with his legs apart and arms raised for up to 20 hours.” *Id.*

173 *Id.*; see also Nigel Rodley (Special Rapporteur for the Commission on Human Rights), *Question of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, at 3, para. 3, U.N. Doc. A/56/156 (July 3, 2001) (“As stated by the Human Rights Committee in its General Comment No. 20 (10 April 1992), on article 7 of the International Covenant on Civil and Political Rights, the Special Rapporteur would like to remind Governments that the prohibition of torture relates not only to acts that cause physical pain but also to acts that cause mental suffering to the victim, such as intimidation and other forms of threats.”); *id.*, at 3, para. 4 (“A number of decisions by human rights monitoring mechanisms have accordingly referred to the notion of mental pain or suffering, including suffering through intimidation and threats, as a violation of the prohibition of torture and other forms

The Inter-American Court of Human Rights has itself repeatedly concluded that fear and terror are sufficient to establish mental torture. If a person is *threatened with bodily harm*, it is characterized as psychological torture. Thus, in *Maritza Urrutia v. Guatemala*, the Inter-American Court concluded in 2003: “An international juridical regime of absolute prohibition of all forms of torture, both physical and psychological, has been developed and, with regard to the latter, it has been recognized that the threat or real danger of subjecting a person to physical harm produces, under determined circumstances, such a degree of moral anguish that it may be considered ‘psychological torture.’”¹⁷⁴ Likewise, in *Baldeón García v. Peru*, the Inter-American Court found in 2006 that “threats and real danger of physical harm causes, in certain circumstances, such a degree of moral anguish that it may be considered psychological torture.”¹⁷⁵ And in *Tibi v. Ecuador*,¹⁷⁶ the Inter-American Court found that the victim “was threatened” during his detention in violation of Article 5 of the American Convention¹⁷⁷ and that such conduct, which “made him feel panic and fear for his life, . . . is a form of torture.”¹⁷⁸ That decision made clear that the American Convention’s prohibition of torture and cruel, inhuman, or degrading punishment or treatment extends to not only physical

of ill-treatment. In particular, the Special Rapporteur would like to draw Governments’ attention to the views expressed by the Human Rights Committee in the case of *Estrella v. Uruguay*.”); *id.*, at 4, para. 8 (“It is the Special Rapporteur’s opinion that serious and credible threats, including death threats, to the physical integrity of the victim or a third person can amount to cruel, inhuman or degrading treatment or even to torture, especially when the victim remains in the hands of law enforcement officials.”).

174 *Maritza Urrutia v. Guatemala*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R., (ser. C) No. 147, para. 92 (Nov. 27, 2003), http://www.corteidh.or.cr/docs/casos/articulos/seriec_103_ing.pdf.

175 *Baldeón García v. Peru*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R., (ser. C) No. 147, para. 119 (Apr. 6, 2006), http://www.corteidh.or.cr/docs/casos/articulos/seriec_147_ing.pdf.

176 Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R., (ser. C) No. 147, para. 147 (Sept. 7, 2004).

177 Article 5 of the American Convention on Human Rights provides in part: “Every person has the right to have his physical, mental, and moral integrity respected.” Organization of American States, American Convention on Human Rights art. 5(1), Nov. 22, 1969, O.A.S.T. No. 36, 1144 U.N.T.S. 123. “No one,” that article further provides, “shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment.” *Id.* at art. 5(2).

178 *Tibi v. Ecuador*, Inter-Am. Ct. H.R., (ser. C) No. 114, para. 149.

suffering but also psychic and moral anguish.¹⁷⁹ “[T]hreats and the real danger of subjecting a person to physical injury,” that court emphasized, “may be considered psychological torture.”¹⁸⁰

A recent report of the Human Rights Clinic of the University of Texas School of Law, “Designed to Break You: Human Rights Violations on Texas’ Death Row,” specifically documents the torture and inhumanity associated with life on death row.¹⁸¹ In that report, its authors note that every individual on Texas’ death row “spends approximately 23 hours a day in complete isolation for the entire duration of their sentence, which, on average, lasts more than a decade.”¹⁸² As the report then emphasizes: “This prolonged solitary confinement has overwhelmingly negative effects on inmates’ mental health, exacerbating existing mental health conditions and causing many prisoners to develop mental illness for the first time.”¹⁸³ “In addition to the detrimental effects of isolation,” the report notes, “the practice of setting multiple execution dates means that many prisoners are subjected to the psychological stress of preparing to die several times during their sentence.”¹⁸⁴ “The right to be free

179 *Id.* at para. 147 (“The Court has also recognized that threats and the real danger of subjecting a person to physical injury, under certain circumstances, cause such a moral anguish that they may be considered psychological torture.”).

180 *Id.*

181 Jacey Fortin, *Report Compares Texas’ Solitary Confinement Policies to Torture*, N.Y. TIMES, Apr. 26, 2017 (citing HUMAN RIGHTS CLINIC, THE UNIVERSITY OF TEXAS SCHOOL OF LAW, DESIGNED TO BREAK YOU: HUMAN RIGHTS VIOLATIONS ON TEXAS’ DEATH ROW (2017)); *see also* *A Death Before Dying: Solitary Confinement on Death Row*, AM. CIV. LIBERTIES UNION (July 2013), www.aclu.org/sites/default/files/field_document/deathbefore-dying-report.pdf; Corinna Barrett Lain, *Following Finality: Why Capital Punishment Is Collapsing Under Its Own Weight*, in FINAL JUDGMENTS: THE DEATH PENALTY IN AMERICAN LAW AND CULTURE 30, 40 (Austin Sarat ed., 2017) (“On death row, each condemned prisoner spends at least 22 hours a day, typically 23, within the confines of a windowless cell the size of a standard parking lot space. . . . Most are not allowed contact visits from family or friends. Death row inmates are typically allowed an hour or less of exercise each day, and typically that takes place in caged exercise pens akin to dog runs.”).

182 HUMAN RIGHTS CLINIC, THE UNIV. OF TEX. SCH. OF LAW, *supra* note 181, at 5; *see also* Lain, *supra* note 181, at 40.

183 HUMAN RIGHTS CLINIC, THE UNIV. OF TEX. SCH. OF LAW, *supra* note 181, at 5.

184 *Id.*; *see also* ROBERT M. BOHM, DEATHQUEST: AN INTRODUCTION TO THE THEORY AND PRACTICE OF CAPITAL PUNISHMENT IN THE UNITED STATES 225 (5th ed. 2017) (“In all death penalty jurisdictions, a death or

from torture is an absolute human right, and it is submitted that the current conditions of confinement on Texas' death row, including mandatory indefinite isolation, amount to a severe and relentless act of torture," the report concludes.¹⁸⁵ "Inmates held in solitary confinement," the report assesses, "are effectively subject to a severe form of psychological torture every day of their lives."¹⁸⁶

The uncertainty and unknowns associated with capital cases only serve to amplify the torturous nature of death penalty regimes. "Another particularly stressful experience is the anticipation of torture," Metin Başoğlu and Susan Mineka emphasize in *Torture and Its Consequences*. As they write in that book: "This vulnerability is often exploited by the torturers who make verbal threats of torture. Many survivors report that having to wait to be taken from their cell to the torture chamber can be even more distressing than torture itself."¹⁸⁷ "The anticipatory distress," they explain, "seems to be greater if the intervals between sessions are variable and/or if there is an uncertainty about the nature of the next torture session; both of these factors obviously maximize unpredictability."¹⁸⁸ "Such observations," they point out, "are corroborated by research in animals showing that shocks delivered at variable intervals (as opposed to fixed intervals) produce greater heart rate elevations and more ulceration."¹⁸⁹ Death row inmates clearly endure enormous

execution warrant instigates the execution process. A death warrant, which typically sets the date and place for a prisoner's execution, usually is issued by a state's governor, or the president of the United States in federal death penalty cases, and authorizes a warden or other prison officials to carry out a death sentence. In Texas, a district court judge sets the execution date. . . . The length of time before a death warrant expires and has to be reissued varies from a few days to several months.").

185 HUMAN RIGHTS CLINIC, THE UNIV. TEX. SCH. LAW, *supra* note 181, at 7.

186 *Id.* at 21. One former death row inmate described life on death row as a "slow mental, physical and spiritual torture." *Id.* at 22.

187 Metin Başoğlu & Susan Mineka, *The Role of Uncontrollable and Unpredictable Stress in Post-Traumatic Stress Responses in Torture Survivors*, in TORTURE AND ITS CONSEQUENCES: CURRENT TREATMENT APPROACHES 182, 206 (Metin Başoğlu ed., 1992).

188 *Id.*

189 *Id.* In that source, Metin Başoğlu and Susan Mineka further emphasize: "Certain forms of torture seem to have a much greater impact than others in inducing loss of control and feelings of helplessness in the detainee. Those that involve a perceived risk of death during the process appear to be more traumatic than the ones that merely involve physical pain but no real threat to life. Submersion of the head under water until near-asphyxiation or sham executions are examples of such methods." *Id.*

uncertainty and mental anguish, vacillating between hope and intense fear and despair while coping with severe depression and psychological trauma and, often, suicidal thoughts or ideation.¹⁹⁰

B. Capital Charges, Death Sentences, and Execution Protocols

Capital charges—or threats of death by police or prosecutors—are themselves extremely problematic when analyzed through the lens of the legal prohibition against torture. It is well known that confessions can be obtained through coercion or torture,¹⁹¹ and those facing death threats can be compelled to make choices—often as a result of duress—they might not have made had the prospect of death been removed from the equation.¹⁹² False or coerced

190 JOHN D. BESSLER, *CRUEL AND UNUSUAL: THE AMERICAN DEATH PENALTY AND THE FOUNDERS' EIGHTH AMENDMENT* 225 (2012) (“Condemned inmates, suffering from bouts of depression, often take their own lives One Florida study showed that 35 percent of death row inmates in that state attempted suicide and that 42 percent considered suicide.”).

191 GEORGE RYLEY SCOTT, *THE HISTORY OF TORTURE THROUGHOUT THE AGES* 276 (2009) (“Terror induced by threats is frequently tried to induce admission of guilt. A police officer may threaten to shoot the accused, and has been known to go so far as to press a revolver, loaded with blank cartridges, against the head or stomach and pull the trigger.”); *see also* *Ashcraft v. Tennessee*, 322 U.S. 143, 155 (1944) (“The Constitution of the United States stands as a bar against the conviction of any individual in an American court by means of a coerced confession. There have been, and are now, certain foreign nations with governments dedicated to an opposite policy: governments which convict individuals with testimony obtained by police organizations possessed of an unrestrained power to seize persons suspected of crimes against the state, hold them in secret custody, and wring from them confessions by physical or mental torture. So long as the Constitution remains the basic law of our Republic, America will not have that kind of government.”); *Chambers v. State of Florida*, 309 U.S. 227, 237–38 (1940) (referring to “physical and mental torture and coercion” in the context of “secret inquisitorial processes”).

192 BESSLER, *THE DEATH PENALTY AS TORTURE*, *supra* note 26, at 83 (“[I]n 1994, an Illinois federal district court emphasized that duress is a valid defense where there is ‘(1) an immediate threat of death or serious bodily harm; (2) a well-grounded fear that the threat will be carried out; and (3) no reasonable opportunity to escape the threatened harm.’ And in the early twentieth century, American marriages were invalidated where the consent of grooms was not freely given, but were obtained through threats of death by the fathers of the brides. . . . In a New Jersey case from the 1950s, ‘threats of gangster violence’ and ‘arsenic poisoning’ against a husband were themselves found to raise important questions of fact as to whether

confessions occur with some frequency,¹⁹³ and the risk of miscarriages of justice is heightened significantly in situations involving threats of death.¹⁹⁴ As one law review article reports: “The threat of a death

conveyances to the wife of property were procured by means of duress. In that case, *Rubenstein v. Rubenstein*, the husband’s allegations of threats of arsenic poisoning were given weight because the wife’s father was then serving a life sentence in a Pennsylvania prison for murder committed when he was associated with an ‘arsenic ring’ engaged in killings to defraud life insurers. Because the threat of arsenic poisoning was credible, the court gave significance to it.”).

193 E.g., DANIEL REISBERG, *THE SCIENCE OF PERCEPTION AND MEMORY: A PRAGMATIC GUIDE FOR THE JUSTICE SYSTEM* 193 (2014) (providing estimates on the number of false confessions); WRIGHTSMAN’S *PSYCHOLOGY AND THE LEGAL SYSTEM* 158 (Edie Greene & Kirk Heilbrun eds., 7th ed. 2011) (“It is undisputed that false confessions led to the wrongful conviction and imprisonment of five people in Beatrice, Nebraska in a case known as the Beatrice Six”); *id.* at 159 (“The Beatrice Six—five people who falsely confessed and one who was wrongfully convicted of the 1985 rape and murder of 68-year-old Helen Wilson in Beatrice, Nebraska—set the record for the most people exonerated by DNA evidence in one case. Their exonerations and pardons in 2008 shed light on the way that interrogators were able to get detailed statements from the suspects about a crime they did not commit.”); *id.* (“Suspect Joann Taylor confessed after interrogators told her they wanted her to be the first female on Nebraska’s death row. In fact, five of the six suspects, easily influenced and probably confused, falsely confessed to escape the threat of a death penalty.”); Mordecai Specktor, *Minneapolis Attorney Steve Kaplan Helps to Free Death Row Inmate Damon Thibodeaux, Who Had Been Wrongly Convicted of Rape and Murder*, *AMERICAN JEWISH WORLD* (Feb. 1, 2013), <https://www.tcdailyplanet.net/minneapolis-attorney-steve-kaplan-helps-free-death-row-inmate-damon-thibodeaux-who-h/> (“After nine hours of police grilling, and going without sleep for more than 30 hours, Thibodeaux cracked and falsely confessed to committing rape and murder.”).

194 E.g., *McHenry v. United States*, 308 F.2d 700, 703 (10th Cir. 1962) (citations omitted) (“An involuntary confession or one obtained by means of threats and promises which subject the mind of the accused to the torture or fear of flattery of hope is inadmissible in a criminal trial.”). As one court put it, in a situation where a man in police custody was threatened with the electric chair should he remain silent, thereby causing him to lose his capacity for rational calculation: “When a confession is forced from the mind by the flattery of hope or by the torture of fear, it is unreliable and no credit ought to be given to it. Promises or suggestions of leniency in exchange for waiving the Fifth Amendment privilege create a *flattery of hope*, which is made even more powerful by the *torture of fear* that accompanying threats of punishment induce in the mind of the accused.” *State v. Petitjean*, 748 N.E.2d 133, 141, 145 (Ohio Ct. App. 2000) (italics in original); accord DAVID V. BAKER, *WOMEN AND CAPITAL PUNISHMENT IN THE UNITED STATES: AN ANALYTICAL HISTORY* 183 (2016) (“Police

sentence causes many defendants to plead guilty in exchange for a life sentence, rather than risk the outcome of a trial.”¹⁹⁵ Just as death threats by prison guards can chill inmates’ exercise of their First Amendment rights,¹⁹⁶ the prospect of being sentenced to death in a court of law is also likely to influence the decision-making of

investigators and state prosecutors used the threat of the death penalty to coerce false confessions from Ada JoAnn Taylor, Debra Shelden, and Kathy Gonzales.”); Joe Duggan, *Beatrice 6 Member Says Threat of Death Penalty Persuaded Her to Confess to a Slaying She Didn’t Commit*, WORLD-HERALD BUREAU (Oct. 25, 2016), https://www.omaha.com/news/crime/beatrice-member-says-threat-of-death-penalty-persuaded-her-to/article_51ebcf4f-7299-5d08-8dfa-ebae55f0f5c2.html (“[W]hen the prosecutor agreed to take the death penalty off the table in exchange for a guilty plea and her cooperation, Taylor and her court-appointed attorney decided it was the best option. . . . Taylor said the decision to give a false confession may have saved her life, but it cost her more than 19½ years of freedom.”); *see also* Statement of Robert Dunham, Executive Director of the Death Penalty Information Center, on the release of the National Registry of Exonerations’ reports *Exonerations in 2016* and *Race and Wrongful Convictions in the United States* (Mar. 7, 2017), <https://deathpenaltyinfo.org/documents/DPICStatementOnNationalRegistryReports.pdf> (last visited Oct. 25, 2018) (“Our review of the 2016 data [from the National Registry of Exonerations] reveals that the death penalty played a role in nearly a quarter of the 54 homicide exonerations last year. In at least six of the wrongful homicide convictions, prosecutors had sought the death penalty at trial; in another, an innocent defendant had pled guilty to avoid the death penalty; and at least six additional exonerations were the product of witnesses having falsely implicated innocent defendants after police had threatened the witness or a loved one with the death penalty unless the witness cooperated with the investigation . . .”).

- 195 Rachel King, *No Due Process: How the Death Penalty Violates the Constitutional Rights of the Family Members of Death Row Prisoners*, 16 PUB. INT. L.J. 195, 214 (2007).
- 196 *Schleig v. Borough of Nazareth*, No. 16-3499, 2017 WL 2591408, at *4 (3d Cir. June 15, 2017) (“In the few cases in which government officials have made death threats in response to constitutionally protected activity, no one has tried to claim that the offending official’s behavior is something other than unlawful retaliation.”); *Knecht v. Collins*, Nos. 96-3682, 96-3735, 96-4114, 1999 WL 427173, at *3 (6th Cir. June 15, 1999) (per curiam) (a reasonable jury could conclude that prison guards’ acts of filing false disciplinary charges and issuing death threats were sufficient to deter a prisoner of ordinary firmness from exercising First Amendment rights); *Walker v. Firman*, No. 16-cv-02221-RBJ-MEH, 2017 WL 4652015, at *10 (D. Colo. Oct. 17, 2017) (“It is also clearly established that making death threats in retaliation for protected conduct violates the First Amendment.”); *Silverburg v. Seeley*, No. 3:09CV-P493-R, 2009 WL 5197870, at *3 (W.D. Ky. Dec. 23, 2009) (“[T]he Court will allow the individual-capacity claims for damages for retaliation based on alleged threats of death . . .”).

those facing capital prosecution or capital charges.¹⁹⁷ In the lead up to actual executions, the mental torment death row inmates face is, no doubt, off the charts.

In states that still put people to death, due process and fairness considerations inevitably yield to finality. “Today’s executions,” Robert Johnson writes in *Death Work: A Study of the Modern Execution Process*, “are highly bureaucratic jobs with clearly delineated roles, responsibilities, and procedures articulated in execution protocols.”¹⁹⁸ These protocols are often laden with minutia about how the executions will be carried out, yet the protocols put condemned inmates on notice, in no uncertain terms, that the

197 *E.g.*, *Bussey v. State*, 184 So. 3d 1138, 1141 (Fla. Dist. Ct. App. 2015) (detectives’ repeated threats of the death penalty amounted to coercion that rendered a murder defendant’s confession involuntary); *id.* at 1145–46 (“The purpose of the detectives’ comments regarding the death penalty . . . was not to inform [Bussey] of the penalties he faced. Rather, the purpose of the comments was to instill fear in Bussey that he would face the death penalty with the hope that his fear would cause him to confess to the robbery and murder.”); *cf.* *Galenski v. Commonwealth*, No. 2012-SC-000407-MR, 2013 WL 6730018, at *2 n.9 (Ky. Dec. 19, 2013) (citation omitted) (“The Beatrice Six is the colloquial name given to a group of six youths that were wrongfully convicted of murder in Beatrice, Nebraska, as a result of confessions induced by the threat of the death penalty.”); *People v. Sanders*, 976 N.Y.S.2d 205, 213 (N.Y. App. Div. 2013) (Hall, J., dissenting) (citations omitted) (“The defendant was threatened, by the FBI agent, with the possibility of death. This threat was used to overcome the defendant’s will, which is so ‘fundamentally unfair as to deny due process.’”); *State v. Knight*, No. 04-CA-35, 2008 WL 4369764, at *8–13 (Ohio Ct. App. Sept. 26, 2008) (Donovan, J., dissenting) (asserting that a murder confession was involuntary and “improperly induced” because “threats of the electric chair” introduced a “torture of fear” in order to “overbear” the suspect’s will). It has long been understood that torturous practices, which can include the use of death threats, can lead to false confessions. As one judge on the Supreme Court of Washington stressed in 2009: “We have reason to believe that, even in our own country and even in our own time, men have gone to prison and even death row on the strength of confessions wrought by torture.” *State v. Riofta*, 209 P.3d 467, 477 (Wash. 2009) (en banc) (Chambers, J., concurring in dissent). The threat of death may also influence the decision-making of lawyers representing those facing the prospect of capital charges or death sentences. *E.g.*, Sherod Thaxton, *Leveraging Death*, 103 J. CRIM. L. & CRIMINOLOGY 475, 482–84 (2013) (finding that the threat of the death penalty increases the probability of a plea agreement by approximately 20 percent, and noting that capital charges enable prosecutors to empanel “death-qualified” juries and that “the use of the death penalty as leverage in plea negotiations raises important legal and ethical issues”).

198 ROBERT JOHNSON, *DEATH WORK: A STUDY OF THE MODERN EXECUTION PROCESS* 42 (1998).

government aims to kill them. In a 2001 news story, *The New York Times* reported about the 56-page “Execution Protocol” to be used by the staff of the federal penitentiary in Terre Haute, Indiana.¹⁹⁹ While professing to allow executions to be carried out “in an efficient and humane manner,” it provided a “systemic countdown to execution” that includes several pre-execution checklists.²⁰⁰ “As soon as practical after establishment of the execution date,” one section of the protocol read, “the warden at U.S.P. Terre Haute or designee, will personally brief the condemned individual regarding relevant aspects of the execution process.”²⁰¹ “A briefing sheet outlining these aspects of the execution will be given to the individual,” the protocol continued.²⁰² In other words, not only is a death row inmate already fully aware that a death sentence has been imposed, but a prison official describes to the inmate the process by which that inmate’s life will be extinguished by the state.

Under that Execution Protocol, the warden’s briefing with the condemned inmate was to take place “By 30 Days Before the Execution,” as was a conference with the condemned inmate pertaining to the selection of execution witnesses, to include “one spiritual adviser, two defense attorneys and three adult friends or relatives (at least 18 years old).”²⁰³ In addition, the condemned inmate was to be asked about “Disposition of Body” and “Disposition of Personal Property and Accounts,” with the inmate “to provide instructions concerning the disposition of his/her body no later than 14 days prior to the execution.”²⁰⁴ Throughout the process, the condemned inmate would be continually reminded, in ways big and small, that the execution was approaching. “At least seven days prior to the execution, the warden or designee will contact the condemned individual to arrange for his/her last meal,” the protocol read.²⁰⁵ “Between 24 and 12 Hours Prior,” it continued, “[t]he warden will contact the condemned individual to finalize arrangements for his/her final meal and ensure that it is properly prepared and served by

199 See Jane Fritsch, *Word for Word/Execution Protocol; Please Order Your Last Meal Seven Days in Advance*, N.Y. TIMES, Apr. 22, 2001, <http://www.nytimes.com/2001/04/22/weekinreview/word-for-word-execution-protocol-please-order-your-last-meal-seven-days-advance.html>.

200 *Id.*

201 *Id.*

202 *Id.*

203 *Id.*

204 *Id.*

205 *Id.*

staff.”²⁰⁶ After the termination of the condemned inmate’s telephone privileges “24 hours prior to the execution,” the condemned inmate’s final meal was to be served “Between 12 and 3 Hours Prior” to the execution.²⁰⁷ The death row inmate would, of course, also be aware of an attorney’s final efforts to save the inmate’s life as well as the submission of any clemency petition, all of which the inmate would be helpless to predetermine the outcome.²⁰⁸

According to the Execution Protocol,²⁰⁹ the warden, during the period “Between 3 Hours and 30 Minutes Prior” to the execution, was to “designate a recorder who will begin logging execution activities in the official execution log book.”²¹⁰ And in “The Final 30 Minutes,” several items were listed to be accomplished by prison authorities.²¹¹ In particular, the Execution Protocol’s section for “Bringing the Condemned Individual to the Execution Room” required the condemned individual to be removed from an inmate holding cell, strip-searched, and then “dressed in khaki pants, shirt and slip-on shoes,” “secured with restraints, if deemed appropriate by

206 *Id.*

207 *Id.*

208 The chances of a clemency petition being granted are quite small. DAVID R. DOW, EXECUTED ON A TECHNICALITY: LETHAL INJUSTICE ON AMERICA’S DEATH ROW 86 (2005) (“Death penalty lawyers file clemency petitions on behalf of their clients because when someone’s life is at stake, lawyers tend to leave nothing on the cutting room floor, but when they are writing the petitions, they know it is a mere formality.”); *see also id.* (italics in original) (noting that “*hope* is too strong a word to describe the clemency process in Texas”; “[d]eath row inmates do not receive clemency in Texas”).

209 This execution protocol is one of many throughout the United States that methodically detail how executions are to be carried out. The texts of various execution protocols can be found on the Death Penalty Information Center’s website. *State by State Lethal Injection*, DEATH PENALTY INFO. CTR., <https://deathpenaltyinfo.org/state-lethal-injection> (last visited Sept. 28, 2018) (containing links to available protocols). *But see* EVAN J. MANDERY, CAPITAL PUNISHMENT IN AMERICA: A BALANCED EXAMINATION 492 (2d ed. 2012) (“[M]any states do not make their procedures known. Professor Deborah Denno of Fordham Law School has tirelessly detailed the failings of states in this regard, offering many examples of states that have vague and even secret execution protocols.”); *see also* DANIEL LACHANCE, EXECUTING FREEDOM: THE CULTURAL LIFE OF CAPITAL PUNISHMENT IN THE UNITED STATES 91 (2016) (“[A]nthropological studies of executions in the modern era have drawn a connection between execution protocols and a loss of agency of both the condemned and the state actors engaged in ‘death work.’”).

210 Fritsch, *supra* note 199.

211 *Id.*

the warden,” and “escorted to the Execution Room by the Restraint Team.”²¹² “In the Execution Room,” the protocol continued, “the ambulatory restraints, if any, will be removed, and the condemned individual will be restrained to the Execution Table.”²¹³ “Once the condemned individual has been secured to the table,” the protocol read for the execution’s final stage, “at the direction of the warden, staff inside the Execution Room will open the drapes covering the windows of the witness rooms.”²¹⁴ “The warden,” the protocol then read, “will ask the condemned individual if he/she has any last words or wishes to make a statement.”²¹⁵ Because executions extinguish life and many executions are botched, a fact that death row inmates are no doubt well aware of, the psychological torment as an execution approaches is especially heightened.²¹⁶

IV. The Torturous Nature of State-Sanctioned Killing

A. *Mental vs. Physical Pain or Suffering*

Cruelty and torture—the aggravated form of cruelty—are prohibited by law.²¹⁷ The U.N. Human Rights Committee, back in 1993, held that “the death penalty must be carried out in such a

212 *Id.*

213 *Id.*

214 *Id.*

215 *Id.* ROBERT M. BOHM, *DEATHQUEST: AN INTRODUCTION TO THE THEORY AND PRACTICE OF CAPITAL PUNISHMENT IN THE UNITED STATES* 202 (5th ed. 2017) (“When the first jolt of 2,000-volt electricity hit Tafero, the sponge in the headpiece gave off a combustible gas, which shot smoke and flames from the top of the leather hood hiding Tafero’s face. The flames—described as 3 inches to a foot long—horrified witnesses. Tafero’s attorney described the flawed execution as torture.”).

216 AUSTIN SARAT, *GRUESOME SPECTACLES: BOTCHED EXECUTIONS AND AMERICA’S DEATH PENALTY* 5 (2014). In some cases, death row inmates have been forced to spend an extended amount of time on the lethal injection gurney or to endure excruciating pain during the execution itself. REV. CARROLL PICKETT & CARLTON STOWERS, *WITHIN THESE WALLS: MEMOIRS OF A DEATH HOUSE CHAPLAIN* 79–98 (2017); Ziva Branstetter & Cary Aspinwall, *Inmate Clayton Lockett Dies of Heart Attack After Botched Execution; Second Execution Postponed*, *TULSA WORLD* (Apr. 30, 2014), http://www.tulsaworld.com/news/state/inmate-clayton-lockett-dies-of-heart-attack-after-botched-execution/article_80cc060a-cff2-11e3-967c-0017a43b2370.html.

217 GREENBERG, *supra* note 170, at 366 (noting that the Convention Against Torture treats torture as an extreme form of cruel, inhuman or degrading treatment).

way as to cause the least possible physical and mental suffering.”²¹⁸ Similarly, the U.S. Supreme Court, while upholding the death penalty’s constitutionality in cases like *Wilkerson v. Utah*,²¹⁹ *In re Kemmler*,²²⁰ *Gregg v. Georgia*,²²¹ *Baze v. Rees*²²² and *Glossip v. Gross*,²²³ has held that torture—as well as any barbaric method of execution²²⁴ (or one causing a “lingering death”)—is prohibited by the U.S. Constitution’s Eighth Amendment.²²⁵ For instance, the Supreme

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- 218 Committee on Civil and Political Rights, *NG v. Canada*, ¶ 1, U.N. Doc. CCPR/C/49/D/469/1991 (Nov. 5, 1993). The Human Rights Committee expressed the view that there would be a real risk of cruel and inhumane treatment were gas asphyxiation to be used to carry out an execution. *Id.*; see also Committee on Civil and Political Rights, *Kindler v. Canada*, U.N. Doc. CCPR/C/48/D/470/1991 (July 30, 1993).
- 219 *Wilkerson v. Utah*, 99 U.S. 130 (1879) (upholding the constitutionality of the public firing squad).
- 220 *In re Kemmler*, 136 U.S. 436 (1890) (upholding the constitutionality of New York’s electric chair).
- 221 *Gregg v. Georgia*, 428 U.S. 153 (1976) (upholding the constitutionality of Georgia’s death penalty). At the same time as the *Gregg* ruling, the U.S. Supreme Court also upheld the constitutionality of the death penalty in Florida and Texas. *Proffitt v. Florida*, 428 U.S. 242 (1976); *Jurek v. Texas*, 428 U.S. 262 (1976).
- 222 *Baze v. Rees*, 553 U.S. 35 (2008) (upholding the constitutionality of Kentucky’s three-drug lethal injection protocol).
- 223 *Glossip v. Gross*, 135 S. Ct. 2726 (2015) (upholding the constitutionality of Oklahoma’s three-drug lethal injection protocol). Although the Supreme Court struck down the death penalty as unconstitutional in *Furman v. Georgia*, 408 U.S. 238 (1972), it reversed course four years later and upheld the death penalty’s constitutionality in *Gregg v. Georgia*, 428 U.S. 153 (1976).
- 224 *Wilkerson*, 99 U.S. at 135–36 (noting in dicta that “burning alive” and other “punishments of torture . . . in the same line of unnecessary cruelty, are forbidden” by the U.S. Constitution’s Eighth Amendment).
- 225 *In re Kemmler*, 136 U.S. at 447. Dissents have asserted that particular methods of executions are unconstitutional. *E.g.*, *Gomez v. U.S. Dist. Ct. for Northern Dist. of Cal.*, 503 U.S. 653, 658 (1992) (Stevens, J., dissenting) (citations omitted) (“More than a century ago, we declared that ‘[p]unishments are cruel when they involve torture or a lingering death.’ In light of our contemporary understanding of the methods of execution and in light of less cruel alternatives presently available, I believe that execution by cyanide gas is ‘incompatible with ‘the evolving standards of decency that mark the progress of a maturing society.’”); *Glass v. Louisiana*, 471 U.S. 1080, 1086 (1985) (Brennan, J. dissenting) (“[T]he Eighth Amendment requires that, as much as humanly possible, a chosen method of execution minimize the risk of unnecessary pain, violence, and mutilation. If a method of execution does not satisfy these criteria—if it causes ‘torture or a lingering death’ in a significant number of cases—then unnecessary cruelty inheres in that method of execution and the method violates the Cruel and Unusual Punishments Clause.”).

Court—staking out its position—held more than a century ago, in its 1890 decision *In re Kemmler*: “Punishments are cruel when they involve torture or a lingering death; but the punishment of death is not cruel within the meaning of that word as used in the [C]onstitution.”²²⁶ The American founders’ use of *cruel* in the Eighth Amendment, the Court ruled, “implies . . . something inhuman and barbarous,—something more than the mere extinguishment of life.”²²⁷ But the *In re Kemmler* pronouncement about the death penalty’s constitutionality came decades before the U.S. ratification of the Convention Against Torture and its clear prohibition of “mental torture.”²²⁸

Although the U.S. Supreme Court has, over the years, upheld the constitutionality of the electric chair, the firing squad, and lethal injection,²²⁹ the Court has yet to take up—has yet to even consider on the merits—the death penalty’s adverse psychological impact. For example, while a few Justices have urged the full Court to take up the issue of the “death row phenomenon,” the Court has yet to accept for review a case dealing with prolonged stays on death row.²³⁰

226 *In re Kemmler*, 136 U.S. at 447.

227 *Id.*

228 AMERICA NEEDS HUMAN RIGHTS 207 (Anuradha Mittal & Peter Rosset eds., 1999) (noting that the United States signed the Convention Against Torture on April 18, 1988, ratified it on October 21, 1994, and that the convention entered into force in the United States on November 20, 1994).

229 In such cases, the U.S. Supreme Court has focused on whether the particular method of execution would produce a lingering death and whether there would be excruciating, *physical* pain at the time of the inmate’s death. Although the Supreme Court has upheld the constitutionality of lethal injection, the most common method of execution today, Supreme Court Justices have sometimes dissented from the Court’s decisions. *E.g.*, *Arthur v. Dunn*, 137 U.S. 725, 725 (2017) (Sotomayor, J., dissenting) (arguing that petitioner Thomas Arthur had “amassed significant evidence that Alabama’s current lethal-injection protocol will result in intolerable and needless agony”); JOHN D. BESSLER, *Introduction to STEPHEN BREYER, AGAINST THE DEATH PENALTY* 1–70 (John D. Bessler ed., 2016) (discussing the dissents in *Glossip v. Gross*, 135 S. Ct. 2726 (2015)).

230 *See* WILLIAM A. SCHABAS, *THE DEATH PENALTY AS CRUEL TREATMENT AND TORTURE: CAPITAL PUNISHMENT CHALLENGED IN THE WORLD’S COURTS* 124–25 (1996) (discussing the death row phenomenon); Patrick Hudson, *Does the Death Row Phenomenon Violate a Prisoner’s Human Rights under International Law?* 11 EUR. J. INT’L L. 833 (2000) (same); Kara Sharkey, *Delay in Considering the Constitutionality of Inordinate Delay: The Death Row Phenomenon and the Eighth Amendment*, 161 U. PA. L. REV. 861, 863 (2013) (“The Supreme Court has repeatedly declined to address the validity of the unconstitutional delay claim raised by Valle and other death row inmates before him. The

Meanwhile, the Court has struck down multiple non-lethal corporal punishments that operate on the body²³¹ as well as death sentences for assorted categories of offenders seen to have diminished capacity or responsibility.²³²

Since the prohibition against torture is absolute and non-derogable,²³³ and because credible death threats and threats of serious bodily harm are, even now, properly considered to be acts of torture,²³⁴ the death penalty must be outlawed post-haste. Already, a

issue first came to the Court's attention over fifteen years ago, in *Lackey v. Texas*." (citing *Valle v. Florida*, 132 S. Ct. 1, 1 (2011); *Lackey v. Texas*, 514 U.S. 1045, 1045 (1995) (memorandum of Stevens, J., respecting the denial of certiorari)).

- 231 *E.g.*, *Hope v. Pelzer*, 536 U.S. 730, 733–35 & n.2, 738, 745 (2002) (alleging that prison officials handcuffed a shirtless inmate to a hitching post for seven hours, leading to "a substantial risk of physical harm" and unnecessary exposure to heat and sun, the Supreme Court held that such conduct constituted an "obvious" Eighth Amendment violation); *Weems v. United States*, 217 U.S. 349, 373 (1910) (striking down as unconstitutional a sentence of *cadena temporal* that entailed a minimum twelve-year sentence of imprisonment, chained day and night at the wrists and ankles, while performing hard and painful labor while so chained).
- 232 *E.g.*, *Kennedy v. Louisiana*, 554 U.S. 407 (2008) (finding that the Eighth Amendment's Cruel and Unusual Punishments Clause prohibits the death penalty for the non-homicidal rape of a child); *Roper v. Simmons*, 543 U.S. 551 (2005) (declaring the unconstitutionality of the death penalty for juvenile offenders); *Atkins v. Virginia*, 536 U.S. 304 (2002) (declaring the unconstitutionality of the death penalty for the intellectually disabled); *Ford v. Wainwright*, 477 U.S. 399 (1986) (barring the execution of the insane); *Enmund v. Florida*, 458 U.S. 782 (1982) (setting aside the death penalty for the driver of a getaway car in a robbery-murder); *Coker v. Georgia*, 433 U.S. 584 (1977) (finding the death penalty to be disproportionate punishment for the non-homicidal rape of an adult woman).
- 233 Jordan J. Paust, *The Absolute Prohibition of Torture and Necessary and Appropriate Sanctions*, 43 VAL. U. L. REV. 1535, 1535 (2009) ("Torture is a form of treatment of human beings that is absolutely prohibited under various forms of customary and treaty-based international law in all social contexts.").
- 234 John Alan Cohan, *Torture and the Necessity Doctrine*, VAL. U. L. REV. 1587, 1596 (2007) ("[I]n addition to physical torture there can be psychological torture, such as threatening to execute the suspect, putting a gun to his head and saying you will shoot, threatening to castrate him, telling him that you are going to kill his family members if he does not tell you the information you are seeking, and similar tactics that, while not physically painful, inflict mental pain or suffering, even when there is no intent to carry out such threats."); *see also* THE TORTURE PAPERS: THE ROAD TO ABU GHRAIB 179 (Karen J. Greenberg & Joshua L. Dratel eds., 2005) (citations omitted) ("In criminal law, courts generally determine whether an individual's words or actions constitute a threat by examining whether a reasonable person in the

number of American judges—many of whom have publicly expressed aversion for death sentences and executions²³⁵—have concluded that capital punishment should be declared unconstitutional.²³⁶ “I yield to no one in the depth of my distaste, antipathy, and, indeed, abhorrence, for the death penalty, with all its aspects of physical distress and fear and of moral judgment exercised by finite minds,” Justice Harry Blackmun wrote in 1972 while dissenting from the Supreme Court’s landmark, 5–4 decision in *Furman v. Georgia*, which found then-existing death penalty laws to be unconstitutional.²³⁷ Although he originally thought legislators, not judges, should decide the matter, Blackmun later changed his mind. “From this day forward, I no longer shall tinker with the machinery of death,” he concluded in 1994, this time taking the view that capital punishment should be declared unconstitutional after seeing the reality of death penalty cases.²³⁸ “I feel morally and intellectually obligated simply to concede that the death penalty experiment has failed,” he emphasized.²³⁹

It is, in fact, simply impossible for the death penalty to be used or administered without resorting to credible threats of death, the very kind of threats that, when made by prison guards or non-state

same circumstances would conclude that a threat had been made.”).

- 235 Many U.S. Supreme Court Justices, while on the Court or after retiring from it, have expressed moral or legal objections to capital punishment. LINDA GREENHOUSE, *BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN’S SUPREME COURT JOURNEY* 113, 176–79 (2005); MICHAEL MELLO, *AGAINST THE DEATH PENALTY: THE RELENTLESS DISSENTS OF JUSTICES BRENNAN AND MARSHALL* (1996); JOHN C. JEFFRIES, JR., *JUSTICE LEWIS F. POWELL, JR.: A BIOGRAPHY* 451–52 (2001). Through the years, trial court and appellate judges have expressed regret about imposing death sentences or described them as cruel and unusual punishments. *E.g.*, 80 *THE FRIEND: A RELIGIOUS AND LITERARY JOURNAL* 99–100 (1907) (noting that Bird Wilson, the son of American Founding Father James Wilson and a judge on Pennsylvania’s Court of Common Pleas, expressed regret for the rest of his life after imposing a death sentence as part of his judicial duties; he was once heard to exclaim of the condemned man: “He was launched into eternity unprepared; but, O God! Impute it not to me!”); Kevin M. Barry, *The Law of Abolition*, 107 *J. CRIM. L. & CRIMINOLOGY* 521 (2017) (discussing American judges who have expressed their objections to capital punishment).
- 236 Barry, *supra* note 235, at 535 (“In all, at least thirty-five federal and state judges have concluded that the death penalty is unconstitutional per se.”).
- 237 *Furman v. Georgia*, 408 U.S. 238, 405–06 (1972) (Blackmun, J., dissenting).
- 238 *Callins v. Collins*, 510 U.S. 1141, 1145 (1994) (Blackmun, J., dissenting from denial of cert.).
- 239 *Id.*

actors, are already properly classified as acts of torture.²⁴⁰ Capital charges and death sentences are plainly credible threats of death because they are enforced by tremendous state power. Not only do threats of death inflict severe mental anguish and psychological torture on their targets,²⁴¹ but they inflict severe mental trauma on capital jurors,²⁴² lawyers,²⁴³ and members of execution teams.²⁴⁴

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- 240 Threats against prison guards by *an inmate* have themselves been found to be highly credible where the guards “were placed in fear” because of the inmate’s “ability to obtain weapons” and his gang connections within the prison. *People v. Mosley*, 65 Cal. Rptr. 3d 856, 864 (Cal. Ct. App. 2007).
- 241 11 HANDBOOK OF PSYCHOLOGY: FORENSIC PSYCHOLOGY 431 (Alan M. Goldstein & Irving B. Weiner eds., 2003) (“Some [death row] inmates may find the sustained isolation and chronic deprivation of years of solitary confinement to be so psychologically painful that the escape of death appears preferable.”); MICHAEL L. PERLIN ET AL., COMPETENCE IN THE LAW: FROM LEGAL THEORY TO CLINICAL APPLICATION 94 n.536 (2008) (“It has been estimated that ‘as many as fifty percent of Florida’s death row inmates become intermittently insane.’”); *see also* LYNDA G. ADAMSON, THEMATIC GUIDE TO POPULAR NONFICTION 206 (2006) (noting that San Quentin, California, guards yelled “dead man walking” when death row inmates were out of their cells).
- 242 Michael E. Antonio, “*I didn’t know it’d Be so Hard*”: Jurors’ Emotional Reactions to Serving on a Capital Trial, 89 JUDICATURE 282, 283–84 (2006) (“[R]esearchers studying criminal cases have identified ‘one or more physical and/or psychological symptoms that could be related to jury duty.’ These included reoccurring thoughts about the trial that would keep the jurors awake at night or nightmares about the crime and the defendant, stomach pains, nervousness, tension, shaking, headaches, heart palpitations, sexual inhibitions, depression, anorexia, faintness, numbness, chest pain, and hives. . . . Findings showed ‘jurors whose jury panel rendered a death penalty did sustain greater PTSD [Post-Traumatic Stress Disorder] symptoms than did jurors whose jury panel rendered a life sentence.’”).
- 243 *See generally* SUSANNAH SHEFFER, FIGHTING FOR THEIR LIVES: INSIDE THE EXPERIENCE OF CAPITAL DEFENSE ATTORNEYS (2013); *see also* 1 APPEALS AND WRITS IN CRIMINAL CASES §6.2 (3d ed. 2017) (“The job of appellate counsel in a capital case is complicated by the wide-ranging scope and fast-changing nature of capital jurisprudence, as well as the length of the time over which the litigation will continue. In addition, the magnitude of the undertaking, including the severity of the consequences of losing the case, create a unique set of pressures.”); Sara Mayeux, *Review of Fighting for Their Lives: Inside the Experience of Capital Defense Attorneys by Susannah Sheffer*, H-NET (Nov. 2013), <http://www.h-net.org/reviews/showrev.php?id=40132> (noting that capital defenders “cycle through rage, fear, anxiety, guilt, helplessness, and numbness; they fall into ruts of depression; they work all night, drink too much, and flail through nightmares”).
- 244 JOHN D. BESSLER, DEATH IN THE DARK: MIDNIGHT EXECUTIONS IN AMERICA 147 (1997) (noting that Utah and other states have stress inoculation programs to try to prevent prison staff members from suffering

In addition, executions inflict extreme mental pain or suffering on the condemned's family and friends,²⁴⁵ and emotional trauma on execution eyewitnesses.²⁴⁶ Family members have experienced serious adverse health consequences in close proximity to the imposition or carrying out of death sentences,²⁴⁷ with one death row

from post-traumatic stress disorder after executions); Annmarie Timmins, *Former Warden 'Haunted' by Executions*, CONCORD MONITOR (Aug. 13, 2010), <https://www.concordmonitor.com/Archive/2010/08/999787691-999787691-1008-CM> (quoting former warden Ron McAndrew, who oversaw Florida executions, as saying, "Many colleagues turned to drugs and alcohol from the pain of knowing a man had died at their hands. And I've been haunted by the men I was asked to execute in the name of the state of Florida.").

- 245 SANDRA JOY, GRIEF, LOSS, AND TREATMENT FOR DEATH ROW FAMILIES: FORGOTTEN NO MORE 212 (2014) ("There are some surviving execution witnesses who strongly regret their decision to witness, thus feel led to advise other families against witnessing subsequent executions."); Rachel King, *No Due Process: How the Death Penalty Violates the Constitutional Rights of the Family Members of Death Row Inmates*, 16 B.U. PUB. INT. L.J. 195, 197–99, 209, 211–17 (2007) (describing the emotional and physical impacts of the death penalty on death row inmates' family members, and listing migraine headaches, skyrocketing blood pressure, nightmares and sleeplessness, grief and uncontrollable crying, drug and alcohol abuse, recurring health problems, severe depression, heart attacks, and attempted suicide).
- 246 ROBERT L. BALDWIN, LIFE AND DEATH MATTERS: SEEKING THE TRUTH ABOUT CAPITAL PUNISHMENT 205 (2009) ("Those whose jobs are part of the process of execution also suffer from long-term effects similar to post-traumatic stress disorder. Because executions are so grim, most states that allow capital punishment offer counseling to all execution witnesses (except those related to the condemned)."); BROKEN IMAGES, BROKEN SELVES: DISSOCIATIVE NARRATIVES IN CLINICAL PRACTICE 68, 84 (Stanley Krippner & Susan Marie Powers eds., 1997) (citing Freinkel, A. et al., *Dissociative Symptoms in Media Execution Witnesses*, 151 AM. J. OF PSYCHIATRY 1335, 1335–39 (1994)) ("Freinkel et al. (1994) described that the witnessing of the execution of a convicted killer produced significant depersonalization among journalists observing the event."); see also SCOTT CHRISTIANSON, THE LAST GASP: THE RISE AND FALL OF THE AMERICAN GAS CHAMBER 182 (2010) ("San Quentin's prison personnel became accustomed to two or three witnesses fainting during each execution, and others vomiting or otherwise breaking down under the stress.").
- 247 Helen Kearney, *Children of Parents Sentenced to Death*, in CAPITAL PUNISHMENT: NEW PERSPECTIVES 162 (Peter Hodgkinson ed., 2016) (citations omitted) (describing examples that "illustrate the extraordinary levels of stress and trauma that the children and family" of death row inmates undergo, including a father in Belarus who suffered a heart attack shortly after learning of his son's execution and the mother of an Indiana death row inmate who overdosed after joining her son for his last meal); *id.*

inmate's mother suffering a heart attack and a stroke after a state governor signed a death warrant.²⁴⁸

B. The Torturous Effects of Death Sentences and Executions

Just as it is considered an act of torture to force someone to watch the rape, sexual assault, or torture of a loved one,²⁴⁹ it should be considered an act of torture to permit the imposition of a death sentence or the use of an execution. Capital sentences and executions inflict severe psychological harm on those closest to the condemned as well as those associated with the process of state-sanctioned killing, from inmates and their family members to prison chaplains, lawyers, and executioners.²⁵⁰ The powerlessness of a loved one to

at 145 (“Recent studies document the serious emotional and psychological distress experienced by the children and families of death row inmates, characterized by symptoms corresponding with post-traumatic stress disorder, ambiguous loss, and complicated and disenfranchised grief.”).

248 Shirley Dicks, *Six Accounts of Wrongly Convicted Prisoners on Death Row*, in CONGREGATION OF THE CONDEMNED: VOICES AGAINST THE DEATH PENALTY 146, 153–54 (Shirley Dicks ed., 1995).

249 *Prosecutor v. Kvočka*, Case No. IT-98-30/1-T, Judgment, ¶ 149 (Int’l Crim. Trib. for the Former Yugoslavia Nov. 2, 2001) (“[T]he *Furund’ija* Trial Chamber found that being forced to watch serious sexual attacks inflicted on a female acquaintance was torture for the forced observer. The presence of onlookers, particularly family members, also inflicts severe mental harm amounting to torture on the person being raped.”) (citing *Furund’ija* judgment); see also *Prosecutor v. Fofana*, Case No. SCSL-04-14-T, Judgment, ¶ 153 (Special Court for Sierra Leone Aug. 2, 2007) (“[A] third party could suffer serious mental harm by witnessing acts committed against others, particularly against family or friends.”).

250 *E.g.*, Walter C. Long, *The Constitutionality and Ethics of Execution-Day Prison Chaplaincy*, 21 TEX. J. C.L. & C.R. 1, 3 (2015) (“Execution-day chaplains work for the State, but there should be no question that they also form quick and strong emotional bonds with the men and women they are assigned to counsel and accompany to their deaths.”); Seema Kandelina & Peter Hodgkinson, *The Greater Stigma? Family Visits to the Condemned*, in CAPITAL PUNISHMENT: NEW PERSPECTIVES 127 (Peter Hodgkinson ed., 2013) (“In Texas, at the instance of being sentenced to death, the condemned’s family become the untouchables—literally—and by implication, the entire constituency of the families of the condemned are marginalized and stigmatized. In a world where there are so many examples of cruel, inhuman and degrading treatment and punishment, Texas’s treatment of the mothers, fathers, husbands, wives, children and grandchildren of its condemned must rank high.”); LOUIS J. PALMER, JR., THE DEATH PENALTY IN THE UNITED STATES: A COMPLETE GUIDE TO FEDERAL AND STATE LAWS 240 (2d ed. 2014) (noting that John Hurlbert, the executioner at New York’s Sing Sing Prison during the 1920s, executed over 120 prisoners in Sing Sing’s electric chair, but resigned in 1926 and, deeply depressed, committed suicide

prevent harm to a close relative is—and long has been—an aspect of torturous conduct,²⁵¹ and the only way to eliminate such torture is to eliminate executions altogether. Just as it is an act of torture to kill a helpless or defenseless victim in the non-state actor context,²⁵² it should be considered an act of torture to deliberately kill an inmate who is tied down on a gurney at the moment of his or her death.²⁵³

in the basement of his home three years later). American laws typically allow condemned inmates' family members, along with a small number of "reputable" or "respectable citizens," to attend executions. BESSLER, *DEATH IN THE DARK*, *supra* note 244, at 44, 46, 72–73. And death row inmates' family members—who, themselves, are not responsible for the particular crimes committed by the condemned inmates—suffer severe pain and suffering as a result of executions. Even if they do not actually attend an execution in person, they know when it will occur and yet will be utterly helpless to stop it. This means that death row inmates' family members experience "anticipatory grief"—a particularly bizarre form of loss. *E.g.*, ROBERT M. BOHM, *DEATHQUEST III: AN INTRODUCTION TO THE THEORY AND PRACTICE OF CAPITAL PUNISHMENT IN THE UNITED STATES* 351 (3d ed. 2007).

- 251 *E.g.*, *United States v. Juvenile (I.H., Jr.)*, 1 F. Supp. 2d 509, 520 (D.V.I. 1998) (noting that the defendant participated "in the brutal violation" of a man's wife "while the husband was only some few feet away, powerless to spare her from such torture").
- 252 *E.g.*, *Van Tran v. Colson*, 764 F.3d 594, 622–23 (6th Cir. 2014) (emphasizing that a victim's helplessness or defenselessness, including in an "execution-style murder," "evinces torture or depravity of mind"); *Lawlor v. Commonwealth*, 738 S.E.2d 847, 887 (Va. 2013) ("The psychological aspect of torture may be established, for example, 'where the victim is in intense fear and is aware of, but helpless to prevent, impending death . . . for an appreciable lapse of time.'" (quoting *Ex parte Key*, 891 So. 2d 384, 390 (Ala. 2004))); *State v. Davis*, 318 S.W.3d 618, 643 (Mo. 2010) (en banc) (finding evidence to support jury determination "that the murder was committed with depravity of mind because the crime involved binding Ms. Spicer, subjecting her to repeated acts of gruesome physical and sexual torture with the purpose of promoting her death, and that Mr. Davis killed or aided in killing Ms. Spicer while she was bound helplessly, thereby exhibiting a callous disregard for human life"); *State v. Frye*, 461 S.E.2d 664, 680 (N.C. 1995) (finding the defendant's crime involved "psychological torture").
- 253 CLIVE STAFFORD SMITH, *INJUSTICE: LIFE AND DEATH IN THE COURTROOMS OF AMERICA* 29–40 (2012) ("Over the years I have watched six of my clients die: two in the electric chair, two in the gas chamber and two on the lethal injection gurney."); *id.* ("It always happens at night, in darkness. I have never been able to decide whether it matters how they do it, since the prisoner ends up dead anyway. In one sense the gurney is most surreal, since the scene is meant to emulate a clinical setting, yet the prisoner is strapped down in the shape of a cross, his arms wide to give room for the needle. Sometimes the prison staff take ten minutes, twenty minutes, three-quarters of an hour probing the prisoner's arm, trying to find

The Convention Against Torture specifically prohibits both physical and psychological torture, so the U.S. Supreme Court should no longer focus only on the risk of maladministration of lethal-injection drugs and the potential for excruciating physical pain at the very moment of an inmate's execution, as it did in *Baze v. Rees*²⁵⁴ and *Glossip v. Gross*.²⁵⁵ Instead, the Supreme Court should use the modern definition of torture and broaden its focus to examine the psychological terror and self-evident mental torture associated with death sentences and executions.²⁵⁶ Mental torture is just as bad as physical torture, and both mental and physical torture are prohibited in the Convention Against Torture and similar human rights instruments.²⁵⁷ There is simply no legitimate justification to condemn one form of torture (i.e. the physical) while tolerating another (i.e. the psychological).

A person experiences severe psychological suffering when that person is incapacitated and helpless to prevent his or her death,²⁵⁸ and that is true for any person, regardless of what that person may have done—or not done—in the past. Already, threats of violence and death threats can form the basis of an intentional infliction of emotional distress (“IIED”) claim²⁵⁹ because they inflict

a vein.”).

254 *Baze v. Rees*, 553 U.S. 35 (2008).

255 *Glossip v. Gross*, 135 S. Ct. 2726 (2015).

256 *Aldana v. Del Monte Fresh Produce, N.A., Inc.*, 416 F.3d 1242, 1251 (11th Cir. 2005) (“When courts seek to define torture in international law, they often look to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Accordingly, we, for ATA [Alien Tort Act] purposes, too look to the Convention when deciding what constitutes torture according to the law of nations.”).

257 *See supra* text accompanying notes 4–5; *see also* ELIZABETH A. SHEEHY, *DEFENDING BATTERED WOMEN ON TRIAL: LESSONS FROM THE TRANSCRIPTS* 259 (2014) (“Psychological torture causes as much mental and traumatic stress as physical torture, and it amplifies brain injuries, making it more difficult to treat for depression and anxiety those who have experienced both.”).

258 *Smith v. State*, 122 So. 3d 224, 242 (Ala. 2011) (“After the initial gunshots rendered Smith helpless to prevent her death she suffered great psychological torture as she listened to her abductors discuss how they were going to kill her and dispose of her body while she begged for medical attention.”).

259 *Harris v. Cellco Partnership*, No. 5:15-cv-529-Oc-30PRL, 2016 WL 232235, at *3 (M.D. Fla. Jan. 15, 2016) (“In cases where Florida courts have permitted a plaintiff to move forward with an IIED claim, they often involve threats of death, rape, or severe bodily harm to the plaintiff or family members of the plaintiff.”); *Allam v. Meyers*, No. 09-cv-10580 (KMW), 2011

severe emotional distress and are considered to be “outside the bounds of decency.”²⁶⁰ And such threats can also be torturous when those threats are credible ones—as death threats made in the death penalty context naturally and inevitably are when one considers their immutable characteristics. In American jurisprudence, “forms of torture” already include “mock executions by placing a gun” in someone’s mouth “and pulling the trigger.”²⁶¹ Likewise, the use of Russian roulette during interrogation has been found to be a

WL 721648, at *10–11 (S.D.N.Y. Feb. 24, 2011) (allowing IIED claim based on a “five month-long, deliberate and malicious campaign of harassment and intimidation” that included “threats of violence” and death threats, as well as “relentless humiliation and emotional abuse”); *Eves v. Ray*, 840 N.Y.S.2d 105, 106 (App. Div. 2007) (sustaining verdict for defendant on IIED counterclaim where, “on several occasions,” plaintiff “threatened the defendant both physically and financially, and stalked him”); *Nims v. Harrison*, 768 So. 2d 1198, 1201 (Fla. Dist. Ct. App. 2000) (finding “as a matter of law” that “Nims’ complaints state a cause of action for intentional infliction of mental distress”; high school teacher stated cause of action against students for IIED where students participated in production and distribution of newsletter that threatened to kill teacher and to rape her and all of her children); *Household Credit Servs., Inc. v. Driscoll*, 989 S.W.2d 72, 81–82 (Tex. App. 1998) (general pattern of harassing behavior, including bomb and death threats, constituted extreme and outrageous behavior that could give rise to IIED claim); *Behringer v. Behringer*, 884 S.W.2d 839, 842, 844–45 (Tex. App. 1994) (allowing IIED claim where evidence of death threats included talk of hiring a hit man, and where there were threats that a husband would be beaten up and, as a result of the death threats and the wife’s actions, the husband “was in fear of his life every day, all the time”).

260 *E.g.*, *Barrios v. Elmore*, No. 3:18-cv-132-DJH-RSE, 2018 WL 3636576, at *4 (W.D. Ky. Ct. App. July 31, 2018) (denying motion to dismiss IIED claim, with the court finding threats to someone’s life “to be sufficiently outside the bounds of decency to be considered outrageous”); *see also* Tania Tetlow, *Criminalizing “Private” Torture*, 58 WM. & MARY L. REV. 183, 233–34 (2016) (“‘Psychological torture’ should be defined, with reference to the tort of intentional infliction of emotional distress, as ‘the use of extreme and outrageous conduct to intentionally cause severe emotional distress.’”); *id.* at 238 (“IIED allows civil damages for ‘outrageous’ behavior resulting in ‘extreme emotional distress.’”).

261 *Cannon v. Burge*, No. 05 C 2192, 2006 WL 273544, at *3 (N.D. Ill. Feb. 2, 2006); *see also* *Massie v. Gov’t of North Kor.*, 592 F. Supp. 2d 57, 64, 66 (D. D.C. 2008) (describing a mock execution and men held in captivity who “endured individual threats of death, threats to kill others, severe beatings, torture, both physical and mental, and other means of coercion”). *Compare* *Zalewski v. City of New York*, No. 1:13-CV-7015 (ARR) (PK), 2018 WL 5113137, at *7 (E.D.N.Y. Oct. 19, 2018) (“Courts in this circuit have found that ‘verbal threats, combined with the brandishing of [a] weapon, could be unreasonable and therefore constitute excessive force.’”) (citations omitted).

form of torture,²⁶² as have “threats to kill” and “the anticipation of physical harm to one’s self or a loved one.”²⁶³ If a threat to kill an inmate in one context (i.e. where a prison guard makes the threat) is torturous, then a threat to kill an inmate in another context (i.e. where the judicial system makes the threat) should also be classified as torturous. In the twenty-first century, the universal rights to human dignity and life and to be free from cruelty and torture should take center stage in the modern death penalty debate.

C. *The Importance of Human Dignity*

Not only are death threats torturous in nature, but they are unnecessary²⁶⁴ and utterly inconsistent with the right to life²⁶⁵ and

262 *In re Estate of Marcos Human Rights Litig.*, 910 F. Supp. 1460, 1463 (D. Haw. 1995). This case also found “[s]olitary confinement while handcuffed or tied to a bed” to be a form of torture. *Id.*

263 *State v. Hall*, 8 S.W.3d 593, 601 (Tenn. 1999) (“This Court has repeatedly held that the anticipation of physical harm to one’s self or a loved one constitutes mental torture. The evidence here clearly supports a finding of mental torture.”) (citations omitted).

264 A core principle of the Enlightenment—one articulated by Cesare Beccaria, Montesquieu and others centuries ago—was that any punishment that goes beyond “absolute necessity” is “tyrannical.” BESSLER, *THE DEATH PENALTY AS TORTURE*, *supra* note 26, at 37, 255; *see also* JOHN D. BESSLER, *THE CELEBRATED MARQUIS: AN ITALIAN NOBLE AND THE MAKING OF THE MODERN WORLD* 7, 217–18 (2018) (discussing Montesquieu’s and Beccaria’s views of necessity as the justification for punishment); JOHN D. BESSLER, *THE BARON AND THE MARQUIS: LIBERTY, TYRANNY, AND THE ENLIGHTENMENT MAXIM THAT CAN REMAKE AMERICAN CRIMINAL JUSTICE* (2019) (discussing the history and modern-day implications of the maxim penned by Montesquieu—and then publicized by Beccaria—that any punishment not grounded in necessity is “tyrannical”). In a world of maximum-security prisons, and in which life-without-possibility-of-parole sentences are authorized by law, it cannot be said that death sentences or executions are necessary, let alone absolutely necessary. JOHN D. BESSLER, *THE BIRTH OF AMERICAN LAW: AN ITALIAN PHILOSOPHER AND THE AMERICAN REVOLUTION* 439 (2014).

265 *CAPITAL PUNISHMENT: GLOBAL ISSUES AND PROSPECTS* 18–19 (Peter Hodgkinson & Andrew Rutherford eds., 1996) (“The original draft of the *Universal Declaration*, prepared by John P. Humphrey in early 1947, recognized a right to life that ‘can be denied only to persons who have been convicted under general law of some crime to which the death penalty is attached’. But Eleanor Roosevelt, who chaired the Drafting Committee, cited movement underway in some states to abolish the death penalty, and suggested that it might be better not to make any explicit mention of the matter. René Cassin reworked Humphrey’s draft and removed any reference to the death penalty. Cassin’s proposal found its way, virtually unchanged,

the notion of human dignity.²⁶⁶ Human dignity has long been called the “touchstone” of the U.S. Constitution’s Eighth Amendment,²⁶⁷ and dignity is also a central value of international law. As the U.N. Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment puts it:

into the final version of the *Declaration*, despite some subsequent attempts to return to the original proposal. It is clear from the *travaux préparatoires* that the death penalty was considered to be incompatible with the right to life, and that its abolition, although not immediately realizable, should be the goal of Member states. Subsequent interpretations, by General Assembly and Economic and Social Council resolutions, support this conclusion.”) (*italics in original*).

- 266 Juan E. Méndez, *The Death Penalty and the Absolute Prohibition of Torture and Cruel, Inhuman, and Degrading Treatment or Punishment*, 20 HUM. RTS. BRIEF 2, 5 (2012) (“I believe it is necessary for the international community to discuss this issue further and for states to reconsider whether the death penalty *per se* fails to respect the inherent dignity of the human person and violates the prohibition of torture or CIDT.”); *see also* *Identoba v. Georgia*, App. No. 73235/12, Eur. Ct. H.R. ¶¶ 69–71 (2015) (citations omitted) (where, during a march conducted to mark the International Day Against Homophobia, LGBT people in Georgia were subjected to death threats, the European Court of Human Rights wrote of the target of those threats: “Given that they were surrounded by an angry mob that outnumbered them and was uttering death threats and randomly resorting to physical assaults, demonstrating the reality of the threats, . . . the situation was already one of intense fear and anxiety. . . . [T]he Court concludes that the treatment of the applicants must necessarily have aroused in them feelings of fear, anguish and insecurity, which were not compatible with respect for their human dignity and reached the threshold of severity within the meaning of Article 3 taken in conjunction with Article 14 of the Convention.”).
- 267 *Trop v. Dulles*, 356 U.S. 86, 100 (1958) (“The basic concept underlying the Eighth Amendment is nothing less than the dignity of man. While the State has the power to punish, the Amendment stands to assure that this power be exercised within the limits of civilized standards.”); *see also* *Moore v. Texas*, 137 S. Ct. 1039, 1048 (2017) (quoting *Hall*, 134 S. Ct. at 1992) (“The Eighth Amendment prohibits ‘cruel and unusual punishments,’ and ‘reaffirms the duty of the government to respect the dignity of all persons.’”); *Hall v. Florida*, 134 S. Ct. 1986, 1992 (2014) (quoting *Weems v. United States*, 217 U.S. 349, 378 (1910) & *Trop*, 356 U.S. at 101) (“The Eighth Amendment ‘is not fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a humane justice.’ To enforce the Constitution’s protection of human dignity, this Court looks to the ‘evolving standards of decency that mark the progress of a maturing society.’”); *Woodson v. North Carolina*, 428 U.S. 280, 304 (1976) (referring to “the fundamental respect for humanity underlying the Eighth Amendment”).

Any act of torture or other cruel, inhuman or degrading treatment or punishment is an offence to human dignity and shall be condemned as a denial of the purposes of the Charter of the United Nations and as a violation of the human rights and fundamental freedoms proclaimed in the Universal Declaration of Human Rights.²⁶⁸

In *Brown v. Plata*,²⁶⁹ the U.S. Supreme Court itself made clear that offenders do not lose their right to human dignity by virtue of their incarceration. As Justice Anthony Kennedy wrote for the Supreme Court in that case: “To incarcerate, society takes from prisoners the means to provide for their own needs. Prisoners are dependent on the State for food, clothing, and necessary medical care. A prison’s failure to provide sustenance for inmates ‘may actually produce physical ‘torture or a lingering death.’”²⁷⁰ “A prison that deprives prisoners of basic sustenance, including adequate medical care,” Justice Kennedy emphasized, “is incompatible with the concept of human dignity and has no place in civilized society.”²⁷¹ In a world of universal human rights, inmates and even heinous offenders, just like everyone else, have a right to be free from torture and from cruel, inhuman, or degrading treatment.²⁷²

268 Declaration on the Protection of All Persons, *supra* note 22, at 91. The preamble to the U.N. Charter, signed in 1945, the year World War II came to a close, explicitly recites that one of its purposes is “to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small.” U.N. Charter pmbl.

269 *Brown v. Plata*, 563 U.S. 493 (2011).

270 *Id.* at 510 (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (quoting *In re Kemmler*, 136 U.S. at 447)); *see also Estelle*, 429 U.S. at 103 (citation omitted) (“An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical ‘torture or a lingering death,’ the evils of most immediate concern to the drafters of the [Eighth] Amendment.”).

271 *Brown*, 563 U.S. at 511.

272 John D. Bessler, *The Inequality of America’s Death Penalty: A Crossroads for Capital Punishment at the Intersection of the Eighth and Fourteenth Amendments*, 73 WASH. & LEE L. REV. ONLINE 487, 555 (2017); Liesel J. Danjczek, *The Mentally Ill Offender Treatment and Crime Reduction Act and Its Inappropriate Non-Violent Offer Limitation*, 24 J. CONTEMP. HEALTH L. POL’Y 69, 97 (2007); *see also* UNITED NATIONS OFFICE ON DRUGS AND CRIME, HANDBOOK FOR PRISON LEADERS: A BASIC TRAINING TOOL AND CURRICULUM

Death sentences and execution protocols, like other acts of torture, dehumanize individuals and strip offenders of their humanity, however tarnished by whatever crimes they have committed in the past.²⁷³ The Convention Against Torture plainly requires that nations prevent and criminalize torture,²⁷⁴ envisioning the elimination of torturous punishments in accordance with the dictates of that convention and the humanitarian impulses

FOR PRISON MANAGERS BASED ON INTERNATIONAL STANDARDS AND NORMS 27 (2010) (noting that certain rights “are non-derogable, meaning that they must be fully respected at all times and in all circumstances” and listing “the right to life, the right to be free from torture and other cruel, inhuman or degrading treatment” as among those rights; “[p]rison officials are responsible for ensuring that they do not violate any of these rights”).

273 David Rose, *Executions Dehumanize Everyone*, PITT. POST-GAZETTE (Sept. 27, 2015), <http://www.post-gazette.com/opinion/Op-Ed/2015/09/27/Having-worked-in-corrections-for-decades-I-hope-Pennsylvania-abolishes-the-death-penalty/stories/201509270109>.

274 Nigel Rodley & Matt Pollard, *Criminalisation of Torture: State Obligations Under the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, EUR. HUM. RTS. L. REV. 115 (2006). Various provisions of law around the world punish torturous acts, though laws proscribing torture vary widely in the actual punishments they impose. See generally Daniel O’Donnell, *The Obligation to Establish Sentences for Torture that Are Commensurate with the Gravity of the Offense*, 22 BUFF. HUM. RTS. L. REV. 95 (2016) (describing legal provisions in various countries that criminalize and punish torture); see also 18 U.S.C. § 114 (1996) (“Whoever, within the special maritime and territorial jurisdiction of the United States, and with intent to torture (as defined in section 2340), maim, or disfigure, cuts, bites, or slits the nose, ear, or lip, or cuts out or disables the tongue, or puts out or destroys an eye, or cuts off or disables a limb or any member of another person; or[,] Whoever, within the special maritime and territorial jurisdiction of the United States, and with like intent, throws or pours upon another person, any scalding water, corrosive acid, or caustic substance— Shall be fined under this title or imprisoned not more than twenty years, or both.”).

behind it.²⁷⁵ In *Kennedy v. Louisiana*,²⁷⁶ the U.S. Supreme Court, in considering an Eighth Amendment case, forthrightly proclaimed: “Evolving standards of decency must embrace and express respect for the dignity of the person, and the punishment of criminals must conform to that rule.”²⁷⁷ “When the law punishes by death,” Justice Anthony Kennedy wrote for the Court, “it risks its own sudden descent into brutality.”²⁷⁸ In declaring the use of the electric chair to be unconstitutional, the Nebraska Supreme Court said something quite similar, with that court writing in 2008: “We recognize the temptation to make the prisoner suffer, just as the prisoner made an innocent victim suffer. But it is the hallmark of a civilized society that we punish cruelty without practicing it. Condemned prisoners must not be tortured to death, regardless of their crimes.”²⁷⁹

D. The Coercive Nature (and Distorting Effects) of Death Threats

The use of any death threat, whether by a state actor or a non-state actor, should raise an immediate red flag because credible death threats, as shown, are already classified as torturous acts.²⁸⁰ In fact, threats of death are serious enough that, in civil cases and the application of the criminal law, they can be the basis of a duress defense.²⁸¹ For example, where threats of death were made in the

275 Not surprisingly, American law already expressly states that the purpose of the Convention Against Torture is to prohibit torture. 8 C.F.R. § 208.18(a) (3) (2018) (noting that the “object and purpose” of the Convention Against Torture is “to prohibit torture”); *see also* Ashika Singh, *The United States, the Torture Convention, and Lex Specialis: The Quest for a Coherent Approach to the CAT in Armed Conflict*, 47 COLUM. HUM. RTS. L. REV. 134, 151 (2016) (noting a Swiss cable emphasizing that “the Convention Against Torture . . . has as its sole purpose the protection against torture”). As criminologist Robert Johnson, of American University, writes of the importance of human dignity in punishment practices: “Punishment that dehumanizes is itself a crime; punishment that respects the human dignity of the criminal is justice. In the matter of crime and just punishment, criminals dehumanize their victims but, ideally, the punishments meted out in society’s name do not dehumanize the criminals.” Robert Johnson, *Reflections on the Death Penalty: Human Rights, Human Dignity, and Dehumanization in the Death House*, 13 SEATTLE J. FOR SOC. JUST. 583, 587 (2014).

276 *Kennedy v. Louisiana*, 554 U.S. 407 (2008).

277 *Id.* at 420.

278 *Id.*

279 *State v. Mata*, 745 N.W.2d 229, 279 (Neb. 2008).

280 *See* PAUST ET AL., *supra* note 40.

281 *See* Bacigalupo v. Santoro, No. 94-cv-02761-BLF, 2018 WL 6272238, at *12

context of a divorce decree, the defense of duress was found to be “an issue of fact to be disposed of at the trial.”²⁸² Death threats

(N.D. Cal. Nov. 30, 2018) (“Central to a defense of duress is the immediacy of the threat or menace on which the defense is premised.”); *In re Chiquita Brands Int’l, Inc.*, 284 F. Supp. 3d 1284, 1324 (S.D. Fla. 2018) (holding that the duress defense “is narrowly construed, and viable only if defendant can show that he or she acted under an immediate threat of death or serious bodily injury at the time the conduct occurred; that he or she had a well-grounded fear that the threat would be carried out, and that he or she had no reasonable opportunity to escape or inform the police”); *Cormier v. State*, 540 S.W.3d 185, 190 (Tex. Ct. App. 2017) (quoting TEX. PENAL CODE § 8.05(a) (1994)) (“Duress is an affirmative defense that applies if the defendant ‘engaged in the proscribed conduct because he was compelled to do so by threat of imminent death or serious bodily injury to himself or another.’”); *Oliver v. Ameriquest Mortg.*, No. 301444, 2012 WL 284618, at *3 (Mich. Ct. App. Jan. 31, 2012) (“[D]eath threats could potentially support a finding of duress”); Kristen Cherry, Comment, *Marriage and Divorce Law in Pakistan and Iran: The Problem of Recognition*, 9 TULSA J. COMP. & INT’L L. 319, 330 (2001) (“If consent needed for the *khul* is obtained by duress, the divorce is void. Such duress must be of a serious nature such as threats of death, bodily harm, or captivity.”); *see also* *People v. Speer*, 255 P.3d 1115, 1119 (Colo. 2011) (en banc) (discussing statutory defense of duress based on conduct resulting from “the use or threatened use of unlawful force” and applying “an objective standard of reasonableness,” said to exculpate “only for threats that a reasonable person would not have been able to resist”); *People ex rel. Rusch v. Rivlin*, 277 Ill. App. 183, 186 (1934) (citation omitted) (“The compulsion which will excuse a criminal act . . . must be present, imminent, and impending, and of such a nature as to induce a well grounded apprehension of death or serious bodily harm if the act is not done. A threat of future injury is not enough.”). *Compare* *People v. Anderson*, 50 P.3d 368, 376 (Cal. 2002) (“The reasons a person acted in a certain way, including threats of death, are highly relevant to whether the person acted with a conscious or wanton disregard for human life.”), *with* *State v. Davis*, No. A07-0331, 2008 WL 2020402, at *5 n.1 (Minn. Ct. App. May 13, 2008) (noting that, in Minnesota, duress is a statutory defense that applies when a person “commits a crime because his will has been overborne by threats of death from another participant in the crime”), *and* GEERT-JAN ALEXANDER KNOOPS, DEFENSES IN CONTEMPORARY INTERNATIONAL CRIMINAL LAW 98 (2d ed. 2008) (“Psychological threats, which amount to imminent death or serious bodily harm, may trigger the defense of necessity.”).

282 *In re Kittinger’s Estate*, 101 N.Y.S.2d 844, 847 (Sur. Ct., N.Y. County, N.Y. 1950). *Accord* *McIntosh v. McIntosh*, 26 Cal. Rptr. 26, 27–28 (Cal. App. 1962) (“[W]e are satisfied that the trial court was justified in finding that plaintiff was coerced into writing the waiver by fear of personal injury or death at the hands of defendant; that said fear was induced by the beating of November 13, 1959, coupled with the subsequent threats of defendant; that the waiver was not the voluntary act of plaintiff and was invalid.”).

have been used to set aside a state court judgment,²⁸³ and threats of death—in both the civil and the criminal contexts—can be highly pertinent to a duress defense’s viability and legitimacy.²⁸⁴

Death threats are inherently coercive. They have been recognized as such since time immemorial, and that is so because death threats remove a person’s ability to make voluntary decisions based on free will. Thus, in *Avco Financial Services, Inc. v. Johnson*,²⁸⁵ the Supreme Court of Utah, citing an earlier precedent, put it this way: “In *Fox v. Piercey*,²⁸⁶ this Court reviewed the development of the law of duress since the time of Lord Coke, when only threats of death, dismemberment, mayhem or imprisonment were recognized as coercive actions constituting duress.”²⁸⁷ “In that case,” Utah’s highest court observed, “we followed the modern trend, and adopted the ‘subjective’ test, holding that ‘any wrongful act or threat which actually puts the victim in such fear as to compel him to act against his will constitutes duress.’”²⁸⁸ Death threats made to someone in police custody, it is important to remember, can easily produce false confessions, with such threats—whether made by police officers or prosecutors—leading individuals to make incriminating statements or plead guilty to crimes they have not committed.²⁸⁹

283 *In re Slater*, 200 B.R. 491, 496 (Bankr. E.D.N.Y. 1996) (“[T]he Debtor’s allegations that her brother physically assaulted her and threatened her life before and during the trial . . . does constitute extrinsic fraud sufficient to attack the state court judgment.”).

284 *Rowley v. Rowley*, 290 P. 181, 184 (Okla. 1930) (“Certainly, a threat to the effect that her husband would kill her and her baby would be sufficient to justify execution of an instrument, if she honestly believed the threat would be carried into execution did she not sign it. The fact that she soon thereafter secured a divorce from her husband, on grounds of extreme cruelty and threats to kill, corroborates her statements and justifies her belief that in all probability his threats would be executed.”); *cf. Hoffman v. Hoffman*, 30 Pa. 417, 420 (Pa. 1858) (“There were no threats of death or bodily harm, which constitutes duress *per minas* in the case.”).

285 *Avco Fin. Servs., Inc. v. Johnson*, 596 P.2d 658 (Utah 1979).

286 *Fox v. Piercey*, 227 P.2d 763 (Utah 1951).

287 *Avco Fin. Servs., Inc.*, 596 P.2d at 660 (citing *Fox*, 227 P.2d at 766).

288 *Id.* (quoting *Fox*, 227 P.2d at 766).

289 Examples of false confessions in the death penalty context are not hard to find. *THE WITNESS STAND AND LAWRENCE S. WRIGHTSMAN, JR.* 60 (Cynthia Willis-Esqueda & Brian H. Bornstein eds., 2016) (citation omitted) (“[M]ore than 300 people in the United States have been exonerated by DNA, including several who served time on death row. To everyone’s astonishment, false confessions have been a contributing factor in over 25% of these wrongful convictions.”); Rob Warden, *Illinois Death Penalty Reform: How It Happened, What It Promises*, 95 J. CRIM. L. & CRIMINOLOGY

E. Death Row, “Mock” Executions, and Threats to Life or Bodily Integrity

Death row inmates endure prolonged periods of confinement in harsh conditions. They confront the prospect of death on a daily basis, inevitably experiencing extreme uncertainty and anxiety as the days and months and years go by and as all the capital litigation and pleas for mercy occur. They are confined in small, spartan cells, and they often wait for death for years, even multiple decades, as their attorneys press their legal claims. The waiting and anxiety can be torturous, especially as it is so prolonged,²⁹⁰ though threats of death—all by themselves—meet the torture threshold because of their inherent features. As one recent study put it: “Common methods of psychological torture involve threats to the victim or the victim’s loved ones, isolation or solitary confinement, sleep and sensory deprivation, exposure to loud noise, or forcing a victim to watch or participate in the torture of others.”²⁹¹ “A typical example,”

381, 382–83 (2005) (noting that false confessions and snitch testimony were the two most common causes of error in Illinois exoneration cases); *see also* TRUE STORIES OF FALSE CONFESSIONS vii, 147 (Rob Warden & Steven A. Drizin eds., 2009) (“false confessions are amazingly common”; “the death penalty can be misused to intimidate an innocent person into making a false confession”); DALE S. RECINELLA, THE BIBLICAL TRUTH ABOUT AMERICA’S DEATH PENALTY 133 (2004) (“False confessions can also be easily obtained from the mentally ill.”); DAVID V. BAKER, WOMEN AND CAPITAL PUNISHMENT IN THE UNITED STATES: AN ANALYTICAL HISTORY 181 (2016) (“False confessions are a significant factor in female wrongful convictions; slightly more than one-fifth of female wrongful convictions involve false confessions.”).

290 ROBERT JOHNSON, DEATH WORK: A STUDY OF THE MODERN EXECUTION PROCESS 196 (1998) (“It is his confinement, culminating in the deathwatch and ending with his execution, that epitomizes death row confinement. This confinement-unto-death, I will argue, is a clear and complete case of torture.”); *cf.* *Habtemicael v. Ashcroft*, 370 F.3d 774, 782 (8th Cir. 2004) (citations omitted) (“An unlawful or extrajudicial threat of imminent death comes within the definition of torture if it is specifically intended to bring about prolonged mental pain or suffering. This intent requirement is satisfied if prolonged mental pain or suffering either is purposefully inflicted or is the foreseeable consequence of a deliberate act.”).

291 ASHLEY McCULLEY, THE PHYSICAL AND PSYCHOLOGICAL SEQUELAE IN ADULT REFUGEES OR ASYLUM SEEKERS WHO HAVE SURVIVED TORTURE 8 (2013), https://ethnomed.org/clinical/torture/torture-literature-review/AshleyMcCulley_Dec2013_final.pdf (“The most common types of psychological torture . . . were threats, witnessing torture, mock execution, humiliation, and sensory, hygiene, or sleep deprivation.”); *id.* (“Psychological sequelae are also a result of physical torture methods. For example, waterboarding is a physical torture method that simulates

Dr. Hernán Reyes, of the International Committee of the Red Cross, writes of psychological torture, “is the ‘sham execution,’ a method known to be extremely traumatic in which prisoners are led out to what they believe is their summary execution.”²⁹² “Verbal threats of death or mutilation” and “[t]hreats involving others (family etc.)” have elsewhere been labeled as forms of psychological torture,²⁹³ along with “[t]hreats of being killed or infliction of serious injury” and “[t]hreats of separation from, torture of or killing of family members.”²⁹⁴

Mock executions, as a matter of fact, have been shown by researchers to be as severe as various physically torturous acts.²⁹⁵ In a study of torture conducted by Metin Başoğlu of King’s College London, Başoğlu and his colleagues surveyed 279 torture survivors—both soldiers and civilians—from the once war-torn former Yugoslavia.²⁹⁶ Between 2000 and 2002, those survivors answered questions about the types of torture that they endured.²⁹⁷

drowning, but the sheer terror of feeling like you are going to die produces psychological sequelae. Merging both physical and psychological torture methods leaves survivors with relentless long-term psychological sequelae.”).

292 Hernán Reyes, *The Worst Scars Are in the Mind: Psychological Torture*, 89 INT’L REV. OF THE RED CROSS 591, 600, 611–12 (2007).

293 Caroline Gorst-Unsworth & Eva Goldenberg, *Psychological Sequelae of Torture and Organised Violence Suffered by Refugees from Iraq*, 172 BRITISH J. PSYCHIATRY 90, 92 (1998), https://www.cambridge.org/core/services/aop-cambridge-core/content/view/8772F08B130FC04BC6A2E29D407DA3C2/S0007125000149244a.pdf/psychological_sequelae_of_torture_and_organised_violence_suffered_by_refugees_from_iraq.pdf.

294 Engelke Randers, *Torture; Mental Sequelae and Treatment Approaches—Are These Applicable in Low-Income Countries?*, UNIVERSITETET I OSLO 8, <https://www.duo.uio.no/bitstream/handle/10852/29693/ProsjektXRanders.pdf?sequence=2> (last visited Oct. 25, 2018).

295 E.g., Linda Piwowarczyk, *Seeking Asylum: A Mental Health Perspective*, 16 GEO. IMMIGR. L.J. 155, 162 (2001) (footnote omitted) (“Partly in response to more aggressive human rights monitoring, methods of torture have evolved to become more psychological in nature, thereby leaving fewer physical signs. This shift is alarming in view of the experience from the Center for Victims of Torture in Minneapolis that indicated that greater psychological damage is inflicted by methods such as sham executions, sexual torture, prolonged arbitrary detention, especially with sensory deprivation, disappearance of a loved one, threats against family members, and witnessing the torture of others.”).

296 Roxanne Khamsi, *Psychological Torture ‘as Bad as Physical Torture’*, NEW SCIENTIST (Mar. 5, 2007), <https://www.newscientist.com/article/dn11313-psychological-torture-as-bad-as-physical-torture/>.

297 *Id.*

In particular, they were asked to rate the distress they felt on a scale of zero (no distress) to four (maximum distress). About 20 of the survivors experienced purely *psychological* torture, including sham executions, the torture of family members, or threats of rape, and the researchers collected medical data on whether the survivors showed signs of Post-Traumatic Stress Disorder (“PTSD”).²⁹⁸ The study found that psychological manipulations—threats and witnessing the torture of others—were ranked very high on the scale.²⁹⁹ Sham executions (3.7), witnessing torture of close ones (3.6), threats of rape (3.6), threats against family (3.4), witnessing torture of others (3.4), threats of death (3.3), and threats of further torture (3.2) were rated in an essentially equivalent manner on the distress scale to these forms of physical torture: hanging by the wrists tied at the back (3.8),³⁰⁰ suffocation/asphyxiation (3.8), electric torture (3.7), *falaga* (3.6),³⁰¹ burning parts of the body (3.6), forced extraction of teeth (3.6), stretching of the body (3.5), beating (3.5), hanging by hands or feet (3.5), needles under toenails or fingernails (3.4), beating over the ears with cupped hands (3.4), and pulling/dragging/lifting by hair (3.2).³⁰² It is now clear that those who endure physical threats

298 *Id.* In 2013, the American Psychiatric Association revised the diagnostic criteria for PTSD in the fifth edition of its *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-5”), a professional manual cited by the U.S. Supreme Court in a recent case dealing with the issue of intellectual disability. *Moore v. Texas*, 137 S. Ct. 1039, 1045 (2017). In the DSM-5, PTSD is included in a new category titled “Trauma- and Stressor-Related Disorders.” One of the criteria for a PTSD classification includes exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence in any of the following ways: direct exposure, witnessing the trauma, learning that a relative or close friend was exposed to a trauma, or indirect exposure to aversive details of the trauma in the course of professional duties (e.g., first responders, medics). *PTSD: National Center for PTSD*, U.S. DEP’T OF VETERANS AFFAIRS, https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp (last updated Feb. 22, 2018).

299 Khamsi, *supra* note 296.

300 CULLEN MURPHY, *GOD’S JURY: THE INQUISITION AND THE MAKING OF THE MODERN WORLD* 91 (2012) (hanging by the wrists tied at the back is also known, among other things, as “reverse hanging”).

301 *Falaga* involves beating the soles of the feet. DARIUS REJALI, *TORTURE AND DEMOCRACY* 274 (2007).

302 Khamsi, *supra* note 296. In speaking about the results of the study’s findings, Dr. Basoglu—a psychiatrist and specialist in trauma studies—made clear that the distinction between physical and psychological torture was artificial. “Until now, both sides of the debate have expressed opinions based on personal impressions,” Basoglu emphasized. “But these data,” he added,

and psychological torture experience severe pain and suffering, commonly developing major depressive disorder and PTSD.³⁰³

V. Taking Psychological Torture Seriously

A. *Death Threats as a Form of Psychological Torture*

Psychological torture is just as abhorrent as physical torture.³⁰⁴ It is, however, sometimes more difficult to identify because the signs of it may not be discernible with the human

“clearly suggest that you cannot make a distinction between physical forms of torture and something else called ‘cruel and degrading treatment.’”

Nicholas Bakalar, *The Line Between Torture and Cruelty*, N.Y. TIMES (Mar. 6, 2007), <http://www.nytimes.com/2007/03/06/health/psychology/06tort.html>.

303 *Kabba v. Mukasey*, 530 F.3d 1239, 1242 (10th Cir. 2008). Psychological torture is itself a common feature of domestic violence and rape, which may or may not involve the loss of life. *E.g.*, *Sneed v. Johnson*, No. 1:04CV588, 2007 WL 709778, at *59 (N.D. Ohio Mar. 2, 2007) (quoting report of Dr. Smalldon) (“Psychological torture often accompanied the rapes. For example, David recalls the man threatening that his dog ‘would eat [David] up’ if he refused to do what he was told.”); *People v. Coffman*, 96 P.3d 30, 54 (Cal. 2004) (“Certain features of defendants’ relationship fit the profile of a battering relationship: a pattern of escalating violence, sexual abuse within the relationship, jealousy, psychological torture, threats to kill”); *State v. Anthony*, 555 S.E.2d 557, 597 (N.C. 2001) (“[T]he evidence showed that Samantha had an *ex parte* domestic violence order served on defendant shortly before her murder and made statements to several witnesses that defendant had threatened and followed her and that she feared him. Samantha even saw defendant slowly driving past the hair salon she was patronizing just hours before her murder. This evidence supports the inference that Samantha experienced psychological unease and fear before her murder.”).

304 In the U.S., emotional and psychological harms are not currently treated as seriously as physical harms within prisons. *E.g.*, *Perkins v. Kan. Dep’t of Corr.*, 165 F.3d 803, 807 (10th Cir. 1999); *Brooks v. Humphrey*, No. 5:12-CV-281 (CAR), 2012 WL 5866293, at *3 n.11 (M.D. Ga. Nov. 19, 2012) (citing 42 U.S.C. § 1997e(e) (1996)) (“Plaintiff could not recover compensatory or punitive damages for the ‘mental, emotional, and psychological’ harm caused by his placement within range of Watson’s ‘daily and constant barrage of death threats.’ An inmate in prison who files a federal civil action cannot recover damages on the basis of mental or emotional injury suffered while in custody without demonstrating a related physical injury.”). The Prison Litigation Reform Act, enacted in 1996, has made it more difficult for prisoners to recover compensatory damages for psychological suffering. JOHN BOSTON & DANIEL E. MANVILLE, *PRISONERS’ SELF-HELP LITIGATION MANUAL* 528 (4th ed. 2010). That federal law, however, does not change the well-settled definition of torture.

eye. In *Psychological Torture: Definition, Evaluation and Measurement*, one expert, Pau Pérez-Sales, begins that scholarly monograph by labeling “the concept of torture (especially psychological torture)” as “elusive and blurred.”³⁰⁵ “There is not an official definition of or consensus on the meaning of psychological torture,” Pérez-Sales emphasizes.³⁰⁶ But that source nonetheless relays how various types of threats—from threats of death to threats against family members, and from threats of inflicting pain to threats to rape loved ones—have previously been classified as methods of torture.³⁰⁷ The New York-based Center for Constitutional Rights, in a report on Guantánamo, has itself classified the following techniques as psychological torture: “Solitary confinement, light and sound manipulation, exposure to the elements and to extreme temperature, . . . sleep deprivation, and threats of transfer for torture in another country.”³⁰⁸

Courts have not always found death threats sufficient to constitute torture, with not every threat of death found to be credible or specific enough to qualify as such.³⁰⁹ One of the horrifying features of death threats, though, is the sheer uncertainty of knowing if, or when, they will be carried out.³¹⁰ For example, as one California

305 PAU PÉREZ-SALES, *PSYCHOLOGICAL TORTURE: DEFINITION, EVALUATION AND MEASUREMENT* 2 (2017).

306 *Id.* at 7.

307 *Id.* at 120.

308 *Id.* at 7. Pérez-Sales considers “psychological torture to be *the use of techniques of cognitive, emotional or sensory attacks that target the conscious mind and cause psychological suffering, damage and/or identity breakdown in most subjects subjected to them; such techniques may be used alone or together with other techniques to produce a cumulative effect.*” *Id.* at 8; see also Edward Domovitch et al., *Human Torture: Description and Sequelae of 104 Cases*, 30 CAN. FAM. PHYSICIAN 827 (1984) (conducting a study of 104 torture victims and noting that common methods of torture included threats of death and sham executions); Katherine J. Eder, *The Importance of Medical Testimony in Removal Hearings for Torture Victims*, 7 DEPAUL J. HEALTH CARE L. 281, 283 (2004) (footnote omitted) (“Common threats of psychological torture include isolation, threats, humiliation, sham executions, and witnessing the torture of others. Rape and sexual assault are also forms of torture commonly practiced during arrest or imprisonment or during conflicts.”).

309 *United States v. Rodriguez-Vasquez*, 4 F. Supp. 3d 1146, 1154 (N.D. Cal. 2013) (“The Court is aware of no case—and the defendant cites none—holding that death threats alone constitute torture under the CAT standard. The receipt of these threats after he returned to Honduras, while undoubtedly disturbing, does not support the defendant’s claim that he could have established a plausible claim of torture prior to removal.”).

310 *People v. Holt*, 937 P.2d 213, 263 (Cal. 1997) (“The crime undoubtedly inflicted mental torture as well as physical violence on the victim who

appellate court has written: “While a victim of domestic violence and continuing death threats might well suspect she will be attacked sometime in the future, she has no way of knowing exactly when or where that attack will occur.”³¹¹ Threats of death are thus often closely associated with—indeed, equivalent to and part and parcel of—torturous conduct.³¹² “Death threats are patently material to the grave risk analysis,” another California appellate decision determined in another case involving allegations of domestic violence.³¹³ As that court wrote: “Due process required the trial court to decide the material issue of father’s alleged death threats and to afford mother the opportunity to offer relevant and competent evidence on that issue.”³¹⁴ As another court, in Michigan, put it in the context of yet another domestic violence case: “The prior acts presented by the prosecution at trial also qualify as acts of domestic violence, since defendant ‘caus[ed] physical harm’ to the victim and made death threats toward her ‘that would make a reasonable person feel terrorized, frightened, intimidated, threatened, harassed, or molested.’”³¹⁵

B. The Definition of Psychological Torture

Of critical importance, psychological torture has been defined in criminal cases as an awareness of, but a helplessness

was forced to accompany defendant to the bedroom, submit to his sexual assault, and lie apprehensively on the floor awaiting her uncertain fate as he ransacked her belongings while she suffered oxygen deprivation.”); Neill v. State, 896 P.2d 537, 556–57 (Okla. Crim. App. 1994) (citations omitted) (“Mental anguish includes the victim’s uncertainty as to his ultimate fate. Our finding of torture is supported by the mental torment of Mr. Zeller prior to the shooting, rather than the events which took place afterwards. In the present case, the evidence clearly supports a finding of mental anguish beyond that which necessarily accompanies a killing. Accordingly, the evidence was sufficient to support the ‘especially heinous, atrocious or cruel’ aggravating circumstance.”).

311 *People v. Arellano*, 23 Cal. Rptr. 3d 172, 176 (Cal. Ct. App. 2004).

312 *Hekmati v. Islamic Republic of Iran*, 278 F. Supp. 3d 145, 160 (D. D.C. 2017) (“[I]n *Moradi*, this Court held that a detainee in Iranian prison experienced torture when his interrogators subjected him to ‘severe physical and mental pain, including threatening him with death and dismemberment’” (citing *Moradi v. Islamic Republic of Iran*, 77 F. Supp. 3d 57, 68–69 (D. D.C. 2015))).

313 *Noergaard v. Noergaard*, 197 Cal. Rptr. 3d 546, 553 (Cal. Ct. App. 2015).

314 *Id.* at 554.

315 *People v. Phillips*, No. 323333, 2016 WL 232324, at *1 (Mich. Ct. App. Jan. 19, 2016).

to prevent, one's impending death.³¹⁶ "Psychological torture," the Court of Criminal Appeals of Alabama has held, "can be inflicted where the victim *is in intense fear and is aware of, but helpless to prevent, impending death.*"³¹⁷ "Such torture," that court has ruled, "must have been present for an appreciable lapse of time, sufficient enough to cause prolonged or appreciable suffering."³¹⁸ Although courts have not established a particular length of time that is necessary for a premeditated murder to be transformed into a torture-murder, and in reality there is no specific time requirement for a finding of torture to be made,³¹⁹ it is clear that a few hours or even a few minutes can suffice.³²⁰ In fact, a murder victim's awareness of, but

316 *Scott v. State*, 937 So. 2d 1065, 1083 (Ala. Crim. App. 2005).

317 *Shanklin v. State*, 187 So. 3d 734, 808 (Ala. Crim. App. 2014) (italics in original) (quoting *Ex parte Key*, 891 So. 2d 384, 390 (Ala. 2004)); accord *Shaw v. State*, 207 So. 3d 79, 122 (Ala. Crim. App. 2014); *Boyle v. State*, 154 So. 3d 171, 234 (Ala. Crim. App. 2013); *Albarran v. State*, 96 So. 3d 131, 208, 214 (Ala. Crim. App. 2011). The court in *Ex parte Key* found that, in that case, "the victim suffered psychological torture for an appreciable period." *Ex parte Key*, 891 So. 2d at 390.

318 *Shanklin v. State*, 187 So. 3d 734, 808 (Ala. Crim. App. 2014) (quoting *Ex parte Key*, 891 So. 2d at 390); accord *Shaw v. State*, 207 So. 3d 79, 122 (Ala. Crim. App. 2014); *Boyle v. State*, 154 So. 3d 171, 234 (Ala. Crim. App. 2013); *Baker v. State*, 87 So. 3d 587, 604 (Ala. Crim. App. 2009); *Ex parte Deardorff*, 6 So. 3d 1235, 1240 (Ala. 2008). As the Court of Criminal Appeals of Alabama, explaining the operation of the standard in that death penalty jurisdiction, has put it: "[T]he factor of psychological torture must have been present for an appreciable lapse of time, sufficient enough to have caused prolonged or appreciable suffering, i.e., the period of suffering must be prolonged enough to separate the crime from 'ordinary' murders for which the death penalty is not appropriate." *Mitchell v. State*, 84 So. 3d 968, 986 (Ala. Crim. App. 2010) (quoting *Norris v. State*, 793 So. 2d 847, 861 (Ala. Crim. App. 1999)). See *Doe v. Qi*, 349 F. Supp. 2d 1258, 1317 (N.D. Cal. 2004) ("In order to establish mental (in contrast to physical torture), the TVPA [Torture Victims Protection Act] requires a showing of 'prolonged' mental harm that is caused by the threat that either the victim or another will be imminently subjected to death or severe physical pain or suffering. The TVPA does not define the length of time required for a finding of 'prolonged' mental harm.") (citing 28 U.S.C. § 1350 note § 3(b)(2)).

319 *E.g.*, *State v. Gailey*, No. 08-0628, 2009 WL 778772, at *3 (Iowa Ct. App. Mar. 26, 2009) ("There is no requirement that torture be inflicted for any minimum period of time. . . . We conclude there is substantial evidence to support the jury's finding that Gailey intentionally subjected his wife and daughter to mental torture to support a conviction for first-degree kidnapping.").

320 *E.g.*, *State v. Walters*, 588 S.E.2d 344, 363 (N.C. 2003) ("The victims were subjected to at least an hour and a half of psychological torture by being trapped in the trunk of a car while pleading for their lives. The victims

helplessness to prevent, impending death for an appreciable period of time, is a defining feature of “especially heinous, atrocious, or cruel” homicides.³²¹ That aggravating circumstance—and a finding of torture—has been made, for example, where a perpetrator discussed whether or not to kill a victim in the presence of that victim or where

were also abducted at gunpoint and robbed of jewelry. Furthermore, Susan Moore was forced to witness Tracy Lambert being shot in the head. We thus conclude that the evidence more than warranted the trial court’s submission of the (e)(9) aggravating circumstance to the jury for both murders.”); *State v. Carter*, 114 S.W.3d 895, 904 (Tenn. 2003) (finding that photographs, including one of “Mrs. Jackson’s partially nude body” and one of “Mr. Jackson’s body in the closet,” aided “in establishing that the victims suffered torture in the form of severe mental anguish” because “[t]he jury could infer from these photographs that both victims anticipated physical harm,” with the court further emphasizing that “[m]ental torture” occurs “when a victim hears or anticipates the harm or killing of a spouse and is helpless to assist”); *State v. Nesbit*, 978 S.W.2d 872, 886–87 (Tenn. 1998) (“the jurors were capable of evaluating the proof and determining whether the victim suffered severe mental pain when, over the course of a six hour time period, her body was burned and beaten in her own home, with four of her young children present”; “[t]he sufficiency of the evidence to support a jury’s finding of torture does not depend upon whether an expert witness utters the magical words ‘severe physical or mental pain’” but “whether, after reviewing the evidence in the light most favorable to the State, any rational trier of fact could have found the existence of the aggravating circumstance beyond a reasonable doubt”; “we conclude that the proof is sufficient to support a jury finding that both severe physical and mental pain was inflicted upon the victim while she remained alive and conscious”).

321 *E.g.*, *Floyd v. State*, No. CR-13-0623, 2017 WL 2889566, at *70 (Ala. Crim. App. July 7, 2017) (containing jury instruction to that effect); *see also* *State v. McNeill*, 624 S.E.2d 329, 339 (N.C. 2006) (noting that killings that involve the infliction of psychological torture leave the victim “in her last moments aware of, but helpless to prevent, impending death”); *State v. Alston*, 461 S.E.2d 687, 718–19 (N.C. 1995) (finding a murder was “especially heinous, atrocious, or cruel” because of “evidence of psychological terror” that included defendant’s prior threats “to ‘smash in’ the victim’s face and kill the victim”; “[i]t is reasonable to infer that the victim suffered psychological torture and anxiety as her fears were realized and the defendant carried out his threats,” with the court citing prior cases where psychological terror was found before determining: “In the last minutes of the victim’s life, as her face was forced into the pillow and she struggled to breathe, she undoubtedly was left aware of, but unable to prevent, her impending death.”); *accord* *State v. Bell*, 603 S.E.2d 93, 121 (N.C. 2004); *State v. Tirado*, 599 S.E.2d 515, 544 (N.C. 2004); *State v. Barden*, 572 S.E.2d 108, 142 (N.C. 2002); *State v. Mann*, 560 S.E.2d 776, 788 (N.C. 2002); *State v. Anthony*, 555 S.E.2d 557, 596–97 (N.C. 2001); *State v. Spruill*, 360 S.E.2d 667, 670, 674 (N.C. 1987); *State v. Gladden*, 340 S.E.2d 673, 694 (N.C. 1986); *State v. Hamlet*, 321 S.E.2d 837, 846 (N.C. 1984).

the victim pleaded for his or her life.³²²

As the Court of Criminal Appeals of Alabama has written of that aggravating circumstance: “In determining the application of this aggravating circumstance ‘we must consider whether the violence involved in achieving the killing went beyond what was necessary to cause death, whether the victims experienced appreciable suffering after a swift assault, and whether there was psychological torture.’”³²³ In determining if an offense is especially heinous, atrocious, or cruel, Alabama courts examine these three factors: “(1) the infliction on the victim of physical violence beyond that necessary or sufficient to cause death; (2) appreciable suffering by the victim after the assault that ultimately resulted in death; and (3) the infliction of psychological torture on the victim.”³²⁴ As regards the last factor, the Alabama courts have stated: “Thus, mental suffering may be found where a victim witnesses the murder of another (particularly a family member) and then realizes that soon he or she will also be killed, as well as where the victim is expressly taunted with the prospect of his or her own death.”³²⁵ The consideration of the existing definition of psychological torture in death penalty states such as Alabama has important—and unmistakable—collateral consequences for capital punishment.

The Alabama case of *Ex parte Deardorff*³²⁶ is noteworthy. In that case, the Supreme Court of Alabama considered the case of Donald Deardorff, a man convicted of capital murder. In determining that the murder was especially heinous, atrocious, or

322 *State v. Hodges*, 944 S.W.2d 346, 357–58 (Tenn. 1997).

323 *Smith v. State*, 122 So. 3d 224, 241 (Ala. Crim. App. 2011) (quoting *Brownfield v. State*, 44 So. 3d 1, 41 (Ala. Crim. App. 2007)).

324 *Saunders v. State*, 10 So. 3d 53, 108 (Ala. Crim. App. 2007) (citing *Brooks v. State*, 973 So. 2d 380, 417–18 (Ala. Crim. App. 2007)).

325 *Id.* at 108–09; accord *Brooks v. State*, 973 So. 2d 380, 418–19 (Ala. Crim. App. 2007); *Norris v. State*, 793 So. 2d 847, 859–60 (Ala. Crim. App. 1999). Psychological torture has been found in multiple Alabama cases. *E.g.*, *Brown v. State*, 982 So. 2d 565, 607 (Ala. Crim. App. 2006) (“The evidence establishes that the victim suffered for an appreciable amount of time following the assault and clearly endured extensive psychological torture.”). But it has not been found where the victims were shot in rapid succession. *Norris v. State*, 793 So. 2d 847, 862 (Ala. Crim. App. 1999) (“[B]ecause the three victims were shot in rapid, uninterrupted succession, any momentary fear or anxiety of impending death did not last sufficiently long as to constitute the unnecessary torture required to elevate the offense to an especially heinous, atrocious, or cruel offense . . .”).

326 *Ex parte Deardorff*, 6 So. 3d 1235 (Ala. 2008).

cruel when compared to other capital offenses, Alabama’s highest court set forth a detailed description of the murder—one involving binding the victim’s hands with duct tape, keeping the victim in a closet, driving him to a remote spot while his hands and mouth were taped, and then shooting him in the head four times while his head was covered with a pillowcase.³²⁷ Deardorff was sentenced to death for the execution-style murder,³²⁸ with the Court of Criminal Appeals finding sufficient evidence to support the determination that the murder was especially heinous, atrocious, or cruel.³²⁹ As the court pointed out, the victim feared for his life, “[t]he terror he experienced must have escalated tremendously when his mouth was taped and his hands were bound,” and “he had to know that his death was imminent.”³³⁰ In affirming Deardorff’s death sentence, the Supreme Court of Alabama specifically highlighted that the victim was “threatened with death” and “held in captivity and confined in a closet” while hooded and with his hands taped.³³¹ Those circumstances, the court observed, constituted “psychological torture so as to meet the standard for a murder that is ‘especially heinous, atrocious, or cruel.’”³³²

Other courts in American death penalty states have also found the presence of psychological torture where the victim had an awareness of impending death but an inability to prevent it. For example, in *State v. Sloan*,³³³ the Supreme Court of Missouri ruled:

327 *Id.* at 1237–40.

328 That various “execution-style” murders have been described as torturous in nature is itself telling about the torturous nature of actual executions. *E.g.*, MICHAEL J. BOYLE, *VIOLENCE AFTER WAR: EXPLAINING INSTABILITY IN POST-CONFLICT STATES* 296 (2014) (quoting U.N. Assistance Mission for Iraq (UNAMI), Human Rights Report (2006)) (“Dozens of bodies bearing signs of torture and showing execution style killings have continued to appear daily in and around Baghdad, as well as other parts of the country.”); CLINT RICHMOND, *FETCH THE DEVIL: THE SIERRA DIABLO MURDERS AND NAZI ESPIONAGE IN AMERICA* 60 (2014) (“The mother and daughter had been methodically tortured over a period of time and then carefully and deliberately put to death—execution style. The prolonged torture of the victims and execution-style killings were the most heinous crimes either of the veteran criminologists had seen in their long careers.”). Both execution-style killings and state-sanctioned killings involve the infliction of severe pain or suffering.

329 *Ex parte Deardorff*, 6 So. 3d at 1238.

330 *Id.* (quoting *Deardorff v. State*, 6 So. 3d 1205 (Ala. Crim. App. 2004)).

331 *Id.* at 1240.

332 *Id.*

333 *State v. Sloan*, 756 S.W.2d 503 (Mo. 1988) (en banc).

Here, the evidence shows that Jason was the last member of the Sloan family to be shot. The jury could have reasonably believed that Jason had heard the previous gunshots and was therefore hiding under a blanket, his arms covering his head, in a hopeless effort to conceal himself from appellant's aim. This is sufficient evidence of psychological torture, as it indicates that Jason had the opportunity to anticipate and reflect upon his impending death while his parents and brother were shot.³³⁴

In another case, *State v. Oliver*,³³⁵ the Supreme Court of North Carolina similarly found especially heinous, atrocious, or cruel murders included those “calculated to leave the victim in his last moments as a sentient being, aware but helpless to prevent impending death, focusing on the deliberate, intentional and senseless aspect of a conscienceless and pitiless murder inflicting psychological torture.”³³⁶ In that case, the court found that the victim had pleaded “please don’t shoot me” before death, concluding that “the evidence was sufficient to support the submission to the jury of the factor that the murder was especially heinous, atrocious, or cruel.”³³⁷ Of course, death row inmates in their final days and hours, if not so depressed that they simply abandon their appeals altogether, are also forced to beg for their lives, if only through their lawyers.

In the context of criminal responsibility, findings of psychological torture have frequently been made where a murder victim begged for his or her own life.³³⁸ The fact that there is a

334 *Id.* at 511.

335 *State v. Oliver*, 307 S.E.2d 304 (N.C. 1983).

336 *Id.* at 318.

337 *Id.* at 319.

338 *Id.* at 318–19 (defendant’s boasting to fellow inmates that he had enjoyed killing victim, who had begged for his life, was evidence of “conscienceless and pitiless murder inflicting psychological torture”); *see also* *State v. Rhines*, 548 N.W.2d 415, 452 (S.D. 1996) (“The evidence also shows that Rhines possessed the necessary intent for a finding of torture. When Schaeffer pleaded with Rhines for his life, Rhines did not tell officers of his desire to quickly end his victim’s life. Instead, Rhines described his own sarcastic and scornful attitude toward Schaeffer’s suffering. Rhines also stated that when he believed Schaeffer had survived the third stab wound, he tied his victim’s hands and left him to die. This evidence supports a finding that Rhines intended to cause unnecessary pain to his victim.”).

short time lapse between a victim's abduction or incapacitation and the victim's death—as one Tennessee court has put it—“does not alone support a finding that the victim was mentally tortured.”³³⁹ As that court stressed: “[P]roof that the victim begged for his life in the last few seconds of his life is, by itself, insufficient to support a finding of mental torture that would distinguish this murder from any other murder.”³⁴⁰ “The fact that the victim begged for his life or that there were multiple gunshots,” the Supreme Court of Florida similarly emphasized, “is an inadequate basis to find this aggravating factor absent evidence that [the perpetrator] intended to cause the victim unnecessary and prolonged suffering.”³⁴¹ But where the victim begged for life and was made to suffer for more than a fleeting amount of time (i.e. an appreciable amount of time), a finding of psychological torture has been made.³⁴² Defendants in capital cases and those sentenced to death plainly suffer for an appreciable amount of time, with the prospect of an untimely death via a state-sanctioned killing hanging over their heads like the Sword of Damocles.³⁴³

Extreme mental anguish, it has been held, occurs where a person realizes that he or she is about to be killed but is unable to do anything to stop it.³⁴⁴ Indeed, torture techniques are specifically

339 State v. Beckman, No. 02C01-9406-CR-00107, 1995 WL 568471, at *17 (Tenn. Crim. App. Sept. 27, 1995).

340 *Id.*

341 Bonifay v. State, 626 So. 2d 1310, 1313 (Fla. 1993); *see also id.* (“The record fails to demonstrate any intent by Bonifay to inflict a high degree of pain or to otherwise torture the victim.”).

342 *E.g.*, Fowler v. State, 779 P.2d 580, 588 (Okla. Crim. App. 1989) (“Mr. Barrier attempted to fight off the attack and begged for his life before he died. Such evidence clearly demonstrated torture and serious physical abuse, thereby supporting the jury’s finding that the death of John Barrier was heinous, atrocious or cruel.”). Whether any particular murder qualifies as a *torture-murder* can be a factual issue for a jury to determine. Talamantez v. Superior Court, 122 Cal. App. 3d 629, 638 (Cal. Ct. App. 1981).

343 VALERI R. HELTERBRAN, WHY FLAMINGOS ARE PINK: . . . AND 250 OTHER THINGS YOU SHOULD KNOW 102 (2007) (*italics in original*) (“The phrase *sword of Damocles* is defined as a threat, peril, or imminent danger.”).

344 Neill v. State, 896 P.2d 537, 556 (Okla. Crim. App. 1994) (“There is ample evidence of the extreme mental anguish suffered by these three (3) women prior to their deaths. This evidence illustrates the realization by these women that they were going to be harmed and even killed by Appellant. Two (2) of the women suffered the additional mental anguish of hearing their co-workers being savagely murdered and realizing they could be next. The cause of this extreme mental torture was Appellant’s intentional

designed to strip the object of the torture from any control or agency and to create a “state of total helplessness.”³⁴⁵ It is for that reason that threats of various kinds, subjecting their targets to an uncertain fate, have long been considered to be torturous in nature.³⁴⁶ In that regard, Almerindo Ojeda, the Director at University of California, Davis’s Center for the Study of Human Rights in the Americas, has specifically classified the following as acts of torture: threats “to self or to others”; “threats of death, physical torture, or rendition”; “mock executions”; and “forced witnessing of torture (visually or aurally).”³⁴⁷ “Mock” executions, of course, are simply credible threats of death, and thus considered classic examples of psychological torture because of their inherent characteristics.³⁴⁸ Ironically, although a simulated or fake execution currently qualifies as an act of torture, state-sanctioned executions, which result in actual deaths, have yet to be categorized as acts of torture by modern jurists.³⁴⁹ If a mock execution or a mock amputation qualifies as an

actions.”).

345 *Mohammed v. Obama*, 704 F. Supp. 2d 1, 27 (D.D.C. 2009) (quoting Metin Başoğlu et al., *Torture vs Other Cruel, Inhuman, and Degrading Treatment: Is the Distinction Real or Apparent?*, 64 ARCHIVES GEN. PSYCHIATRY 277, 283 (2007)) (“Torture and ‘enhanced interrogation techniques’ employed by the Government during the War on Terror have been shown to be ‘geared toward creating anxiety or fear in the detainee while at the same time removing any form of control from the person to create a state of total helplessness.’”).

346 Andrea Montavon-McKillip, *CAT Among Pigeons: The Convention Against Torture, A Precarious Intersection Between International Human Rights Law and U.S. Immigration Law*, 44 ARIZ. L. REV. 247, 253–54 (2002) (“Mental torture can be inflicted by direct or implied threats that cause fear, including death threats or threats of serious injury against an individual or her family, or by forcing an individual to watch the abuse or murder of loved ones.”).

347 David Luban & Henry Shue, *Mental Torture: A Critique of Erasures in U.S. Law*, 100 GEO. L.J. 823, 836–37 (2012).

348 LUBAN, *supra* note 1, at 166; *see also* PÉREZ-SALES, PSYCHOLOGICAL TORTURE, *supra* note 305, at 308, 333 (noting that “[t]hreats of death” and “mock executions,” along with “[p]sychological techniques to break down the individual,” are classified as torture under the Istanbul Protocol (1985), and listing mock executions as a form of psychological torture).

349 The debate about how to classify executions—and whether they are legitimate or illegitimate exercises of state power—has led to heated debate over the years. *Compare* HANS GÖRAN FRANCK, THE BARBARIC PUNISHMENT: ABOLISHING THE DEATH PENALTY 35 (William Schabas ed., 2003) (“The conditions surrounding the execution itself and the period between the sentence and the carrying out of the sentence, which is frequently quite long, make it possible to compare the death penalty to torture.”), *with* Ernest van den Haag, *Introduction: Death but Not Torture*, in THE DEATH PENALTY: A DEBATE 13 (1983) (containing Ernest van den

act of torture (as it should),³⁵⁰ then a real execution—logically and rationally—must also qualify.

C. *The Torturous Nature of Non-Lethal Acts*

Many acts short of death can qualify as torture under existing law.³⁵¹ “Rape can constitute torture,” the Third Circuit explicitly ruled in *Zubeda v. Ashcroft*,³⁵² for example. As the Third Circuit stated: “Rape is a form of aggression constituting an egregious violation of humanity. The scarring effects of rape compare with ‘psychological sequelae of . . . survivors of abuse constituting torture under international law’”³⁵³ Indeed, “rape” and “threats to rape” have been listed among common “torture techniques.”³⁵⁴ If acts short of death, including threats of non-homicidal rape or bodily harm, can qualify as torture, then (once again) it is only logical that credible threats of death—threats designed to put individuals in fear for their lives—should also qualify under that legal rubric.³⁵⁵ In short, just

Haag’s views on the death penalty in a “Pro”/“Con” debate between Ernest van den Haag and John P. Conrad).

- 350 NOAM LUBELL, *EXTRATERRITORIAL USE OF FORCE AGAINST NON-STATE ACTORS* 180 (2010) (“In addition to the ‘classic’ examples of torture such as electric shocks, examples of acts which have been determined as torture or other prohibited ill-treatment, include methods such as severe beatings; mock executions and mock amputations; sensory manipulation and deprivation, and forced positions causing severe pain; rape and other sexual violence.”).
- 351 Such non-lethal acts include rape, forced impregnation, branding, beating, electric shocks administered to the genitals, pulling out fingernails, burning with hot irons, suspension from ceiling fans, and threats to inflict bodily harm. *E.g.*, *Al-Saher v. INS*, 268 F.3d 1143, 1147 (9th Cir. 2001); *see also* *Kadic v. Karadzic*, 70 F.3d 232, 242 (2d Cir. 1995) (referring to allegations of “murder, rape, forced impregnation, and other forms of torture”); *In re Extradition of Suarez-Mason*, 694 F. Supp. 676, 682 (N.D. Cal. 1988) (“shock sessions were interspersed with rapes and other forms of torture”).
- 352 *Zubeda v. Ashcroft*, 333 F.3d 463, 472 (3d Cir. 2003).
- 353 *Id.* (citations omitted); *see also id.* (“courts have equated rape with conduct recognized under the law of nations as torture”).
- 354 *Al-Saher*, 268 F.3d at 1147; *see also* ANNE-MARIE L.M. DE BROUWER, *SUPRANATIONAL CRIMINAL PROSECUTION OF SEXUAL VIOLENCE: THE ICC AND THE PRACTICE OF THE ICTY AND THE ICTR* 211 (2005) (“[T]he case law of the ICTY has recognised that rape and other forms of sexual violence can rise to the level of torture [O]ther forms of sexual violence qualifying as torture are threats to sexually mutilate a person, threats to rape someone”).
- 355 Whether someone intends his words “to be taken as a threat,” and whether those words are “sufficiently unequivocal, unconditional, immediate and specific” to convey to the target of them “an immediacy of purpose and

as prison officials are not allowed to threaten inmates with death or bodily harm during their confinement in prison, state actors should not be allowed to threaten inmates with death in connection with interrogations or during plea bargaining or as part of the criminal justice system more broadly. A death threat is a death threat,³⁵⁶ and the fact that an inmate has done something heinous in the past does not justify a government official in making a torturous threat of death that is backed by the enormous power of the state.³⁵⁷

That mock executions, non-judicial threats of death, and threats of severe pain or suffering are already classified as acts of torture makes clear that real executions should also be so classified. Tellingly, the U.S. Department of State has previously recognized mock executions to be a form of torture,³⁵⁸ as have federal courts in the United States.³⁵⁹ The United States Code itself defines “torture”

immediate prospect of execution of the threat,” is to be based on “all the surrounding circumstances and not just on the words alone.” *People v. Mosley*, 65 Cal. Rptr. 3d 856, 864 (Cal. Ct. App. 2007); cf. *Nifadev v. Holder*, 577 F. App’x 481, 487 (6th Cir. 2014) (“Nifadev was subjected to credible threats to his life and subjected to a period of suffocation at the hands of the police when handcuffed and helpless in a police vehicle on account of a protected ground. This treatment bears a striking resemblance to torture . . .”).

356 As Shakespeare put it in a much different context: “A rose by any other name would smell as sweet.” Or, as Gertrude Stein once emphasized, playing off of Shakespeare’s line: “A rose is a rose is a rose is a rose.” SUNIL SETHI, *THE BIG BOOKSHELF: SUNIL SETHI IN CONVERSATION WITH 30 FAMOUS WRITERS* 83 (2011).

357 And this is to say nothing of the horror that must be experienced by innocent people who are mistakenly sentenced to death. Miscarriages of justice are relatively common, especially in death penalty cases. *Innocence and the Death Penalty*, DEATH PENALTY INFORMATION CENTER, <https://deathpenaltyinfo.org/innocence-and-death-penalty> (last visited Sept. 24, 2018); see also THE NATIONAL REGISTRY OF EXONERATIONS, <https://www.law.umich.edu/special/exoneration/Pages/about.aspx> (last visited Sept. 24, 2018). The stories of just some of the exonerees are highlighted in a series of short documentary films produced in 2013 and available online. See ONE FOR TEN, <http://oneforten.com> (last visited Sept. 24, 2018).

358 U.S. DEPT’ OF STATE, *COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 1993*, S. Prt. 103-7 (Joint Comm. Print 1994) (recognizing mock executions as a form of torture in Chad, Columbia, Liberia, Moldova and Sudan).

359 *Orantes-Hernandez v. Meese*, 685 F. Supp. 1488, 1492 (C.D. Cal. 1988) (“The form of the persecution includes the following: arbitrary arrest, short term detention, torture including use of electric shock, *capucha*, beatings, rape, ‘disappearance’, extra-judicial executions, abductions, threats against family members, intimidation, forced ingestion of food,

to mean “an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control.”³⁶⁰ Not only are “mock” executions already treated as acts of torture,³⁶¹ they are, under existing law put in place by U.S. Congress and the executive branch, banned by the U.S. Code³⁶² and the U.S. Army

false imprisonment, mock-executions, sleep deprivation, mass killings, and forced relocations.”); *Acree v. Republic of Iraq*, 271 F. Supp. 2d 179, 185 (D. D.C. 2003) (“[T]he pilot POWs were tortured more severely than other POWs. The torture inflicted included severe beatings, mock executions, threatened castration, and threatened dismemberment.”), *vacated on other grounds*, *Acree v. Republic of Iraq*, 370 F.3d 41 (2004); *Acree*, 271 F. Supp. 2d at 210, 218 (describing “mock executions” and “several death threats” by the Saddam Hussein’s Iraqi Intelligence Service that caused “great distress” and “psychological torture,” and referring to Iraq’s “all-encompassing environment of physical and mental torture through extreme physical brutality and physical injury, mock executions, threats of death, intense fear”).

360 18 U.S.C. § 2340(1) (2004). The phrase “severe mental pain or suffering” in that federal statute is defined as follows: “[T]he prolonged mental harm caused by or resulting from—(A) the intentional infliction or threatened infliction of severe physical pain or suffering; (B) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality; (C) the threat of imminent death; or (D) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality” *Id.* § 2340(2) (A)–(D) (italics added).

361 *Tshitenge Muteba v. Zaire*, Communication 124/1982, Human Rights Committee [U.N. Doc. Supp. No. 40 (A/39/40)] at 182, ¶ 10.2 (Mar. 25, 1983), <http://hrlibrary.umn.edu/undocs/session39/124-1982.htm> (“During the first nine days of detention he was interrogated and subjected to various forms of torture including beatings, electric shocks and mock executions.”). The Human Rights Committee lists “beatings, electric shocks, mock executions, deprivation of food and water and thumb presses” under the torture rubric. Sarah Joseph et al., *Seeking Remedies for Torture Victims: A Handbook on the Individual Complaints Procedures of the UN Treaty Bodies* 159 (2006). In 1999, the Clinton Administration—in a report to the U.N. Committee Against Torture—itsself described “[t]he intentional infliction of ‘mental’ pain and suffering” to include “various psychological forms of torture and ill-treatment,” including “mock executions.” Bessler, *THE DEATH PENALTY AS TORTURE*, *supra* note 26, at 324 n.18.

362 18 U.S.C. § 2340(2)(C) (2004); *see also* David R. Dow et al., *The Extraordinary Execution of Billy Vickers, the Banality of Death, and the Demise of Post-Conviction Review*, 13 WM. & MARY BILL RTS. J. 521, 550 n.150 (2004) (“Mock executions and other threats of imminent death are widely recognized to be

Field Manual.³⁶³ “Sham executions,” a book on trauma notes of simulated executions, are “a widely practiced form of torture.”³⁶⁴

If threats of death or threats to inflict severe pain or suffering

a form of unconscionable torture. Legislation passed by the United States Congress on April 30, 1994, implementing the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, identifies ‘the threat of imminent death’ as a form of torture. This provision was designed to bring ‘mock executions’ within the ambit of the legislation.” (citing 18 U.S.C. § 2340(2)(C) (2004); David P. Stewart, *The Torture Convention and the Reception of International Criminal Law Within the United States*, 15 NOVA L. REV. 449, 455–56 (1991)).

- 363 DEPT’ OF THE ARMY, FIELD MANUAL 34–52: INTELLIGENCE INTERROGATION 1-8 (Washington, D.C., Sept. 28, 1992) (listing “Mock executions” as an example of “mental torture,” and listing the following as “[e]xamples of coercion”: “Threatening or implying physical or mental torture to the subject, his family, or others to whom he owes loyalty”); *see also* DAVID P. GUSHEE, IN THE FRAY: CONTESTING CHRISTIAN PUBLIC ETHICS, 1994–2013, 121 (2014) (noting that the U.S. Army Field Manual prohibits military personnel from beating prisoners, waterboarding them, sexually humiliating them, threatening them with dogs, depriving them of food and water, performing mock executions, shocking them with electricity, burning them, or causing other types of pain); David E. Graham, *The Treatment and Interrogation of Prisoners of War and Detainees*, 37 GEO. J. INT’L L. 61, 89–90 (2005) (noting that Army Field Manual 34-52 prohibits “[p]hysical or mental torture and coercion” and lists “Mock executions” as an example of mental torture); MATTHEW LIPPMAN, LAW AND SOCIETY 495 (2015) (“In 2005, Congress amended the Detainee Treatment Act to prohibit the use of cruel, inhuman, or degrading treatment by government personnel and to prohibit military interrogators from employing interrogation techniques not authorized under the Army Field Manual. The manual, for example, prohibits the use of dogs, hooding, forced nakedness, hypothermia, mock executions, electric shocks, and waterboarding.”).
- 364 METIN BAŞOĞLU & EBRU ŞALCIOĞLU, A MENTAL HEALTHCARE MODEL FOR MASS TRAUMA SURVIVORS: CONTROL-FOCUSED BEHAVIORAL TREATMENT OF EARTHQUAKE, WAR, AND TORTURE TRAUMA 41 (2011). As that source observes: “Sometimes the detainee is subjected to a prolonged threat of execution.” For instance, detainees are told that “they are going to be shot the next morning.” As that source continues of how such torturous acts unfold: “The next day they are taken from their cell, blindfolded and taken to another room where someone holds an unloaded gun at their head and pulls the trigger. The same procedure may be repeated for days or weeks on end.” *Id.* Studies of torture have revealed that “[p]otentially life-threatening (e.g. deprivation of basic needs), fear-inducing treatments (e.g. threats of harm to self and close ones, sham executions, asphyxiation), and humiliating treatments were the major determinants of perceived severity of the torture experience.” *Id.* at 52; *see also id.* at 61 (noting “various stressor events that are said not to involve intense physical pain” (e.g., “sham executions”) “can be as distressing as physical torture”).

already are classed as acts of torture,³⁶⁵ then plainly such credible threats, when coupled with a clear intention that those threats be actualized, must also be classified as torture.³⁶⁶ It has sometimes

365 *E.g.*, James P. Terry, *Torture and the Interrogation of Detainees*, 32 CAMPBELL L. REV. 595, 612–13 (2010) (“The cases brought under the TVPA [Torture Victims Protection Act] reference seven distinct forms of severe abuse that would constitute torture: (1) severe beatings using weapons such as truncheons and clubs; (2) threats of imminent death, to include mock executions; (3) threats of removing body parts and[/]or extremities; (4) burning, especially burning with cigarettes; (5) electric shocks to genital areas, or threats to do so; (6) rape or sexual assault, to include injury to sexual organs, or threats of the same; and (7) forcing the detainee to watch the extreme physical or mental torture of others. The severity of these examples of treatment found in civil proceedings suggests that similar severity would have to be found to warrant conviction under the criminal provisions in 18 U.S.C. §§ 2340-2340A.”).

366 Torture has been described as a specific intent crime. MICHAEL OTTERMAN, *AMERICAN TORTURE: FROM THE COLD WAR TO ABU GHRAIB AND BEYOND* 109 (2007); COMMENTARY ON THE FIRST GENEVA CONVENTION: CONVENTION (I) FOR THE AMELIORATION OF THE CONDITION OF THE WOUNDED AND SICK IN ARMED FORCES IN THE FIELD 2971 (2016). But in the case of capital punishment, even if a particular judge has no specific intent to inflict severe pain or suffering, the result—in every case—is that severe pain and suffering is inflicted. Moreover, capital punishment is a torturous punishment that society imposes collectively. THE DEATH PENALTY TODAY 115 (Robert M. Bohm ed., 2008) (“Vengeance is a human emotion experienced by individual people. Retribution is a collective response to wrongdoing from society rather than individual family members.”). Research shows that some like to see bad people suffer. Malcolm Ritter, *Men Enjoy Seeing Bad People Suffer*, USA TODAY (Jan. 18, 2006). To date, courts have yet to find executions, even botched executions, to be torturous acts. *E.g.*, *Estate of Lockett v. Fallin*, 841 F.3d 1098, 1113 (10th Cir. 2016) (*italics in original*) (citation omitted) (“The Supreme Court has determined that, in the execution context, ‘torture’ and ‘cruel and unusual punishment’ require that executing officials *mean* to choose an execution method that will cause extra pain beyond that necessary to carry out the death sentence.”). The legal prohibitions against torture and cruelty, however, are designed to insulate ourselves from our baser instincts. As Justice Thurgood Marshall once wrote: “The Eighth Amendment is our insulation from our baser selves.” CHARLES L. ZELDEN, *THURGOOD MARSHALL: RACE, RIGHTS, AND THE STRUGGLE FOR A MORE PERFECT UNION* 149 (2013). This helps explain why the prohibition against torture is—and should be—*absolute*. THE ROUTLEDGE HANDBOOK OF GLOBAL ETHICS 123 (Darrel Moellendorf & Heather Widdows eds., 2015) (“The function of the absolute moral prohibition against torture as an archetype of the fact that there are some activities in which civilized people do not engage is too important to allow a breach of the prohibition even if the degree of the wrongfulness of torturing

been suggested, including in the infamous Torture Memo prepared during the Bush Administration after 9/11, that a threat must be “imminent” in order for the threat to constitute torture.³⁶⁷ But when a capital charge is brought or a death sentence is imposed, the consequences of that capital charge or death sentence are clearly known by government officials at the very moment that it is brought or imposed. An execution might not occur for years, or even decades, down the road.³⁶⁸ But it is readily apparent to all concerned that the threat of death for the offender will be real, immediate, and dire. As the execution date approaches, the seriousness of the threat of death (already highly credible) will only be magnified.³⁶⁹ And all of this is

the person in question were not reason enough in itself.”); RICHARD MATTHEWS, *THE ABSOLUTE VIOLATION: WHY TORTURE MUST BE PROHIBITED* 220 (2008) (“[T]he absolute prohibition against torture, including the nonderogability clause of the United Nations Convention against Torture, is morally sound. Hence torture must be absolutely forbidden, no matter what.”).

- 367 Memorandum from Jay S. Bybee, Assistant Att’y Gen., to Alberto R. Gonzales, Counsel to the President 12 (Aug. 1, 2002) (on file with the U.S. Dep’t of Justice) (emphasis in original) (“The third predicate act listed in Section 2340(2) is threatening a prisoner with ‘imminent death.’ 18 U.S.C. § 2340(2)(C). The plain text makes clear that a threat of death alone is insufficient; the threat must indicate that death is ‘imminent.’ . . . Common law cases and legislation generally define imminence as requiring that the threat be almost immediately forthcoming. 1 Wayne R. LaFave & Austin W. Scott, Jr., *Substantive Criminal Law* § 5.7, at 655 (1986). By contrast, threats referring vaguely to things that might happen in the future do not satisfy this immediacy requirement. See *United States v. Fiore*, 178 F.3d 917, 923 (7th Cir. 1999). Such a threat fails to satisfy this requirement not because it is too remote in time but because there is a lack of certainty that it will occur. Indeed, timing is an indicator of certainty that the harm *will* befall the defendant. Thus, a vague threat that someday the prisoner *might* be killed would not suffice. Instead, subjecting a prisoner to mock executions or playing Russian roulette with him would have sufficient immediacy to constitute a threat of imminent death. Additionally, as discussed earlier, we believe that the existence of a threat must be assessed from the perspective of a reasonable person in the same circumstances.”).
- 368 The average time that an American death row inmate spends on death row between sentencing and execution is now more than fifteen years. Michael Johnson, *Fifteen Years and Death: Double Jeopardy, Multiple Punishments, and Extended Stays on Death Row*, 23 B.U. PUB. INT. L.J. 85, 86, 103–12 (2014). Death row inmates in other countries, including Pakistan and Japan, also spend many years on death row before execution. ROGER HOOD & CAROLYN HOYLE, *THE DEATH PENALTY: A WORLDWIDE PERSPECTIVE* ch. 5 (5th ed. 2015).
- 369 Cf. *Volloldo v. Ruz*, No. 1:14-MC-25 (LEK/CFH), 2017 WL 4838780 at *6 (N.D.N.Y. Oct. 14, 2017) (“Were Plaintiffs to provide evidence that

known well in advance by every actor in the criminal justice system, from prosecutors and defense lawyers to trial and appellate judges.

It is also known by everyone involved that the inmate will suffer tremendous psychological torment while that inmate is under a constant threat of death, whether or not the threat is carried out. A mock execution may not actually inflict any observable physical harm, though someone who goes through a sham execution obviously experiences extreme psychological terror during and after the ordeal.³⁷⁰ Just as the victim of a mock execution is tortured (and is considered a torture victim) despite the lack of any observable physical indicators that torture has occurred, a person capitally charged and sentenced to death suffers severe psychological torment³⁷¹ even if an execution is physically painless

Defendants made ‘imminent death threats,’ they may be able to establish torture under the TVPA [Torture Victim Protection Act of 1991].”). In the non-state actor context, the line between a *murder* and a *torture-murder* often boils down to how long the victim was aware that his or her death would occur. *Compare Mitchell v. State*, 84 So. 3d 968, 987 (Ala. Crim. App. 2010) (“The record establishes that at least one victim suffered psychological torture. . . . ‘These murders were not accomplished in a rapid-fire manner; there was sufficient time between the . . . murders for the next victim to be placed in significant fear for his or her life’ Therefore, the circuit court did not abuse its discretion in finding that at least one of the victims suffered psychological torture.”) (quoting *Taylor v. State*, 808 So. 2d 1148, 1169 (Ala. Crim. App. 2000)), *with Norris v. State*, 793 So. 2d 847, 861 (Ala. Crim. App. 1999) (holding that the murder of three individuals was not psychologically torturous because the three victims were shot in rapid succession; the “first three shots were sudden, without any warning or precipitating event”; “[t]here was nothing preceding the first murder that would have evoked in the victims intense apprehension, fear, or anticipation of their deaths”). In the death penalty context, a death row inmate is fully aware of his or her impending death—and is helpless to prevent that death—for substantially longer than a typical victim of torture-murder. The heinous actions of torture-murderers are inexcusable, but those actions do not justify the use of torture against already-incarcerated inmates. Acts of torture should be prohibited in all circumstances.

370 JOHN CONROY, *UNSPEAKABLE ACTS, ORDINARY PEOPLE: THE DYNAMICS OF TORTURE* 180 (2001) (“Dr. Rasmussen’s survey of two hundred victims (examined three days to twelve years after their torture) found that the incidence of mental symptoms at the time of examination was significantly higher among those who had been subjected to a mock execution. Rasmussen’s *Danish Medical Bulletin* article noted that 83 percent of those who experienced mock executions exhibited mental symptoms, about 20 percent more than those who had not been subjected to that particular torture.”).

371 *E.g.*, Amanda K. Eklund, *The Death Penalty in Montana: A Violation of the*

or averted altogether through an appeal or executive clemency.³⁷² Just as prison officials are not allowed to use correctional practices or techniques that exacerbate serious mental illnesses or that inflict psychological torture,³⁷³ government actors should not be allowed to use punishment practices that do just that.³⁷⁴ In allowing death

Constitutional Right to Individual Dignity, 65 MONT. L. REV. 135, 142–43 (2004) (noting that “[t]here are numerous accounts of mental anguish suffered by death row inmates” and discussing the case of one inmate, Henry Arsenault, who was on death row for two years, “during which time he became obsessed with his impending death”; Arsenault’s “psychosis manifested itself in uncontrollable sweating, frequent inability to sleep or eat, unbearable nightmares, uncontrollable urination, and constant fidgeting”; when Arsenault’s execution was called off after the administration of last rites and less than half an hour before the execution was scheduled to take place, Arsenault “was so distraught that he was unable to walk, and guards had to carry him back to his cell”; a judge later described Arsenault’s condition of “raw terror and unabating stress” as “torture”).

- 372 During a mock execution and in lead up to an actual execution, the object of the mock execution or the actual execution also experiences *physical* symptoms such as an increased heart rate or urinating on oneself. *E.g.*, JEFFREY D. SIMON, *THE TERRORIST TRAP: AMERICA’S EXPERIENCE WITH TERRORISM* 144 (2d ed. 2001) (describing a mock execution); CONROY, *supra* note 370, at 35–36 (same). Prison officials themselves go through their own “mock” executions (of a different sort) as they test execution equipment or prepare for executions. LOUIS J. PALMER, JR., *ENCYCLOPEDIA OF CAPITAL PUNISHMENT IN THE UNITED STATES* 427 (2d ed. 2008) (“testing of the execution equipment” in Florida “is performed a minimum of eight times each year”).
- 373 *Walker v. State*, 68 P.3d 872, 884 (Mont. 2003) (“[I]f the particular conditions of confinement cause serious mental illness to be greatly exacerbated or if it deprives inmates of their sanity, then prison officials have deprived inmates of the basic necessity for human existence and have crossed into the realm of psychological torture.”).
- 374 James L. Knoll IV & Gary E. Beven, *Supermax Units and Death Row*, in *HANDBOOK OF CORRECTIONAL MENTAL HEALTH* 435, 467 (Charles L. Scott ed., 2d ed. 2010) (citations omitted) (“[E]xtended stays on death row have been associated with psychiatric decompensation. Prisoners on death row have been found to demonstrate aberrant behavior and paranoia.”); *id.* (“Treating psychiatrists should also be aware that the suicide rate of male death row inmates was found to be approximately five times higher than the rate among men in the community.”); KENNETH WILLIAMS, *MOST DESERVING OF DEATH? AN ANALYSIS OF THE SUPREME COURT’S DEATH PENALTY JURISPRUDENCE* 103 (2012) (“It is not surprising that the conditions on death row often create or exacerbate inmates’ mental problems. For example, death row inmates in Texas are housed alone in small cells measuring 6½ feet by 10 feet, containing a bed and a toilet, for 23 hours a day. They are allowed to leave their cells for one hour a day

sentences and executions, government actors are engaged in, or acquiescing to, deliberate and intentional conduct that runs afoul of the absolute prohibition against torture.³⁷⁵

D. The “Lawful Sanctions” Issue

Death penalty proponents will assert that death sentences and executions are, and traditionally have been, classified as “lawful sanctions” that constitute an exception to the definition of torture. But death sentences and executions are no longer lawful or in use in many places throughout the world,³⁷⁶ and given the absolute, non-

of recreation, which is also done alone.”). *See also* 1 ENCYCLOPEDIA OF GENDER AND SOCIETY 187 (Jodi O’Brien ed., 2009) (“Because 75 percent of all women who are on death row are mothers, the failure to be able to connect with their children further fosters their isolation. The isolation that women experience on death row is a risk factor for developing a mental illness or further exacerbating an existing mental condition.”).

375 *Compare* Garcia-Milian v. Holder, 755 F.3d 1026, 1034 (9th Cir. 2014) (citations omitted) (“Public officials acquiesce in torture if, ‘prior to the activity constituting torture,’ the officials: (1) have awareness of the activity (or consciously close their eyes to the fact [that] it is going on); and (2) breach their legal responsibility to intervene to prevent the activity because they are unable or unwilling to oppose it.”), *and* Sanchez-Ponce v. Whitaker, No. 17-579, 2018 WL 6266311, at *2 (2d Cir. Nov. 30, 2018) (“A government’s inability to prevent torture—even when some state actors take ‘preventative efforts’—may be adequate to state a CAT claim.”), *with* Mouawad v. Gonzales, 485 F.3d 405, 413 (8th Cir. 2007) (citations omitted) (“A government does not acquiesce in the torture of its citizens merely because it ‘is aware of torture but powerless to stop it,’ but it does cross the line into acquiescence when it shows ‘willful blindness toward the torture of citizens by third parties.’”), *and* Ticas-Guillen v. Whitaker, No. 16-72981, 2018 WL 6266766, at *1 (9th Cir. Nov. 30, 2018) (citations omitted) (“[T]he government ‘does not acquiesce in the torture of its citizens merely because it is aware of torture but powerless to stop it.’”). Acquiescence “requires that the public official, prior to the activity constituting torture, have awareness of such activity and thereafter breach his or her legal responsibility to intervene to prevent such activity.” 8 C.F.R. § 1208.18(a) (7) (2018). *See also* Parada v. Sessions, 902 F.3d 901, 916 (9th Cir. 2018) (“[T]he acquiescence standard is met where the record demonstrates that public officials at any level—even if not at the federal level—would acquiesce in torture the petitioner is likely to suffer.”).

376 BESSLER, CRUEL AND UNUSUAL, *supra* note 190, at 64 (noting that a growing number of countries have outlawed executions either in law or in practice); *see also* Federico Mayor Zaragoza, *The Abolition of the Death Penalty: A Question of Respect for Human Rights*, in DEATH PENALTY: A CRUEL AND INHUMAN PUNISHMENT 11, 13 (L. Arroyo Zapatero et al. eds., 2013) (discussing the work of the International Commission against the Death Penalty, which seeks the universal abolition of capital punishment).

derogable prohibition against torture,³⁷⁷ it seems self-evident that to genuinely be a “lawful sanction” the sanction itself should not constitute an otherwise torturous act. There is already a *jus cogens* norm prohibiting torture,³⁷⁸ and a reservation to a human rights treaty such as the Convention Against Torture cannot violate the “object and purpose” of that treaty.³⁷⁹ The clear object and purpose of the Convention Against Torture is, manifestly, to combat, prevent, and outlaw acts of cruelty and torture.³⁸⁰ And a nation that publicly

377 E.g., THE OXFORD HANDBOOK OF INTERNATIONAL HUMAN RIGHTS LAW 545 (Dinah Shelton ed., 2013) (noting that the prohibition of torture is non-derogable).

378 SARAH JOSEPH ET AL., SEEKING REMEDIES FOR TORTURE VICTIMS: A HANDBOOK ON THE INDIVIDUAL COMPLAINTS PROCEDURES OF THE UN TREATY BODIES 488 (Boris Wijkström ed., 2006) (“The absolute nature of the prohibition of torture under treaty law is reinforced by its higher, *jus cogens* status under customary international law. *Jus cogens* status connotes the fundamental, peremptory character of the obligation, which is, in the words of the International Court of Justice, “intransgressible.” There is ample international authority recognising the prohibition of torture as having *jus cogens* status. The prohibition of torture also imposed obligations *erga omnes*, and every State has a legal interest in the performance of such obligations which are owed to the international community as a whole.”).

379 The Vienna Convention on the Law of Treaties provides that “[a] State may, when signing, ratifying, accepting, approving or acceding to a treaty, formulate a reservation unless: (a) [T]he reservation is prohibited by the treaty; (b) [T]he treaty provides that only specified reservations, which do not include the reservation in question, may be made; or (c) [I]n cases not falling under sub-paragraphs (a) and (b), the reservation is incompatible with the object and purpose of the treaty.” Vienna Convention on the Law of Treaties art. 19, May 23, 1969, 1155 U.N.T.S. 331. Although the United States has not ratified the Vienna Convention, it is considered to be the authoritative statement of the customary law of treaties. Meyer, *Customary International Law in the 21st Century*, in PROGRESS IN INTERNATIONAL LAW 197, 210 (Russell A. Miller & Rebecca M. Bratspies eds., 2008) (“[D]espite the fact that the United States has not ratified the Vienna Convention on the Law of Treaties, other states view the United States as being bound by the customary law of treaties. Insofar as the Vienna Convention is the most authoritative statement of what the customary law of treaties is, the United States is bound by the terms of the treaty.”). Moreover, U.S. law already provides that a State Party to the Convention Against Torture cannot use the “lawful sanctions” exception in Article 1 to “defeat the object and purpose of the Convention to prohibit torture.” 8 C.F.R. § 208.18(a)(3) (2018).

380 CHRIS INGELSE, THE UN COMMITTEE AGAINST TORTURE: AN ASSESSMENT 391 (2001) (“In view of the object and purpose of the Convention against Torture, the objective of the Committee is to combat torture.”); United Nations Convention Against Torture art. 2(1), Feb. 4, 1985, 1465 U.N.T.S. 85 (“Each State Party shall take effective legislative,

renounces torture should not, logically, then be allowed to turn around and engage in acts that bear all the indicia of torture. As one commentator, writing about the Vienna Convention on the Law of Treaties, has aptly pointed out: “[A] reservation going against a treaty’s object and purpose would be one whereby a State ratifying the U.N. Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 seeks to exclude torture from it.”³⁸¹

A U.S. understanding of the Convention Against Torture—part of the U.S. reservations, understandings, and declarations (“RUDs”) to the convention—specifically reflects the U.S. Senate’s concern that the “lawful sanctions” language may be too expansive.³⁸² Indeed, case law already makes clear that even a “lawful sanction” in a country must not defeat the “object and purpose” of the Convention Against Torture.³⁸³ For example, in *Nuru v. Gonzales*,

administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.”).

381 MARK E. VILLIGER, COMMENTARY ON THE 1969 VIENNA CONVENTION ON THE LAW OF TREATIES 272 (2009).

382 See Louis Henkin, *U.S. Ratification of Human Rights Conventions: The Ghost of Senator Bricker*, 89 AM. J. INT’L L. 341, 341–48 (1995) (noting the U.S. ratification of the Convention Against Torture in 1994 along with a package of RUDs); *Pierre v. Gonzales*, 502 F.3d 109, 120 (2d Cir. 2007) (“[T]he United States understands that a State Party could not through its domestic sanctions defeat the object and purpose of the Convention to prohibit torture.” (quoting 136 Cong. Rec. S17,486-01, S17,491)); *Tun v. INS*, 445 F.3d 554, 566, 571 (2d Cir. 2006) (citations omitted) (“‘lawful sanctions’ ‘do not include sanctions that defeat the object and purpose of the Convention Against Torture to prohibit torture’”; “the Senate’s understanding that ‘a State Party could not through its domestic sanctions defeat the object and purpose of the Convention to prohibit torture,’ 136 Cong. Rec. S17491, ¶ II (c), has been incorporated into this country’s refugee law.”); see also *Nuru v. Gonzales*, 404 F.3d 1207, 1221 (9th Cir. 2005) (italics in original) (“[T]he Attorney General promulgated implementing regulations defining ‘lawful sanctions’ as ‘judicially imposed sanctions and other enforcement actions authorized by law, including the death penalty,’ *but* only so long as those sanctions do not ‘defeat the object and purpose of [CAT] to prohibit torture.’” (quoting 8 C.F.R. § 1208.18(a)(3) (2018))).

383 *Garcia-Miller v. Holder*, 755 F.3d 1026, 1033 (9th Cir. 2014) (quoting *Nuru*, 404 F.3d at 1221) (“Torture is ‘an extreme form of cruel and inhuman treatment,’ 8 C.F.R. § 208.18(a)(2), ‘that either (1) is not lawfully sanctioned by that country or (2) is lawfully sanctioned by that country, but defeats the object and purpose of CAT[.]’”); *Zhang v. Gonzales*, 214 F. App’x 3, 5 (2d Cir. 2007) (citations omitted) (“To the extent that the agency found that Zhang’s prior treatment did not qualify because the harm he identified was the result of a lawful sanction, we find that the beating and dousing

the Ninth Circuit put it this way: “[T]orture cannot be ‘inherent in or incidental to lawful sanction’ and is never a lawful means of punishment. The official sanctioning of torture necessarily defeats the object and purpose of the Convention. CAT outlaws torture absolutely”³⁸⁴ In that same vein, it is clear that the protection provided by the Convention Against Torture extends to anyone accused of a crime³⁸⁵ or imprisoned for one.³⁸⁶

There are existing U.S. regulations that purport to include

in water were sanctions that defeated the object and purpose of CAT and therefore could qualify if that mistreatment otherwise meets the definition of torture under the regulations and BIA and court decisions.”); *see also* *Pendrak v. Holder*, 375 Fed. App’x 439, 443 (6th Cir. 2010) (emphasis added) (“[L]awful sanctions’ that *do not defeat the object and purpose of the CAT* are excluded from the definition of torture.”).

384 *Nuru*, 404 F.3d at 1222.

385 *Lian v. Gonzales*, 201 Fed. App’x 808, 810 (2d Cir. 2006) (quoting *Khouzam v. Ashcroft*, 361 F.3d 161, 169 (2d Cir. 2004)) (“[I]n *Khouzam*, we interpreted this provision to mean that CAT ‘extend[s] to situations where the victim has been accused of a crime,’”). As the Second Circuit emphasized in *Khouzam*: “When the Senate considered the CAT, its concern over the CAT’s reference to ‘lawful sanctions’ led it to qualify its ratification with the understanding that a state ‘could not through its domestic sanctions defeat the object and purpose of the Convention to prohibit torture.’ In directing the Attorney General to implement the CAT subject to the Senate’s understandings, it was Congress’ aim for the CAT’s protections to extend to situations where the victim has been accused of a crime.” *Khouzam*, 361 F.3d at 169.

386 *E.g.*, J. HERMAN BURGERS & HANS DANIELIUS, *THE UNITED NATIONS CONVENTION AGAINST TORTURE: A HANDBOOK ON THE CONVENTION AGAINST TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT* 120–21 (1988) (“The 1975 *Declaration* was drawn up by the Fifth UN Congress on the Prevention of Crime and the Treatment of Offenders in response to a request from the General Assembly ‘to include, in the elaboration of the Standard Minimum Rules for the Treatment of Prisoners, rules for the protection of *all persons subjected to any form of detention or imprisonment* (italics added) against torture and other cruel, inhuman or degrading treatment or punishment’. Two years after the adoption of the 1975 *Declaration*, the General Assembly requested the Commission on Human Rights to draw up a draft convention ‘in the light of the principles embodied in the Declaration’. All work undertaken in the framework of the Commission for preparing the present *Convention* was performed under an agenda item reading ‘Question of the human rights of *all persons subjected to any form of detention or imprisonment* (italics added)’. The connection between the phenomenon of torture as dealt with in the *Convention* and deprivation of liberty is also apparent from articles 10 and 11 which explicitly refer to persons ‘subjected to any form of arrest, detention or imprisonment’.”).

the death penalty as a “lawful sanction,” but those regulations also emphasize that “lawful sanctions” do not include “sanctions that defeat the object and purpose of the Convention Against Torture to prohibit torture.”³⁸⁷ In fact, when the U.S. Senate ratified the Convention Against Torture in 1994, it crafted the following understanding to make clear that the “lawful sanctions” exception was not without limits: “[T]he United States understands that a State Party could not through its domestic sanctions defeat the object and purpose of the Convention to prohibit torture.”³⁸⁸ In

387 8 C.F.R. § 208.18(a)(3) (2018) (“Torture does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. Lawful sanctions include judicially imposed sanctions and other enforcement actions authorized by law, including the death penalty, but do not include sanctions that defeat the object and purpose of the Convention Against Torture to prohibit torture.”). Those regulations also cannot somehow modify what a torturous act is; the factual nature of an act does not change with how one describes it. A pronouncement on a piece of paper or in the Code of Federal Regulations cannot transform a *torturous* act into a *non-torturous* one. The act has the characteristics inherent in it, and in the case of the death penalty those characteristics (which include the fact that capital charges and death sentences constitute death threats) are *immutable*.

388 Gail H. Miller, *Defining Torture*, in OCCASIONAL PAPER #3 (Benjamin N. Cardozo Sch. of Law/Floersheimer Ctr. for Constitutional Democracy, New York, N.Y.), Dec. 2005, at 21. In the past, it has been noted that the “lawful sanctions” provision of the Convention Against Torture has “precluded arguments that capital punishment constitutes torture.” *Id.* at 20. But capital punishment has become *unlawful* in many places, and there has been much controversy surrounding the “lawful sanctions” exception (e.g., as regards the use corporal punishments in some countries). As one commentator notes: “Many signatories agree that the lawful sanctions language creates problematic ambiguities. It diminishes the universality of the definition by infusing exceptions based on national law. As practices that may be lawful in one state may be unlawful in another, this provision undermines the effort to achieve a uniform definition of torture.” *Id.* at 21. “The U.N. Special Rapporteur on Torture, Nigel S. Rodley, recognized the potential slippery slope of the lawful sanctions exemption and has interpreted the provision so that differences in national laws would not effect the strength of the CAT. Rodley concluded that the term ‘lawful sanctions’ refers to practices that the international community widely accepts as permissible sanctions, such as imprisonment. He cited the Standard Minimum Rules for the Treatment of Prisoners as an example of international standards that may guide determinations of acceptable practices. In particular, Rodley concluded that corporal punishment may amount to torture: ‘I cannot accept the notion that the administration of such punishments as stoning to death, flogging and amputation—acts which would be unquestionably unlawful in, say, the context of custodial interrogation—can be deemed lawful simply because the punishment

other words, an act of torture is an act of torture—and a country cannot turn a torturous act into a non-torturous one simply by labeling it a “lawful sanction.”³⁸⁹ Given that the Eighth Amendment has already been interpreted to bar torture³⁹⁰ and that the Eighth Amendment’s meaning evolves with the times,³⁹¹ and given that the modern definition and understanding of torture now plainly includes both physical and mental forms of torture,³⁹² the U.S. Supreme Court should rule that death sentences and executions constitute impermissible sanctions because death threats are extremely cruel and torturous in nature.³⁹³ Torture, by definition, involves the infliction of severe pain or suffering,³⁹⁴ and that is exactly what

has been authorized in a procedurally legitimate manner, i.e. through the sanction of legislation, administrative rules or judicial order. To accept this view would be to accept that any physical punishment, no matter how torturous and cruel, can be considered lawful, as long as the punishment has been duly promulgated under the domestic law of a State.” *Id.* at 22.

- 389 *Ghebrehiwot v. Attorney General of U.S.*, 467 F.3d 344, 359 (3d Cir. 2006) (citations omitted) (“[T]he regulation defines ‘lawful sanctions’ as ‘judicially imposed sanctions and other enforcement actions authorized by law, . . .’ but only so long as those sanctions do not ‘defeat the object and purpose of the [CAT] to prohibit torture.’ Consequently, ‘[a] government cannot exempt torturous acts from CAT’s prohibition merely by authorizing them as permissible forms of punishment in its domestic law.’”); *Khouzam v. Ashcroft*, 361 F.3d 161, 169 (2d Cir. 2004) (“It would totally eviscerate the CAT to hold that once someone is accused of a crime it is a legal impossibility for any abuse inflicted on that person to constitute torture.”).
- 390 LINDA E. CARTER ET AL., *UNDERSTANDING CAPITAL PUNISHMENT* § 4.04 (3d ed. 2012) (“the Eighth Amendment prohibits torture or barbaric punishments”).
- 391 *Moore v. Texas*, 137 S. Ct. 1039, 1048 (2017) (quoting *Hall v. Florida*, 134 S. Ct. 1986, 1992 (2014)) (“‘To enforce the Constitution’s protection of human dignity,’ we ‘loo[k] to the evolving standards of decency that mark the progress of a maturing society,’ recognizing that ‘[t]he Eighth Amendment is not fastened to the obsolete.’”).
- 392 *E.g.*, *ENCYCLOPEDIA OF INTERPERSONAL VIOLENCE* 709 (Claire M. Renzetti & Jeffrey L. Edelson eds., 2008) (discussing physical and psychological torture).
- 393 BESSLER, *THE DEATH PENALTY AS TORTURE*, *supra* note 26, at 217–19.
- 394 *State v. Piper*, 709 N.W.2d 783, 799 (S.D. 2006) (“Torture requires: ‘(1) the unnecessary and wanton infliction of severe pain, agony, or anguish; and (2) the intent to inflict such pain, agony or anguish’”); *State v. Zagorski*, 701 S.W.2d 808, 814 (Tenn. 1985) (“Although the victims died from gunshot wounds, the defendant also slit their throats, leaving them to bleed to death in the woods. This evinces depravity of mind and is a form of torture. Defendant’s actions were an infliction of gratuitous violence, and needless mutilation of victims who were already helpless from fatal wounds”); *cf. State v. Holman*, 540 S.E.2d 18, 23 (N.C. 2000) (“We have interpreted

the death penalty—an unnecessary, barbarous and dehumanizing punishment—does.³⁹⁵ In a world of maximum-security prisons and life-without-parole sentences, death sentences and executions are also completely unnecessary.³⁹⁶

VI. Conclusion

The psychological torture associated with capital punishment is self-evident and undeniable. Death threats have long been recognized as a form of torture, and there is no denying that the death penalty involves the use of death threats and worse (i.e. actual executions). Capital punishment, in truth, is a torturous practice hiding in plain sight. It has been used for centuries, with jurists in the past only occasionally, as in *People v. Anderson*,³⁹⁷ taking note of its torturous nature. In the eighteenth century, Enlightenment thinkers thought of torture and capital punishment in separate categories. When the Italian philosopher Cesare Beccaria, the anti-death penalty pioneer, wrote in *Dei delitti e delle pene* (1764) about torture and capital punishment, he did so in separate chapters. Jeremy Bentham, the English criminal-law theorist, also conceptualized and compartmentalized torture and punishment as separate practices.³⁹⁸ In writings not published in his lifetime, Bentham infamously justified the use of torture on the basis of utilitarianism, with pre-

the phrase ‘unnecessarily torturous’ to encompass both physical and psychological torture, and to include a killing that leaves the victim aware of impending death but helpless to prevent it.”).

395 GABRIELE SCHWAB, HAUNTING LEGACIES: VIOLENT HISTORIES AND TRANSGENERATIONAL TRAUMA 155 (2010) (“We should no longer think of torture as a practice that happens in a torture chamber or dungeon and consists exclusively of the unnecessary and willful infliction of atrocious bodily pain, but as a much more encompassing practice of inflicting unnecessary pain and instrumentalizing pain for punitive and disciplinary measures or for purposes of control.”).

396 BESSLER, CRUEL AND UNUSUAL, *supra* note 190, at 334; *see also* E. THOMAS SULLIVAN & RICHARD S. FRASE, PROPORTIONALITY PRINCIPLES IN AMERICAN LAW: CONTROLLING EXCESSIVE GOVERNMENT ACTIONS 132 (2009) (“The means-proportionality argument is that the death penalty is unnecessary and therefore excessive relative to the next-most-severe alternative penalty (life in prison, with or without parole) whenever death adds no additional deterrent or other social benefits.”).

397 *People v. Anderson*, 493 P.2d 880, 894 (1972) (referring to the “psychological torture” associated with the death penalty).

398 BESSLER, THE DEATH PENALTY AS TORTURE, *supra* note 26, at 310–11 n.17.

trial judicial torture frequently thought of in the civil law context as necessary to procure confessions (with post-conviction torture then used to discover the names of accomplices).³⁹⁹ But it is now crystal clear, as confirmed by the text of the Convention Against Torture, that punishments themselves can be torturous in nature. And whereas torture was largely seen in Beccaria and Bentham's time as operating on the body, it is now clear that either physical or mental torture is possible—and that both are strictly prohibited.

In reality, capital punishment has always been torturous, even if it was more torturous in Medieval times when offenders were disemboweled and drawn and quartered or burned or boiled alive⁴⁰⁰ instead of being put to death through lethal injection.⁴⁰¹ Before *Furman v. Georgia*,⁴⁰² the California Supreme Court—in a telling admission—candidly opined in its 1972 decision in *People v. Anderson*: “The cruelty of capital punishment lies not only in the execution itself and the pain incident thereto, but also in the dehumanizing effects of the lengthy imprisonment prior to execution during which the judicial and administrative procedures essential to due process of law are carried out.”⁴⁰³ “Penologists and medical experts agree,” that court determined, “that the process of carrying out a verdict of death is often so degrading and brutalizing to the human spirit as to constitute psychological torture.”⁴⁰⁴ “When people on death rows are waiting to die,” the wrongfully convicted boxer Rubin “Hurricane” Carter stressed after his own exoneration, “it is easy for me to feel exactly what they are going through: the torture of waiting, the

399 Michelle Farrell, On Torture 241–45 (Apr. 26, 2011) (unpublished Ph.D. thesis, National University of Ireland Galway), https://aran.library.nuigalway.ie/bitstream/handle/10379/2171/FarrellM_OnTorture_PhD2011.pdf?sequence=1&isAllowed=y. See also LEONORE LOFT, PASSION, POLITICS, AND PHILOSOPHIE: REDISCOVERING J.-P. BRISSOT 112 (2002); THOMAS GLYN WATKIN, AN HISTORICAL INTRODUCTION TO MODERN CIVIL LAW 415 (2017).

400 BESSLER, THE DEATH PENALTY AS TORTURE, *supra* note 26, at 3–4 (describing ancient punishments).

401 Fordham law professor Deborah Denno has written at length about the progression of methods of execution in the United States. *E.g.*, Deborah W. Denno, *Lethal Injection Chaos Post-Baze*, 102 GEO L.J. 1331 (2014); Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 FORDHAM L. REV. 49 (2007); Deborah W. Denno, *Getting to Death: Are Executions Constitutional?*, 82 IOWA L. REV. 319 (1997).

402 *Furman v. Georgia*, 408 U.S. 238 (1972).

403 *People v. Anderson*, 493 P.2d 880, 894 (Cal. 1972).

404 *Id.*

helplessness, the pain and humiliation, and the gagging death, the obliteration.”⁴⁰⁵ “It is real torture,” Oklahoma death row inmate, Richard Glossip, similarly observed from first-hand experience after his execution was delayed at the last minute after he spent 50 days in a windowless cell getting ready for his scheduled execution. “You are just in that cell and it is just like a morgue,” Glossip reported.⁴⁰⁶

It is hypocritical for governments and state officials to condemn the use of death threats, then turn around and use threats of death as part of a misguided policy that, in all candor, strays into the land of torture. It is also hypocritical for the judicial system to avoid labelling death sentences and executions as torturous when various non-lethal acts (and properly so) are already so characterized.⁴⁰⁷ When a person is murdered and the victim is aware of, but helpless to prevent, death, American courts readily label the offender’s actions as involving an act of extreme cruelty (i.e. torture).⁴⁰⁸ Yet, when it is the offender who is aware of, but helpless to prevent, his or her own death, the judicial system currently terms it a “lawful sanction.” Just as governments should not tolerate individuals making death threats, societies should not themselves resort to Orwellian or Kafkaesque death threats. As Albert Camus warned against state-sanctioned killing and the death penalty’s disproportionality in relation to acts of criminality in “Reflections on the Guillotine”:

405 RUBIN “HURRICANE” CARTER & KEN KLONSKY, *EYE OF THE HURRICANE: MY PATH FROM DARKNESS TO FREEDOM* 203 (2011).

406 Leon Neyfakh, *Richard Glossip Describes Preparing to Die*, SLATE (Nov. 13, 2015), http://www.slate.com/articles/news_and_politics/crime/2015/11/richard_glossip_the_condemned_oklahoma_prisoner_describes_preparing_to_die.html.

407 John D. Bessler, *What I Think About When I Think About the Death Penalty*, 62 ST. LOUIS U. L.J. 781, 790 (2018); John D. Bessler, *The Abolitionist Movement Comes of Age: From Capital Punishment as a Lawful Sanction to a Peremptory, International Law Norm Barring Executions*, 79 MONT. L. REV. 7, 38–40 (2018).

408 *E.g.*, *State v. Cooper*, 718 S.W.2d 256, 259–60 (Tenn. 1986) (“It would be difficult to describe a more deliberate, brutal and horrifying infliction of death upon an innocent, unarmed person. In our opinion the circumstances of this homicide were heinous, atrocious and cruel. The deliberate taunting and threatening of a victim for hours before shooting at her once, causing her and her fellow employee to dive to the floor for safety, and then deliberately pumping the contents of four shotgun shells into her while she was helplessly trapped inside a small building could, in our opinion, convince a reasonable jury that the victim was subjected to torture and that the perpetrator of such conduct evinced depravity of mind.”).

For there to be equivalence, the death penalty would have to punish a criminal who had warned his victim of the date at which he would inflict a horrible death on him and who, from that moment onward, had confined him at his mercy for months. Such a monster is not encountered in private life.⁴⁰⁹

409 "Reflections on the Guillotine," *in* RESISTANCE, REBELLION, AND DEATH (J. O'Brien, trans. 1960).

Family Protection in the Law of Succession: The Policy Puzzle

Richard F. Storror*

Protecting surviving spouses and dependent children is one of the most important policies of the law of wills and intestacy. To promote this policy, succession law diminishes the power of testation in a variety of ways that shield surviving spouses and children from disinheritance. The specific policies behind these protections have long puzzled scholars, and a comprehensive study based on a survey of statutes in all 50 states, the five main territories, and the District of Columbia has never before been conducted. After executing such a study, this article uncovers a remarkable diversity of family protection statutes in the law of succession and concludes that uniting them is a combination of concerns that decedents not use their testamentary freedom in ways that impoverish those who are dependent upon them or work unfairness against family members who have contributed in important ways to the accumulation of their wealth. In addition to these concerns is a notable ambivalence about the extent to which family protection statutes should undercut the expectations of those who have been promised a share of a decedent's estate.

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I. Introduction

The family has long been considered a cornerstone of civil society.¹ It stands to reason, then, that legal institutions, including our system of inheritance, strive to protect those who participate and have participated in familial arrangements.² In particular, the protection of the nuclear family, consisting of one's spouse and children, is a salient policy in both the law of descent and distribution and the law of wills. Thomas Atkinson traces the notion that widows and minor children need temporary shelter and sustenance when heads of household die to the Magna Carta's quarantine of dower or widow's quarantine provision, which gave the widow the right to occupy the homestead of her deceased husband for 40 days after his death.³ Intestacy law expresses solicitude for surviving kin and channels a decedent's bounty into their possession, favoring the intestate's surviving spouse and descendants over other family members.⁴ The law of wills recognizes the freedom of testators to depart from these default preferences, but it too embodies explicit protections for surviving spouses and children that curb even a testator's plainly expressed intention not to benefit his family. Examples include the surviving spouse's elective share;⁵ the surviving spouse's and dependent children's homestead, family allowance, and personal property claims;⁶ and amounts guaranteeing a portion of the estate to spouses and children omitted from a will executed before the marriage or birth.⁷

1 MARTHA ALBERTSON FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY* 72 (2004) (discussing the ideology that the family is the "cradle of citizenship"); Laurence H. Tribe, *Lawrence v. Texas: The "Fundamental Right" That Dare Not Speak Its Name*, 117 HARV. L. REV. 1893, 1934 (2004).

2 RALPH C. BRASHIER, *INHERITANCE LAW AND THE EVOLVING FAMILY* 7 (2004) ("[P]robate laws ultimately should promote and protect the state. Fortuitously, recognizing members of the decedent's created family as heirs has a stabilizing effect on family life and society as a whole, as those family members are also the people most likely to be dependent upon him.").

3 THOMAS E. ATKINSON, *HANDBOOK OF THE LAW OF WILLS* 128 (2d ed. 1953); see also Janet Loengard, *Interpretation and Re-interpretation of a Clause: Magna Carta and the Widow's Quarantine*, 25 WM. & MARY BILL RTS J. 403, 403 (2016) (quoting the Magna Carta). The use of the word quarantine in this context is based on the Latin word for forty. LAWRENCE M. FRIEDMAN, *DEAD HANDS: A SOCIAL HISTORY OF WILLS, TRUSTS, AND INHERITANCE LAW* 36 (2009).

4 See, e.g., BRASHIER, *supra* note 2, at 4.

5 See *infra* Part II.B.

6 See *infra* Parts II.D, II.E.

7 See *infra* Part II.C.

The mechanisms used in succession law to protect the interests of surviving family members are well understood by scholars and practitioners.⁸ Less understood and studied is their potential to come into conflict with each other and how these conflicts may be manifestations of competing public policies. Consider the following case study example. May, who has no children, executes a will that devises her estate to her husband Saul and her sister Nance in equal shares. Two years later, May and Saul adopt Cai. May then dies without having changed her will or having provided a settlement outside of her will for Cai. At her death, May has a probate estate of \$500,000 available for distribution after all taxes, debts and funeral expenses have been paid.⁹ Saul would likely be perfectly happy to share the estate with Nance. After all, the typical elective share is only one-third of the decedent's estate.¹⁰ Some jurisdictions will augment this estate with certain inter vivos and non-probate transfers May may have made during her lifetime.¹¹ Since one-third of May's probate estate would be no more than \$167,000, May would have to have entered into some rather sizable inter vivos arrangements for the elective share to be appealing to Saul.¹² But if Cai claims a pretermitted child's share of May's estate, which typically amounts to an intestate share, then in many jurisdictions Cai will be able to claim fully half of the probate estate,¹³ leaving \$250,000 to be

8 See, e.g., Thomas P. Gallanis & Josephine Gittler, *Family Caregiving and the Law of Succession: A Proposal*, 45 U. MICH. J.L. REFORM 761 (2012) (arguing in favor of an elective share for family members who provided the decedent uncompensated care in the decedent's home); Mark Glover, *Formal Execution and Informal Revocation: Manifestations of Probate's Family Protection Policy*, 34 OKLA. CITY U.L. REV. 411 (2009); Efrain Gonzalez Tejera, *Mortis Causa Wealth Transfer and the Protection of the Family: The Spanish-Puerto Rican Experience*, 60 TUL. L. REV. 1231, 1244 (1986); L. William Schmidt, Jr., *Family Protection under the Uniform Probate Code*, 50 DENV. L.J. 137, 144 (1973) (explaining how family protection mechanisms are "deeply rooted in the historical foundations of probate law").

9 Debts, funeral expenses, costs of administration, and exempt property are deducted from the estate before computing the elective share or the share of a pretermitted child. See, e.g., KANS. STAT. ANN. § 59-6a204 (West 2018); *In re Bassford's Will*, 127 N.Y.S.2d 653, 657-58 (Sur. Ct. 1953).

10 See, e.g., BRASHIER, *supra* note 2, at 15.

11 *Id.* at 18 (describing the augmented estate).

12 Note that if May did make an extra-testamentary settlement for Cai, that sum might well be used to augment the probate estate for elective share purposes.

13 The sum would be less in jurisdictions that guarantee the surviving spouse a minimum amount, e.g., New York's provision granting surviving spouses of intestate decedents \$50,000 plus half the balance of the estate. N.Y. EST.

shared between Saul and Nance. Sharing \$250,000 with Nance will certainly not be as attractive to Saul as electing against the will. A final wrinkle, of course, is the possibility that May is contractually committed to leave Nance half of her estate. To what extent should such a contractual obligation impinge upon Saul's and Cai's statutory rights?

The potential for conflict between family protection regimes, contractual obligations and a testator's expressed preferences has seldom arisen in reported litigation.¹⁴ Treatises, encyclopedias, casebooks and even the Restatement skirt the issue. The reason for the lack of discussion of this issue may be due to the fact that, as New York's Surrogate's Court Judge James Foley recognized,

[e]xperience has shown that in the great majority of wills, the preliminary legacies are given to charities, distant relatives, and friends of the testator. The residue is usually given to the spouse for life or absolutely or to the children or to the dependent and nearer relatives either outright or in trust.¹⁵

In other words, given that most wills are already consonant with family protection policies, the conflict between promoting family protection and a testator's attempt to short-circuit it seldom arises. Nonetheless, a study of this subject will yield significant insights into what the law seeks to achieve when singling out spouses and children for special treatment that can damage the expectations of more distant heirs and creditors. The role of creditors in family protection schemes has been largely ignored, but this role is important for understanding whether family protection schemes are truly about providing support. What explains, for example, the fact that the elective share and the shares of pretermitted children and spouses are subject to creditors' claims,¹⁶ but that set-asides and the

POWERS & TRUSTS LAW § 4-1.1(a)(1) (LexisNexis 2018). In New York, then, Cai would be entitled to \$225,000.

14 Some well-known examples of decisions that confront the conflict are *Shimp v. Huff*, 556 A.2d 252 (Md. 1989), and *Via v. Putnam*, 656 So. 2d 460 (Fla. 1995), discussed *infra* Part IV.

15 *In re Byrnes' Estate*, 267 N.Y.S. 627, 631 (Sur. Ct. 1933); *see also Salvaging a Will After the Widow Renounces*, 61 HARV. L. REV. 850, 851 (1948).

16 *See, e.g.*, FLA. STAT. ANN. § 733.805(1) (LexisNexis 2018); N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A(a)(2) (LexisNexis 2018); 33 R.I. GEN. LAWS § 33-6-27 (2018); *Brakefield v. Hocutt*, 779 So. 2d 1165, 1166 (Ala.

family allowance are not?¹⁷ At a state-specific level, what explains Oklahoma's shielding of legacies to surviving spouses from creditors until legacies to others have been charged?¹⁸ What explains Rhode Island's protection of the surviving spouse's mandatory life estate in all of the decedent's real estate against unsecured creditors?¹⁹ The phantasmagoric variety of legislation in this area belies the notion that family protection policies are reducible to promoting either necessary support or fairness in the dissolution of the marital economy. The fact that the Uniform Laws Commission has explicitly grounded its proposed reforms of the elective share in the theory that marriage is an economic partnership proves little, since those reforms remain unreflected in the legislation of most jurisdictions.

Part II of this article explores the intricate mechanics of family protection legislation in all 50 states, the District of Columbia, and the five main overseas territories. This up-to-date and comprehensive survey is made necessary by its absence from the scholarship in this area. The research lays bare the bewildering array of mechanisms different states have enacted to protect the decedent's surviving family members. The survey lays the groundwork for Part III, which takes a closer look than has been attempted to date at the sometimes conflicting policies that appear to drive family protection enactments. Part IV probes more deeply into the conflicts between family members who wish to claim statutory rights and those the decedent promised to remember in his will. Such disputes have been resolved in incoherent ways by courts at different levels of the judiciary and reveal more fully that the policy behind family protection in the law of succession, at least in this area, remains indeterminate but leans noticeably in the direction of benefiting those who remain married until death.

II. The Mechanics of Family Protection

The law of wills and estates displays abundant solicitude for surviving family members. This section explores how family protection regimes work to achieve these aims. Highlighted are rules of intestate succession, pretermission of spouses and children, the spouse's elective share and the family's rights to the

2000). Tennessee exempts the elective share from the claims of *unsecured* creditors. TENN. CODE ANN. § 31-4-101(d) (2018).

17 See, e.g., *Brakefield v. Hocutt*, 779 So. 2d 1165, 1166 (2000).

18 OKLA. STAT. ANN. tit. 84, § 5 (2018) (West 2018).

19 33 R.I. GEN. LAWS § 33-25-3 (2018).

homestead, personal property and a monetary allowance.²⁰ Statutes that automatically revoke a will's provisions upon divorce are not considered herein.²¹

A. Intestate Succession

When a person dies without a will, his surviving spouse is entitled to a share of the estate unless guilty of certain forms of bad behavior.²² The decedent's surviving children may or may not be entitled to a share of the estate. The shares of surviving spouses and children in intestacy are completely compatible in all states. In general, they take one of two forms. Either the surviving spouse takes the entire estate unless the decedent had children in another relationship, in which case she shares with the surviving children and their representatives,²³ or the surviving spouse shares with any descendants of the decedent.²⁴ In Maryland, the share of

20 Categorized as "statutory allowances," the latter four protections, apart from the elective share, are virtually ignored by the Restatement, except in its remarks that these allowances may be satisfied by will substitutes in appropriate cases, RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 7.2 cmt b (AM. LAW INST. 1999), and that a slayer forfeits his right to any of these allowances, RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 8.4 cmt j (AM. LAW INST. 1999).

21 See, e.g., COLO. REV. STAT. § 15-11-804 (2018).

22 See, e.g., N.Y. EST. POWERS & TRUSTS LAW § 5-1.2(5) (LexisNexis 2018) (demonstrating unjustifiable abandonment of decedent spouse without consent); 33 R.I. GEN. LAWS § 33-1.1-2 (2018) (depriving a slayer of the decedent of any property in the decedent's estate); *Middleton v. Lockhart*, 43 S.W.3d 113, 121 (Ark. 2001) (ruling that murdering one's spouse works forfeiture of homestead rights); Susan N. Gary, *The Probate Definition of Family: A Proposal for Guided Discretion in Intestacy*, 45 U. MICH. J.L. REFORM 787, 790 nn.18-19 and accompanying text (2012).

23 See, e.g., ARIZ. REV. STAT. §§ 14-2102(1), 14-2103(1) (LexisNexis 2018); COLO. REV. STAT. §§ 15-11-102(1)(b), 15-11-103(2) (2018); FLA. STAT. ANN. § 732.102(1)-(3) (LexisNexis 2018); OHIO REV. CODE ANN. § 2105.06(B)-(D) (LexisNexis 2018); TEX. EST. CODE ANN. § 201.003(c) (West 2017) (applying to decedent's community estate); VT. STAT. ANN. tit. 14, § 311(2) (2018); UNIF. PROB. CODE §§ 2-102(4), 2-102A(4) (amended 2008); BRASHIER, *supra* note 2, at 4. Iowa's formulation also contains the provision that she must share if all of his children are theirs but she has at least one that is hers alone. IOWA CODE ANN §§ 633.211, 633.212, 633.219(1) (West 2018). If the surviving spouse shares with the decedent's issue, her share must equal at least \$50,000. IOWA CODE ANN § 633.212(4) (West 2018).

24 CAL. PROB. CODE § 6401(c)(2)-(3) (Deering 2018) (making the share dependent upon the number of children and their issue surviving the

the surviving spouse depends upon whether the surviving kindred include a minor child.²⁵ In Arkansas and Kentucky, surviving children take the entire estate subject to the surviving spouse's dower or curtesy rights.²⁶ And in Rhode Island, the surviving children take the decedent's real estate subject to a life estate in the surviving spouse.²⁷ The surviving spouse is entitled to \$50,000 and one-half of the balance of the personal property²⁸ and can also apply for up to \$150,000 of the decedent's real estate.²⁹ In some iterations, if the surviving spouse has a child from another union, she must nonetheless share the decedent's estate with the surviving children

decedent); N.C. GEN. STAT. § 29-14(a)(1)–(2) (2018) (same); CONN. GEN. STAT. ANN. § 45a-437(a)(3)–(4) (West 2018); DEL. CODE ANN. tit. 12, § 502(3)–(4) (2018) (share depends on whether the surviving children are also the children of the surviving spouse); GA. CODE ANN. § 53-2-1(c)(1) (2018) (requiring that surviving spouse receive at least one-third); 755 ILL. COMP. STAT. ANN. 5 / 2-1(a) (LexisNexis 2018); KAN. STAT. ANN. §§ 59-504, 59-506 (West 2018); LA. CIV. CODE ANN. §§ 888, 890 (2018) (surviving spouse takes usufruct in decedent's share of community property); MD. CODE ANN., EST. & TRUSTS § 3-103 (LexisNexis 2018); MICH. COMP. LAWS SERV. § 700.2102(1) (LexisNexis 2018); MISS. CODE ANN. § 91-1-7 (2018); MO. ANN. STAT. § 474.010(1)(b)–(c) (West 2018); 8 N. MAR. I. CODE § 2912(b) (2018); OKLA. STAT. ANN. tit. 84, §§ 213(B)(1)(c)–(d), 213(B)(2)(a) (West 2018); 20 PA. STAT. AND CONS. STAT. ANN. §§ 2102(3)–(4), 2103(1) (West 2018); P.R. LAWS ANN. tit. 31, § 2411 (2018); 33 R.I. GEN. LAWS §§ 33-1-1(1), 33-1-5, 33-1-10(2) (2018); TEX. EST. CODE ANN. § 201.002(b) (West 2017) (rule applies to decedent's separate estate); ATKINSON, *supra* note 3, at 63.

- 25 MD. CODE ANN., EST. & TRUSTS § 3-102(b)–(c) (LexisNexis 2018).
- 26 ARK. CODE ANN. §§ 28-9-214(1), 28-9-206(b)(1) (2018); KY. REV. STAT. ANN. §§ 391.010(1), 391.030(1), 392.020 (LexisNexis 2018). Dower gives the surviving spouse a life estate in a third of the real property of the decedent. ARK. CODE ANN. § 28-11-301(a) (2018); *see also* TEX. EST. CODE ANN. § 201.002(b)(3) (West 2017) (applying rule to decedent's separate estate). If the decedent dies without children, the surviving spouse takes one-half of all of the property unless the property is "ancestral," in which case the surviving spouse takes only a life estate of one-half of the lands. ARK. CODE ANN. § 28-11-307(a)(1), 28-11-307(b) (2018). American Samoa's version of dower is a fee simple in one-third of all of the decedent's property. AM. SAMOA CODE ANN. § 40.0103 (2011).
- 27 33 R.I. GEN. LAWS §§ 33-1-1, 33-1-5 (2018). Note that this life estate in all of the decedent's real estate is not limited to cases of intestacy. *See* 33 R.I. GEN. LAWS § 33-25-2(a) (2018).
- 28 33 R.I. GEN. LAWS § 33-1-10(1) (2018); *Jerome v. Prob. Court of Barrington*, 922 A.2d 119, 122 (R.I. 2007).
- 29 33 R.I. GEN. LAWS § 33-1-6 (2018).

they have in common.³⁰ With some exceptions,³¹ if the decedent left no children, the surviving spouse takes all,³² and if the decedent left no surviving spouse, the surviving children take all.³³ In community

30 ALASKA STAT. §§ 13.12.102(a)(3), 13.12.103(1) (2018); COLO. REV. STAT. §§ 15-11-102(b), 15-11-103(2) (2018); FLA. STAT. ANN. § 732.102(4) (LexisNexis 2018); UNIF. PROB. CODE §§ 2-102(3), 2-102A(3) (amended 2010).

31 ALA. CODE § 43-8-41(1) (LexisNexis 2018). In some states, the surviving spouse may have to share with surviving parents or the decedent's brothers and sisters and their issue. ALA. CODE §§ 43-8-41(2), 43-8-42(2) (LexisNexis 2018); ALASKA STAT. §§ 13.12.102(a)(2), 13.12.103(2) (2018); CAL. PROB. CODE §§ 6401(c)(2)(B), 6402(b) (Deering 2018); COLO. REV. STAT. §§ 15-11-102(2), 15-11-103(3) (2018); CONN. GEN. STAT. ANN. §§ 45a-437(a)(1), 45a-439(a)(1) (West 2018); DEL. CODE ANN. tit. 12, §§ 502(1), 503(2)–(3) (2018); IND. CODE ANN. §§ 29-1-2-1(b)(1)–(3), 29-1-2-1(d)(2) (LexisNexis 2018); MD. CODE ANN., EST. & TRUSTS § 3-102(d) (LexisNexis 2018); MICH. COMP. LAWS SERV. §§ 700.2102(1)(c), 700.2103(c) (LexisNexis 2018); N.C. GEN. STAT. §§ 29-14(a)(3), 29-14(b)(3), 29-15(3) (2018); 8 N. MAR. I. CODE § 2912(c) (2018); OKLA. STAT. ANN. tit. 84, § 213(B)(1)(b)(2), 213(B)(2)(b)–(c) (West 2018) (applying to property not acquired by the “joint industry” of the spouses); 20 PA. STAT. AND CONS. STAT. ANN. §§ 2102(2), 2103(2) (West 2018); UNIF. PROB. CODE §§ 2-102(2), 2-102A(2), 2-103(a)(2) (amended 2010); TEX. EST. CODE ANN. § 201.002(c)(3) (West 2017) (rule applies to one-half of the decedent's separate real property). In Arkansas, the surviving spouse takes 50% of the estate if there are no surviving descendants and she has been married less than three years to the decedent at the time of his death. ARK. CODE ANN. § 28-9-214(2) (2018). In such cases, she shares the estate with the decedent's parents. ARK. CODE ANN. § 28-9-214(4) (2018). In Rhode Island, if there is a surviving spouse but no children, the decedent's parents take the decedent's real estate subject to the spouse's life estate and also share in the decedent's personal property. 33 R.I. GEN. LAWS §§ 3-1-1, 33-1-5, 33-1-10(1), 33-1-10(3) (2018). *Jerome v. Prob. Court of Barrington*, 922 A.2d 119, 122 (R.I. 2007) (“In most states, statutory substitutions for dower and curtesy dictate that when a decedent dies intestate and without issue, the surviving spouse receives the entire estate”).

32 ARIZ. REV. STAT. § 14-2102(1) (LexisNexis 2018); ARK. CODE ANN. § 28-9-214(2) (2018); GA. CODE ANN. § 53-2-1(c)(1) (2018); 755 ILL. COMP. STAT. ANN. 5 / 2-1(c) (LexisNexis 2018); IOWA CODE ANN. § 633.211 (West 2018); KAN. STAT. ANN. § 59-504 (West 2018); LA. CIV. CODE ANN. art. 889, 894 (2018); MISS. CODE ANN. § 91-1-7 (2018); N.D. CENT. CODE § 30.1-04-02(1)(a) (2017); OHIO REV. CODE ANN. § 2105.06(E) (LexisNexis 2018); OKLA. STAT. ANN. tit. 84, § 213(B)(1)(b)(1) (West 2018) (applies only to property acquired by the “joint industry” of the spouses); TEX. EST. CODE ANN. § 201.003(b)(1) (West 2018) (rule applies to decedent's community estate); VT. STAT. ANN. tit. 14, § 311(1) (2018); UNIF. PROB. CODE § 2-102A(a)(1)(A) (amended 2010).

33 ARIZ. REV. STAT. § 14-203(1) (LexisNexis 2018); CAL. PROB. CODE § 6402(a)

property states, the surviving spouse also inherits the decedent's one-half of the community property.³⁴

B. The Elective Share

In its most conventional form, an election by the surviving spouse to renounce the will guarantees her the “forced share” defined by the applicable statute and substitutes a share of the estate for what the spouse would otherwise have been entitled to under the decedent's will, in partial intestacy and under certain will substitutes such as a revocable trust.³⁵ She is treated either as if she predeceased the execution of the will³⁶ or as if she predeceased the testator.³⁷ As such, her share will be deemed to pass outside the terms of the will.³⁸

Common elective share provisions entitle the surviving spouse to one-third or 30% of the “augmented” or “elective” estate³⁹

(Deering 2018); COLO. REV. STAT. § 15-11-103(2) (2018); GA. CODE ANN. § 53-2-1(c)(2)–(3) (2018); 755 ILL. COMP. STAT. ANN. 5 / 2-1(b) (LexisNexis 2018); IOWA CODE ANN. § 633.219(1) (West 2018); KAN. STAT. ANN. § 59-506 (West 2018); LA. CIV. CODE ANN. art. 888 (2018); 8 N. MAR. I. CODE § 2912(d); OHIO REV. CODE ANN. § 2105.06(A) (LexisNexis 2018); OKLA. STAT. ANN. tit. 84, § 213(B)(2)(a) (West 2018); MISS. CODE ANN. §§ 91-1-3, 91-1-11 (2018); MO. ANN. STAT. § 474.010(2)(a) (West 2018); N.C. GEN. STAT. § 29-15(a)(3) (2018); 33 R.I. GEN. LAWS §§ 33-1-1(1), 33-1-10(3) (2018); TEX. EST. CODE ANN. § 201.001(b) (West 2017) (rule applies to decedent's separate estate); UNIF. PROB. CODE § 2-103(a)(1) (amended 2008); ATKINSON, *supra* note 3, at 63.

34 ARIZ. REV. STAT. § 14-2102(1) (LexisNexis 2018) (if the surviving issue are also issue of the surviving spouse); CAL. PROB. CODE § 6401(a) (Deering 2018); UNIF. PROB. CODE § 2-102A(b) (amended 2010).

35 IOWA CODE ANN. § 633.238(3) (West 2018). Some states explicitly recognize an elective share in an intestate decedent's estate. *See, e.g.*, TENN. CODE ANN. § 31-4-101 (2018). North Carolina gives the surviving spouse an elective share of a life estate in one-third of an intestate decedent's real property. N.C. GEN. STAT. § 29-30(a) (2018). If the surviving spouse elects a life estate in the homestead under this provision, such an election includes fee simple title to the household furnishings. N.C. GEN. STAT. § 29-30(b) (2018).

36 MD. CODE ANN., EST. & TRUSTS § 3-208(a)(1) (LexisNexis 2018); *In re Estate of Eakin*, 708 P.2d 476, 477 (Colo. Ct. App. 1985) (“[A]n election to take against a will voids will as to the elector . . .”).

37 MO. ANN. STAT. § 474.160(1)(3) (West 2018).

38 *In re Estate of Shapiro*, 380 N.W.2d 796, 800 (Minn. 1986).

39 DEL. CODE ANN. tit. 12, § 901(a) (2018); FLA. STAT. ANN. § 732.2065 (LexisNexis 2018); IOWA CODE ANN. § 633.238(1) (West 2018); ME. REV. STAT. ANN. tit. 18-a, § 2-201(a) (2018); MO. ANN. STAT. § 474.160(1) (1) (West 2018) (increasing the share to one-half of the estate if the any

or \$50,000, whichever is greater.⁴⁰ The share may be as much as one-half if the testator left no descendants.⁴¹ Some iterations of the elective share grant generally the lesser of the entire estate if the estate is small or one-third of a larger estate.⁴² In some states, the statutory share is a reflection of dower and gives the surviving spouse a life estate in one-third of the value of all property passing under the will.⁴³ In others, the elective share is the same as an intestate share.⁴⁴ Obviously, provisions vary widely. The elective share under the Uniform Probate Code, for example, increases with the length of the marriage.⁴⁵ Several states have similar provisions.⁴⁶ Depending upon the length of the marriage, these provisions give the surviving spouse the right to elect up to 50% of the marital portion of the augmented estate,⁴⁷ plus additional assets

descendants survive the decedent); N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A (a)(2) (LexisNexis 2018); BRASHIER, *supra* note 2, at 15. *But see* VT. STAT. ANN. tit. 14, § 319(a) (2018) (one-half). The augmented or “elective” estate is defined in some jurisdictions as the decedent’s taxable estate. *See, e.g.*, DEL. CODE ANN. tit. 12, § 902(a) (2018).

40 ALASKA STAT. § 13.12.202(a)(1) (2018).

41 755 ILL. COMP. STAT. ANN. 5 / 2-8(a) (LexisNexis 2018); IND. CODE ANN. § 29-1-3-1(a) (LexisNexis 2018) (applying where the testator had no children of another union); MD. CODE ANN., EST. & TRUSTS § 3-203(b) (LexisNexis 2018); MISS. CODE ANN. § 91-5-25 (2018); MO. ANN. STAT. § 474.160(1) (1) (West 2018).

42 ALA. CODE. § 43-8-70(a) (LexisNexis 2018).

43 AM. SAMOA CODE ANN. §§ 40.0103, 40.0105; CONN. GEN. STAT. ANN. § 45a-436(a) (West 2018); BRASHIER, *supra* note 2, at 15, 33 (arguing that reflections of dower in the elective share perpetuates “the lingering notion of male dominance and female subservience during the marriage”).

44 *See, e.g.*, OHIO REV. CODE ANN. § 2106.01(A) (LexisNexis 2018). Oklahoma’s provision is singular. It entitles the surviving spouse to “an undivided one-half (1/2) interest in the property acquired by the joint industry of the husband and wife during coverture.” OKLA. STAT. ANN. tit. 84, § 44(B)(1)–(2) (West 2018).

45 UNIF. PROB. CODE § 2-203(b) (amended 2008).

46 COLO. REV. STAT. § 15-11-202(1) (2018); MINN. STAT. ANN. § 524.2-202(a) (West 2018); N.C. GEN. STAT. § 30-3.1 (2018); OR. REV. STAT. ANN. § 114.605 (West 2018); TENN. CODE ANN. § 31-4-101(1)(a) (2018); VA. CODE ANN. §§ 64.2-308.3(A), 64.2-308.4(B) (2018); S.D. CODIFIED LAWS § 29A-2-202 (2018).

47 COLO. REV. STAT. § 15-11-202(1) (2018); UNIF. PROB. CODE § 2-202(a) (amended 2013). The “marital portion” results from multiplying the augmented estate by a percentage that increases with the length of the marriage. COLO. REV. STAT. § 15-11-203(2) (2018); UNIF. PROB. CODE § 2-209(b) (amended 2013).

necessary to bring the sum to at least \$75,000.⁴⁸ Other jurisdictions provide for more particularized shares. Rhode Island, for example, allows the surviving spouse to renounce the will in favor of her mandatory life estate in the entirety of the decedent's real estate, the discretionary allowance of real estate in fee, and her intestate share of the decedent's personal estate.⁴⁹

In Mississippi, omission of a surviving spouse from a decedent's will automatically triggers the forced share.⁵⁰ But in that same state, a surviving spouse is barred from taking a forced share if she has property of her own "equal in value to what would be her lawful portion of her husband's real and personal estate."⁵¹ If her separate property is not quite equivalent, she may use the forced share to make up the difference.⁵² Similarly, in some states the value of bequests to the surviving spouse may be deducted from the elective share resulting in a "net elective share."⁵³

The definition of the estate against which an election may be taken also varies across states. Some states specify that the share is determined only against the probate or "net" estate.⁵⁴ Augmenting the probate estate by certain nonprobate transfers is meant to capture amounts the decedent has technically given away, but over which he has retained some control. The first augmenting provision was enacted in New York in 1966 and served as a model for the Uniform Probate Code's "augmented estate" provision, promulgated in 1969.⁵⁵

The elective share may be personal, not available after the

48 UNIF. PROB. CODE § 2-202(b) (amended 2013). *See also* COLO. REV. STAT. § 15-11-202(2)(a) (2018) (providing \$50,000 as a minimum share).

49 *See* 33 R.I. GEN. LAWS §§ 33-25-4, 33-28-1 (2018); *see also In re Estate of Gervais*, 770 A.2d 877, 881 (R.I. 2001).

50 MISS. CODE ANN. § 91-5-27 (2018).

51 *Id.* § 91-5-29.

52 *Id.*

53 *See* N.C. GEN. STAT. §§ 30-3.1(a), 30-3.4 (2018); N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A(4) (LexisNexis 2018); *see also* S.C. CODE ANN. §§ 62-2-206, 62-2-207(a) (2018).

54 IND. CODE ANN. § 29-1-3-1(a) (LexisNexis 2018) ("[T]he court shall consider only such property as would have passed under the laws of descent and distribution."); MD. CODE ANN., EST. & TRUSTS § 3-203(b) (LexisNexis 2018); S.C. CODE ANN. §§ 62-2-201(a), 62-2-202(b) (2018).

55 Raymond C. O'Brien, *Integrating Marital Property into a Spouse's Elective Share*, 59 CATH U. L. REV. 617, 655 (2010).

surviving spouse's death,⁵⁶ and must be claimed timely.⁵⁷ It can also be waived via agreement between the spouses.⁵⁸ Georgia, a title-theory jurisdiction, does not recognize the elective share.⁵⁹ Nor do community property states,⁶⁰ although in his will a testator in a community property state may force his surviving spouse to elect between her homestead and exempt property rights and her one-half interest in the community estate, and the provisions made for her in the will.⁶¹ In some states retaining dower, a will provision benefiting the surviving spouse is presumed to be in lieu of dower unless a contrary intention is shown.⁶² In such a jurisdiction, a spouse could

56 See, e.g., IND. CODE ANN. § 29-1-3-4(a) (LexisNexis 2018); MD. CODE ANN., EST. & TRUSTS § 3-204 (LexisNexis 2018); MO. ANN. STAT. § 474.200 (West 2018); NEB. REV. STAT. ANN. § 30-2315 (LexisNexis 2018); OKLA. STAT. ANN. tit. 84, § 44(B)(4) (West 2018); 33 R.I. GEN. LAWS 33-28-2(a) (2018); WIS. STAT. ANN. § 861.09 (West 2018); UNIF. PROB. CODE § 2-212(a) (amended 2010); *In re Estate of Davis*, 274 A.2d 491, 494 (Vt. 1971); ATKINSON, *supra* note 3, at 120.

57 MD. CODE ANN., EST. & TRUSTS § 3-206(a)(1)(i)–(ii) (LexisNexis 2018) (stating that a surviving spouse can take an elective share within the later of nine months after decedent's death or six months after appointment of executor); N.C. GEN. STAT. § 30-3.4(b) (2018) (requiring election within six months after the issuance of letters testamentary or letters of administration); OKLA. STAT. ANN. tit. 84, § 44(B)(3) (West 2018); ATKINSON, *supra* note 3, at 120–21.

58 MD. CODE ANN., EST. & TRUSTS § 3-205 (LexisNexis 2018); MO. ANN. STAT. § 474.120 (West 2018); NEB. REV. STAT. ANN. § 30-2316(a) (LexisNexis 2018); N.C. GEN. STAT. § 30-3.6 (2018); S.C. CODE ANN. § 62-2-204(A) (2018); WIS. STAT. ANN. § 861.10(1) (West 2018); UNIF. PROB. CODE § 2-213(a) (amended 2010); see, e.g., *In re Estate of Barrows*, 945 A.2d 1217, 1220 (Me. 2008); see also *Campbell v. Campbell*, 377 S.W.2d 93, 95 (Ky. 1964) (postnuptial contract waiving dower rights).

59 Alan Newman, *Incorporating the Partnership Theory of Marriage into Elective-Share Law: The Approximation System of the Uniform Probate Code and the Deferred-Community-Property Alternative*, 49 EMORY L.J. 487, 489 n.16 (2000); BRASHIER, *supra* note 2, at 27.

60 These states are Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, and Washington. 33 AM. JUR. 2D *Federal Taxation* ¶ 1653 (2018).

61 *Berg v. Bregman*, No. B149130, 2002 WL 31256677, at *6 n.5 (Cal. Ct. App. Oct. 8, 2002); *In re Estate of Cole*, No. 02-13-00417-CV, 2015 WL 392230, at *4 (Tex. Ct. App. Mar. 5, 2015); *In re Estate of McBride*, Nos. 49085-1-I, 49146-6-1, 2003 WL 352777, at *1 (Wash. Ct. App. Feb. 18, 2003). Whether a will forces a surviving spouse to make an election is a question of intent. The presumption is that the testator intended to dispose only of his own property. *In re Estate of Cole*, 2015 WL 392230, at *4. Thus the will must exhibit an intention to dispose of the surviving spouse's community property. *In re Estate of Cole*, at * 4–5.

62 AM. SAMOA CODE ANN. § 40.0104 (requiring “clear and explicit evidence” to

be entitled to the bequests in the will as well as dower.⁶³ Legal theorist Paul Haskell has commented that “[t]he decedent spouse’s creditors come ahead of the surviving spouse’s forced share; if the decedent spouse is insolvent at his death, the forced share usually avails the surviving spouse nothing.”⁶⁴

We now turn to the effect of a spouse’s election against the will on the will’s other beneficiaries or on property used to augment the estate.⁶⁵ The difficulty lies generally in deciding how to reconcile the terms of the will with the satisfaction of statutory shares in order to craft an “equitable adjustment of the estate.”⁶⁶ Courts and legislatures have taken different approaches to this issue. Some courts hold that each taker under the will or each taker of a portion of the estate must contribute ratably to the elective share of the surviving spouse.⁶⁷ The rationale for this approach may be that the testamentary framework is thereby more appropriately honored.⁶⁸ Other courts hold that “diminution is to follow the usual order of abatement . . .” for insolvent estates.⁶⁹ This scheme prioritizes

rebut the presumption); *Morguelan v. Morguelan’s Ex’r*, 209 S.W.2d 824, 826 (Ky. 1948).

63 See, e.g., KY. REV. STAT. ANN. § 392.080(2) (LexisNexis 2018).

64 PAUL G. HASKELL, PREFACE TO WILLS, TRUSTS AND ADMINISTRATION 150 (2d ed. 1994).

65 See, e.g., BRASHIER, *supra* note 2, at 26.

66 ATKINSON, *supra* note 3, at 124.

67 See, e.g., *Meadowbrook Farms Apts. v. Carter*, 326 N.Y.S.2d 281 (Sup. Ct. 1971); *In re Glasenberg’s Estate*, 223 N.Y.S.2d 564, 565 (Sur. Ct. 1961); *In re Byrnes’ Estate*, 267 N.Y.S. 627, 629 (Sur. Ct. 1933); *In re Estate of Curley*, 160 Misc. 844, 854 (N.Y. Sur. Ct. 1936); *Ziegenbein v. Hastings College (In re Estate of Ziegenbein)*, 519 N.W.2d 5, 8 (Neb. 1994); *First Union Nat’l Bank of N.C. v. Melvin (In re Estate of Melvin)*, 130 S.E.2d 387, 393 (N.C. 1963). Codifications of this rule include DEL. CODE ANN. tit. 12, § 908(a) (2018); 755 ILL. COMP. STAT. ANN. 5 / 2-8(d) (LexisNexis 2018); KY. REV. STAT. ANN. § 394.382(2) (LexisNexis 2018); MD. CODE ANN., EST. & TRUSTS § 3-208(b)(1) (LexisNexis 2018); NEB. REV. STAT. ANN. § 30-2319(b) (LexisNexis 2018); N.Y. EST. POWERS & TRUSTS LAW § 5-1.1 (LexisNexis 2018); OHIO REV. CODE ANN. § 2107.34(A) (LexisNexis 2018); 33 R.I. GEN. LAWS ANN. § 33-6-24 (2018); see also UNIF. PROB. CODE § 2-209(c)–(d) (amended 2010); ATKINSON, *supra* note 3, at 124; Andrew W. Tanick & Pamela L. Johnson, *The New Minnesota Elective Share Statutes*, 70 MINN. L. REV. 241, 256 (2011).

68 *In re Estate of Ziegenbein*, 519 N.W.2d at 8.

69 R.D. Hursh, Annotation, *Who Must Bear Loss Occasioned by Election Against the Will*, 36 A.L.R.2d 291 § 2 (1954). Codifications of this rule include ALA. CODE § 43-8-75(b) (LexisNexis 2018); FLA. STAT. ANN. § 733.805(1) (LexisNexis 2018); IOWA CODE ANN. § 633.436(1) (West 2018). See also UNIF. PROB.

specific devisees, then general devisees, residuary devisees, and property not disposed of by the will.⁷⁰ There is also some authority for tailoring the abatement of legacies so that those “whose welfare was of primary concern to the testator [and] are provided for in residuary gifts . . . [not] suffer disproportionate hardship in the case of an election to take against the will.”⁷¹ The modern trend is to disturb the testamentary scheme as little as possible, as in elective share regimes that look to nonprobate assets first and strive to leave charitable gifts undisturbed.⁷²

C. Omitted Spouses and Children

Where a will omits a spouse⁷³ or a child and was executed before the marriage or before the testator had the child in question, the omitted individuals may receive a share of the estate.⁷⁴ The

CODE §§ 2-301(b), 2-302(d), 3-902 (amended 2010); ATKINSON, *supra* note 3, at 124; Tanick & Johnson, *supra* note 67, at 248–49. Some statutes further protect the surviving spouse by making bequests “given in satisfaction of, or instead of, the surviving spouse’s statutory rights in the estate” abate last within a given classification. FLA. STAT. ANN. § 733.805(2) (LexisNexis 2018). Other iterations of this idea simply declare that “[p]roperty devised to a surviving spouse who takes under the will” abates last. *See, e.g.*, IOWA CODE ANN. § 633.436(1)(e) (West 2018).

70 *See, e.g.*, IDAHO CODE ANN. §15-3-902(a) (West 2018); WASH. REV. CODE ANN. §§ 11.10.010(1), 11.54.060(1) (LexisNexis 2018).

71 Hursh, *supra* note 69, § 2, at 291.

72 *See, e.g.*, FLA. STAT. ANN. §§ 732.2075, 733.805 (LexisNexis 2018).

73 Provisions for pretermitted spouses are not as common as provisions for pretermitted children; indeed, some states explicitly reject the principle. *See, e.g.*, KY. REV. STAT. ANN. § 394.090 (LexisNexis 2018); N.C. GEN. STAT. § 31-5.3 (2018); OHIO REV. CODE ANN. § 2107.37 (LexisNexis 2018). Note that the common law rule providing for revocation of premarital wills upon marriage exists in statutory form in very few states today. RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 4.1 cmt. q (AM. LAW INST. 1999).

74 *See, e.g.*, CAL. PROB. CODE § 21610 (Deering 2018); N.Y. EST. POWERS & TRUSTS LAW § 5-3.2 (LexisNexis 2018). Some statutes include a living child whom the testator believed to be dead within the definition of an omitted child. *See, e.g.*, ALA. CODE § 43-8-91(b) (LexisNexis 2018); ALASKA STAT. § 13.12.302(c) (2018); ARIZ. REV. STAT. § 14-2302(E) (LexisNexis 2018); CAL. PROB. CODE § 21622 (Deering 2018); COLO. REV. STAT. § 15-11-302(3) (2018); CONN. GEN. STAT. ANN. § 45a-257b(c) (West 2018); GA. CODE ANN. § 53-4-58 (2018); IND. CODE ANN. § 29-1-3-8(b) (LexisNexis 2018); MO. ANN. STAT. § 474.240(2) (West 2018); 8 N. MAR. I. CODE § 2702(b) (2018); UNIF. PROB. CODE § 2-302(b) (amended 2010). Pretermitted statutes rarely include the descendants of the decedent’s children. Exceptions include N.H. REV. STAT. ANN. § 551:10 (LexisNexis 2018); 33 R.I. GEN.

prevailing theory is that such omissions are unintentional.⁷⁵ To correct this “testamentary thoughtlessness,”⁷⁶ pretermitted heir statutes often typically give the omitted family member the share of the estate he would have been entitled to had the decedent died intestate.⁷⁷

An omitted spouse’s share may be limited to what the spouse would have been entitled to receive out of whatever estate does not pass to the testator’s child or descendant who is not also the child or descendant of the surviving spouse.⁷⁸ Some states may limit the share of an omitted spouse in other ways⁷⁹ and disallow a spouse who claims an omitted spouse’s share from also claiming a forced

LAWS § 33-6-23 (2018).

75 BRASHIER, *supra* note 2, at 101. Indeed, Oklahoma’s provision is specifically dubbed a “[p]rovision for children unintentionally omitted,” OKLA. STAT. ANN. tit. 84, § 132 (West 2018), and includes children who were in existence when the will was executed. *See also* ARK. CODE ANN. § 28-39-407(b) (2018) (entitling existing children not mentioned in the will to an intestate share).

76 *Young v. Young*, 703 S.W.2d 457, 459 (Ark. 1986).

77 JESSE DUKEMINIER ET AL., *WILLS, TRUSTS, AND ESTATES* 515 (8th ed. 2009) (describing omitted-spouse statutes). *See, e.g.*, ALA. CODE §§ 43-8-90(a), 43-8-91(a) (LexisNexis 2018); ARK. CODE ANN. § 28-39-407(a) (2018); ARIZ. REV. STAT. § 14-2301(A) (LexisNexis 2018); CAL. PROB. CODE § 21620 (Deering 2018); COLO. REV. STAT. §§ 15-11-301(1), 15-11-302(1)(a) (2018); CONN. GEN. STAT. ANN. §§ 45a-257a, 45a-257b(1) (West 2018); DEL. CODE ANN. tit. 12, §§ 301,321(1)–(2) (2018); FLA. STAT. ANN. §§ 732.301–732.302 (LexisNexis 2018); 755 ILL. COMP. STAT. ANN. 5 / 4-10 (LexisNexis 2018); IDAHO CODE ANN. § 15-2-301(a) (West 2018); IND. CODE ANN. § 29-1-3-8(a) (LexisNexis 2018); IOWA CODE § 633.267(1) (2018); ME. REV. STAT. ANN. tit. 18-A, § 2-301(a) (2018); MINN. STAT. ANN. § 524.2-301(a) (West 2018); MISS. CODE ANN. §§ 91-5-3, 91-5-5 (2018); N.J. STAT. ANN. § 3B:5-15(a) (West 2018); N.C. GEN. STAT. § 31-5.5 (2018); 8 N. MAR. I. CODE §§ 2701(a), 2702(a) (2018); OHIO REV. CODE ANN. § 2107.34(A) (LexisNexis 2018); *See e.g.*, 33 R.I. GEN. LAWS § 33-6-23 (2018); VT. STAT. ANN. tit. 14, § 333 (2018); WASH. REV. CODE ANN. §§ 11.12.091(3), 11.12.095(3) (LexisNexis 2018); W. VA. CODE ANN. §§ 41-4-1, 41-4-2 (LexisNexis 2018); UNIF. PROB. CODE §§ 2-301(a), 2-302(a)(1) (amended 2010). The protection of pretermitted children can be traced to a Massachusetts statute of 1700 that was imitated by other colonies. Orrin K. McMurray, *Liberty of Testation and Some Modern Limitations Thereon*, 14 ILL. L. REV. 96, 118–19 (1919).

78 ALASKA STAT. § 13.12.301(a) (2018); ARIZ. REV. STAT. § 14-2301(A) (LexisNexis 2018); COLO. REV. STAT. § 15-11-301(1) (2018); HAW. REV. STAT. ANN. § 560:2-301(a) (LexisNexis 2018); UNIF. PROB. CODE § 2-301(a) (amended 1993).

79 CAL. PROB. CODE § 21610(c) (Deering 2018) (limiting the omitted spouse’s share of decedent’s separate property to “one-half the value of the separate property in the estate”).

share.⁸⁰ The omitted spouse or child receives no pretermitted share if the omission was intentional⁸¹ or the testator provided for the omitted person outside of the will.⁸²

Where the decedent already had children when he executed his will, an omitted child will typically share in the gift to the other children.⁸³ Provisions vary. An omitted child may be denied an intestate share if the decedent left nearly all of his estate to his

80 CONN. GEN. STAT. ANN. § 45a-257a(c) (West 2018). The theory here may be grounded in the incompatibility of rejecting the will for the purposes of taking a forced share and accepting the will for the purposes of claiming an omitted spouse's share.

81 ALA. CODE §§ 43-8-90(a), 43-8-91(a)(1) (LexisNexis 2018); ALASKA STAT. §§ 13.12.301(a)(1)–(2), 13.12.302(1) (2018); ARIZ. REV. STAT. §§ 14-2301(A)(2), 14-2302(D)(1) (LexisNexis 2018); CAL. PROB. CODE §§ 21611(a), 21621(a) (Deering 2018); COLO. REV. STAT. §§ 15-11-301(1)(b), 15-11-302(2)(a) (2018); CONN. GEN. STAT. ANN. §§ 45a-257a(a)(1), 45a-257b(b)(1) (West 2018); DEL. CODE ANN. tit. 12, § 301 (West 2018); FLA. STAT. ANN. §§ 732.301(3), 732.302(1) (LexisNexis 2018); 755 ILL. COMP. STAT. ANN. 5 / 4-10 (LexisNexis 2018); IND. CODE ANN. § 29-1-3-8(a) (LexisNexis 2018); IOWA CODE ANN. § 633.267(1) (West 2018); KY. REV. STAT. ANN. § 394.382(1)(a) (LexisNexis 2018); MISS. CODE ANN. §§ 91-5-3, 91-5-5 (2018); MO. ANN. STAT. §§ 474.235(1), 474.240(1) (West 2018); N.J. STAT. ANN. § 3B:5-16(b)(1) (West 2018); N.C. GEN. STAT. § 31-5.5(2) (2018); 8 N. MAR. I. CODE §§ 2701(a), 2702(a)(1) (2018); OHIO REV. CODE ANN. § 2107.34(A) (LexisNexis 2017); 33 R.I. GEN. LAWS § 33-6-23 (2018); UNIF. PROB. CODE §§ 2-301(a)(1), 2-302(b)(1) (amended 2010). The test for intentional exclusion sets a high bar. In *Estate of Shannon*, for example, the court remarked that a will specifically disinheriting one's spouse but written before the marriage would be insufficient. 274 Cal. Rptr. 338, 341 (Cal. Ct. App. 1990).

82 ALA. CODE §§ 43-8-90(a), 43-8-91(a)(3) (LexisNexis 2018); ALASKA STAT. §§ 13.12.301(a)(3), 13.12.202(b)(2) (2018); ARIZ. REV. STAT. §§ 14-2301(A)(2), 14-2302(D)(2) (LexisNexis 2018); CAL. PROB. CODE §§ 21611(b), 21621(c) (Deering 2018); COLO. REV. STAT. §§ 15-11-301(1)(c), 15-11-302(2)(b) (2018); CONN. GEN. STAT. ANN. §§ 45a-257a(a)(2), 45a-257b(b)(2) (West 2018); FLA. STAT. ANN. §§ 732.301(1) (LexisNexis 2018) (mentioning pre- and postnuptial agreements), 732.302 (mentioning advancements); KY. REV. STAT. ANN. § 394.382(1)(c) (LexisNexis 2018); MISS. CODE ANN. §§ 91-5-3, 91-5-5 (2018); MO. ANN. STAT. §§ 474.235(1), 474.240(3) (West 2018); N.C. GEN. STAT. § 31-5.5(5) (2018); UNIF. PROB. CODE §§ 2-301(a)(3), 2-302(b)(2) (amended 2010). Such a "settlement" might take the form of life insurance proceeds. See, e.g., *In re Estate of Faber*, 114 N.Y.S.2d 119, 121 (App. Div. 1952); *In re Estate of Fredenthal*, 206 N.Y.S.2d 194, 197 (Sur. Ct. 1960); *In re Estate of Magrow*, 2001 N.Y. Misc. LEXIS 1423, at *20 (Sur. Ct. May 16, 2001).

83 ALASKA STAT. § 13.12.302(B) (2018); ARIZ. REV. STAT. § 14-2302(A)(2)(a)–(b) (LexisNexis 2018); COLO. REV. STAT. § 15-11-302(1)(b)(I)–(II) (2018); UNIF. PROB. CODE 2-302(a)(2)(B) (amended 2010).

surviving spouse⁸⁴ or the omitted child's surviving other parent⁸⁵ or only to the extent provisions favoring the omitted child's other parent or the surviving spouse are not reduced.⁸⁶ In some states, if the decedent left nothing to his children living at the time of the will's execution,⁸⁷ then the pretermitted child also takes nothing, unless it is shown that the testator was singling his other children out specifically as undeserving of a gift for whatever reason.⁸⁸ In Kansas and Maryland, pretermission of a child revokes the entire will but does not arise unless the testator *both* became married and had the child after the making of the will.⁸⁹ The Maryland provision further requires that the will contain "a legacy for a child of the testator but make[] no provision for a person who becomes a child of the testator subsequent to the execution of the will."⁹⁰ The child's share in Maryland is the lesser of an intestate share or an equal share of the testamentary gifts to the decedent's children.⁹¹

As with the elective share, satisfying the share of omitted family members requires the will's beneficiaries to contribute. Ratable contribution is the scheme of choice in this context among jurisdictions that have not adopted the Uniform Probate Code.⁹²

84 IND. CODE ANN. § 29-1-3-8(a) (LexisNexis 2018); N.C. GEN. STAT. § 31-5.5(4) (2018).

85 ALA. CODE § 43-8-91(a)(2) (LexisNexis 2018); ALASKA STAT. § 13.12.302(1) (2018); ARIZ. REV. STAT. § 14-2302(A)(1) (LexisNexis 2018); COLO. REV. STAT. § 15-11-302(1)(a) (2018); CAL. PROB. CODE § 21621(b) (Deering 2018); CONN. GEN. STAT. ANN. § 45a-257b(a)(1) (West 2018); FLA. STAT. ANN. § 732.302(2) (LexisNexis 2018); KY. REV. STAT. ANN. § 394.382(1)(b) (LexisNexis 2018); MO. ANN. STAT. § 474.240 (West 2018); 8 N. MAR. I. CODE § 2702(a)(2) (2018); UNIF. PROB. CODE § 2-302(a)(1) (amended 2010).

86 GA. CODE ANN. § 53-4-58(1) (2018); OHIO REV. CODE ANN. § 2107.34(A) (LexisNexis 2018).

87 N.C. GEN. STAT. § 31-5.5(3) (2018).

88 CONN. GEN. STAT. ANN. § 45a-257b(a)(2)(E) (West 2018); N.Y. EST. POWERS & TRUSTS LAW § 5-3.2(a)(1)(A) (LexisNexis 2018).

89 KANS. STAT. ANN. § 59-610 (West 2018); MD. CODE ANN., EST. & TRUSTS § 4-105(3) (LexisNexis 2018). A Maryland court, however, has ruled that it is sufficient by itself if the child was born after the execution of the will. *Karr v. Robinson*, 173 A. 584, 586-87 (Md. 1934).

90 MD. CODE ANN., EST. & TRUSTS § 3-301(b)(1) (LexisNexis 2018).

91 MD. CODE ANN., EST. & TRUSTS § 3-302(a)(1)-(2) (LexisNexis 2018).

92 *See, e.g.*, 755 ILL. COMP. STAT. ANN. § 5-4 / 10 (LexisNexis 2018); MD. CODE ANN., EST. & TRUSTS § 3-303 (LexisNexis 2018); MISS. CODE ANN. §§ 91-5-3, 91-5-5 (2018); N.Y. EST. POWERS & TRUSTS LAW § 5-3.2(c) (LexisNexis 2018); TEX. EST. CODE ANN. § 255.055(a) (West 2017); W. VA. CODE ANN. §§ 41-4-1, 41-4-2 (LexisNexis 2018).

Other jurisdictions prefer the abatement method.⁹³ Some hybrids exist. One scheme uses abatement according to classification for omitted spouses and children in general but ratable abatement for omitted children who share in the bequest to the decedent's children living at the time of the execution of the will.⁹⁴ Another hybrid approach requires abatement of the intestate estate followed by ratable contribution from all testamentary bequests.⁹⁵ The Uniform Probate Code's hybrid approach specifies an apportionment scheme for satisfying the elective share but a traditional abatement scheme for satisfying the shares of omitted spouses and children.⁹⁶ For omitted spouses, Delaware's provision simply directs each of the devisees to contribute "a just portion."⁹⁷ Some contribution schemes shield devisees to a child born to the testator before he married the omitted spouse and who is not also a child of the surviving spouse.⁹⁸ In a similar fashion, a contribution scheme might shield a portion of the estate passing to the surviving spouse if the omitted child is not also a child of the surviving spouse.⁹⁹

D. Property Set-Asides

Certain items of personal property and homestead property may be set aside for a surviving spouse and dependent children.¹⁰⁰ These protections are vested in the surviving spouse upon the death of the decedent and, as such, are exempt from and have priority over most other claims.¹⁰¹ They are also available, in most states,

93 See, e.g., ALA. CODE §§ 43-8-76, 43-8-90(b), 43-8-91(c) (LexisNexis 2018); IOWA CODE ANN. § 633.436(1) (West 2018); MO. ANN. STAT. §§ 474.235(2), 474.240(4), 473.620 (West 2018).

94 See, e.g., CONN. GEN. STAT. ANN. §§ 45a-257a(b), 45a-257b(a)(2)(D), 45a-257b(d) (West 2018). A similar scheme exists for posthumous children. See, e.g., KY. REV. STAT. ANN. § 394.460 (LexisNexis 2018).

95 CAL. PROB. CODE §§ 21612(a)(1)–(2), 21623(a)(1)–(2) (Deering 2018); DEL. CODE ANN. tit. 12, § 302 (2018); VT. STAT. ANN. tit. 14, § 334 (2018).

96 Compare UNIF. PROB. CODE §§ 2-301(b), 2-302(d), 3-902 (amended 2010) with UNIF. PROB. CODE § 2-209(c)–(d) (amended 2008).

97 See, e.g., DEL. CODE ANN. tit. 12, § 322 (2018).

98 See, e.g., ALASKA STAT. § 13.12.301(b) (2018).

99 See, e.g., TEX. EST. CODE ANN. § 255.056 (West 2018).

100 See, e.g., D.C. CODE § 101.03 (2018); 15 GUAM CODE ANN. § 2411 (2018); TEX. EST. CODE ANN. § 353.051(a) (West 2018); TEX. PROP. CODE ANN. § 42.002 (West 2018); BRASHIER, *supra* note 2, at 91. According to McMurray, these protections were recognized in the early years of the Union. McMurray, *supra* note 77, at 120. They appear to be an American invention that has spread to other countries. ATKINSON, *supra* note 3, at 127–28.

101 IOWA CODE ANN. §§ 633.211(2), 633.212(2), 633.238(1)(b) (West 2018);

in addition to property given by will,¹⁰² intestate succession,¹⁰³ or available to the surviving spouse as an elective share.¹⁰⁴ As such, they do not constitute an election against devises made in the will,¹⁰⁵ but nor are they included in the estate for the purposes of computing the elective share.¹⁰⁶ One caveat is that in some states the decedent may, by will, make the amounts chargeable against gifts made in the will or the gifts in the will in lieu of the exercise of these rights.¹⁰⁷

KANS. STAT. ANN. § 59-401 (West 2018); MISS. CODE ANN. § 91-1-19 (2018); MO. ANN. STAT. § 474.290(1) (West 2018); UNIF. PROB. CODE §§ 2-402, 2-403 (amended 2010) (the homestead allowance has priority over all claims; exempt property has priority over all claims but will abate to pay the homestead and family allowances); *But see* ARIZ. REV. STAT. §§ 14-2402(B), 14-2403(D) (LexisNexis 2018) (except expenses of administration); COLO. REV. STAT. § 15-11-403(1)(b) (2018); TEX. EST. CODE ANN. §§ 353.102(b), 353.155 (West 2017) (specifying that exempt personal property is nonetheless liable for the payment of “Class 1 claims,” which consist of “funeral expenses and the expenses of the decedent’s last illness”); ATKINSON, *supra* note 3, at 132 (noting that exempt property may be subject to “last illness, funeral and administration expenses”); HASKELL, *supra* note 64, at 170 (“[T]hese statutory dispositions are exempt from the claims of the decedent’s creditors.”).

102 ATKINSON, *supra* note 3, at 131. *See, e.g.*, ALA. CODE §§ 43-8-111, 43-8-112 (LexisNexis 2018).

103 *See, e.g.*, ARK. CODE ANN. § 28-9-206(b)(2)–(3) (2018).

104 *See, e.g.*, COLO. REV. STAT. § 15-11-202(3) (2018) (does not include homestead allowance); KY. REV. STAT. ANN. § 391.030(4)(c) (LexisNexis 2018); MO. ANN. STAT. § 474.160 (West 2018); NEB. REV. STAT. ANN. § 30-2318(b) (LexisNexis 2018); 33 R.I. GEN. LAWS § 33-28-1(b) (2018); UTAH CODE ANN. § 75-2-402 (LexisNexis 2018); UNIF. PROB. CODE § 2-402 (amended 2010). But note that in Missouri, the homestead allowance offsets the forced share and amounts the surviving spouse is entitled to receive in intestacy. MO. ANN. STAT. §§ 474.160(2), 474.290(1) (West 2018); *see also* OHIO REV. CODE ANN. § 2106.10(A) (LexisNexis 2018).

105 FLA. STAT. ANN. §§ 732.402(4), 732.403 (LexisNexis 2018); KANS. STAT. ANN. § 59-404 (West 2018); UNIF. PROB. CODE § 2-403 (amended 2010).

106 COLO. REV. STAT. § 15-11-204 (2018); UNIF. PROB. CODE §§ 2-202(c), 2-204 (amended 2010).

107 ATKINSON, *supra* note 3, at 131 (noting the “great weight of authority” requiring an election in accordance with “a clear testamentary stipulation”); Schmidt, Jr., *supra* note 8, at 143 (“[B]y an express provision in a will, a testator may force the spouse or children to take certain property under the will in lieu of any exempt property.”). *See, e.g.*, ALA. CODE §§ 43-8-110(a), 43-8-111, 43-8-112 (LexisNexis 2018); KANS. STAT. ANN. § 59-404 (West 2018); 8 N. MAR. I. CODE § 2601 (2018) (“unless the court finds that the will expressly provides an adequate substitute for the loss of these rights”); UNIF. PROB. CODE § 2-402 (amended 2010) (“unless otherwise provided”); UNIF. PROB. CODE § 2-403 (amended 2010) (“unless otherwise provided”).

Although in general, as Atkinson notes, “the courts are loathe to require an election between the allowances and the ultimate benefits contemplated under the will,”¹⁰⁸ in Mississippi, provisions in a will are presumed to bar the surviving spouse from succeeding to exempt property.¹⁰⁹ Iowa law allows the surviving spouse to elect a life estate in the homestead in lieu of the real property interests she would receive in intestacy or under a forced share.¹¹⁰ Testamentary provisions benefiting her are presumed to be in lieu of any homestead rights.¹¹¹

The homestead exemption or homestead allowance preserves the decedent’s homestead for the surviving spouse and dependent children and shields it from the claims of the decedent’s creditors.¹¹² The homestead allowance may be a sum of money,¹¹³ the right to

108 ATKINSON, *supra* note 3, at 131.

109 MISS. CODE ANN. § 91-5-23 (2018).

110 IOWA CODE ANN. § 633.240 (West 2018).

111 IOWA CODE ANN. § 633.268 (West 2018).

112 George L. Haskins, *Estates Arising from the Marital Relationship and Their Characteristics*, in 1 THE AMERICAN LAW OF PROPERTY 809, 892 (James A. Casner ed., 1952).

113 ALA. CODE § 43-8-110(a) (LexisNexis 2018) (\$15,000); ARIZ. REV. STAT. § 14-2402 (LexisNexis 2018) (\$18,000); COLO. REV. STAT. §§ 38-41-201, 38-41-204 (2018) (\$75,000–\$105,000 exempt from execution and attachment); D.C. CODE. § 9-101.02 (2018) (\$15,000); FLA. STAT. ANN. § 732.403 (LexisNexis 2018) (\$18,000); MO. ANN. STAT. § 474.290(1) (West 2018) (not exceeding 50% of the value of the estate up to \$15,000); MONT. CODE ANN. § 72-2-412 (West 2018) (\$20,000); 8 N. MAR. I. CODE § 2602 (2018) (\$5,000); VA. CODE ANN. § 64.2-311(A) (2018) (\$20,000); UNIF. PROB. CODE § 2-402 (amended 2010) (\$22,500). According to Paul Haskell, “[t]his means that the homestead allowance is essentially a legislated disposition of a specific dollar amount not subject to creditors’ claims.” HASKELL, *supra* note 64, at 172. Some states have rejected the allowance approach in favor of the homestead descending “to the surviving spouse immediately on the other spouse’s death.” Tanick & Johnson, *supra* note 67, at 251 n.49.

occupy the dwelling,¹¹⁴ an amount of land¹¹⁵ or personal property,¹¹⁶ or even an election between a life estate and a one-half interest as tenant in common with the decedent's descendants.¹¹⁷ By contrast, exempt property, also known as exempt personalty,¹¹⁸ is typically not simply a monetary sum but a set-aside or allowance of, for example, necessities such as household goods, a car, and "money on hand"¹¹⁹ often up to a certain value.¹²⁰ An amount of money may be made available to substitute for "articles not among the effects."¹²¹ Some statutes give the surviving spouse or children the right to select the

114 CONN. GEN. STAT. ANN. § 45a-321(b) (West 2018); MASS. ANN. LAWS ch. 190B, § 2-403(b) (LexisNexis 2018); OHIO REV. CODE ANN. § 2106.15 (LexisNexis 2018) (granting occupation of "the mansion house" for one year); OR. REV. STAT. ANN. § 114.005(1) (West 2018) (specifying that the surviving spouse and children must also have occupied the homestead); TENN. CODE ANN. § 31-1-104(a) (2018).

115 KANS. STAT. ANN. § 59-401 (West 2018) ("160 acres of land lying without, or of one acre lying within, the limits of an incorporated city . . ."). Rhode Island has an unusual provision vesting discretion in the court to set aside to the surviving spouse real estate in addition to her intestate share of the decedent's estate "as may be suitable for her or his situation and support . . ." 33 R.I. GEN. LAWS § 33-10-4 (2018). The provision applies only if the decedent dies without issue. *Id.*

116 MO. ANN. STAT. § 474.290(1) (West 2018).

117 FLA. STAT. ANN. § 732.401(1)–(2) (LexisNexis 2018).

118 *See, e.g., Ames Tr. & Sav. Bank v. Reichardt*, 121 N.W.2d 200, 202 (Iowa 1963).

119 ALA. CODE § 43-8-111 (LexisNexis 2018); ARIZ. REV. STAT. § 14-2403(A) (LexisNexis 2018); CONN. GEN. STAT. ANN. § 45a-320(c) (West 2018); FLA. STAT. ANN. § 732.402(2)(a)–(b) (LexisNexis 2018); KANS. STAT. ANN. § 59-403(a) (West 2018); KY. REV. STAT. ANN. § 391.030(1)(c) (LexisNexis 2018) ("money on hand"), KY. REV. STAT. ANN. § 391.030(4)(a) (LexisNexis 2018); MO. ANN. STAT. § 474.250 (West 2018) (including such specifics as "the family bible" and musical instruments); 33 R.I. GEN. LAWS § 33-10-1 (2018). Kansas includes a sum of money "of not more than \$50,000" within its personal property allowance statute. KANS. STAT. ANN. § 59-403(b) (West 2018).

120 ATKINSON, *supra* note 3, at 129; *see also* Tanick & Johnson, *supra* note 67, at 251 n.49. *See, e.g.,* ARIZ. REV. STAT. § 14-2403(A) (LexisNexis 2018) (\$7,000); COLO. REV. STAT. § 15-11-403 (2018) (\$30,000); MASS. ANN. LAWS ch. 190B, § 2-403(a) (LexisNexis 2018) (\$10,000); N.M. STAT. ANN. § 45-2-403 (LexisNexis 2018) (\$15,000); UNIF. PROB. CODE § 2-403 (amended 2010) (\$15,000). Ohio has specific provisions for setting aside automobiles and watercraft, OHIO REV. CODE ANN. §§ 2106.18(A), 2106.19(A) (LexisNexis 2018) (not to exceed \$65,000); Vermont for snowmobiles and all-terrain vehicles, VT. STAT. ANN. tit. 14, § 313 (2018).

121 *See, e.g.,* TEX. EST. CODE ANN. § 353.053(a)–(b) (West 2018) (not to exceed \$30,000 in exempt personal property, \$45,000 for the homestead).

personal property to be set aside.¹²² Such a selection may vest a right of contribution in beneficiaries specifically bequeathed such items.¹²³ Some statutes also specifically provide for a personal property set-aside to the surviving spouse when the estate is insolvent.¹²⁴ The homestead election and the family allowance (discussed below) may be personal to the surviving spouse,¹²⁵ but the right to an allowance for exempt property does not necessarily expire on death.¹²⁶ As is true of the elective share, all of these rights are waivable by agreement.¹²⁷

E. Monetary Allowance

The family allowance, in contrast to the set-asides, is typically a sum of money¹²⁸ to enable the surviving spouse, the decedent's minor children, and adult children who depended upon the decedent for support a sum of money for their maintenance during the administration of the estate.¹²⁹ It might be provided for a specific period of time after the death of the decedent¹³⁰ or simply be given

122 See, e.g., VA. CODE ANN § 64.2-312(A) (2018).

123 See, e.g., KY. REV. STAT. ANN. § 391.030 (4)(d) (LexisNexis 2018).

124 CONN. GEN. STAT. ANN. § 45a-435 (West 2018); ATKINSON, *supra* note 3, at 133.

125 ARIZ. REV. STAT. § 14-2404(D) (LexisNexis 2018); IOWA CODE ANN. § 633.242 (West 2018); *Easton v. Fessenden*, 14 A.2d 508, 510–11 (R.I. 1940).

126 See, e.g., *Foiles v. Whittman* (*In re Estate of Whittman*), 233 P.3d 697 (Colo. 2010) (distinguishing between the elective share and the family allowance, on the one hand, and exempt property, on the other).

127 See, e.g., ARIZ. REV. STAT. § 14-2207(A) (LexisNexis 2018); *In re Estate of Lutz*, 620 N.W.2d 589, 594 (N.D. 2000); *Dowling v. Rowan*, 621 S.E.2d 397, 400 (Va. 2005); Schmidt, Jr., *supra* note 8, at 140.

128 Rhode Island has an unusual provision vesting the probate court with discretion, upon application, to set off an allowance of up to \$150,000 of the real property of an intestate decedent for the surviving spouse. 33 R.I. GEN. LAWS § 33-1-6 (2018). The provision is unusual because it is not an entitlement, it exists only in cases of intestacy, and its features resemble the family allowance more than the property set-asides common in other states. See 33 R.I. GEN. LAWS § 33-1-10(3) (2018) (labelling this provision a “discretionary allowance”). Rhode Island also has a separate provision that embodies a typical family allowance. See 33 R.I. GEN. LAWS § 33-10-3 (2018).

129 ALA. CODE § 43-8-112 (LexisNexis 2018); CAL. PROB. CODE § 6540(a) (Deering 2018); ARIZ. REV. STAT. § 14-2404(A) (LexisNexis 2018); CONN. GEN. STAT. ANN. § 45a-320 (West 2018); S.D. CODIFIED LAWS § 29A-2-403 (2018); MO. ANN. STAT. § 474.260(1) (West 2018); *In re Estate of George*, 51 V.I. 43, 52 (V.I. Super. Ct. 2009) (referring to the family allowance as “spousal support”); UNIF. PROB. CODE § 2-404 (amended 2010).

130 GA. CODE ANN. § 53-3-1(c) (2018); 755 ILL. COMP. STAT. ANN. 5 / 15-1(a), 5 / 15-2(a) (LexisNexis 2018); MISS. CODE ANN. § 91-7-135 (2018); N.C. GEN. STAT. § 30-15, 30-17 (2018); 33 R.I. GEN. LAWS. § 33-10-3 (2018);

for the family members' "personal use."¹³¹ Most statutes require the court to make a reasonable or sufficient allowance,¹³² others state a specific amount,¹³³ and some allow satisfaction of the allowance with personal property.¹³⁴ The allowance is personal; it cannot be exercised after the death of the beneficiary.¹³⁵ Like the homestead allowance and personal property set-aside, the family allowance is exempt from and usually has priority over any other claims¹³⁶ and may be in addition to property given by will, intestate succession, or

TEX. EST. CODE ANN. § 353.102(a) (West 2017).

- 131 MD. CODE ANN., EST. & TRUSTS § 3-201(a)–(b) (LexisNexis 2018) (granting \$10,000 to the surviving spouse and \$5,000 to each unmarried child under 18); *see also* N.M. STAT. ANN. § 45-2-402 (LexisNexis 2018) (\$30,000).
- 132 ARIZ. REV. STAT. § 14-2404(A) (LexisNexis 2018); COLO. REV. STAT. § 15-11-404(1) (2018); KAN. STAT. ANN. § 59-403(b) (West 2018); MASS. ANN. LAWS. ch. 190B, §2-404(a) (LexisNexis 2018); MO. ANN. STAT. § 474.260(1) (West 2018); N.D. CENT. CODE § 30.1-07-02(1) (2017); 8 N. MAR. I. CODE § 2603 (2018); OR. REV. STAT. ANN. §§ 114.015, 114.035 (West 2018); TEX. EST. CODE ANN. § 353.102(a) (West 2017); V.I. CODE ANN. tit. 15, §§ 353, 356 (2018); UNIF. PROB. CODE § 2-404 (amended 2010). The court will make the reasonableness determination based on a variety of factors. TEX. EST. CODE ANN. § 353.102(b) (West 2017) (specifying "the facts or circumstances" at the time of the determination and "anticipated to exist during the first year after the decedent's death"); *In re Estate of Wheat*, 955 P.2d 1339, 1341 (Kans. Ct. App. 1998) (judge makes determination based on various factors); ATKINSON, *supra* note 3, at 134 (listing factors that might be employed in setting the amount).
- 133 IND. CODE ANN. § 29-1-4-1(a) (LexisNexis 2018) (\$25,000); N.C. GEN. STAT. §§ 30-15, 30-17 (2018) (\$30,000 and \$5,000, respectively); OHIO REV. CODE ANN. § 2106.13(A) (LexisNexis 2018) (\$40,000).
- 134 TEX. EST. CODE ANN. § 353.106(a) (West 2017).
- 135 COLO. REV. STAT. § 15-11-404(2) (2018); GA. CODE ANN. § 53-3-2(a)–(b) (2018); MO. ANN. STAT. § 474.260(1) (West 2018); N.D. CENT. CODE § 30.1-07-02(2) (2017); UNIF. PROB. CODE § 2-404(b) (amended 2010). *But see* MO. ANN. STAT. § 474.300 (West 2018).
- 136 ARIZ. REV. STAT. § 14-2404(B) (LexisNexis 2018) (except expenses of administration and the homestead allowance); COLO. REV. STAT. § 15-11-404(1) (2018) (same); MO. ANN. STAT. § 474.260(2) (West 2018); NEV. REV. STAT. ANN. § 146.040 (LexisNexis 2017); TEX. EST. CODE ANN. §§ 353.104, 355.102(b) (West 2017) (giving preference to the family allowance against all but "Class 1 claims," which consist of "funeral expenses and the expenses of the decedent's last illness . . . "); UNIF. PROB. CODE § 2-404(a) (amended 2010) (the family allowance has priority over all claims except the homestead allowance); *In re Estate of Wilhelm*, 760 P.2d 718, 724 (Mont. 1988) (ruling family allowance exempt from judgment lien). North Carolina's version of this provision refers specifically to "any lien, by judgment or execution, acquired against the property of the deceased spouse . . ." N.C. GEN. STAT. § 30-15 (2018); *see also* N.C. GEN. STAT. § 30-17 (2018).

available to the surviving spouse as a forced share.¹³⁷ Nonetheless, a testator may specify that a provision in the will is meant to be in lieu of the allowance, forcing the beneficiary to make an election.¹³⁸ Georgia explicitly bars the allowance where the surviving spouse marries or a minor child attains the age of 18 before petitioning the court for the allowance.¹³⁹ Illinois and Missouri allow those entitled to the allowance to elect to take some or all of it in the form of chattels belonging to the estate.¹⁴⁰ As is true of exempt property in Mississippi, a statute in that state establishes a presumption that testamentary provisions benefiting a surviving spouse bar the surviving spouse from taking a family allowance.¹⁴¹

III. The Policies of Family Protection

Linking the various family protection mechanisms canvassed in Part II is a fairly clear policy to protect one's surviving spouse and children when one dies. Protection against disinheritance in the context of intestacy and pretermission is based on the decedent's either failing to make a will or failing to renew his will so as to include a new spouse or new children. The policy against disinheritance extends to the statutory allowances as well, suggesting that the surviving spouse should not be denied, in the case of the elective share, a minimum share of the decedent's estate and that, in the case of the other statutory allowances, she and the surviving children should be entitled to certain of the decedent's real and personal property.

137 COLO. REV. STAT. § 15-11-404(2) (2018); IND. CODE ANN. § 29-1-4-1(e) (LexisNexis 2018) ("An allowance under this section is not chargeable against the distributive shares of either the surviving spouse or the children."); MO. ANN. STAT. § 474.260(1) (West 2018); 33 R.I. GEN. LAWS § 33-28-1(b) (2018); UNIF. PROB. CODE § 2-404(b) (amended 2010); *Williams v. Pollard*, 72 P.2d 476, 478 (Colo. 1937); Schmidt, Jr., *supra* note 8, at 140.

138 GA. CODE ANN. § 53-3-3 (2018) (will provision for spouse in lieu of family allowance); 755 ILL. COMP. STAT. ANN. 5 / 15-1(b) (LexisNexis 2018); IND. CODE ANN. § 29-1-3-7 (LexisNexis 2018); MO. ANN. STAT. § 474.260(1) (West 2018) ("unless otherwise provided"); UNIF. PROB. CODE § 2-404(b) (amended 2010) ("unless otherwise provided"). North Carolina law specifies that the family allowance will be charged against bequests to the surviving spouse, N.C. GEN. STAT. § 30-15 (2018), but not against those to the surviving children, N.C. GEN. STAT. § 30-17 (2018).

139 GA. CODE ANN. § 53-3-2(a)-(b) (2018).

140 755 ILL. COMP. STAT. ANN. 5 / 15-4(a) (LexisNexis 2018); MO. ANN. STAT. § 474.260(2) (West 2018).

141 MISS. CODE ANN. § 91-5-23 (2018).

Scholars have expressed varying opinions as to why, as Sheldon Plager recognized in 1933, family protection policies frustrate “such other policies as freedom of testamentary disposition, protection of creditors, and alienability of land”¹⁴² When these protections take priority over the interests of creditors, Orrin McMurray has noted that “[t]he evils suffered by society through the pauperization of individuals outweigh the benefits accruing from the strict payment of his debts by a debtor.”¹⁴³ Legal theorist Ralph Brashier has opined that “[p]robate rules should further the intent of the typical decedent to provide for his family.”¹⁴⁴ Succession law achieves this aim and simultaneously aims for efficiency by protecting the decedent’s “created” family, defined as his surviving spouse and children.¹⁴⁵ Brashier explains that “[a]lthough legislatures recognized both families of the typical decedent, they always concluded that the typical decedent would want, first and foremost, to protect the family that he *created* or *chose*. This explains why the spouse and children (or their descendants) are the initial distributees under virtually all intestacy laws.”¹⁴⁶ The most important ramification of protecting decedents’ created families, according to Brashier, is that “probate laws ultimately should promote and protect the state. Fortuitously, recognizing members of the decedent’s created family as heirs has a stabilizing effect on family life and society as a whole, as those family members are also the people most likely to be dependent upon him.”¹⁴⁷ More recently, Hendrik Hartog has theorized that behind family protection policies in succession law lies “an understanding that situates parents’ responsibilities for their children and the overarching significance of the marriage bond at the center of what the family ‘means’”¹⁴⁸

Harmonizing these theories, we can discern that the concerns thought primarily to drive the policy that one should not suffer disinheritance upon the death of a parent or spouse are threefold: that the decedent intended to bestow his bounty upon his surviving spouse and children, that the surviving spouse should be

142 Sheldon J. Plager, *The Spouse’s Nonbarrable Share: A Solution in Search of a Problem*, 33 U. CHI. L. REV. 681, 681 (1966).

143 McMurray, *supra* note 77, at 121; *see also* ATKINSON, *supra* note 3, at 127.

144 BRASHIER, *supra* note 2, at 6.

145 *Id.* at 5.

146 *Id.*

147 *Id.* at 7.

148 HENDRIK HARTOG, *SOMEDAY ALL THIS WILL BE YOURS: A HISTORY OF INHERITANCE AND OLD AGE 50* (2012).

rewarded for her contributions to the marital economy, and that the necessities of a surviving spouse and children should not be placed in jeopardy by one's death. This section explores whether these concerns convincingly explain the devices that legislatures have created to protect the family in the area of succession law.

A. Allowances

At their root, the homestead, personal property and family allowances are allowances meant to provide support during a stressful period when family members may need access to funds in the estate in order to support themselves and maintain their home.¹⁴⁹ By extension, statutory allowances aim to protect the state “from the burden of indigent families.”¹⁵⁰

In comparison to the intestate, elective, or pretermitted-heir shares, statutory allowances are meager.¹⁵¹ It stands to reason, then, that the decedent is typically powerless, barring consumption of the property, to place his assets beyond the reach of these allowances or for his creditors to attach them.¹⁵² Consider *In re Estate of Wagley*.¹⁵³ In this dispute involving a small estate, most of which was contained in a joint bank account for the benefit of the decedent's daughter, the surviving spouse applied for a personal property set-aside.¹⁵⁴ The inventory of probate assets amounted to less than \$5,000, an amount insufficient to satisfy debts, administrative expenses, and statutory allowances.¹⁵⁵ The probate court denied satisfaction of her exempt property claim from the joint bank account.¹⁵⁶ The Supreme

149 See *In re Wallace's Estate*, 246 P.2d 894, 898 (Colo. 1952); *French v. French*, 533 P.2d 1357, 1360 (Nev. 1975) (in resolving competing petitions for exempt property of widow and minor children from prior marriage, court determined that widow had the greater need).

150 EUGENE F. SCOLES ET AL., *PROBLEMS AND MATERIALS ON DECEDENTS' ESTATES AND TRUSTS* 69 (7th ed. 2006).

151 Compare N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A(a)(2) (LexisNexis 2018) (the greater of \$50,000 or one-third of the net estate) with N.Y. EST. POWERS & TRUSTS LAW § 5-3.1(a)(6) (LexisNexis 2018) (family allowance of \$25,000 to be reduced by amounts in excess of personal property allowances).

152 But see MONT. CODE ANN. §§ 72-2-412, 72-2-413, 72-2-414 (West 2017) (“unless otherwise provided” by will); UTAH CODE ANN. §§ 75-2-402, 75-2-403, 75-2-404 (LexisNexis 2018) (making allowances chargeable against amounts received via will, intestate succession, the elective share, and non-probate transfers).

153 *In re Estate of Wagley*, 760 P.2d 316 (Utah 1988).

154 *Id.* at 317.

155 *Id.* at 318. The homestead exemption was not claimed. *Id.*

156 *Id.* at 317.

Court of Utah reversed in part, reasoning that statutory allowances are meant to provide “essential protection” to a surviving spouse that can be provided from non-probate assets in cases where the estate is insolvent.¹⁵⁷

Another case in this vein is *In re Estate of Lawson*.¹⁵⁸ In this case, married couple James and Karen Lawson held certain assets with survivorship provisions.¹⁵⁹ When James died, Karen succeeded to enough of these assets to enable her to purchase a new home.¹⁶⁰ When she moved there from the marital home, Karen took with her certain items of personal property. James’s niece, having been appointed personal representative of the estate, moved to offset the sums due Karen as statutory allowances by the value of the personal property.¹⁶¹ Karen was granted all three allowances free from the estate’s claims, the Supreme Court of Montana noting that

[t]he purpose of the allowances is to ensure that a surviving spouse is not left penniless and abandoned by the death of a spouse. The allowances are not designed to support the family until they share in the estate, but irrespective of whether they do or do not share.¹⁶²

Wagley, Lawson, and other authorities send the message that allowances are necessary to prevent the destitution of the surviving spouse and children¹⁶³ or, as one court colorfully put it, “so that

157 *Id.* at 318 (internal quotation marks omitted).

158 *In re Estate of Lawson*, 721 P.2d 760 (Mont. 1986).

159 *Id.* at 761.

160 *Id.*

161 *Id.*

162 *Id.* at 762.

163 *Wagley*, 760 P.2d at 318; *Lawson*, 721 P.2d at 762. See also 33 R.I. GEN. LAWS §§ 33-10-3 (2018) (describing the allowance as “for the support of [the decedent’s] family”), 33-10-4 (2018) (describing the real property set-aside as “for her or his situation and support and in accordance with the circumstances of the estate”); *In re Bradley’s Estate*, 106 P.2d 1063, 1065 (Colo. 1940) (describing the policy as “providing a measure of support to a widow or minor children during the process of administration”); *Easton v. Fessenden*, 14 A.2d 508, 511 (R.I. 1940) (describing the personal property set-aside as “based on considerations of public policy directed toward the preservation of the home and family of a decedent by assuring his widow and minor children immediate assistance”); *In re Estate of Woodward*, 40 Cal. Rptr. 781, 783 (Ct. App. 1964) (describing the family allowance as “an extension of the decedent’s obligation of support”); *In re Wheat*, 955 P.2d 1339, 1341 (Kan. Ct. App. 1998)

she would not be stripped of the means with which to carry on.”¹⁶⁴ Although outwardly plausible, this rationale breaks down a bit at the margins. In particular, some families might not need \$50,000 to weather the probate period. Similarly, set-asides and allowances that benefit adult children who are self-supporting do not appear to be aimed at preventing pauperization. Finally, the separate assets of the surviving spouse may not affect her entitlement to sums she appears not to need,¹⁶⁵ as we see in *Lawson*. The conclusion of the Montana Supreme Court that the statutory allowances are, simply put, so essential that they should not be offset by other assets received by the surviving spouse¹⁶⁶ does not hew particularly closely to a support rationale.

Another important policy that might simultaneously be in play here, as the Utah Supreme Court implied, is judicial economy.¹⁶⁷ “The prompt settlement of estates,”¹⁶⁸ as suggestive as it may be of concern for a decedent’s close family, also ensures that judicial resources are preserved and the resolution of issues accelerated through the circumscription of judicial tasks. Providing support expeditiously may come at the cost of providing support when it is not entirely critical, but these rare instances actually serve the larger aim of providing support immediately than would a system requiring

(describing the policy as helping the family “get through a difficult period of readjustment” and not leaving the family “entirely destitute”); J. Rodney Johnson, *Wills, Trusts, and Estates*, VA. L. REV. 521, 522 (1982) (describing the “basic aim” of the family allowance as making “necessary funds available to the family as soon as reasonably possible”); Carolyn S. Bratt, *Family Protection under Kentucky’s Inheritance Laws: Is the Family Really Protected?*, 76 KY. L.J. 387, 390 (1988).

164 Schmidt, Jr. *supra* note 8, at 139 (quoting *Wallace v. First Nat’l Bank*, 246 P.2d 894, 901 (Colo. 1952)).

165 A surviving spouse’s separate assets could be a factor used by the court to decide what is a “reasonable” family allowance. See, e.g., *In re Wheat*, 955 P.2d 1339, 1341 (Kans. Ct. App. 1998) (“A court may use its discretion and take into consideration various factors, such as the financial condition of the decedent’s spouse and minor children, when determining the amount of allowance to award.”); UNIF. PROB. CODE § 2-404 (amended 2010) (“In determining the amount of the family allowance, account should be taken of both the previous standard of living and the nature of other resources available to the family to meet current living expenses . . .”).

166 *Lawson*, 721 P.2d at 762.

167 UNIF. PROB. CODE art. II, pt. 2, gen. cmt. at 143 (2013) (amended 2010) (noting that “ease of administration and predictability of result are prized features of the probate system”).

168 UNIF. PROB. CODE § 3-101 (amended 2010).

the exercise of judicial discretion after extensive fact-finding.

B. Intestacy and Pretermitted Heirs

We now turn to the purposes of intestacy and pretermission statutes. As the default estate plan, the contours of intestacy provisions have most often been described as reflecting the wishes of the average decedent who, by and large, desires to benefit those with whom he has significant emotional ties or who are economically dependent upon him.¹⁶⁹ The prevailing wisdom counsels that in matters of intestacy, testamentary freedom simply needs a bit of assistance from the law when decedents fail to provide for their close family members. As such, the most apparent purpose of intestacy rules is to carry out what a testator would have included in a will. From this perspective, whatever protective function intestacy statutes are meant to serve seems to protect the decedent, not the beneficiary. The same theory justifies pretermission statutes that protect heirs apparent against unintentional disinheritance. For example, an Oklahoma court has remarked that the “pretermitted heir statute . . . is not a limitation on a testator’s power to dispose of his property. [It] is an assurance that a child is not unintentionally omitted from a will.”¹⁷⁰ But the typical statute does not merely carve out a share of the estate for the omitted child. The typical pretermitted child statute specifies that if the testator had other children at the time of the execution of the will, the omitted child’s share will be subsumed within theirs, even if the will grants them nothing.¹⁷¹ The idea here is that the reasonable testator would have

169 Efrain Gonzalez Tejera, *Mortis Causa Wealth Transfer and the Protection of the Family: The Spanish-Puerto Rican Experience*, 60 TUL. L. REV. 1231, 1244 (1986) (arguing against including in Puerto Rico’s intestacy code beneficiaries who lack “true emotional ties” with and economic dependence upon decedents); *See generally*, Adam J. Hirsch, *Cognitive Jurisprudence*, 76 S. CAL. L. REV. 599, 621 (2003); Susan N. Gary, *Adapting Intestacy Laws to Changing Families*, 18 L. & INEQ. 1, 12 (2000); *but see* Lee-Ford Tritt, *Technical Correction or Tectonic Shift: Competing Default Rules Theories under the New Uniform Probate Code*, ALA. L. REV. 273, 283 (2010) (noting that the stated policy of the Uniform Probate Code’s intestacy provisions is “to provide suitable rules for the person of modest means who relies on the estate plan provided by law”) (quoting UNIF. PROB. CODE art. II, pt. 1, cmt. (amended 2008), 8 U.L.A. 79 (1998)).

170 *In re Estate of Jackson*, 194 P.3d 1269, 1274 (Okla. 2008); *see also In re Estate of Sprenkle-Hill*, 703 N.W.2d 191, 195 (Mich. 2005) (expounding the theory that the reasonable testator intended to provide for the pretermitted spouse in the will but neglected to do so).

171 *See, e.g.*, N.Y. EST. POWERS & TRUSTS LAW § 5-3.2 (LexisNexis 2018).

wanted his children to be treated equally. This would counsel that the pretermitted child not receive a share that either eclipses or is substantially less than the testator has already set aside for his other children. Ostensibly, then, both intestacy and pretermission provisions have more to do with carrying out an estate plan the decedent would have preferred than with ensuring that surviving members of the decedent's nuclear family receive support.

Consider the case study example described at the beginning of this article. There, May's will provided that her husband Saul and sister Nance share her estate, but she adopted Cai after she executed it. The solution to this problem is relatively straightforward under current law. The court would first calculate what would have been Cai's intestate share had May died without a will. Calculating that share will require us to acknowledge who would have shared the estate with Cai in that event. If New York intestacy law applies, Saul, as May's surviving spouse, would take \$50,000 plus half of the remainder of the estate; in intestacy, Saul would thus be entitled to \$275,000.¹⁷² In intestacy, surviving children take what is left, in this case \$225,000. Thus Cai's pretermitted share is \$225,000, which will reduce the estate to \$275,000. That amount is now made subject to the terms of May's will, which bestows half of that amount upon Saul and half upon Nance.

Benefiting Cai may be precisely what May would have preferred to the will she did create; nonetheless, the notion that intestacy and pretermission provisions protect beneficiaries the decedent never explicitly named as the objects of her bounty is certainly not missing from these provisions.¹⁷³ After all, reasonable testators may wish to benefit their immediate families precisely because they do need support¹⁷⁴ or have earned the testator's largesse. Breadwinners tend to die before homemakers, children may be minors, and most adult children have earned a share of their

172 $\$500,000 - 50,000 = \$450,000$. $\$450,000/2 = \$225,000$. $\$50,000 + 225,000 = \$275,000$.

173 *Woodward v. Comm'r of Social Security*, 760 N.E.2d 257, 266 (Mass. 2002) (noting "the protection of children who are alive or conceived before the intestate parent's death").

174 Susan N. Gary, *The Probate Definition of Family: A Proposal for Guided Discretion in Intestacy*, 45 U. MICH. J.L. REFORM 787, 790 n.14 (2012); Gary, *supra* note 169, at 11. Frederick R. Schneider, *Recommendations for Improving Kentucky's Inheritance Laws*, 22 N. KY. L. REV. 317, 318 (1995) (arguing for reform that would balance the desires of the reasonable testator with "adequate protection to the financially dependent surviving spouse and family.").

parent's bounty through their loyalty.¹⁷⁵ Thus, when we speculate on how a reasonable testator would exercise his testamentary prerogatives, we understand that, in most cases, that exercise will reflect concerns about the need to provide support and recognize deservedness, with the rare departures from this—demonstrations of eccentricity and nonconformity—reflecting little of the norms typically followed either in testamentary planning or reflected in intestacy provisions.

What explains, then, intestacy provisions singling out “ancestral” property for special treatment? Under the common law, real property “returned to the branch of the family from which the decedent inherited it,”¹⁷⁶ to a descendant of “the blood of the first purchaser.”¹⁷⁷ Some intestacy provisions still embody a modified version of this rule.¹⁷⁸ The policy behind ancestral property rules appears to have little to do with the wishes of most reasonable testators; indeed, the rules have the effect of guaranteeing that the decedent's real property will not descend to those who are the natural objects of his bounty. The most common provision bypasses the surviving spouse in favor of ancestors and collateral kin.¹⁷⁹ Another ancestral property provision that cuts against the intent of the average

175 American intestacy provisions are less explicit about providing support or desert than, say, provisions in Chinese intestacy law guaranteeing those who provided support to a decedent before his death a share of any of his estate distributed in intestacy. Thomas E. Simmons, *A Chinese Inheritance*, 30 QUINNIPIAC PROB. L.J. 124, 140 (2017). Simmons recognizes that the policy behind such provisions “is to encourage and reward adult children who support their parents, financially or emotionally.” *Id.* at 147.

176 RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 2.4 cmt d (AM. LAW. INST. 1999).

177 1 JAMES B. McLAUGHLIN, JR., & RICHARD T. BOWSER, WIGGINS WILLS & ADMINISTRATION OF ESTATES IN NORTH CAROLINA § 16:4 (4th ed. 2016). The blood of the first purchaser refers to “the person who first brought the land into the family and who thus acquired it by some means other than by descent or by escheat.” Sheila Solomon, *Michigan Ancestral Property Doctrine*, 3 WAYNE L. REV. 51, 52 (1956).

178 RESTATEMENT (THIRD) OF PROP.: WILLS & OTHER DONATIVE TRANSFERS § 2.4 cmt. d (AM. LAW INST. 1999); *Statutory Treatment of Ancestral Estate and the Half Blood in Intestate Succession*, 42 YALE L.J. 101, 103 (1932). See, e.g., KY. REV. STAT. ANN. § 391.020 (LexisNexis 2018). North Carolina did not abolish the distinction between ancestral and nonancestral property until 2012. See N.C. GEN. STAT. § 29-3(2) (2018).

179 See, e.g., *In re Smith's Estate*, 63 P. 729 (Cal. 1901) (intestate's real property inherited from her father descended not to surviving spouse but to decedent's sisters).

reasonable testator applies to the inheritance of real property by a minor child who then later dies while still a minor and unmarried.¹⁸⁰ Shades of this provision appear in West Virginia's pretermitted child law. Under that law, the property bestowed upon a pretermitted child nonetheless goes to the testamentary beneficiaries the testator originally intended if that child dies unmarried and under the age of 18.¹⁸¹ Under either regime, the real estate or personal property is distributed at that later time to the decedent's other children and their representatives¹⁸² or to those the testator originally intended,¹⁸³ as if the minor child had died during the decedent's lifetime.¹⁸⁴ The policy behind ancestral property provisions is primarily to keep real estate in the hands of consanguineous kin of the whole blood;¹⁸⁵ indeed, half-blood relations and adopted children were excluded from the ranks of heirs of ancestral property.¹⁸⁶ Concerns about testamentary intent and the need for support have no role in the mechanics of ancestral property statutes. Such provisions sound quite archaic to our ears today and it is true that their influence is currently minimal,¹⁸⁷ but an acknowledgment of them reveals a dimension of intestacy law that has nearly been forgotten. The reason for perpetuating such provisions, albeit partially, in pretermitted child provisions like West Virginia's is unclear, but the preservation of testamentary intent is surely part of the story. After all, minors cannot own property or write enforceable wills and so arguably have no testamentary intent independent of the testator's about which the law should be concerned.

180 Such a provision remained in effect in Oklahoma until 1985. See OKLA. STAT. ANN. tit. 84, § 213(A) (West 2018).

181 See, e.g., W. VA. CODE ANN. §§ 41-4-1, 41-4-2 (LexisNexis 2018).

182 See OKLA. STAT. ANN. tit. 84, § 213(A) (West 2018).

183 See, e.g., W. VA. CODE ANN. §§ 41-4-1, 41-4-2 (LexisNexis 2018).

184 4 HERBERT THORNDIKE TIFFANY & BASIL JONES, THE LAW OF REAL PROPERTY § 1125 (3d ed. 1975).

185 Solomon, *supra* note 177, at 57. (Solomon further explains that the objective was to "maintain a landed aristocracy and to concentrate the ownership of real property . . .").

186 26B C.J.S. *Descent and Distribution* §§ 17, 46 (2018); Solomon, *supra* note 177, at 52-53.

187 RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 2.4 cmt. d (AM. LAW INST. 2003) (commenting that "any benefits of the rule are outweighed by the administrative costs, which include tracing and accounting for accretions").

C. *The Elective Share*

The elective share replaces and seeks to remedy the inadequacies of the common law rights of dower and curtesy.¹⁸⁸ Dower was meant to save some of a man's property for his wife; nonetheless, widows could be left destitute due to the options their husbands could use to undermine the protection of dower.¹⁸⁹ But the elective share had its own shortcomings, the primary one being the ability of a predeceasing spouse to disinherit the surviving spouse by transferring property out of his estate prior to his death, and there being no limit on inter vivos transfers.¹⁹⁰ This had a disproportionate impact on women, who tended to outlive their spouses.¹⁹¹

The objective of the elective share, like the statutory allowances, is ostensibly to protect the surviving spouse by restraining the dead hand of the decedent spouse.¹⁹² One court has described the policy behind the elective share statute as a limitation “on a married person's power to dispose of his or her property.”¹⁹³ The

188 Haskins, *supra* note 112; Bernard S. Mark, *Questions and Answers about the Elective Share*, 93 N.J. LAW. 37, 37 (1980). Common law dower and curtesy have been abolished in almost all states. *Jerome v. Prob. Court of Barrington*, 922 A.2d 119, 122 (R.I. 2007). Some states have statutes that explicitly abolish dower and/or curtesy. *See, e.g.*, ALA. CODE § 43-8-57 (LexisNexis 2018); FLA. STAT. ANN. § 732.111 (LexisNexis 2018); 755 ILL. COMP. STAT. ANN. 5 / 2-9 (LexisNexis 2018); MD. CODE ANN., EST. & TRUSTS § 3-202 (LexisNexis 2018); MONT. CODE ANN. § 72-2-122 (West 2017); N.C. GEN. STAT § 29-4 (2018); OKLA. STAT. ANN. tit. 84, § 214 (West 2018); 33 R.I. GEN. LAWS § 33-25-1 (2018); OR. REV. STAT. ANN. § 112.685 (West 2017); TENN. CODE ANN. § 31-2-102 (2018); VA. CODE ANN. § 64.2-308.2 (2018); VT. STAT. ANN. tit. 14, § 302 (2018); WASH. REV. CODE ANN. § 11.04.060 (LexisNexis 2018); W. VA. CODE ANN. § 43-1-1 (LexisNexis 2018); WYO. STAT. ANN. § 2-4-101(b) (2018); *see also* UNIF. PROB. CODE § 2-112 (amended 2010); ATKINSON, *supra* note 3, at 62. An unusual forced share provision is Ohio's, which allows the surviving spouse to elect against the will and retain dower rights. OHIO REV. CODE ANN. § 2106.24 (LexisNexis 2018).

189 THOMAS L. SHAFFER ET AL., *THE PLANNING AND DRAFTING OF WILLS AND TRUSTS* 85–86 (5th ed. 2007) (mentioning conveyances before marriage and conveyances in lieu of dower).

190 ATKINSON, *supra* note 3, at 113.

191 *See* Adam J. Hirsch, *Freedom of Testation / Freedom of Contract*, 95 MINN. L. REV. 2180, 2231 (2011); *see also* LAWRENCE W. WAGGONER ET AL., *FAMILY PROPERTY LAW: CASES AND MATERIALS ON WILLS, TRUSTS, AND FUTURE INTERESTS* 598 (3d ed. 2002) (“Because women's average life expectancy is seven years longer than men's, the surviving spouse is more likely to be a woman.”).

192 Lewis M. Simes, *Protecting the Surviving Spouse by Restraints on the Dead Hand*, 26 U. CIN. L. REV. 1, 4 (1957).

193 *In re Estate of Jackson*, 194 P.3d 1269, 1274 (Okla. 2008).

policy is stated not as promoting a positive virtue, but as prohibiting a harmful act. It is contained within provisions speaking specifically to testators' capacity and powers. Although the election belongs to the surviving spouse,¹⁹⁴ its function is to prohibit the decedent from devising "away from the other so much of the estate of the testator that the other spouse would receive less in value than an undivided one-half (1/2) interest in the property acquired by the joint industry of the husband and wife during coverture."¹⁹⁵ Another formulation is to guarantee the surviving spouse at least an intestate share of the estate.¹⁹⁶ Thus, at their root, elective share statutes strive to protect the spouse against disinheritance.¹⁹⁷

Elective share statutes have not been entirely equal to the task, as cases illustrating the many methods of evading the widow's share attest.¹⁹⁸ Testators have been known to transfer assets into nonprobate vehicles within short periods of their death, thereby in essence defeating the surviving spouse's elective share.¹⁹⁹ This placed a termination of marriage by death in sharp contrast with divorce, where such maneuvers are impotent to defeat a spouse's right to

194 OKLA. STAT. ANN. tit. 84, § 44(B)(2) (West 2018).

195 *Id.* at § 44(B)(1).

196 *In re Estate of Davis*, 274 A.2d 491, 494 (Vt. 1971).

197 *In re Estate of Karnen*, 607 N.W.2d 32, 36 (S.D. 2000). These policies have little relevance in community property states where ownership of property is settled by different rules that render an elective share superfluous. DUKEMINIER, *supra* note 77, at 511; THOMAS L. SHAFFER & CAROL ANN MOONEY, *THE PLANNING AND DRAFTING OF WILLS AND TRUSTS* 76 (3d ed. 1991) ("Community property theory disposes of questions about a surviving spouse's share of a property-owner's wealth by making the spouses equal owners from the time property is acquired.").

198 W.D. MACDONALD, *FRAUD ON THE WIDOW'S SHARE* 67–258 (1960); SHAFFER & MOONEY, *supra* note 197, at 77–8 (revealing intent, reality and control to be the three "schools of thought" in such cases); Abraham M. Mora & Sanford J. Schlesinger, *Reforming Florida's Elective Share Law: Is the Cure Worse Than the Disease?*, 72 FLA. B.J. 44 (1988); *Staples v. King*, 433 A.2d 407, 408 (Me. 1981); *Siefert v. Southern Nat'l Bank of South Carolina*, 409 S.E.2d 337, 338 (S.C. 1991).

199 Mora & Schlesinger, *supra* note 198 (citing, e.g., *Friedberg v. Sunbank/Miami, N.A.*, 648 So. 2d 204 (Fla. Dist. Ct. App. 1995)); William D. McEachern, *The Elective Share*, 56 FLA. B.J. 648, 648 (1982); Bernard S. Mark, *Questions and Answers about the Elective Share*, N.J. LAW. 37, 37 (1980); Tanick & Johnson, *Probate Reform: The New Minnesota Elective Share Statutes*, 70 MINN. L. REV. 241, 244, 246 (1985) (distinguishing between inter vivos transfers of property over which the decedent retained control and of property to which he relinquished all control); Helene S. Shapo, *The Widow's Mite Gets Smaller: Deficiencies in Illinois Elective Share Law*, 24 S. ILL. U. L.J. 95, 98 (1999).

equitable distribution of the marital property.²⁰⁰ Policymakers and commentators have queried why the same prohibition should not apply to estates.²⁰¹ Why, for example, should a surviving spouse receive permanent support when the marriage ends due to divorce rather than death?²⁰² To address the disparity between the ramifications of marital dissolution during life and marital dissolution because of death, legislators in some states have reformed elective share law by expanding its scope to what is now known as the “augmented estate.”²⁰³ Courts, too, have issued policy-based decisions enlarging the amount of the estate for elective-share purposes where the estate subject to the elective share was legislatively limited to the probate estate.²⁰⁴ Not all commentators believe these decisions are defensible. Martin Begleiter, for example, believes they are products of judicial activism.²⁰⁵

The augmentation of the decedent’s estate is accomplished by including within the property subject to the elective share transfers the testator made during the marriage to a third party “without the spouse’s written consent,” and for which the decedent did not receive “adequate compensation.”²⁰⁶ Also included are gifts made within one year of death that exceed \$30,000 and transfers to nonprobate vehicles or property held in nonprobate vehicles over which the decedent retained an interest or control.²⁰⁷ Finally, the augmented

200 Mora & Schlesinger, *supra* note 198, at 44.

201 See, e.g., Angela M. Vallario, *The Elective Share Has No Friends: Creditors Trump Spouse in Battle over the Revocable Trust*, 45 CAP. U. L. REV. 333, 338 (2017). One suggestion for reform has been instead to set up a system of maintenance payments, the amount of which would be established by reference to a set of factors, much the way spousal maintenance is set for divorcing spouses. Plager, *supra* note 142, at 682, 715 (remarking on the need for “individuation”).

202 See Laura Hamister, *‘Til Death or Irreconcilable Differences Do Us Part: Comparison of Support Obligations at Death and Divorce*, 22 J. CONTEMP. LEGAL ISSUES 29, 46 (2014–15).

203 BRASHIER, *supra* note 2, at 18; DUKEMINIER, *supra* note 77, at 511. An early example, presuming certain conveyances to be fraud, is MO. ANN. STAT. § 474.150 (West 2018).

204 See, e.g., *Sullivan v. Burkin*, 460 N.E.2d 572, 576–77 (Mass. 1984).

205 See, e.g., Martin D. Begleiter, *Grim Fairy Tales: Studies of Wicked Stepmothers, Poisoned Apples, and the Elective Share*, 78 ALB. L. REV. 521, 537–38 (2014–15) (arguing that expanding the definition of the estate subject to the elective share beyond what is specified in legislation is an impermissible exercise of judicial power).

206 Tanick & Johnson, *supra* note 67, at 249.

207 *Id.*, *supra* note 67, at 252–53; see, e.g., *In re Vitelli*, 231 N.Y.L.J. 31 (N.Y. Sur. Ct. 2004) (employee’s death benefit).

estate includes property the surviving spouse “derived” from the decedent.²⁰⁸ Although “[t]he augmented estate specifically does not include funeral and administrative expenses, the homestead, family allowances and exemptions, liens, mortgages, and enforceable claims,”²⁰⁹ the elective share is reduced by what the spouse receives under the will, including the present value of a life estate in trust,²¹⁰ and is thus referred to in some statutes as the “net elective share”²¹¹ or a limited election.²¹² In this sense, the theory of the elective share is not to reject the will but to supplement bequests in the will.²¹³

The elective share can further be shaped to reflect equitable distribution law by calibrating the amount of the share to the length of the marriage, with a longer marriage entitling the surviving spouse to a larger elective share.²¹⁴ This is true in Kansas and under the Uniform Probate Code, but their provisions nonetheless specify that the spouse is entitled to at least \$50,000 and \$75,000, respectively.²¹⁵

The effort to make the elective share track the law of equitable distribution upon divorce is grounded in the view that equitable distribution treats marriage as an economic partnership and that the elective share should do likewise.²¹⁶ Legislatures and the judiciary have been quite plain in theorizing that equitable distribution should be a recognition of the marital economy, leaving questions of support to be dealt with under alimony laws. Within equitable distribution, a spouse leaves the marriage with whatever she came to it with.²¹⁷ Her separate property is not considered part of the marital economy unless its value has been enhanced through

208 In one case, this included assets received by the surviving spouse from the decedent in a divorce; they later remarried. *In re Estate of Zimmerman*, 633 N.W.2d 594, 600–01 (N.D. 2001).

209 Tanick & Johnson, *supra* note 67, at 251 n.49.

210 *See, e.g., In re Estate of Karnen*, 607 N.W.2d 32, 36–38 (S.D. 2000).

211 *See, e.g., N.Y. EST. POWERS & TRUSTS LAW* § 5-1.1A(a)(4) (LexisNexis 2018).

212 *In re Rosenzweig’s Will*, 224 N.E.2d 705, 709 (N.Y. 1966).

213 *Estate of Fischer*, 545 A.2d 1266, 1271–72 (Me. 1988).

214 *See, e.g., COLO. REV. STAT.* § 15-11-202(1) (2018); *N.C. GEN. STAT.* § 30-3.1 (2018).

215 *KANS. STAT. ANN.* § 59-6a202(b) (West 2018); *UNIF. PROB. CODE* §§ 2-202(b), 2-203(b) alt. A (amended 2010).

216 *WAGGONER ET AL.*, *supra* note 191, at 592(referring to the “pressure on separate-property states” to reform their elective share law to conform with the partnership theory of equitable distribution).

217 *N.Y. DOM. REL. LAW* § 236-B(5)(b) (LexisNexis 2018).

the toil of the other spouse.²¹⁸ The marital property is distributed equitably.²¹⁹ The court uses a list of factors to accord each party a fair share of the marital assets.²²⁰ In most cases, fault in causing the breakdown of the marriage is irrelevant.²²¹ The only bad acts that are relevant to equitable distribution are acts that have harmed the marital economy or are particularly egregious.²²²

The elective share, though, does not resemble this scheme. First, it makes no distinction between marital and separate property.²²³ It also does not take into account the needs of the surviving spouse. If the elective share were meant to foster fairness in the distribution of marital assets it would more closely resemble community property principles where the law prevents the decedent's will from controlling any portion of the surviving spouse's 50% share of the community property and at the same time leaves the decedent with full control over his share of the community property and his own separate property. For this reason, the elective share is not recognized in community property states.

The Uniform Probate Code has famously fashioned an elective share whose express purpose is to reify an economic partnership of marriage,²²⁴ albeit without the lengthy list of factors that courts apply with significant discretion when a marriage ends in divorce.²²⁵ The overriding factor is the duration of the marriage, which has the effect of decreasing or eliminating the elective share where a marriage of brief duration disabled the spouse from contributing to the other's wealth.²²⁶ At the margins, even a fault analysis enters in here: as mentioned above, fault is irrelevant to equitable distribution unless it is economic or egregious. It thus stands to reason that the Uniform Probate Code deprives an individual who slays her spouse

218 Price v. Price, 503 N.E.2d 684, 685 (N.Y. 1986).

219 N.Y. DOM. REL. LAW § 236-B(5)(c) (LexisNexis 2018).

220 *Id.* § 236-B(5)(d).

221 Smith v. Smith, 331 S.E.2d 682, 683 (N.C. 1985).

222 Smith, 331 S.E.2d at 683; Howard S. v. Lillian S., 928 N.E.2d 399, 401 (N.Y. 2010).

223 HASKELL, *supra* note 64, at 153 ("The forced share, however, is not limited to the earnings accumulated during the marriage. It is also available to the working husband who survives the homemaking wife whose estate consists of inherited wealth from her parents. The forced share is also available to the surviving spouse of the second marriage late in life during which there was no homemaking or wealth accumulation.").

224 UNIF. PROB. CODE art. II, pt. 2 cmt. at 140 (amended 2010).

225 *See, e.g.*, Smith v. Smith, 444 S.E.2d 420, 422 (N.C. 1985) (listing factors).

226 UNIF. PROB. CODE art. II, pt. 2 gen. cmt. at 140, 142–43 (amended 2010).

not only of her intestate share or her share under the will but of her elective share as well.²²⁷ But oddly, *economic* fault appears not to be a relevant consideration under the Uniform Probate Code's version of the elective share, undermining the sense that recognizing marriage as an economic partnership is the Code's true rationale.

The Uniform Probate Code's elective share also embodies a support feature in the form of a "hardship" provision recognizing that even those who may not be entitled to an elective share may need "a special supplemental elective-share amount" to be capable of supporting themselves.²²⁸ The provision most resembles alimony, more commonly known today as spousal maintenance. Spousal maintenance at divorce is established according to a list of factors that enables the court to calculate the non-monied spouse's need for support.²²⁹ Fault in breaking up the marriage is a relevant consideration, the theory being that the monied spouse should not have to support a former spouse outside of marriage if that spouse is at fault for the breakdown of the marriage. A surviving spouse, by contrast, receives an elective share whether or not she has economic needs exacerbated by the decedent's death. Likewise, her fault, short of slaying her spouse, does not deprive her of an elective share.

The drafters of the Uniform Probate Code admit that there is no indication that extant elective-share laws embody an ethic of support.²³⁰ Statutory provisions governing the elective share have by and large also not embraced the notion of marriage as an economic partnership, and a few commentators have argued that the Uniform Probate Code does so awkwardly.²³¹ After all, the typical elective share does not come close to giving the surviving spouse the equivalent of an intestate share, and if we assume that the reasonable testator, had he embraced the partnership aspect of his marriage, would have

227 UNIF. PROB. CODE § 2-803(a) (amended 2010), 8 pt.1 U.L.A. (2013); see also RESTATEMENT (THIRD) OF PROP.: WILLS AND OTHER DONATIVE TRANSFERS § 8.4 cmt. j (AM. LAW INST. 2003); Mary Louise Fellows, *The Slayer Rule: Not Solely a Matter of Equity*, 71 IOWA L. REV. 489, 505 n.55 (1986).

228 UNIF. PROB. CODE art. II pt. 2 cmt. at 140, 143, 147 (amended 2010).

229 See, e.g., *Hastings v. Hastings*, 497 S.E.2d 203, 207 n.8 (W. Va. 1997).

230 UNIF. PROB. CODE art. II, pt. 2 gen. cmt. at 147 (amended 2010) ("Current elective-share law implements this theory poorly.").

231 *Margaret v. Turano*, *UPC Section 2-201: Equal Treatment of Spouses?*, 55 ALB. L. REV. 983 (1992); Mary Moers Wenig, *The Marital Property Law of Connecticut: Past, Present, and Future*, 1990 WIS. L. REV. 807; Charles H. Whitebread, *The Uniform Probate Code's Nod to the Partnership Theory of Marriage*, 11 PROB. L.J. 125 (1992); Ellen J. Beardsley, *The Revised UPC Elective Share: Missing Essential Partnership Principles*, 13 QUINNIPIAC PROB. L.J. 225 (1998).

bestowed at least as much on his surviving spouse as pretermitted-spouse statutes do, we are faced with very little support for the economic partnership idea.²³² From this intestacy perspective, the elective share appears to be more promotive of testamentary freedom. It allows the testator to contradict the assumptions upon which intestacy law is built and then, only if the surviving spouse complains, scales them back to an amount less than what society has deemed she should receive in intestacy. Less support for the theory of marriage as an economic partnership can scarcely be imagined.

The question becomes, then, whether the elective share, like other forms of family protection in succession law, protects the surviving spouse against penury. There is reason to call this rationale into question. First, because an assessment of the surviving spouse's needs is not part of the elective-share calculus, as it is, for example, with respect to the family allowance, a forced share will typically "give a spouse more or less than is necessary for support."²³³ Over- and under-protection of a surviving spouse's need for support does not establish that support is not an important driver of elective-share policy. But cutting substantially against the support theory is that the elective share, unlike other family protection measures that are clearly meant for support,²³⁴ does not take priority over the estate's debts, security interest and liens.²³⁵

Some commentators, acknowledging the schizophrenic nature of elective-share laws, have become convinced that the statutes are meant *both* to provide support to the surviving spouse and to compensate her for her contributions to the marriage.²³⁶ As discussed above, there is little evidence to support such a proposition. Left with no support for either the avoidance-of-penury or the economic-partnership theory, we are left to compare the elective share with the regime it replaced. As a replacement for dower,²³⁷ the elective share

232 UNIF. PROB. CODE art. II pt. 2 gen. cmt. at 141 (amended 2010) ("The original elective-share fraction of one-third of the decedent's estate plainly does not implement a partnership principle.").

233 WILLIAM M. MCGOVERN ET AL., WILLS, TRUSTS AND ESTATES INCLUDING TAXATION AND FUTURE INTERESTS 89 (1988); *see also* UNIF. PROB. CODE art. II, pt. 2 gen. cmt (amended 2010) ("Current elective-share law implements this theory poorly.").

234 *See supra* Part III.A.

235 *See, e.g.*, N.Y. EST. POWERS & TRUSTS LAW § 5-1.1A (LexisNexis 2018).

236 Mora & Schlesinger, *supra* note 198; DUKEMINIER, *supra* note 77, at 514.

237 Note that some states have retained dower, *e.g.*, Ohio. *See, e.g.*, OHIO REV. CODE ANN. § 2103.02 (LexisNexis 2018).

may have been intended to override dower's purpose to protect and provide for the widow against disinheritance.²³⁸ Dower is, in most iterations, merely a life estate.²³⁹ During her lifetime, the surviving spouse has limited control over the assets that comprise her dower. At her death, she has no dispositional control over what is left over. The elective share is distinct: it is less protective than dower because it gives the surviving spouse no protection against the decedent spouse's creditors. It does, however, give the surviving spouse more dispositional control than does the typical provision for dower.²⁴⁰ As a replacement for dower, then, elective share appears to emphasize fairness rather than protection. Because the elective share is an election of the surviving spouse, it has little to do with whether a testator attempted deliberately to prevent her from benefiting from his estate. This is because the surviving spouse may exercise the election even if she is named a beneficiary of the estate. The elective share not only gives the surviving spouse the right to benefit from the estate but the opportunity to claim *a larger share* of the assets than the testator provided.²⁴¹ A concern about disinheritance by itself does not explain these mechanics. The protective function is thus secondary to some concern about fairness, with the surviving spouse vested with the right to make the decision on her own. Whether this is fairness concerning the marital economy can well be doubted, as most elective share provisions take no account of the contributions of the surviving spouse.

Thus, although it is an unsatisfying conclusion, the elective share does not track either of the common rationales for family protection provisions. As Ralph Brashier has noted, “[c]onventional elective-share laws are typically simple but completely arbitrary; they make no pretense that spouses are participants in a partnership. [The n]eeds of the surviving spouse and length of the marriage are irrelevant under the conventional elective share, which generally provides the surviving spouse with a fixed fractional part of the decedent's estate.”²⁴² The protection afforded by the elective share, then, must have something to do with the threat of disinheritance on another level. Under the elective share, disinheritance is not perceived as the threat it is when it comes up against policies of

238 See HASKELL, *supra* note 64, at 150, 153, 155.

239 See, e.g., OHIO REV. CODE ANN. § 2103.02 (LexisNexis 2018).

240 HASKELL, *supra* note 64, at 150.

241 BRASHIER, *supra* note 2, at 14–15.

242 *Id.* at 38.

support and deservedness; thus, the share does not match our assumptions about what testators who do not want to disinherit their spouses would do. This understanding that the elective share is an entitlement to property by virtue of having survived the decedent as his spouse, and nothing more, seems to have been overlooked in the literature. Haskell comes closest to detecting it: “the forced share may be justified as the sharing which inheres in the marriage relationship regardless of financial need or compensation.”²⁴³ “It never exceeds the intestate share; it would make no sense to provide for a fraction which exceeded that which would pass to the spouse if there were no disinheriting will.”²⁴⁴ The real point, though, is that it *does* make sense to provide for a fraction *less* than what would pass to the spouse if there were no disinheriting will.

IV. Creditor’s Rights and Family Protection

Up to this point, this article has focused primarily on what form of protection legislatures are advancing when they enact family protection statutes. Do family protection regimes serve primarily the interests of the decedent or those of the survivors? When we say that disinheritance is the primary issue family protection measures are attempting to address, the answer, as the foregoing analysis reveals, is both. What is missing, then, is the dimension of family protection laws that is hiding in plain sight: the interests of creditors. Discussion of the precise interest of creditors in this context is scant in jurisprudence, beyond the very general admonition specifying that an important legislative purpose behind probate laws is “the prompt settlement of estates.”²⁴⁵ Delving more deeply into the role creditors play in schemes meant to protect the family is imminently more revealing about the policies behind those schemes than are the largely unexamined statements, contested in Part II, that they promote policies of support and fairness.

A. Creditors in Probate Law

As a general matter, creditors of a decedent’s estate have priority over legatees,²⁴⁶ whether or not a will contains a “just debts”

243 HASKELL, *supra* note 64, at 153.

244 *Id.* at 151.

245 UTAH CODE ANN. § 75-3-101 (LexisNexis 2018).

246 *In re Estate of Farren*, 131 A.3d 817, 840 (Del. Ch. 2016) (noting the general priority that creditors’ claims have over bequests in the will).

clause.²⁴⁷ This rule is not affected by any provisions in the will, even a clause attempting to elevate a pecuniary legacy to the level of a “just debt.”²⁴⁸ One wills law doctrine of specific interest to creditors is the exoneration of liens. The doctrine states that liens on real property shall be satisfied with other assets in the estate and pass unencumbered to the beneficiary unless the will expresses a contrary intention.²⁴⁹ A just debts clause is not required for the exoneration of liens doctrine to apply but may be used as evidence supporting its application.²⁵⁰ Many states have abolished the exoneration of liens doctrine by statute, leaving real estate to pass encumbered to the named beneficiary unless the will specifically directs otherwise.²⁵¹ A just debts clause by itself would not be sufficient to alter this result.²⁵²

Family protection schemes provide prophylaxis against penury for surviving spouses and children, but the matter is not as simple as saying that creditors must take a back seat to the protection of the family. Probate law has traditionally favored creditors over heirs and will beneficiaries.²⁵³ For example, intestate takers may take nothing under intestacy provisions if the testator’s entire estate is required for the satisfaction of her debts. Efforts to protect the family, then, “must strike some balance between the need to protect the immediate family and the desire to protect the creditors of the decedent.”²⁵⁴ Striking this balance is the aim of measures that entitle creditors to payment from the decedent’s estate in accordance with a system that classifies their claims. Funeral expenses, the costs of the decedent’s last illness, and the family allowance often have the highest priority, followed by debts owed in the form of wages to employees, taxes and rents, and finally obligations in the form of judgments and contracts.²⁵⁵

247 97 C.J.S. *Wills* § 2222 (2018) (noting that a just debts clause “is meaningless as to actual debts”).

248 *Id.*

249 *Estate of Fussell v. Forney*, 730 S.E.2d 405, 410 (W. Va. 2012).

250 *See, e.g., id.* at 411.

251 *Id.* at 410.

252 *Id.* (noting Ohio’s provision denying exoneration “regardless of a general direction in the will to pay the testator’s debts . . .”). This is not to deny that extrinsic evidence in a case might show that the testator intended the just debts clause to effect exoneration of the mortgage. *See, e.g., In re Estate of Payne*, 895 A.2d 428, 435 (N.J. 2006).

253 97 C.J.S. *Wills* § 2222 (2018).

254 Schmidt, Jr., *supra* note 8, at 137.

255 *See, e.g., DEL. CODE ANN. tit. 12, § 2105* (2018); *TEX. EST. CODE ANN. §§*

Understanding the role creditors play in family protection mechanisms requires familiarity with the hierarchy among the statutory allowances. The Uniform Probate Code, for example, prioritizes the homestead allowance over the family allowance and the family allowance over the personal property set-aside.²⁵⁶ Since general creditors' claims are subordinate to these allowances, creditors are understandably keenly interested in the establishment of their value. For example, Missouri's statute allows creditors to participate in the determination of a reasonable family allowance.²⁵⁷ Once established, the family allowance is by no means sacrosanct. Although it has priority over the claims of general creditors, it is not allowed to extend beyond one year if the estate is "inadequate to discharge allowed claims."²⁵⁸ By contrast, a surviving spouse's creditors cannot compel her to renounce the will,²⁵⁹ but of course her own creditors may reach whatever she receives if she does: family protection measures, after all, "bar[] only the general creditors of the estate."²⁶⁰ Finally, it bears noting that a decedent's will may always provide "otherwise,"²⁶¹ affording the testator an indirect manner of protecting his creditors.

It goes without saying that the elective share is primary to the interests of the beneficiaries named in a will,²⁶² but it, like intestate and pretermitted shares, is not shielded from creditors; moreover, testators are free to specify the apportionment of responsibility for paying the elective share among the beneficiaries under the will.²⁶³

355.102, 355.103 (West 2017).

256 UNIF. PROB. CODE §§ 2-403 (amended 2008), 2-404 (amended 2010); *see also* ALA. CODE § 43-8-112 (LexisNexis 2018). *But see* VA. CODE ANN. § 64.2-309(B) (2018) (prioritizing the family allowance).

257 JOHN A. BORRON, JR. & DAVID ENGLISH, MISSOURI PRACTICE VOLUME 5B, PROBATE LAW & PRACTICE § 964 (3d ed. 1999).

258 CAL. PROB. CODE § 6543 (Deering 2018); Schmidt, Jr., *supra* note 8, at 141, 144.

259 Schmidt, Jr., *supra* note 8, at 145.

260 *Id.* at 140 (quoting *In re Wallace's Estate*, 246 P.2d 894, 901 (Colo. 1952) (emphasis added)). *But see* WASH. REV. CODE ANN. § 11.54.070(1) (LexisNexis 2018) (award to spouse is immune from her debts). I do not mean to suggest here that the surviving spouse's homestead rights are subject to the claims of her creditors. The theory behind the protection of the homestead is that it is not a part of the estate at all but is held personally by the surviving spouse. *See In re Wallace's Estate*, 246 P.2d 894, 901 (Colo. 1952).

261 Schmidt, Jr., *supra* note 8, at 141–42.

262 *In re Bassford's Will*, 127 N.Y.S.2d 653, 659 (Sur. Ct. 1953).

263 *See, e.g.*, N.Y. EST. POWERS & TRUSTS LAW §5-1.1-A(c)(2) (LexisNexis

Nonetheless, statutory allowances may not be charged against the elective share or charged against by the elective share;²⁶⁴ they are simply excluded from the value of the estate upon which elective or pretermitted shares are determined.²⁶⁵ Furthermore, it is important to highlight the lack of consistency among provisions exempting the family allowance and exempting property set-asides from claims for funeral expenses and the decedent's last illness.²⁶⁶ The relationship between creditors and statutory enactments that provide family protection is thus more complicated than meets the eye.

B. Family-Member Contract Creditors and Family Protection

Contracts to make a will are very often employed by spouses to ensure that the children of the marriage will be taken care of even if the surviving spouse remarries. Such contracts curtail the ability of the surviving spouse to alter his estate plan without the estate incurring liability.²⁶⁷ The potential for conflict arising from such contracts is great in a society where the incidence of "blended" families due to multiple marriages is high.²⁶⁸ Estate planning

2018); *In re Boschen's Will*, 137 N.Y.S.2d 8, 10 (Sur. Ct. 1954) (direction to leave trust provisions intact "as far as possible"); *In re Gingold's Will*, 127 N.Y.S.2d, 653, 659 (Sur. Ct. 1952) (direction to pay elective share exclusively from residuary devise). As a practical matter, however, rare is the will that specifies how the elective share will impact the gifts to the other beneficiaries, R.D. Hursh, Annotation, *Who Must Bear Loss Occasioned by Election Against the Will*, 36 A.L.R.2d 291, § 3 & n.2 (1954), and this may be due to testators' failure to consider the possibility that his spouse will choose to elect against the will, see, e.g., *In re Rosenzweig's Will*, 224 N.E.2d 705, 199 (N.Y. 1966); Note, *Salvaging a Will after the Widow Renounces*, 61 HARV. L. REV. 850, 851 (1948); ATKINSON, *supra* note 3, at 123 ("[S]eldom does the will indicate that the testator contemplated his spouse's renunciation, much less what should be done in that event.").

264 ALASKA STAT. § 13.12.202(c) (2018); FLA. STAT. ANN. § 732.2105 (LexisNexis 2018); KANS. STAT. ANN. § 59-6a202(c) (West 2018); MASS. ANN. LAWS ch. 190B, § 2-404(b) (LexisNexis 2018); VA. CODE ANN. §§ 64.2-308.3(B), 64.2-309(C), 64.2-310(C), 64.2-311(D) (2018).

265 See, e.g., FLA. STAT. ANN. § 732.402 (LexisNexis 2018); NEB. REV. STAT. ANN. § 30-2314(a) (LexisNexis 2018).

266 See *supra* note 104. See generally William W. Horne, Jr., *Family Protection in New York: A Proposal*, 47 ALB. L. REV. 1343, 1360-62 (1983); Bratt, *supra* note 163, at 402-04.

267 Carolyn L. Dessin, *Troubled Relationship of Will Contracts and Spousal Protection: Time for an Amicable Separation*, 45 CATH. U. L. REV. 435, 438-39 (1996) (noting that contracts relating to wills do not technically prevent testator from changing his will).

268 Plager, *supra* note 142, at 687; Dessin, *supra* note 267, at 435 (noting that "the

professionals recognize that the society we now live in is one where many, if not most, first marriages do not last and testators may have been twice or three times married before they die.²⁶⁹ Contracts in this context may be used to prevent the children of a first marriage from taking nothing from their deceased parent's estate because he has left all of his property to his surviving second spouse. One perennial issue is the extent to which the survivor of the contracting parties may consume the property that would otherwise go to her deceased spouse's children on her death.²⁷⁰ But an even more enduring issue is the right of a surviving second spouse or a child of the second marriage to claim statutory protections that conflict with the terms of the contract. A variety of rationales have led courts to reach opposing outcomes. Moreover, these conflicting conclusions are difficult to harmonize across jurisdictions.

Contracts to make or not to revoke a will are enforceable obligations, the breach of which gives rise to a claim for money damages or equitable relief.²⁷¹ Scoles and Halbach explain how such claims are pursued outside of the probate system:

The contract cannot be probated, for example, if the will is not made; nor can a revoked will be probated even if its revocation was in violation of a contract. Also a contract generally cannot be used to oppose probate of an inconsistent will because the remedy for breach is not at probate.²⁷²

Breach of such a contract gives rise to an action for a constructive trust or damages against the estate or the devisees.²⁷³

The important question for family protection is not so

growing number of multiple marriages has helped set the stage for a conflict that often occurs between the children from one marriage and the spouse of another").

269 George B. Kozol, *State Elective Share Laws*, 60 J. OF FIN. SERV. PROFESSIONALS, March 2006, at 27, 28; Mora & Schlesinger, *supra* note 198, at 44, 46.

270 Phillip E. Hassman, Annotation, *Right of Party to Joint or Mutual Will, Made Pursuant to Agreement as to Disposition of Property at Death, to Dispose of Such Property During Life*, 85 A.L.R.3d 8 (1978); SCOLES, ET AL., *supra* note 150, at 221.

271 SCOLES ET AL., *supra* note 150, at 207–08.

272 *Id.*; see, e.g., WASH. REV. CODE ANN. § 11.12.060 (LexisNexis 2018).

273 *Shimp v. Huff*, 556 A.2d 252, 258 n.4 (Md. 1989); *Shimp v. Shimp*, 412 A.2d 1228, 1236 (Md. 1980); SCOLES, *supra* note 150, at 221; DUKEMINIER, *supra* note 77, at 325.

much whether the contract has been breached, but rather the more common scenario where the decedent promises to bequeath property to his children from his first marriage. The decedent usually does *not* breach the contract but instead remarries. When he dies, the surviving spouse brings a claim for statutory allowances or an elective or pretermitted share, damaging the expectations of the children of the first marriage. Do the contract beneficiaries become creditors of the estate and achieve priority over claims for statutory shares or allowances? In all likelihood, no: as noted above, statutory allowances take priority over the claims of contract beneficiaries.²⁷⁴ The real controversy is whether a contract beneficiary should take precedence over the elective or pretermitted shares, given that all of these claimants' rights are subject to creditors' claims.²⁷⁵ As Scoles and Halbach note, "[t]his problem arises with some frequency, and the cases are split."²⁷⁶ Carolyn Dessin goes further in describing this area of the law as "a tangled mess of decisions."²⁷⁷

This section will discuss a handful of these cases in chronological order, beginning with a decision of the New York Court of Appeals from 1967 and ending with a decision of the Court of Appeals of Alabama from 1997. But first, an illustration demonstrating that we are dealing here exclusively with the probate estate; there is no question raised about augmenting the estate with other assets. In *Norris v. Bradshaw*, there was no contract either to make or not to revoke a will.²⁷⁸ The decedent made a gift to his son-in-law several years after his marriage to the surviving spouse.²⁷⁹ The surviving spouse sued to claw back the gift, arguing that the family allowance was a debt encumbering the gift at the time it was made.²⁸⁰ The court reasoned that a claim to a family allowance has no existence during a marriage, and thus there was no basis for the surviving spouse's argument that she was a creditor of the decedent at the time he made the gift and that the debt somehow encumbered

274 See, e.g., *Patecky v. Friend*, 350 P.2d 170, 177 (Or. 1960); *Shimp*, 556 A.2d at 264 (holding that the family allowance has priority over "the claims of ordinary contract creditors and legatees under a will").

275 See, e.g., FLA. STAT. ANN. § 733.805(1) (LexisNexis 2018); N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A(a)(2) (LexisNexis 2018).

276 SCOLES ET AL, *supra* note 150, at 221.

277 Dessin, *supra* note 267, at 457.

278 *Norris v. Bradshaw*, 45 P.2d 638 (Colo. 1935).

279 *Id.* at 638.

280 *Id.*

the gift.²⁸¹ *Norris* establishes an important baseline: statutory allowances and the elective share do not create rights before a decedent's death. Surviving family members are thus not creditors of the estate based on family protection provisions alone. They may become creditors, however, based on contracts the decedent enters into during his lifetime that burden his estate at the time of his death.

In *Rubenstein v. Mueller*, married couple Bertha and Conrad bound themselves, via a joint and mutual will, to bequeath their entire estate to certain beneficiaries.²⁸² Bertha died first, and Conrad then married Martha and, in a new will, made her his sole beneficiary.²⁸³ The court determined that this new will, though admitted to probate, was ineffective to bar the claims of the beneficiaries who were supposed to take Conrad and Bertha's collective property pursuant to the joint will and that a constructive trust would be imposed in the beneficiaries' favor upon any property received by Martha from Conrad's estate.²⁸⁴ Martha attempted to undermine this result by claiming a forced share, arguing that public policy "guarantee[s] the widow a distributive share in her husband's estate [and] constitutes a limitation upon the right of a party to a joint will to bind himself to a testamentary arrangement which would not provide a surviving spouse with such a share in his estate."²⁸⁵ The court held for the beneficiaries, reasoning that, having promised all of his probate estate to the beneficiaries, "[Conrad] had no property interest in these assets against which his widow's right of election could operate."²⁸⁶ The agreement had, in effect, transformed his title in his property into a mere life estate with the power to consume.²⁸⁷

In the course of its analysis, the *Rubenstein* court distinguished *In re Hoyt's Estate*, wherein the decedent had entered into a marital termination agreement with his first spouse to establish a \$1.5 million testamentary trust for her and their children.²⁸⁸ Hoyt, having remarried, complied with this obligation.²⁸⁹ He died less than four

281 *Id.* at 639. *Cf. In re Estate of Fox*, 440 N.Y.S.2d 811, 814 (Sur. Ct. 1981) (elective share did not apply to assets outside of the estate).

282 *Rubenstein v. Mueller*, 278 N.Y.S.2d 845, 847 (1967).

283 *Id.*

284 *Id.* at 848.

285 *Id.* at 847.

286 *Id.* at 849.

287 *Id.*

288 *In re Estate of Hoyt*, 174 Misc. 512, 513 (N.Y. Sur. Ct. 1940).

289 *Id.*

years after his remarriage.²⁹⁰ The surviving spouse applied for a forced share in the amount of one-third of the estate and argued that she should have priority over the establishment of the trust.²⁹¹ In response, the trust beneficiaries claimed that they were creditors of the estate and that the forced share should be paid out of what remained of the estate after the trust was funded.²⁹² Although the priority of the general creditors' claims over the elective share was not questioned, those creditors and the surviving spouse claimed that the trust beneficiaries were not general creditors and that the surviving spouse's elective share had priority over their rights under the separation agreement.²⁹³ The court agreed, reasoning that a debt owed to a general creditor is a promise to convey property, whereas a contract to make a testamentary provision is not; its breach cannot transform the expectant beneficiary into a creditor but merely entitle her to an action in equity to enforce the obligation.²⁹⁴ Citing precedent, the court suggested that the ex-spouse could be deemed a creditor of the estate only if the agreement expressly gave her that status.²⁹⁵ Since the testator in this case had performed the obligation to set up the trust in the amount agreed to, there was no breach of contract in any event.²⁹⁶ The fact that the trust could not be funded in the amount agreed to because of the priority of the surviving spouse's election did not constitute a breach of contract.²⁹⁷ Since the expectant beneficiaries were in no measure elevated to the status of creditors, "they take subject to the operation of the statutes relating to testamentary dispositions, including the right of the surviving widow to take her [elective] share Their rights are also subordinate to all true creditors of the estate."²⁹⁸

In re Beeruk, a Pennsylvania decision, is in substantial conformity with *Rubenstein*.²⁹⁹ In this case, the testator contracted

290 *Id.*

291 *Id.* at 514.

292 *Id.*

293 *Id.* at 512.

294 *Id.* at 515.

295 *Id.* at 514–15.

296 *Id.* at 516 ("The testator performed that agreement. He undertook to do no more.").

297 *Id.*

298 *Id.* at 516.

299 *Compare In re Estate of Beeruk*, 241 A.2d 755, 759 (Pa. 1968) (holding that beneficiary of testamentary contract was a creditor of the estate with priority over the surviving spouse's elective share), *with Rubenstein v. Mueller*, 278 N.Y.S.2d 845, 849 (1967) (holding that the testamentary agreement

to give his entire estate to his nephew and did so in a duly executed will.³⁰⁰ He later remarried and executed a new will bestowing the residue of his estate upon his wife.³⁰¹ The *Beeruk* decision states with certainty that under the contract the nephew became a creditor of the estate and thus had priority over the elective share.³⁰² *In re Dunham's Will*, on the other hand, tilts in the direction of *Hoyt*.³⁰³ Pursuant to a separation agreement, Walter agreed to bequeath certain property to Mary, his ex-wife.³⁰⁴ He did so and also remarried. When he died, his second wife claimed her elective share.³⁰⁵ Thirty years after the decision in *Hoyt*, the *Dunham* court chose not to focus on whether an agreement to make a will elevates the contract beneficiaries to the status of creditors but instead emphasized that public policy dictates that "a man who is obligated to support his wife during his lifetime should not by his will be permitted to disinherit her."³⁰⁶ Because of this policy, the court reasoned that it is not possible for "a married person to bind himself by contract to devise or bequeath property by will in a manner that would deprive his surviving spouse of her statutory rights."³⁰⁷

Contracts to make or not to revoke a will can also arise and conflict with pretermitted heir statutes. A case of this type is *Dotson v. Dotson*.³⁰⁸ In *Dotson*, having no children of their own, married couple Elbert and Irma executed a joint will that benefited Elbert's nephew Robert and Irma's daughter Deborah.³⁰⁹ After this will was executed, the couple had a son, Mark.³¹⁰ Elbert's death triggered the provision that Irma and Robert would divide his estate, but Irma argued that Mark was entitled to all of Elbert's estate as a

transformed the decedent's title into a life estate with the power to consume).

300 *In re Estate of Beeruk*, 241 A.2d 755, 757 (Pa. 1968).

301 *Id.*

302 *Id.* at 759.

303 Compare *In re Dunham's Will*, 314 N.Y.S.2d 29, 35 (Sur. Ct. 1970) (basing holding that testamentary contract beneficiaries are not creditors on public policy that surviving spouse not be disinherited), with *In re Estate of Hoyt*, 174 Misc. 512, 515 (N.Y. Sur. Ct. 1940) (basing holding that testamentary contract beneficiaries are not creditors on distinction between a debt and a contract to make a testamentary devise).

304 *In re Dunham's Will*, 314 N.Y.S.2d 29, 30 (Sur. Ct. 1970).

305 *Id.*

306 *Id.* at 34–35.

307 *Id.* at 35.

308 *Dotson v. Dotson*, 372 S.W.3d 398 (Ark. Ct. App. 2009).

309 *Id.* at 399.

310 *Id.*

pretermitted child.³¹¹ The trial court agreed, despite the fact that the joint will constituted a contract.³¹² On appeal, the court recognized the potential for conflict between a contract not to revoke a will and protection for pretermitted children.³¹³ Without a great deal of analysis, the court held “that the rights of the after-born child must prevail,”³¹⁴ later remarking that an after-born child “is entitled to the highest level of protection.”³¹⁵ Note that when faced with a contract creditor, the court cannot simply claim that upholding the pretermitted child statute is necessary to carry out the decedent’s presumed intent. The decedent has arguably expressed his intent by entering into a contract regarding the disposition of his estate. He well understands that he has the choice to marry or have children and intends the contract creditor to take priority over their rights. A court asked to resolve the conflict thus has a choice between reasoning, as in *Hoyt*, that beneficiaries of will contracts are not true creditors; or holding, as in *Dotson*, that the overarching policy is to protect the omitted child. This latter position is tantamount to holding that a will contract contains an implied term making it contingent on the decedent’s not having another child.

This brings us to the most frequently cited opinions in this area, *Shimp v. Huff*³¹⁶ and *Via v. Putnam*.³¹⁷ In *Shimp*, the court made the implied-term rationale more explicit. The testator and his first wife had executed a joint and mutual will that was adjudged in an earlier case to constitute a binding contract.³¹⁸ Dicta in the opinion mentions the possibility that Lester Shimp might marry again and that his second spouse would simply have to accept whatever disadvantages the contract would impose upon her rights should Lester die before her.³¹⁹ At Lester’s death, his second spouse Lisa Mae sued for the right to elect against the will and for a family allowance.³²⁰ The court found in her favor, using reasoning that

311 *Id.*

312 *Id.* at 400. Irma raised the question in the appeals court whether the will constituted a contract. *Id.* at 402–03. The appeals court did not take up the issue because it was not properly appealed. *Id.* at 403.

313 *See id.* at 401–02.

314 *Id.* at 401.

315 *Id.* at 402.

316 *Shimp v. Huff*, 556 A.2d 252 (Md. 1989).

317 *Via v. Putnam*, 656 So. 2d 460 (Fla. 1995).

318 *Shimp v. Shimp*, 412 A.2d 1228, 1236 (Md. 1980).

319 *Id.* at 1235.

320 *Shimp v. Huff*, 556 A.2d 252, 255 (Md. 1989).

contradicted the previous decision to the effect that benefits under contracts not to revoke a will are “limited by the possibility that the survivor might remarry and that the subsequent spouse might elect against the will.”³²¹ This is because the protection accorded surviving spouses by forced share and family allowance legislation is prior to, and thus superior to, any contract rights a decedent might exercise to make a will or not to revoke one.³²² The court’s reasoning was thus grounded in the public policy “surrounding the marriage relationship” generally, and in favor of a surviving spouse’s right to elect against the will specifically.³²³ The court, in essence, read an implied term into the contract.

A precursor to *Via v. Putman* was *Johnson v. Girtman*.³²⁴ J.D. and Kate Girtman wanted their grandchildren to one day own a valuable parcel of land in downtown Miami.³²⁵ Instead of settling the parcel into a trust established to achieve this aim, the Girtmans conveyed it to their six children pursuant to a contract binding each of the children to devise his or her share of the property to their bodily heirs or, alternatively, their siblings.³²⁶ The agreement specifically stated that the grantees would provide for their spouses in their wills so that they could claim no dower interest in the parcel.³²⁷ The spouses, including Katherine Girtman’s husband Lee Johnson, signed a document promising that they would “take whatever steps necessary by deed or gift or otherwise to accomplish your desire that your grandchildren will ultimately inherit that [property].”³²⁸ When Katherine Girtman died, her will bequeathed her entire estate to Lee, and the surviving siblings sued to enforce the contract.³²⁹ The trial court determined that the contract was enforceable and that by signing the document, Lee had effectively waived his elective share with respect to the property.³³⁰ On appeal, Lee made several arguments, among them that “the Agreement and 1957 letter constitute an impermissible attempt to circumvent the spouse’s

321 *Via v. Putnam*, 656 So. 2d 460, 465 (Fla. 1995); *Putnam v. Via*, 638 So. 2d 981, 984 (Fla. Dist. Ct. App. 1994); *Shimp*, 556 A.2d at 263.

322 *Shimp*, 556 A.2d at 261.

323 *Id.* at 263.

324 *Johnson v. Girtman*, 542 So. 2d 1033 (Fla. Dist. Ct. App. 1989).

325 *Id.* at 1034.

326 *Id.*

327 *Id.*

328 *Id.*

329 *Id.* at 1035.

330 *Id.*

elective share.”³³¹ The argument failed because, among other reasons, Florida’s elective share statute, at the time this case was litigated, applied only to the net probate estate.³³² Given that the net probate estate does not include “valid claims against the estate,” including the contract Katherine signed, the Girtman parcel could not be included in any property against which Lee might take an elective share.³³³

Perhaps acknowledging the circularity of the reasoning in *Johnson*, the Supreme Court of Florida, in *Via v. Putnam*, disapproved of *Johnson* and embraced the reasoning in *Shimp*.³³⁴ The case involved a decedent, Edgar, who with his first wife Joann executed mutual wills naming the surviving spouse the beneficiary of the estate of the first to die and the couple’s children the beneficiaries upon the death of the survivor.³³⁵ Each will contained a binding term that it would not be revoked by the testator.³³⁶ Edgar outlived Joann and married Rachel, but he did not change his will after his remarriage.³³⁷ When Edgar died, Rachel claimed a pretermitted spouse’s share of the estate.³³⁸ The children sued the estate for breach of contract.³³⁹ The Court of Appeal characterized the quandary presented as follows: “If the appellees receive the residuary estate, Rachel will receive nothing except family allowance and any exempt property that may pass to her free from claims of creditors.”³⁴⁰ Although the trial court ruled in favor of the children,³⁴¹ the appellate courts disapproved of that result because of the strong public policy favoring the protection of a surviving spouse’s right to her deceased spouse’s estate.³⁴² Since marriage is “the most important type of contract ever formed,”³⁴³ testamentary contracts are “‘limited by the possibility that the survivor might remarry’”³⁴⁴

Commentators on the clash of will contracts and family

331 *Id.*

332 *Id.* at 1037.

333 *Id.*

334 *Via v. Putnam*, 656 So. 2d 460, 465–66 (Fla. 1995).

335 *Putman v. Via*, 638 So. 2d 981, 984 (Fla. Dist. Ct. App. 1994).

336 *Id.*

337 *Via v. Putnam*, 656 So. 2d 460, 461 (Fla. 1995).

338 *Id.*

339 *Id.*

340 *Putman v. Via*, 638 So. 2d 981, 982 (Fla. Dist. Ct. App. 1994).

341 *Id.*

342 *Via v. Putnam*, 656 So. 2d 460, 464–65 (Fla. 1995).

343 *Id.* at 465 (internal quotation marks omitted).

344 *Id.* (quoting *Shimp v. Huff*, 556 A.2d 252, 263 (Md. 1989)).

protection provisions have not been kind toward the decision in *Putnam* and, by extension, in *Shimp*. Adam Hirsch, for example, finds the decision indefensible because it fails to acknowledge that if the testator had breached the contract, Rachel would not have been a pretermitted spouse and would have had to settle for the lesser amount guaranteed by the elective share.³⁴⁵ But of more concern for our purposes is Hirsch's statement that the surviving spouse carries the day seemingly with an analysis that merely skims the surface and "reads more like an afterthought."³⁴⁶ In a related criticism, Carolyn Dessin opines that decisions of this sort generally cast about for the "'right' result" rather than grounding their analysis "on careful analysis or consistent policy."³⁴⁷

The policy puzzle in this area has indeed given rise to a cacophony of conflicting decisions. Although the cases are split, there appears, if *Putnam* and *Shimp* are any indication, to be a definite trend in the direction of upholding the statutory shares of a surviving spouse against contract beneficiaries.³⁴⁸ Nonetheless, "[i]n such a climate, the practitioner is ill-advised to bargain for testamentary benefits as part of a negotiated divorce settlement"³⁴⁹ because, given the microscopic discussion of policy in the decisions,³⁵⁰ it is next to impossible to predict the direction a court will take. Where one court makes an admittedly unconvincing distinction between contracts to make a will and marital termination agreements,³⁵¹ another court believes there is no valid distinction, that beneficiaries of both constitute creditors of the estate.³⁵² Where one court believes equity favors the surviving spouse,³⁵³ another court believes in strict

345 Hirsch, *supra* note 169, at 1356–57.

346 *See id.* at 1357.

347 Dessin, *supra* note 267, at 437.

348 *See id.* at 456 (citing MACDONALD, *supra* note 198, app. D at 368).

349 MARGARET VALENTINE TURANO, PRACTICE COMMENTARIES, in N.Y. EST. POWERS & TRUSTS LAW § 5-1.1-A (LexisNexis 2018).

350 *See* Peter B. Swann & Kevin J. Earnest, *Developments in Maryland Law: Property*, 49 MD. L. REV. 715, 734 (1990) (citing *Shimp v. Huff*, 556 A.2d 252, 263 (Md. 1989)) (noting the lack of analysis in *Shimp* regarding the policy behind Maryland's elective-share statute and why it assumed priority in the case).

351 *See, e.g.*, *Rubenstein v. Mueller*, 225 N.E.2d 540, 544 (N.Y. 1967).

352 Audley William Sheppard, *Contracts to Make Wills and the Family Protection Act of 1955: Is The Promisee a Creditor or a Beneficiary?*, VICT. U. WELLINGTON L. REV. 157, 159–60 (1985) (discussing *Schaefer v. Schuhmann* [1972] AC 572 (PC) (appeal taken from Austl.)).

353 *In re Estate of Beeruk*, 241 A.2d 755, 759 n.6 (Pa. 1968) (referring to the trial court's reasoning).

enforcement of contracts to devise.³⁵⁴ What policies are driving these decisions—“freedom of testation and sanctity of contract,” “adequate provision for dependants of deceased persons,”³⁵⁵ or none of these? When examined closely, the cases boil down to the question of who knew what when or, rather, who should be charged with notice that their position is or might be deemed subordinate to the rights of another.³⁵⁶ As the Supreme Court of Montana reasoned in the context of a judgment creditor who had attached property of the decedent prior to his death,

The creditor was aware of the family protection laws at the time he engaged in business with the debtor and knew that his remedy for breach might be subject to the same. Unlike a mortgage, a judgment lien does not create a vested right in a specific piece of property. Short of such a right, the existence of the lien should not prevent the property to which the lien attached from being marshalled as assets of the estate.³⁵⁷

This reasoning is a more pointed version of the remark made by the *Shimp* court and quoted above that a will contract beneficiary must realize that her “rights under the contract were limited by the possibility that the survivor might remarry and that the subsequent spouse might elect against the will,”³⁵⁸ reasoning that was overshadowed by the court’s subsequent discussion of the importance of marriage.³⁵⁹

In will contract cases, the policy choice is not plain. Surviving spouses might equally be deemed to understand that creditors

354 See, e.g., *Hudson v. Hudson*, 701 So. 2d 13, 15 (Ala. Civ. App. 1997). The courts in New Zealand have, similarly, reached contradictory decisions. See Sheppard, *supra* note 352, at 158.

355 Sheppard, *supra* note 352, at 158.

356 See, e.g., *Estate of Donner v. Anton*, 364 So. 2d 742, 748–51 (Fla. Dist. Ct. App. 1978) (disapproving of the idea that dower rights could in any way be interfered with by “contracts which he may have entered into without the wife’s actual knowledge or consent”); *Shimp v. Huff*, 556 A.2d 252, 263 (Md. 1989) [*Putnam v. Via*, 638 So. 2d 981, 984 (Fla. Ct. App. 1994)]. In *Patecky v. Friend*, lack of knowledge of the contract was equated with innocence; enforcing the contract in such circumstances would be “harsh, oppressive, or unjust . . .” 350 P.2d 170, 175–76 (Or. 1960) (citation omitted).

357 *In re Estate of Wilhelm*, 760 P.2d 718, 724 (Mont. 1988).

358 *Shimp v. Huff*, 556 A.2d at 261.

359 See *id.* at 261–62.

whose claims predate the marriage take precedence as creditors might be deemed to understand that a debtor might one day marry and subordinate their claims to the claims of the surviving spouse.³⁶⁰ The question is one of pure policy and should not be resolved upon the pretense that concepts such as constructive notice are in any way analogous so as to be reasonably applicable. Despite our conclusion in Part III that, for elective share purposes, marriage deserves special recognition, the courts have not decided whether marriage is so desirable that it deserves a degree of protection that would elevate it above the contracts the decedent entered into during his lifetime regarding the disposition of his estate. Suffice it to say that the fact that marriage is special and encouraged is too slender a reed upon which to build a theory of implied terms in contracts to make wills, especially those that were crafted to protect the family in the first place. For the time being, then, the policy behind family protection in the realm of will contracts will unfortunately remain amorphous.

V. Conclusion

As made clear above, protecting surviving spouses and dependent children is an overarching policy of the law of wills and intestacy. Alongside testamentary freedom and a commitment to promoting the presumed intent of intestate decedents, probate rules embrace the notion that the decedent's closest family members should not suffer disinheritance. Many defensible assumptions have been made about why the law should prohibit disinheritance in such cases. They range from ideas about testamentary intent itself to concepts about the need to provide support for surviving spouses and children and to recognize the surviving spouse's important contributions to the marital economy.

The remarkable diversity of family protection statutes canvassed in this article certainly does reflect a combination of concerns that decedents might use their testamentary freedom in ways that impoverish those who are dependent upon them or might be unfair to family members who have contributed in important ways to the accumulation of their wealth. Jurisprudence in this realm also underscores the point that where decedents have not made their testamentary preferences known, the law is justified in making assumptions, grounded in the role families play in society,

360 See, e.g., *Patecky v. Friend*, 350 P.2d at 176–77 (“[R]emarriage of either Samuel or Emma was within their contemplation when the contract was made and became a part thereof.”).

about whom the decedent would have wished to benefit and to what degree.

Where the jurisprudential trail goes cold, we must probe more deeply. The policies promoted by the elective share are not easily explained. The share is not merely a way of winding up the marital economy or providing support. If it were, the share would be something larger or more meager depending on the rationale. Placing the share somewhere in the middle of where it would fall if it were meant to recognize a marital partnership or offer support appears to balance the testamentary freedom of the disinheriting testator with a desire to reward the surviving spouse for remaining married to him until his death. Whether this rationale will be embraced by courts hearing cases involving contracts to make or not to revoke a will is something the scant and conflicting body of jurisprudence in that area does not yet reveal. The most salient message from those cases at the present time is a notable ambivalence about the extent to which family protection statutes should be pressed into the service of promoting marriage for marriage's sake.

Firearms and Physicians: Finding a Duty to Discuss

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“[S]ome moral obligations do not translate easily into legal obligations . . .”¹

I. Introduction

In 2011, Florida enacted a statute known as the Firearms Owners’ Privacy Act,² which quickly became known nationwide as simply the “Docs vs. Glocks” law.³ This law essentially forbade doctors from asking their patients about gun ownership, recording information about guns in the home, and “unnecessarily harassing” patients for their gun ownership. The penalty was potential medical license sanctions and a fine up to \$10,000. Championed by the National Rifle Association (NRA) and the state of Florida as protecting Second Amendment rights,⁴ the law set off a nationwide debate about the free speech rights of physicians,⁵ the role the medical community plays in the fight against gun violence,⁶ and the rights of patients to keep the exercise of their Second Amendment rights private.⁷ Several Florida doctors challenged the law almost immediately, claiming that it infringed not only on their right to speak with patients, but on the rights of patients to hear that speech.⁸

1 Logarta v. Gustafson, 998 F. Supp. 998, 1001 (E.D. Wis. 1998).

2 H.R. 155, 2011 Leg. (Fla. 2011), <https://www.flsenate.gov/Session/Bill/2011/155/BillText/er/PDF>.

3 See Dahlia Lithwick & Sonja West, *The Absurd Logic Behind Florida’s Docs vs. Glocks Law*, SLATE (Jan. 8, 2016, 3:45 PM), http://www.slate.com/articles/news_and_politics/jurisprudence/2016/01/florida_s_docs_vs_glocks_bans_doctors_from_discussing_guns.html.

4 See Stephanie Francis Ward, *First and Second Amendments Square off in ‘Docs v. Glocks’ Case Before en banc 11th Circuit*, A.B.A. J. (June 20, 2016, 4:20 PM), http://www.abajournal.com/news/article/first_and_second_amendments_square_off_in_docs_v_glocks_case_before_en_ban.

5 See, e.g., Wendy E. Parmet et al., *Wollschlaeger v. Governor of Florida – The First Amendment, Physicians Speech, and Firearm Safety*, 374 NEW ENG. J. MED. 2304 (June 2016).

6 See, e.g., Mike Weisser, *Doctors Are Getting More Engaged in the Gun Violence Debate, but It’s Not Rocket Science*, HUFFINGTON POST (Jan. 9, 2018, 10:59 AM), https://www.huffingtonpost.com/entry/gun-violence-research-doctors_us_5a54e016e4b003133eccac90.

7 See Joseph Greenlee, “Docs vs. Glocks” and the Firearm Owners’ Privacy Act, FEDERALIST SOC’Y (Apr. 5, 2016), <https://fedsoc.org/commentary/blog-posts/docs-vs-glocks-and-the-firearm-owners-privacy-act>.

8 Complaint at 2–4, *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012) (No. 11 Civ. 22026).

While the ensuing procedural history of *Wollschlaeger v. Governor of Florida* was complex to say the least, the full Eleventh Circuit Court of Appeals ultimately struck down most of the law as a violation of the First Amendment in 2017.⁹

Though the ruling technically applies only within the Eleventh Circuit, the decision (which Florida wisely declined to appeal to the United States Supreme Court¹⁰) had social and legal ramifications far beyond that region. The message is clear: physicians have a right to talk to their patients about firearms. The next logical step is to ask whether physicians have a duty to do so.

Quite simply, no *currently articulated* duty exists for physicians to warn their patients about the dangers of firearms or to ask about the presence of firearms in the home. This article argues, however, that such a duty can easily be read into many of the other existing duties that physicians have, including the basic duty of care. However, imposing such a duty would not be the best way to address or reduce gun violence and may even harm that effort. The legal community and the public health community need the alliance of the medical community in order to best reduce the deaths and injuries attributable to firearm violence. The best way to accomplish this goal is not by forcing a newly articulated legal obligation on physicians, but by joining with them to promote the discussion of firearms as an integral part of their work.

II. Firearm violence as a public health issue

In the U.S., firearm violence killed more than 36,000 people in 2015,¹¹ which is more than twice as many as brain cancer killed,¹²

9 *Wollschlaeger v. Governor*, 848 F.3d 1293, 1323 (11th Cir. 2017); *see also* Ben Guarino, *Appeals Court Strikes Down Florida ‘Docs v. Glocks’ Law That Barred Physicians from Asking About Gun Ownership*, WASH. POST (Feb. 17, 2017), https://www.washingtonpost.com/news/morning-mix/wp/2017/02/17/appeals-court-strikes-down-fla-docs-v-glocks-law-that-barred-physicians-from-asking-about-gun-ownership/?utm_term=.4c9611705b9a.

10 *See* Dara Kam, *‘Docs vs. Glocks’ Legal Battle Ends*, TALLAHASSEE DEMOCRAT (June 12, 2017), <https://www.tallahassee.com/story/news/2017/06/12/docs-vs-glocks-legal-battle-ends/388627001/>.

11 Nat’l Ctr. for Health Statistics, *All Injuries*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/nchs/fastats/injury.htm> (last updated May 3, 2017).

12 *United States Cancer Statistics: Data Visualizations*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://gis.cdc.gov/grasp/USCS/DataViz.html> (set “Cancer Type” to “Brain and Other Nervous System”) (last visited Oct. 2, 2018).

and slightly more than motor vehicle incidents killed that same year.¹³ Of those 36,000 deaths due to firearms, 22,018—more than 60%—were suicides.¹⁴ About 13,000 (36%) were homicides,¹⁵ and the remaining 1,000 (3%) were due to unintentional incidents. More than half of all unintentional fatal firearm victims are under the age of 25.¹⁶ Firearm-related deaths are the third leading cause of death for children ages 1 to 17.¹⁷ People who live in homes with firearms are also significantly more likely to die by homicide, suicide, or accidental injury.¹⁸

Firearms further accounted for more than 116,000 additional non-fatal injuries in 2016,¹⁹ though that number may be a significant underestimate, given that nonfatal gun violence is much trickier to measure than deaths.²⁰ Nevertheless, that represents an increase of almost 30,000 nonfatal firearms injuries from just one year prior

13 Nat'l Ctr. for Health Statistics, *supra* note 11.

14 Nat'l Ctr. for Health Statistics, *Suicide and Self-Inflicted Injury*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Mar. 17, 2017), <https://www.cdc.gov/nchs/fastats/suicide.htm>.

15 Nat'l Ctr. for Health Statistics, *Assault or Homicide*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/nchs/fastats/homicide.htm> (last updated Mar. 17, 2017).

16 DAVID HEMENWAY, *PRIVATE GUNS PUBLIC HEALTH* 27 (2004).

17 Katherine Fowler et al., *Childhood Firearm Injuries in the United States*, 140 J. AM. ACAD. PEDIATRICS 1, 2 (2017).

18 See Alexander McCourt & Jon S. Vernick, *Law, Ethics, and Conversations Between Physicians and Patients about Firearms in the Home*, 20 JAMA ETHICS 69, 69 (2018); Andrew Anglemeyer, et al., *The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members*, 160 ANNALS INTERNAL MED. 101, 105 (2014) (“All but 1 study (20) found significantly higher odds of suicide among participants who had firearm access than among those who did not, with ORs ranging from 1.38 to 10.38.”).

19 *Nonfatal Injury Reports, 2000-2016*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://webappa.cdc.gov/sasweb/ncipc/nfirates.html> (Set “Year Range” to “Years 2001-2106;” set “Intent of Injury” to “All Intents;” set “Cause of Injury” to “Firearm;” set “Sex” to “Both Sexes;” set “Disposition” to “All Cases;” set “Year(s) of Report” to “2016 to 2016;” click “Submit Request”) (last updated July 10, 2018).

20 David S. Bernstein, *Americans Don't Really Understand Gun Violence*, THE ATLANTIC (Dec. 14, 2017), <https://www.theatlantic.com/politics/archive/2017/12/guns-nonfatal-shooting-newtown-las-vegas/548372/>.

in 2015,²¹ the largest increase in more than a decade.²² Nonfatal gunshot wounds can be devastating and severely disabling, not only physically and psychologically, but also financially.²³ One woman who survived being shot with a high-powered rifle at a 2017 Las Vegas music festival—where 58 others were killed—endured nine surgeries to repair injuries to her lungs, stomach, spleen, and liver, all within five months.²⁴ Few survive similar attacks, though.

As a radiologist who helped treat victims of the February 2018 massacre at Marjory Stoneman Douglas High School in Florida noted, “In a typical handgun injury . . . a bullet leaves a laceration through an organ such as the liver. To a radiologist, it appears as a linear, thin, gray bullet track through the organ. There may be bleeding and some bullet fragments. . . . The organ [of a student shot by an AR-15] looked like an overripe melon smashed by a sledgehammer, with extensive bleeding. There was nothing left to repair, and utterly, devastatingly, nothing that could be done to fix the problem. The injury was fatal.”²⁵

Exposure to violence often causes extensive psychological trauma, leading to depression, anger, anxiety, dissociation, and posttraumatic stress.²⁶ That surviving Las Vegas victim continues

21 Web-Based Injury Statistics Query and Reporting Sys., *Nonfatal Injury Reports, 2000-2016*, CTR. FOR DISEASE CONTROL AND PREVENTION, <https://webappa.cdc.gov/sasweb/ncipc/nfrates.html> (last updated July 10, 2018) (choose Years 2001-2106, All Intentions, Firearm, Both Sexes, All Cases, 2015 to 2015).

22 *Gun Violence Increased by 28% in 2016, According to CDC*, GIFFORDS LAW CTR. TO PREVENT GUN VIOLENCE, <http://lawcenter.giffords.org/gun-violence-increased-by-28-in-2016-according-to-cdc/> (last updated May 7, 2018).

23 Sarabeth Spitzer et al., *Costs and Financial Burden of Initial Hospitalizations for Firearm Injuries in the United States, 2006-2014*, 107 AM. J. PUB. HEALTH 770, 774 (2017) (“[F]irearm-related injuries place a particular burden on governmental payers and the poor.”).

24 Sarah Kaplan, *Las Vegas Fund Begins Payouts to Shooting Victims, but one Long-Hospitalized Survivor isn't Among Them*, WASH. POST (Mar. 12, 2018), https://www.washingtonpost.com/news/post-nation/wp/2018/03/12/las-vegas-fund-begins-payouts-to-shooting-victims-but-one-long-hospitalized-survivor-isnt-among-them/?utm_term=.c2165ca49c2b; Meghan Keneally, *47 guns, loaded high capacity magazines found in Vegas shooter's hotel suite and Nevada home*, ABC NEWS (Oct. 4, 2017), <https://abcnews.go.com/US/guns-loaded-high-capacity-magazines-found-vegas-shooters/story?id=50228093>.

25 Heather Sher, *What I Saw Treating the Victims From Parkland Should Change the Debate on Guns*, THE ATLANTIC (Feb. 22, 2018), <https://www.theatlantic.com/politics/archive/2018/02/what-i-saw-treating-the-victims-from-parkland-should-change-the-debate-on-guns/553937/>.

26 Mark I. Singer et al., *Adolescents' Exposure to Violence and Associated Symptoms of*

to suffer “crushing anxiety caused by the trauma of the shooting and her excruciating recovery.”²⁷ Even those who are not physically harmed by gun violence can still be psychologically traumatized by it, such as children who witness mass shootings²⁸ and people who live in high-violence neighborhoods.²⁹ Gun violence further takes a devastating, though generally less measurable, toll on communities and families,³⁰ as well as the economy.³¹

In recent years, nearly 1,300 children per year died from firearms in the U.S.; emergency departments treated almost 6,000 more for non-fatal firearm injuries.³² While both unintentional and homicide firearm deaths of children ages 0 to 17 have declined since

Psychological Trauma, 273 JAMA 477, 481 (1995).

- 27 Sarah Kaplan, *Las Vegas fund begins payouts to shooting victims, but one long-hospitalized survivor isn't among them*, WASH. POST (Mar. 12, 2018), https://www.washingtonpost.com/news/post-nation/wp/2018/03/12/las-vegas-fund-begins-payouts-to-shooting-victims-but-one-long-hospitalized-survivor-isnt-among-them/?utm_term=.c2165ca49c2b.
- 28 Phil Glaewitz, *After Shooting, 'Honor How Kids Want to Deal With Their Feelings'*, KAISER HEALTH NEWS (Feb. 22, 2018), <https://khn.org/news/after-shooting-honor-how-kids-want-to-deal-with-their-feelings/>; see also Sarah Lowe et al., *Mental Health Consequences of Mass Shootings*, 18 TRAUMA, VIOLENCE, & ABUSE 62 (2015).
- 29 Steven Ross Johnson, *Gun Violence Survivors and Witnesses Could Face Lifetime of Trauma and Bad Health*, MODERN HEALTHCARE (Nov. 5, 2016), <https://www.modernhealthcare.com/article/20161105/MAGAZINE/311059989>; see also Devin Carey et al., *Exposure to Community Violence and Social Maladjustment Among Urban African American Youth*, 37 J. OF ADOLESCENCE 1161 (2014); Ctr. for Inj. Res. and Prevention, *School Shootings*, CHILD. HOSP. OF PHILA., <https://injury.research.chop.edu/violence-prevention-initiative/types-violence-involving-youth/school-shootings#.W5wNiKZKhPZ> (last visited Jan. 19, 2019); Fran H. Norris, *Impact of Mass Shootings on Survivors, Families, and Communities*, 18 PTSD RES. Q., Summer 2007, at 1; Ask Elklit & Sessel Kurdahl, *The Psychological Reactions After Witnessing a Killing in Public in a Danish High School*, 4 EUR. J. PSYCHOTRAUMATOLOGY, Jan 2013, at 1.
- 30 See Julie Collins & Emily Swoveland, *The Impact of Gun Violence on Children, Families, & Communities*, CHILD WELFARE LEAGUE OF AMERICA, <https://www.cwla.org/the-impact-of-gun-violence-on-children-families-communities> (last visited May 23, 2018); Ryan Connelly Holmes, *Chicago's gun violence crisis is also a mental health crisis*, PBS (Aug. 22, 2017), <https://www.pbs.org/newshour/health/chicagos-gun-violence-crisis-also-mental-health-crisis>; Richard Conway, *Go Inside the Lives of Families Affected by Gun Violence*, TIME (Jan. 22, 2015), <http://time.com/3669792/gun-violence-chicago-families/>.
- 31 See, e.g., Yasemin Irvin Erikson et al., *The Effects of Gun Violence on Local Economies*, URBAN INSTITUTE (Nov. 2016), https://www.urban.org/research/publication/effect-gun-violence-local-economies/view/full_report.
- 32 Katherine Fowler et al., *Childhood Firearm Injuries in the United States*, 140 PEDIATRICS 1, 3 (Apr. 4, 2017).

2002, suicides by firearm among this age group first declined, but then increased sharply, beginning in 2007.³³ Firearm-related deaths account for the third leading cause of mortality among children ages 1 to 17 in the U.S., representing more deaths than congenital abnormalities, heart disease, the flu, pneumonia, chronic respiratory disease, and cerebrovascular causes.³⁴

Approximately 82% of children who die by firearms are boys.³⁵ In recent years, black children have the highest overall firearm mortality rate and homicide mortality rate.³⁶ White and American Indian children have the highest firearm suicide mortality rate.³⁷ And while the firearm homicide rates for children have been declining since 2007, child firearm suicide rates have increased by a staggering 60% from 2007 to 2014.³⁸ Unintentional child deaths by firearms have also been declining.³⁹ Children playing with a gun is the most common reason for such deaths,⁴⁰ and children as young as three years old may be strong enough to pull the trigger on a firearm.⁴¹

Until the late 20th century, “gun assaults were seen almost exclusively as a criminal justice problem, gun suicides as a mental health problem, and unintentional gunshot wounds as a safety issue.”⁴² In 1979, the U.S. Surgeon General published a report called “Healthy People,”⁴³ which identified both suicide and homicide as “[i]mportant,” though preventable, problems in American health. The report even stated that “[e]asy access to firearms appears to be

33 *Id.* at 4–5.

34 *Id.* at 2.

35 *Id.* at 4.

36 *Id.*

37 *Id.*

38 *Id.* at 4–6.

39 *Id.*

40 *Id.* at 8; *see also* Nicholas Bakalar, *A Dire Weekly Total for the U.S.: 25 Children Killed by Guns*, N.Y. TIMES (June 19, 2017), <https://www.nytimes.com/2017/06/19/health/guns-children-cdc-us-firearms.html>.

41 NAT’L PHYSICIANS ALL. & LAW CTR. TO PREVENT GUN VIOLENCE, GUN SAFETY & PUBLIC HEALTH: POLICY RECOMMENDATIONS FOR A MORE SECURE AMERICA 7 (2013), http://npalliance.org/wp-content/uploads/Gun_Safety_Public_Health_Joint_Report-092513.pdf (citing S.M. Naureckas et al., *Children’s and Women’s Ability to Fire Handguns*, 149 ARCHIVES OF PEDIATRIC & ADOLESCENT MED. 1318 (1995)).

42 DAVID HEMENWAY, PRIVATE GUNS PUBLIC HEALTH 8 (2004).

43 U.S. DEP’T OF HEALTH, EDUC., & WELFARE, HEALTHY PEOPLE: THE SURGEON GENERAL’S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION, ch. 5, at 8 (1979).

the one factor with a striking relationship to murder,” highlighting that both the U.S. homicide rate and the sale of firearms rose steeply from 1960 to 1974.⁴⁴ This report appears to be the first major, nationwide recognition of violence, and gun violence in particular, as a public health issue.⁴⁵ In the years since then, this notion of gun violence as a public health issue has spread widely but has been continually stymied politically.

In the mid-1980s, the Centers for Disease Control and Prevention (CDC) established an injury-control division,⁴⁶ which included the study of firearm violence as the second leading cause of injuries in the U.S. In 1993, the CDC provided funding for a study published in the *New England Journal of Medicine* entitled, “Gun Ownership as a Risk Factor for Homicide in the Home.”⁴⁷ This study concluded that “[r]ather than confer protection, guns kept in the home are associated with an increase in the risk of homicide by a family member or intimate acquaintance.”⁴⁸ The NRA seized on this article as government promotion of gun-control and campaigned to eliminate the CDC National Center for Injury Prevention.⁴⁹ Congress did not get rid of the injury center entirely, but in 1996, it did take \$2.6 million from the CDC budget—the exact amount that had previously been allocated for gun violence research—and earmarked it instead for traumatic brain injury research.⁵⁰ Congress also inserted a budget clause, authored by Republican Congressman Jay Dickey from Arkansas, stating, “[N]one of the funds made available for injury prevention and control at the Centers for Disease Control and Prevention may be used to advocate or promote gun control.”⁵¹

44 *Id.* at ch. 5, 14–15.

45 See LINDA L. DHALBERG & JAMES A. MERCY, CTR. FOR DISEASE CONTROL AND PREVENTION, *THE HISTORY OF VIOLENCE AS A PUBLIC HEALTH ISSUE 2* (2009), https://www.cdc.gov/violenceprevention/pdf/history_violence-a.pdf.

46 HEMENWAY, *supra* note 42, at xi.

47 Christine Jamieson, *Gun Violence Research: History of the Federal Funding Freeze*, AM. PSYCHOLOGICAL ASS'N (Feb. 2013), <http://www.apa.org/science/about/psa/2013/02/gun-violence.aspx>.

48 Arthur L. Kellermann et al., *Gun Ownership as a Risk Factor for Homicide in the Home*, 329 *NEW ENG. J. MED.* 1084 (1993).

49 Jamieson, *supra* note 47.

50 *Id.*; Julie Rovner, *US Budget Cut May End CDC Gun-Violence Research*, 348 *THE LANCET* 1025 (1996).

51 Act of Sept. 30, 1996, Pub. L. No. 104-208, Title II, 110 Stat. 3009, 244 (1996) (making omnibus consolidated appropriations for the fiscal year ending Sept. 30, 1997); Jamieson, *supra* note 47.

This language, which became known as the “Dickey Amendment,” has remained in every federal budget since its original inclusion.⁵² While it does not outright forbid the CDC from studying or funding gun violence research, no one within the CDC was willing to risk losing more money or further incurring the wrath of the NRA to conduct such research.⁵³ Federal gun violence research and funding effectively ceased entirely after the Dickey Amendment.⁵⁴

Advocacy and professional groups tried, in vain, to remove the Dickey Amendment language from the annual federal budget.⁵⁵ In 2012, retired Congressman Dickey even expressed regret at the outcome of his namesake budget clause. He co-authored a *Washington Post* op-ed, stating that “scientific research should be conducted into preventing firearm injuries and that ways to prevent firearm deaths can be found without encroaching on the rights of legitimate gun owners.”⁵⁶ Soon after, in 2013, President Barack Obama issued an official memo to the Secretary of the Department of Health and Human Services (HHS)—which oversees the CDC—instructing HHS to “conduct or sponsor research into the causes of gun violence and the ways to prevent it.”⁵⁷ In response, the National Institutes of Health (NIH) began a program to fund gun violence research, which provided more than \$11 million in funds over three years.⁵⁸ Then, in 2017 and with no explanation, NIH stopped accepting proposals and stopped funding most gun-related studies.⁵⁹

Even though Congress was under political pressure to enact stricter gun control legislation,⁶⁰ it again refused to eliminate the

52 Allen Rostron, *The Dickey Amendment on Federal Funding for Research on Gun Violence: A Legal Dissection*, 108 AM. J. PUB. HEALTH 865, 866 (2018).

53 Jamieson, *supra* note 47.

54 AM. MED. ASS'N, REPORT OF THE BOARD OF TRUSTEES I (2017), <https://www.ama-assn.org/sites/default/files/media-browser/public/hod/i17-bot03.pdf>.

55 *See, e.g., id.*

56 Jay Dickey & Mark Rosenberg, *We Won't Know the Cause of Gun Violence Until We Look for It*, WASH. POST (July 27, 2012), https://www.washingtonpost.com/opinions/we-wont-know-the-cause-of-gun-violence-until-we-look-for-it/2012/07/27/gJQAPfenEX_story.html?utm_term=.99d6875355f8.

57 Memorandum on Engaging in Public Health Research on the Causes and Prevention of Gun Violence, 78 Fed. Reg. 4295 (Jan. 16, 2013), <https://www.gpo.gov/fdsys/pkg/FR-2013-01-22/pdf/2013-01272.pdf>.

58 Meredith Wadman, *NIH Quietly Shelves Gun Research Program*, SCI. (Sept. 13, 2017, 12:13 PM), <http://www.sciencemag.org/news/2017/09/nih-quietly-shelves-gun-research-program>.

59 *See id.*

60 Sheryl Gay Stolberg et al., *Is This the Moment for Gun Control? A Gridlocked*

Dickey Amendment language in the 2018 omnibus appropriations bill.⁶¹ It did, however, insert some language into the accompanying “guide” provided to HHS: “While appropriations language prohibits the CDC and other agencies from using appropriated funding to advocate or promote gun control, the Secretary of Health and Human Services has stated the CDC has the authority to conduct research on the causes of gun violence.”⁶² This language does not create any new legal authorization, but it does represent a (tiny) step toward recognizing gun violence as a public health issue. The bill did not include any funding,⁶³ however, and that dearth means the agency still (as of May 2018) has not initiated any actual firearms research.⁶⁴

Physicians see the effects gun violence—be it from intentional assault, unintentional injury, or suicide attempt—on the bodies, minds, families, and communities of patients. Even though they address it on a patient-by-patient basis, physicians constitute an integral part of a larger public health approach to gun violence.⁶⁵ Key to the public health approach is the notion that “prevention is preferable to treatment.”⁶⁶ Because people in homes with guns are at an increased risk of dying by homicide, suicides, or unintentional gun injury, physicians occupy one of the most crucial spaces in terms of accomplishing prevention.

III. Suicide and firearms

When compared with other industrialized countries, the

Congress Is Under Pressure, N.Y. TIMES (Feb. 25, 2018), <https://www.nytimes.com/2018/02/25/us/politics/gun-control-congress-governors.html>.

61 Consolidated Appropriations Act of 2018, Pub. L. No. 114-141, H.R. 1625-389, § 210 (2018).

62 115TH CONG., MEMORANDUM TO ACCOMPANY CONSOLIDATED APPROPRIATIONS ACT OF 2018 TO DIVISION H – DEP'TS OF LABOR, HEALTH AND HUMAN SERVS., AND EDUC., AND RELATED AGENCIES 23 (2018), <https://docs.house.gov/billsthisweek/20180319/DIV%20H%20LABORHHS%20SOM%20FY18%20OMNI.OCR.pdf>.

63 Nell Greenfieldboyce, *Spending Bill Lets CDC Study Gun Violence; But Researchers Are Skeptical It Will Help*, NAT'L PUB. RADIO (Mar. 23, 2018, 12:17 PM), <https://www.npr.org/sections/health-shots/2018/03/23/596413510/proposed-budget-allows-cdc-to-study-gun-violence-researchers-skeptical>.

64 See Dan Diamond, *CDC 'Ban' Is Gone, But Firearm Research Is Still Lacking*, POLITICO (May 21, 2018, 10:00 AM), <https://www.politico.com/newsletters/politico-pulse/2018/05/21/cdc-ban-is-gone-but-firearm-research-is-still-lacking-224062>.

65 See David Hemenway, *The Public Health Approach to Reducing Firearm Injury and Violence*, 17 STAN. L. & POL'Y REV. 635, 644, 649 (2006).

66 See *id.* at 649.

suicide rate in the U.S. is roughly in the middle,⁶⁷ but the U.S. suicide rate using firearms is 10 times more than the average of other countries.⁶⁸ Shifting the usual psychologically-focused inquiry from *why* a person attempts or completes suicide⁶⁹ has led to a promising public health focus that instead asks *how* people attempt and complete suicide.⁷⁰ “Intent matters, but so does method, because the method by which one attempts suicide has a great deal to do with whether one lives or dies.”⁷¹ Only one percent of suicide *attempts* are with firearms, yet more than half of all suicide deaths are from firearms.⁷² Attempted suicides using a firearm are also more than 90% fatal, compared to 35% from jumping, and 2% percent from poisoning.⁷³ More people kill themselves with guns in the U.S. “than with all other intentional means combined, including hanging, poisoning/overdose, jumping, and cutting.”⁷⁴

One of the single most significant risk factors for suicide completion is the presence of a firearm in the home.⁷⁵ Gun owners do not have a higher prevalence of mental health issues, nor do they have higher rates of suicide ideation.⁷⁶ Rather, when gun owners—as well as their spouses and children—attempt suicide, they do so with a gun.⁷⁷ In the states with the highest levels of household firearm ownership, almost twice as many people died by suicide compared to the states with the lowest levels of firearm ownership.⁷⁸

67 DAVID HEMENWAY, *PRIVATE GUNS, PUBLIC HEALTH* 37 (2004).

68 *Id.*

69 See, e.g., Todd B. Kashdan, *Why Do People Kill Themselves? New Warning Signs*, *PSYCHOL. TODAY* (May 15, 2014), <https://www.psychologytoday.com/us/blog/curious/201405/why-do-people-kill-themselves-new-warning-signs>.

70 *Means Matter*, HARV. T.H. CHAN SCH. OF PUB. HEALTH (2018), <https://www.hsph.harvard.edu/means-matter/> (last visited Oct. 2, 2018).

71 Madeline Drexler, *Guns & Suicide: The Hidden Toll*, HARV. PUB. HEALTH, https://www.hsph.harvard.edu/magazine/magazine_article/guns-suicide/ (last visited Oct. 2, 2018).

72 Catherine Barber et al., *How Physicians Can Reduce Suicide – Without Changing Anyone’s Mental Health*, 129 *AM. J. MED.* 1016, 1016 (2016).

73 NAT’L PHYSICIANS ALL. & LAW CTR TO PREVENT GUN VIOLENCE, *supra* note 41, at 4 (citing Matthew Miller et al., *The Epidemiology of Case Fatality Rates for Suicide in the Northeast*, 43 *ANNALS EMERGENCY MED.* 723, 726 (2004)).

74 Drexler, *supra* note 71.

75 Matthew Miller et al., *Household Firearm Ownership and Rates of Suicide Across the 50 United States*, 62 *J. OF TRAUMA: INJURY, INFECTION, & CRITICAL CARE* 1029 (2007); Barber et al., *supra* note 72.

76 Barber et al., *supra* note 72.

77 *Id.*

78 Miller et al., *supra* note 75, at 1031 (“Almost twice as many individuals

The presence of a gun in the home was associated with a risk of suicide 4.8 times higher than the risk of suicide in a home without a gun, even after controlling for factors such as living alone, taking prescribed psychiatric medications, having a history of arrest, using drugs/alcohol, and not graduating from high school.⁷⁹

People who attempt suicide often do so very impulsively. In one study of people who survived a suicide attempt, “a startling 24 percent said less than 5 minutes” had passed “between when they decided to take their lives and when they actually made the attempt.”⁸⁰ Only 14% of people who attempted suicide did so more than eight hours after making the decision.⁸¹ Underscoring this impulsivity, about 90% of people who survive a suicide attempt do not go on to later die by suicide,⁸² dispelling the myth that someone who wants to die by suicide will find a way to do it, whether a firearm is available or not.⁸³

“A central tenet of public health is that environment shapes individual behavior When widely used lethal means are made less available or less deadly, suicide rates by that method decline, as do suicide rates overall.”⁸⁴ As discussed below, physicians play a crucial role in assessing suicide risk and, given that the presence of a firearm contributes so heavily to the risk of death by suicide, incorporating inquiries about firearms could very well be part of their existing duty of care.

IV. Homicide and firearms

Gun availability is not just correlated with higher rates of suicide, but with higher rates of homicide as well.⁸⁵ The U.S., where

completed suicide in the 15 states with the highest levels of household firearm ownership . . . compared with the 6 states with the lowest levels of household firearm ownership.”); *see also* Barber et al., *supra* note 72.

79 Arthur L. Kellerman et al., *Suicide in the Home in Relation to Gun Ownership*, 327 *NEW ENG. J. MED.* 467, 467 (1992).

80 Drexler, *supra* note 71.

81 *Id.*

82 NAT'L PHYSICIANS ALL. & LAW CTR. TO PREVENT GUN VIOLENCE, *supra* note 41, at 4 (citing Matthew Miller et al., *Suicide Mortality in the United States: The Importance of Attending to Method in Understanding Population Level Disparities in the Burden of Suicide*, 33 *ANN. REV. PUB. HEALTH* 393 (2012)).

83 *Myths About Suicide*, TENN. SUICIDE PREVENTION NETWORK, <http://tspn.org/myths-about-suicide> (last visited Oct. 2, 2018).

84 Drexler, *supra* note 71.

85 Lisa M. Hepburn & David Hemenway, *Firearm availability and homicide: A review of the literature*, 9 *AGGRESSION & VIOLENT BEHAV.* 417 (2004).

five percent of the world's population owns as much as 50% of the world's firearms,⁸⁶ has a homicide rate seven times higher than other developed countries.⁸⁷ Its homicide rate by firearms is a staggering 25.2 times that of other comparable countries.⁸⁸

A common refrain from the NRA and other pro-gun lobbies says that “[t]he only way to stop a bad guy with a gun is a good guy with a gun.”⁸⁹ The NRA touts anecdotes about “armed citizen[s]” thwarting robbers and home invaders,⁹⁰ championing the image that more guns equals less crime. But, the data shows otherwise. Not only does no correlation exist between gun ownership rates and stranger homicide rates (in other words, more guns do not reduce stranger homicides), but a significant correlation exists between gun ownership rates and non-stranger homicide rates. This data indicates that more guns lead to more homicides of family, friends, and acquaintances.⁹¹

Access to and availability of firearms in the U.S. particularly increases the lethality of intimate partner violence.⁹² Current or former intimate partners murder women in the U.S. nine times more often than strangers.⁹³ “Domestic violence incidents involving firearms are twelve times more likely to result in a death compared to non-firearm abuse incidents.”⁹⁴ Though the overall rate of homicide by firearms is lower for women than for men (1.6 per 100,000 people for women, versus 7.0 per 100,000 people for men), the presence of a gun in the home constitutes one of the major risk factors that a

86 Elspeth Reeve, *Some Uncomfortable Numbers About Guns in America*, THE ATLANTIC (Dec. 17, 2012), <https://www.theatlantic.com/politics/archive/2012/12/guns-in-america-statistics/320409/>.

87 Spitzer et al., *supra* note 23, at 770.

88 *Id.*

89 Emily Rupertus, *A Good Guy with a Gun*, NAT'L RIFLE ASS'N (July 20, 2016), <https://www.nrablog.com/articles/2016/7/a-good-guy-with-a-gun/>.

90 *Id.*

91 Michael Siegel et al., *The Relationship Between Gun Ownership and Firearm Homicide Rates in the United States, 1981-2010*, 103 AM. J. PUB. HEALTH 2098, 2103 (2013).

92 Jacquelyn C. Campbell et al., *Intimate Partner Homicide: Review and Implications of Research and Policy*, 8 TRAUMA, VIOLENCE, & ABUSE 246, 255 (2007).

93 *Id.* at 246.

94 NAT'L PHYSICIANS ALL. & LAW CTR. TO PREVENT GUN VIOLENCE, GUN SAFETY & PUBLIC HEALTH: POLICY RECOMMENDATIONS FOR A MORE SECURE AMERICA 4 (2013), http://npalliance.org/wp-content/uploads/Gun_Safety_Public_Health_Joint_Report-092513.pdf (citing Shannon Frattaroli & Jon S. Vernick, *Separating Batterers and Guns: A Review and Analysis of Gun Removal Laws in 50 States*, 30 EVALUATION REV. 296, 297 (2006)).

woman will be killed by either an intimate partner or another non-stranger.⁹⁵ More than 40% of women killed by homicide are killed by intimate partners; almost 90% are killed by non-strangers.⁹⁶

V. A brief history of firearm laws in the United States

The Second Amendment to the U.S. Constitution states, “A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.”⁹⁷ Virtually no commentary exists specific to the Second Amendment from the time of the Bill of Rights ratification in 1791.⁹⁸ Prior to the 20th century, gun regulations were almost entirely locally-based and the Second Amendment remained essentially irrelevant.⁹⁹

Throughout the 20th century though, the U.S. passed several major firearm-related laws, including the National Firearms Act (NFA) in 1934. This law, which was at least partially a response to likes of Al Capone and other gangsters trading in illegal alcohol and utilizing “Tommy Guns” to target their enemies,¹⁰⁰ created the first firearms licensing scheme and the first tax on the interstate sale of certain weapons, such as sawed-off shotguns.¹⁰¹ By the 1960s, the number of guns in American civilian hands had skyrocketed and the number of imported handguns had exploded from 67,000 per year in 1955 to over one million in 1968.¹⁰² The Gun Control Act of 1968 (GCA), partially fueled by the fear of groups like the Black Panthers, the increasing “race riots,” and the assassination of Martin

95 Campbell et al., *supra* note 92, at 255.

96 Michael B. Siegel & Emily F. Rothman, *Firearm Ownership and the Murder of Women in the United States: Evidence That the State-Level Firearm Ownership Rate Is Associated with the Nonstranger Femicide Rate*, 3 VIOLENCE & GENDER 20, 21, 24 (2016).

97 U.S. CONST. amend. II.

98 NICHOLAS J. JOHNSON ET AL., FIREARMS LAW AND THE SECOND AMENDMENT: REGULATION, RIGHTS, AND POLICY 3, 218–19 (1st ed. 2012).

99 See ADAM WINKLER, GUN FIGHT: THE BATTLE OVER THE RIGHT TO BEAR ARMS IN AMERICA 3, 95–115 (2011); see also JOHNSON ET AL., *supra* note 98, at 218–19.

100 NPR Staff, *Prohibition-Era Gang Violence Spurred Congress To Pass First Gun Law*, NAT'L PUB. RADIO (June 30, 2016), <https://www.npr.org/2016/06/30/484215890/prohibition-era-gang-violence-spurred-congress-to-pass-first-gun-law>; WINKLER, *supra* note 99, at 203.

101 WINKLER, *supra* note 99, at 203. The tax was \$200 in 1934 and remains \$200 today.

102 *Id.* at 250.

Luther King Jr.,¹⁰³ prohibited gun shipments across state lines to anyone other than a federally licensed dealer. It also created a ban on gun sales to “prohibited persons,” such as felons, individuals with mental illness, people with substance use disorders, and minors.¹⁰⁴ In 1986, the Firearm Owners Protection Act loosened many provisions of the GCA and also explicitly prohibited any sort of centralized government gun registry.¹⁰⁵

In 1981, John Hinckley Jr. attempted to assassinate President Ronald Reagan and, in doing so, also shot Press Secretary James Brady in the head; Brady survived, but was permanently paralyzed.¹⁰⁶ That incident marks the real birth of the modern gun debate. Sarah Brady, Secretary Brady’s wife, became an outspoken advocate of gun control, and particularly of restricting the access of people with mental illness to firearms.¹⁰⁷ In 1993, she was instrumental in passing the “Brady Bill,” which included a mandate to create the National Instant Criminal Background Check System (NICS), which all federally licensed firearms dealers utilize to check a buyer’s records for potential disqualifiers in a matter of minutes.¹⁰⁸

Firearm laws in America entered a new era in 2008, when the U.S. Supreme Court decided *District of Columbia v. Heller*,¹⁰⁹ the single most important firearms law decision in American history.¹¹⁰ In 1976, the District of Columbia city council passed a law that banned handguns from private possession and required long guns to be disassembled or secured with a trigger lock.¹¹¹ Almost 30 years later, carefully-orchestrated litigation¹¹² moved forward with deliberately

103 WINKLER, *supra* note 99, at 249, 251; Gun Control Act of 1968, Pub. L. No. 90-618, 82 Stat. 1213 (1968).

104 WINKLER, *supra* note 99, at 251.

105 18 U.S.C. § 926 (2012); 82 Stat. at 1213.

106 WINKLER, *supra* note 99, at 69.

107 *Id.*; see also Jon Thurber, *Sarah Brady, Longtime Advocate for Gun Control, Dies at 73*, WASH. POST (Apr. 3, 2015), https://www.washingtonpost.com/local/obituaries/sarah-brady-longtime-advocate-for-gun-control-dies-at-73/2015/04/03/2f9cc2e0-da48-11e4-ba28-f2a685dc7f89_story.html?utm_term=.3983dcac5b1f.

108 WINKLER, *supra* note 99, at 69–71.

109 *D.C. v. Heller*, 554 U.S. 570 (2008).

110 See James Vicini, *Americans Have Right to Guns Under Landmark Ruling*, REUTERS (June 26, 2008), <https://www.reuters.com/article/us-usa-guns-court/americans-have-right-to-guns-under-landmark-ruling-idUSWBTO0928420080626>; see also WINKLER, *supra* note 99.

111 WINKLER, *supra* note 99, at 17.

112 *Id.*

selected plaintiff, Dick Heller. He was a security guard who was allowed to have a handgun while on the job, but not at home because of the ban.¹¹³ The case's architects intended, from the outset, for the case to go all the way to the U.S. Supreme Court, with the aim of receiving an explicit ruling that the Second Amendment protected an individual right to bear arms, as opposed to a "collective," or militia-only right.¹¹⁴ Though such a strategy risked getting an adverse decision that could derail the direction of gun rights for good, Justice Antonin Scalia wrote a majority opinion strongly in the plaintiff's favor, holding, "[T]he Second Amendment protects an individual right to possess firearms and . . . the city's total ban on handguns, as well as its requirement that firearms in the home be kept nonfunctional even when necessary for self-defense, violated that right."¹¹⁵ Importantly, however, the decision also contained the qualifier, "[N]othing in our opinion should be taken to cast doubt on longstanding prohibitions on the possession of firearms by felons and the mentally ill, or laws forbidding the carrying of firearms in sensitive places such as schools and government buildings, or laws imposing conditions and qualifications on the commercial sale of arms."¹¹⁶ Ultimately, *Heller* "validated a compromise position on guns. Individuals have a right to possess a gun for self-defense, but that right can and should be subject to some regulation in the interest of public safety."¹¹⁷

Since 2008, no gun regulation has gained traction on the federal level, even after the massacre of 26 people (20 of them children) at a Newtown, Connecticut elementary school in 2012.¹¹⁸ In 2018, after a former student killed 17 people at his high school

113 *Heller*, 554 U.S. at 574–75.

114 WINKLER, *supra* note 99, at 91–92.

115 *Heller*, 554 U.S. at 576 (citing *Parker v. District of Columbia*, 478 F.3d 370, 395, 399–401 (2007)) (lower court decision).

116 *Id.* at 626–27.

117 WINKLER, *supra* note 99, at 294.

118 Ed O'Keefe & Philip Rucker, *Gun-Control Overhaul Is Defeated in Senate*, WASH. POST (Apr. 17, 2013), https://www.washingtonpost.com/politics/gun-control-overhaul-is-defeated-in-senate/2013/04/17/57eb028a-a77c-11e2-b029-8fb7e977ef71_story.html?utm_term=.1297752e18c1; Rebecca Shabad, *Why More than 100 Gun Control Proposals in Congress Since 2011 Have Failed*, CBS NEWS (June 20, 2016), <https://www.cbsnews.com/news/how-many-gun-control-proposals-have-been-offered-since-2011/>; Joshua Gillin, *Congress Blocked Obama's Call for New Gun Laws After Mass Shootings*, POLITIFACT (Jan. 6, 2017), <https://www.politifact.com/truth-o-meter/article/2017/jan/06/congress-blocked-obama-call-gun-control-mass-shoot/>.

in Parkland, Florida, several of the teenage survivors managed to renew a push to institute several reforms.¹¹⁹ Despite initial support from President Donald Trump,¹²⁰ nothing has come to fruition in Congress. Several states, however, including Vermont¹²¹ and the teenage activists' home state of Florida,¹²² have passed additional firearm restrictions in the months after the massacre at Marjory Stoneman Douglas High School. Most firearm regulation, in fact, takes place at the state level.¹²³ States cannot contradict federal law restrictions—such as minimum ages for handgun purchases¹²⁴ or prohibitions on certain sales across state lines¹²⁵—but states can either impose additional restrictions (within the bounds of the Second Amendment) or they can impose no restrictions beyond those at the federal level.¹²⁶ The differing levels of regulations across states has created a confusing patchwork of laws where no cohesion exists.¹²⁷

A. Some existing legal duties physicians owe to patients

The notion that physicians have a multitude of legal obligations to patients dates back to ancient times.¹²⁸ Even the Code

119 See Emanuella Grinberg & Steve Almasy, *Students at town Hall to Washington, NRA: Guns are the Problem, Do Something*, CNN (Feb. 22, 2018, 5:19 AM), <https://www.cnn.com/2018/02/21/politics/cnn-town-hall-florida-shooting/index.html>.

120 See Matthew Nussbaum, *White House: Trump Supports Stronger Background Checks for Gun Buys*, POLITICO (Feb. 19, 2018, 9:41 AM), <https://www.politico.com/story/2018/02/19/trump-gun-control-417101>.

121 See Jason Hanna & Lawrence Davidson, *Vermont Governor Signs Sweeping Gun Control Measures*, CNN (Apr. 11, 2018, 6:28 PM), <https://www.cnn.com/2018/04/11/us/vermont-gun-control/index.html>.

122 Maggie Astor, *Florida Gun Bill: What's in It, and What Isn't*, N.Y. TIMES (Mar. 8, 2018), <https://www.nytimes.com/2018/03/08/us/florida-gun-bill.html>.

123 See Leslie Shapiro et al., *How Strictly Are Guns Regulated Where You Live?*, WASH. POST (Feb. 20, 2018), https://www.washingtonpost.com/graphics/2017/national/assault-weapons-laws/?utm_term=.dab20bcb282d.

124 18 U.S.C. § 922(b)(1) (2018); see U.S. CONST. art. VI, cl. 2.

125 18 U.S.C. § 922(a)(5) (2018); see U.S. CONST. art. VI, cl. 2.

126 See U.S. CONST. art. VI, cl. 2; see also Emma Roller, *Idaho Has Declared It Won't Obey New Federal Gun Laws*, THE ATLANTIC (Mar. 25, 2014), <https://www.theatlantic.com/politics/archive/2014/03/idaho-has-declared-it-wont-obey-new-federal-gun-laws/455652/>.

127 See, e.g., Andrew Hay, *Waffle House Shooting Shows Pitfalls in Patchwork of U.S. Gun Laws*, REUTERS (Apr. 26, 2018, 3:28 PM), <https://www.reuters.com/article/us-usa-tennessee-shooting-law/waffle-house-shooting-shows-pitfalls-in-patchwork-of-u-s-gun-laws-idUSKBN1HX36T>.

128 Andrew A. Sandor, *Legal Duties of Physicians*, 74 CAL. MED. 385, 385 (1951).

of Hammurabi (from around 2000 B.C.) contains an edict to the effect that if a patient died during an operation, the doctor's hands would be cut off.¹²⁹ This harsh idea that the physician "practiced at his peril and paid a penalty"¹³⁰ pursuant to "absolute liability"¹³¹ evolved into the notion that a physician who "followed established treatments" remained free of liability, even if the patient was not cured or healed.¹³² This concept remains generally intact today.

Physicians, most generally (and most importantly), must provide a patient with treatment using the degree of skill, care, and diligence of a reasonably competent physician under the same or similar circumstances.¹³³ Failure to do so—either by an act or the omission of an act that deviates from acceptable norms and results in injury—could constitute grounds for medical malpractice, a relatively common legal claim in the U.S.¹³⁴ Generally governed by state law, specifics differ as to how plaintiffs may initiate and proceed with medical malpractice claims, but the essence is the same: in order to establish negligence, a patient (or representative) plaintiff must prove four elements: "(1) a professional duty owed to the patient; (2) breach of such duty; (3) injury caused by the breach; and (4) resulting damages."¹³⁵

The establishment of a patient-doctor relationship is vital to determining the existence of a duty of care; if no patient-doctor relationship exists, no such duty of care exists either.¹³⁶ In the simplest terms, this patient-doctor relationship "exists when a physician serves a patient's medical needs," generally via mutual consent.¹³⁷ This relationship usually begins as soon as the physician "affirmatively acts . . . by examining, diagnosing, treating, or agreeing

129 See *id.*; see also *The Code of Hammurabi*, THE AVALON PROJECT (L.W. King trans., 2008), <http://avalon.law.yale.edu/ancient/hamframe.asp>.

130 Sandor, *supra* note 128.

131 *Id.*

132 *Id.*

133 See *What Is a Doctor's Duty of Care?*, FINDLAW, <http://injury.findlaw.com/medical-malpractice/what-is-actionable-medical-malpractice.html> (last visited Oct. 2, 2018).

134 B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPAEDICS & RELATED RES. 339, 342 (2009).

135 *Id.*

136 Carol A. Kelly & Philip E. Murray, Jr., *The Physician's Legal Duty to Non-Patients*, CRICO (June 1, 2008), <https://www.rmhf.harvard.edu/Clinician-Resources/Article/2008/Insight-The-Physicians-Legal-Duty-to-Non-Patients>.

137 CODE OF MEDICAL ETHICS § 1.1.1 (AM. MED. ASS'N 2018).

to do so.”¹³⁸ Once that physician-patient relationship exists, the doctor has the duty to not abandon the patient; that is, he or she cannot terminate the relationship “at an unreasonable time and without giving the patient the chance to find an equally qualified replacement.”¹³⁹

Physicians also owe patients a duty of confidentiality. This duty too dates back to ancient times.¹⁴⁰ The classic Hippocratic Oath highlights strict confidentiality: “What I may see or hear in the course of the treatment . . . in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.”¹⁴¹ Though subject to an increasing number of exceptions, patient confidentiality “constitutes a technically and morally essential element of efficient medical care.”¹⁴² The federal government enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996, partly to standardize exactly what information was covered by confidentiality and what exceptions existed to that coverage.¹⁴³ Relevant to the issue of firearms, HIPAA allows a physician to disclose private health information if the physician, acting in good faith, believes that the information disclosure “[i]s necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and . . . is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.”¹⁴⁴

Physicians cannot be held liable for “honest errors in professional judgment,” but “the line between medical judgment and deviation from good medical practice (i.e., negligence) is not easy to draw, especially in cases involving psychiatric treatment.”¹⁴⁵ While laws hold psychiatrists to the same standard of care as other

138 Valarie Blake, *When is a Patient-Physician Relationship Established?*, AMA J. ETHICS 403, 404 (2012).

139 Martin Merritt, *Ethics on Ending the Patient-Physician Relationship*, MOD. MED. NETWORK (Oct. 27, 2013), <http://www.physicianspractice.com/compliance/ethics-ending-patient-physician-relationship>.

140 Peter Tyson, *The Hippocratic Oath Today*, NOVA (Mar. 21, 2001), <http://www.pbs.org/wgbh/nova/body/hippocratic-oath-today.html>.

141 *Id.*

142 *Id.* (citing Michael H. Kottow, *Medical Confidentiality, an Intransigent and Absolute Obligation*, 12 J. MED. ETHICS 117, 118 (1986)).

143 Amy Barnhorst et al., *How Should Physicians Make Decisions about Mandatory Reporting When a Patient Might Become Violent?*, 20 AMA J. ETHICS 29, 30 (2018).

144 45 C.F.R. § 164.512(j)(1)(i)(A) (2018).

145 Allen P. Wilkinson, *What is the Legal Liability for Outpatient Suicide?*, 23 PSYCHIATRIC TIMES 63, 64 (2006).

physicians, the nature of psychiatry creates a particularly challenging environment of professional judgment.¹⁴⁶ Psychiatry is “not an exact science and involves subjective professional treatment about the mental state of a patient[.]”¹⁴⁷ Patient suicide and the clinician’s response to suicidal behaviors and ideation (discussed further below) form the basis of a significant number of malpractice claims against psychiatrists.¹⁴⁸

B. Some existing legal duties physicians owe to third-parties

While the establishment of a physician-patient relationship creating a duty of care is relatively settled, less clear is when a physician owes a duty of care to a person other than a patient. In cases involving harm to someone other than the patient, several courts seek to limit the extent of liability exposure.¹⁴⁹ Most often, duties to third parties arise out of an original breach of patient care. Specifically, “the physician has breached a duty to the patient by failing to warn the patient of dangers, and the physician plainly would be subject to liability to the patient if the patient suffered harm.”¹⁵⁰ Liability, therefore, often hinges on foreseeability and states have, unsurprisingly, approached this issue differently. In Massachusetts, for example, the Supreme Judicial Court has held that when a physician failed to provide the patient warnings about driving while taking certain medications, the physician breached his duty of reasonable care to everyone foreseeably put at risk, including the young boy that the patient hit and killed while driving.¹⁵¹ In a case with similar facts, though, the Tennessee Supreme Court held that a physician does owe a duty to the patient in terms of warning about a medication’s side effects, but that he or she does not owe a duty to the members of the public when determining whether or not to prescribe such medication.¹⁵² The care of the patient outweighs

146 15 David C. Cook et al., N.Y. Prac., *New York Law of Torts* § 13:16 (2018).

147 *Id.*

148 *See What Puts a Psychiatrist at Risk for a Malpractice Lawsuit?*, 6 PSYCHIATRY 38, 38 (2009).

149 RESTATEMENT (THIRD) OF TORTS: PHYSICAL AND EMOTIONAL HARM § 7 cmt. e (AM. LAW INST. 2010).

150 *Id.*

151 *Coombes v. Florio*, 877 N.E.2d 567, 568–69 (Mass. 2007).

152 *Burroughs v. Magee*, 118 S.W.3d 323, 335 (Tenn. 2003); *see also* Thomas J. Leonardo, Case Comment, *Tort Law - Extending Physician’s Duty of Care to Third Parties for Breach of Duty Owed to Patient - Coombes v. Florio*, 877 N.E.2D 567 (Mass. 2007), 42 SUFFOLK U. L. REV. 277, 280 n.29 (2008).

any potential foreseeable harm to others.¹⁵³

Particularly relevant in the context of firearms, physicians and some non-physician mental health professionals also owe a duty to warn third parties if a patient poses a serious threat to an identifiable victim. Courts first recognized this duty in *Tarasoff v. The Regents of the University of California*,¹⁵⁴ in 1976. In 1969, a graduate student at the University of California at Berkeley named Prosenjit Poddar told his psychologist that he was going to kill a fellow student, unnamed, but “readily identifiable” as Tatiana Tarasoff.¹⁵⁵ Poddar and Tarasoff were acquaintances, but when Tarasoff rebuffed Poddar’s romantic advances, he became obsessed with her.¹⁵⁶ He secretly taped their conversations and obsessively listened to the recordings, “trying to understand why she did not love him.”¹⁵⁷ Eventually, Poddar voluntarily sought counseling on the university campus.¹⁵⁸ When Poddar admitted his intention to kill Tarasoff, his psychologist told Poddar that “if he continued to talk about killing this . . . woman he would have him hospitalized.”¹⁵⁹ Poddar thereafter stopped going to his therapy appointments and the psychologist subsequently reported Poddar’s threats to the police.¹⁶⁰ The police interviewed Poddar at his home,¹⁶¹ but took no action upon “his promise to stay away from Tatiana.”¹⁶² Two months later, Poddar confronted Tarasoff at her home and stabbed her to death with a kitchen knife.¹⁶³ He was eventually convicted of second-degree murder and served five years of a life sentence, but the Supreme Court of California overturned the conviction based on errors in the jury instructions.¹⁶⁴ The state decided not re-try him once he agreed to return to his home country of India and never to come back to the U.S.; he complied.¹⁶⁵

153 *Burroughs*, 118 S.W.3d at 335; Leonardo, *supra* note 152, at 280 n.29.

154 *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 437–39 (1976).

155 *Id.* at 432.

156 Romeo Vitelli, *Revisiting Tarasoff*, PSYCHOLOGY TODAY (July 28, 2014), <https://www.psychologytoday.com/us/blog/media-spotlight/201407/revisiting-tarasoff>; *People v. Poddar*, 518 P.2d 342, 344–45 (Cal. 1974).

157 Donald N. Bersoff, *Protecting Victims of Violent Patients While Protecting Confidentiality*, 69 AM. PSYCHOLOGIST 461, 461 (2014).

158 Vitelli, *supra* note 156; Bersoff, *supra* note 157, at 462.

159 Bersoff, *supra* note 157, at 462.

160 *Id.*

161 *Id.*

162 *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334, 340 (Cal. 1976).

163 Vitelli, *supra* note 156; *Tarasoff*, 551 P.2d at 334, 340.

164 *People v. Poddar*, 518 P.2d 342, 344 (Cal. 1974); Vitelli, *supra* note 156.

165 Bersoff, *supra* note 157, at 462.

Tatiana's parents then sued for wrongful death, claiming that the psychologist, and the university hospital that employed him, had a duty to warn Tatiana that Poddar had specifically threatened to kill her.¹⁶⁶ The defendants claimed that they owed no duty to Tatiana because she was not their patient.¹⁶⁷ The Supreme Court of California, in a novel ruling, found that:

[T]herapists cannot escape liability merely because Tatiana herself was not their patient. When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.¹⁶⁸

That protection could take the form of alerting the police, alerting the intended victim directly, or "whatever other steps are reasonably necessary under the circumstances."¹⁶⁹

Though the *Tarasoff* decision applied only to California, it became "perhaps the most notorious case in mental health law,"¹⁷⁰ and now all but four states have some form of a mental health professional "duty to warn" law.¹⁷¹ Even the Third Restatement of Torts codifies the concept that a mental-health professional has a special relationship with a patient and therefore "owes a duty of reasonable care to third parties with regard to risks posed by the [patient] that arise within the scope of the relationship."¹⁷² Many of these state laws prescribe the somewhat broad duty recognized by the Supreme Court of California.

In Massachusetts, as in most states, mental health professionals have a mandatory duty to warn in certain circumstances.¹⁷³ The relevant statute states that a licensed mental

166 *Tarasoff*, 551 P.2d at 334, 340.

167 *Id.* at 341–42.

168 *Id.* at 340.

169 *Id.*

170 Bersoff, *supra* note 157, at 461.

171 *Mental Health Professionals' Duty to Warn*, NAT'L CONFERENCE OF ST. LEGISLATURES (July 6, 2018), <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>.

172 RESTATEMENT (THIRD) OF TORTS: PHYSICAL & EMOTIONAL HARM § 41 (AM. LAW INST. 2012).

173 See MASS. GEN. LAWS ch. 123, § 36B (2018).

health professional¹⁷⁴ owes no duty to warn the potential victim of a patient unless “the patient has communicated to the licensed mental health professional an explicit threat to kill or inflict serious bodily injury upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat”¹⁷⁵ Alternatively, if

the patient has *a history of physical violence* which is known to the licensed mental health professional and the licensed mental health professional has a reasonable basis to believe that there is *a clear and present danger* that the patient will attempt to *kill or inflict serious bodily injury* against a reasonably identified victim or victims¹⁷⁶

the duty also applies. In the situations in which a duty does exist, the mental health professionals must take “reasonable precautions,” such as communicating the threat to the potential victim, notifying law enforcement, arranging for the patient’s voluntary hospitalization, or initiating the procedure for the patient’s involuntary hospitalization.¹⁷⁷

A handful of states, such as Mississippi, have permissive “duty to warn” statutes. Mississippi law states that all records of patients being treated by physicians, psychologists, licensed master social workers, and licensed professional counselors are confidential.¹⁷⁸ However,

when the patient has communicated to the [provider] *an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims . . . the [provider] may communicate the threat only to the potential victim or victims, a law enforcement agency, or the parent or guardian of a minor who is identified*

174 MASS. GEN. LAWS ch. 123, § 1 (2017), a “licensed mental health professional” is “any person who holds himself out to the general public as one providing mental health services and who is required pursuant to such practice to obtain a license from the commonwealth.” This includes psychiatrists. *See* Shea v. Caritas Carney Hosp., Inc., 947 N.E.2d 99, 104 n.9 (Mass. App. Ct. 2011).

175 MASS. GEN. LAWS ch. 123, § 36B(1) (2018) (emphasis added).

176 MASS. GEN. LAWS ch. 123, § 36B(1)(b) (2018) (emphasis added).

177 MASS. GEN. LAWS ch. 123, §§ 1, 36B (2018).

178 MISS. CODE ANN. § 41-21-97 (2017).

as a potential victim."¹⁷⁹

The difficulty for physicians, of course, lies in determining whether a patient is at risk for harming themselves (discussed below) or another person. As then-President of the American Psychological Association stated in 2014, "[I]t is extremely difficult to accurately predict which outpatients who express violent thoughts or fantasies will actually engage in violence [T]he only population for which accurate assessments of risk can be made are acutely psychotic, usually paranoid, active substance abusers who recently committed an act of violence."¹⁸⁰

VI. Physicians and firearms

A. *The right to counsel about firearms: Wollschlaeger v. Governor of Florida*

In 2011, Florida enacted the Firearm Owners' Privacy Act (FOPA), which prohibited health care practitioners from entering any information about a patient's firearm ownership into their medical record¹⁸¹ and stated that practitioners "should refrain"¹⁸² from even asking about firearm ownership or the presence of firearms in the home, unless such an inquiry was "relevant to the patient's medical care or safety or the safety of others."¹⁸³ The law also prohibited a practitioner from "discriminat[ing] against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition."¹⁸⁴ Finally, the statute required practitioners to "respect a patient's legal right to own or possess a firearm" and instructed that they "should refrain from

179 *Id.* (emphasis added).

180 Donald N. Bersoff, *Protecting Victims of Violent Patients While Protecting Confidentiality*, 69 AM. PSYCHOLOGIST 461, 464 (2014).

181 H.R. 155, 2011 Leg., 113th Sess. (Fla. 2011); *see also* *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251, 1267, 1270 (S.D. Fla. 2012).

182 This was apparently an attempt at compromise language between the Florida Medical Association and the NRA. *See* Clay Calvert et al., *Physicians, Firearms & Free Expression: Reconciling First Amendment Theory with Doctrinal Analysis Regarding the Right to Pose Questions to Patients*, 12 FIRST AMEND. L. REV. 1, 14–15 (2013). In the first district court injunction ruling, the judge found that shall/should both meant mandatory, given the sanctions attached to them. *Wollschlaeger v. Farmer*, 814 F. Supp. 2d 1367, 1375-77 (S.D. Fla. 2011).

183 Fla. H.R. 155 § 1.

184 *Id.* § 4.

unnecessarily harassing a patient about firearm ownership during an examination.”¹⁸⁵ If practitioners violated these prohibitions, that constituted grounds for professional discipline.¹⁸⁶ Such discipline could include the suspension of a license to practice medicine or an administrative fine up to \$10,000.¹⁸⁷

Ostensibly, the Florida legislature was motivated to pass FOPA based on the story of a pediatrician in Ocala, who asked the mother of a young child whether she kept a gun in her home.¹⁸⁸ When she refused to answer the question (and yelled that it was none of his business),¹⁸⁹ the doctor finished the rest of the exam, but then told the mother she would have to find a new pediatrician.¹⁹⁰ He told her that “they could not develop a relationship of trust essential to dealing with important health issues in the future.”¹⁹¹ The legislature pointed to this incident as an instance of a physician discriminating against a gun owner¹⁹² (though she refused to actually say whether she owned a gun or not). Even while creating the law, the legislature acknowledged that it was contrary to the guidance of organizations like the American Medical Association, potentially difficult to enforce, and perhaps even a violation of the First Amendment.¹⁹³

In reality, what amounted to a “human interest”¹⁹⁴ story and a handful of other similar anecdotes¹⁹⁵ did not truly inspire the Florida legislature to enact FOPA. Rather, the NRA seized upon the stories as apparent evidence that “doctors were ‘carrying out a gun-

185 Fla. H.R. 155.

186 *Id.*

187 *Id.* The earliest version of the bill made asking a patient about a firearm a third degree felony, punishable by up to 5 years imprisonment, with potential fines up to \$5 million. S. 432, 2011 Leg. (Fla. 2011); FLA. STAT. § 775.082 (2018).

188 Marla Spector Bowman, *Docs v. Glocks: Speech, Guns, Discrimination, and Privacy – Is Anyone Winning?*, 67 FLA. L. REV. 1455, 1461 (2015) (citing Fred Hiers, *Family and Pediatrician Tangle over Gun Question*, Ocala.com (July 24, 2010, 11:52 AM), <http://www.ocala.com/news/20100724/family-and-pediatrician-tangle-over-gun-question>).

189 Helena Rho, *The Pediatricians v. The NRA*, SLATE (Feb. 1, 2013, 2:53 PM), http://www.slate.com/articles/health_and_science/medical_examiner/2013/02/pediatricians_and_nra_physician_gag_rules_and_the_cdc_aca_and_states.html.

190 *Id.*

191 Bowman, *supra* note 188 (citing Hiers, *supra* note 187).

192 Bowman, *supra* note 188, at 1461.

193 *Id.* at 1462–63.

194 Calvert et al., *supra* note 182, at 20.

195 *Id.* at 12–13.

ban campaign.”¹⁹⁶ The NRA had been pushing similar legislation starting in 2006¹⁹⁷ and essentially drafted the Florida legislation.¹⁹⁸ Marion Hammer, a longtime and powerful NRA lobbyist in Florida, had a line straight to legislators.¹⁹⁹ She even directly reprimanded a legislature policy chief for proposing changes while the bill was in development. Hammer insisted that the policy chief do things, such as “put the first section back as it was and amend it as I suggested.”²⁰⁰ The policy chief agreed and made the NRA’s desired changes.²⁰¹

Within days of Governor Rick Scott signing the bill into law, three medical professionals, led by Dr. Bernd Wollschlaeger, filed suit, claiming that FOPA violated not only their First Amendment right to free speech but also that of their patients to hear from their doctors.²⁰² Eventually, a plethora of other health care workers and medical organizations joined the suit. As the complaint stated, “[b]y severely restricting . . . speech and the ability of physicians to practice such preventative medicine, the Florida statute could result in grievous harm to children, adolescents, adults, and the elderly. The First Amendment does not permit such a gross and content-based intrusion on speech”²⁰³ The plaintiffs deemed FOPA the “Physician Gag Law.”²⁰⁴

Florida offered two primary justifications for the law: (1) protecting the privacy rights of patients with guns, and (2) protecting the Second Amendment rights of all Floridians.²⁰⁵ The claim that FOPA protects the Second Amendment fails easily. Physicians are private actors and the Second Amendment applies only to the

196 Mike Spies, *The N.R.A. Lobbyist Behind Florida’s Pro-Gun Policies*, THE NEW YORKER (Mar. 5, 2018), <https://www.newyorker.com/magazine/2018/03/05/the-nra-lobbyist-behind-floridas-pro-gun-policies>.

197 Bowman, *supra* note 188, at 1469.

198 Carl Hiaasen, *Florida Loses Another Ridiculous Legal Battle*, MIAMI HERALD (July 7, 2012, 12:00AM; updated May 15, 2018, 6:19PM), <http://www.miamiherald.com/opinion/opn-columns-blogs/carl-hiaasen/article211205739.html>; see also Michelle Foody, Note, *Docs Versus Glocks: N.R.A. Takes Aim at Florida Physicians’ Freedom of Speech: Leaving Patients’ Health, Safety, and Welfare at Risk*, CARDOZO L. REV. DE NOVO 228, 233 (2013).

199 Spies, *supra* note 196.

200 *Id.*

201 *See id.*

202 Rho, *supra* note 189.

203 Complaint for Declaratory and Injunctive Relief at 1, *Wollschlaeger v. Farmer*, 880 F. Supp. 2d 1251 (S.D. Fla. 2012) (No. 11-22026-Civ.).

204 *Id.*

205 Foody, *supra* note 198, at 243.

government. Even if physicians were state actors (as, perhaps, a Veterans Administration employee might be), mere inquiry²⁰⁶ does not infringe on the right of any patient to keep firearms in the home for the purposes of self-defense, which is what the Supreme Court has deemed protected.²⁰⁷ Quite simply, “no doctor’s speech has any power to take away any guns.”²⁰⁸

That a law as extreme as FOPA came out of Florida is hardly surprising. Florida has long been known as a gun-friendly location, even dubbed the “Gunshine State.”²⁰⁹ The gun ownership rate is almost one-third.²¹⁰ At the time of FOPA’s enactment, Florida had also recently passed laws requiring that employers allow employees to keep firearms in their on-site vehicles and that county governments allow guns in public buildings and parks.²¹¹ Interestingly, back in 1989, Florida actually became the first state in the country to pass safe-storage laws for firearms; the legislature specifically invoked the “tragically large number of Florida children [who] have been accidentally killed or seriously injured by negligently stored firearms.”²¹² Improper storage of firearms, of course, is precisely one of the issues that physicians wished to speak to parents about, but which FOPA prohibited.²¹³

Over the next several years, the *Wollschlaeger* case went through a complicated procedural tangle. Initially, the federal district court agreed with the plaintiffs that the law violated physicians’ First Amendment right to free speech and struck down the law.²¹⁴ The judge, who emphasized an almost total lack of evidentiary support

206 Eugene Volokh, *Content-based restriction on doctors’ speech to patients about guns passes ‘strict scrutiny’*, WASH. POST (Dec. 16, 2015), https://www.washingtonpost.com/news/volokh-conspiracy/wp/2015/12/16/content-based-restriction-on-doctors-speech-to-patients-about-guns-passes-strict-scrutiny/?utm_term=.9ce299ba6cac.

207 *District of Columbia v. Heller*, 554 U.S. 570 (2008); *McDonald v. City of Chicago*, 561 U.S. 742, 791 (2010).

208 Volokh, *supra* note 206.

209 Calvert, *supra* note 181, at 17.

210 Andy Kiersz & Brett LoGiurato, *Here’s Where You’re Most Likely to Own a Gun*, BUSINESS INSIDER (July 3, 2015), <http://www.businessinsider.com/gun-ownership-by-state-2015-7>.

211 Calvert, *supra* note 182, at 17.

212 Foody, *supra* note 198, at 246.

213 See H.B. 155, 2011 Leg. (Fla. 2011).

214 Recent Case, *First Amendment – Eleventh Circuit Upholds Florida Law Banning Doctors from Inquiring about Patients’ Gun Ownership when Such Inquiry is Irrelevant to Medical Care: Wollschlaeger v. Governor of Florida*, 760 F.3d 1195 (11th Cir. 2014), 128 HARV. L. REV. 1045, 1046 (2015).

for Florida's assertions,²¹⁵ issued a permanent injunction against the law's enforcement. But Governor Rick Scott appealed the decision to the Eleventh Circuit, whose three-judge panels (through a series of hearings and re-hearings), issued three different rulings,²¹⁶ all of which upheld the law on varying grounds.²¹⁷ The final three-panel ruling even upheld the law under strict scrutiny.²¹⁸

After garnering national attention²¹⁹ and being dubbed the "Docs vs. Glocks"²²⁰ case, the Eleventh Circuit agreed to an *en banc* review of the case. The full court, in a 10–1 decision, overturned the panel, striking down most provisions of the law as violating the First Amendment, even using heightened rather than strict scrutiny.²²¹ The court emphasized that "doctors and medical professionals, as private actors, do not have any authority (legal or otherwise) to restrict the ownership or possession of firearms by patients (or by anyone else for that matter). The Second Amendment right to own and possess firearms does not preclude questions about, commentary on, or criticism for the exercise of that right."²²²

The Eleventh Circuit struck down the record-keeping, inquiry, and anti-harassment provisions at issue in FOPA.²²³ It upheld only the anti-discrimination clause, interpreting it to mean that physicians cannot single out gun-owning patients by doing things such as deliberately failing to return messages, charging more for the same services, or delaying treatment.²²⁴ The court acknowledged that "the applicable standard of care encourages doctors to ask questions about firearms,"²²⁵ and that overall, "there is no claim,

215 Calvert, *supra* note 182, at 33.

216 Volokh, *supra* note 206, at 1; Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014); Wollschlaeger v. Governor of Fla., 797 F.3d 859 (11th Cir. 2015); Wollschlaeger v. Governor of Fla., 814 F.3d 1159 (11th Cir. 2015).

217 Wollschlaeger v. Governor of Fla., 848 F.3d 1293, 1301 (11th Cir. 2017).

218 *See Wollschlaeger*, 814 F.3d at 1186.

219 *See, e.g.,* Ward, *supra* note 4; Clay Calvert, *Docs v. Glocks Case Fires Up in Florida: ACLU Files Brief on First Amendment Speech Rights*, HUFFINGTON POST (Aug. 27, 2014, 1:12 PM), https://www.huffingtonpost.com/clay-calvert/docs-v-glocks-case-fires-_b_5718743.html.

220 *See, e.g.,* Scott Maxwell, *Docs v. Glocks: Nutty Nonsense Run Amok*, ORLANDO SENTINEL (Feb. 21, 2017, 5:00 PM), <http://www.orlandosentinel.com/opinion/os-florida-docs-glocks-nra-scott-maxwell-20170221-story.html>.

221 *Wollschlaeger*, 848 F.3d at 1301.

222 *Id.* at 1313.

223 *Id.* at 1318.

224 *Id.* at 1317.

225 *Id.*

much less any evidence, that routine questions to patients about the ownership of firearms are medically inappropriate, ethically problematic, or practically ineffective.”²²⁶

Before the Florida law was struck down, the NRA helped get similar legislation introduced in Alabama, Minnesota, Montana, North Carolina, Oklahoma, South Carolina, Virginia, and West Virginia.²²⁷ Only Montana, which has one of the highest gun suicide rates in the country,²²⁸ actually enacted anything close to FOPA. Focusing on discrimination rather than speech, Montana now prohibits a health care provider or facility from making a patient’s firearm ownership (or a refusal to talk about firearms ownership) a condition of receiving health care.²²⁹

Florida wisely chose not to appeal the Eleventh Circuit *Wollschlaeger* decision to the U.S. Supreme Court.²³⁰ And though the ruling technically only applies to Florida, Alabama, and Georgia, the case had social and legal ramifications far beyond that region.²³¹ The message was clear: physicians have a right to talk to their patients about firearms. The next logical step is to ask whether physicians actually have a duty to do so.

B. So there’s a right to talk about firearms, but is there a duty?

No statute or case law currently requires physicians to discuss firearms with their patients in any situation.²³² Indeed, most physicians “ask infrequently about firearms and counsel poorly, if at all”²³³ However, duties to ask about firearms—whether about ownership, possession, access to, or storage of—are easily read into existing physician duties of care, particularly in the context of suicidal or pediatric patients. So, while there may be no currently

226 *Id.* at 1316.

227 Bowman, *supra* note 188, at 1469–70.

228 Nat’l Ctr. for Health Statistics, *Stats of the State of Montana*, CTRS. FOR DISEASE CONTROL AND PREVENTION (Apr. 11, 2018), <https://www.cdc.gov/nchs/pressroom/states/montana/montana.htm>; Mont. Dep’t of Pub. Health and Human Servs., *Montana Strategic Suicide Prevention Plan* 9, 14, 18 (July 2016), <https://www.sprc.org/sites/default/files/State%20Suicide%20Plan-2017.pdf>.

229 MONT. CODE ANN. § 50-16-108 (2013).

230 Kam, *supra* note 10.

231 *See, e.g.*, Parmet et al., *supra* note 5.

232 Garen J. Wintemute et al., *Yes, You Can: Physicians, Patients, and Firearms*, 165 ANNALS OF INTERNAL MED. 205, 205 (2016).

233 *Id.*

articulated duty to discuss firearms, such a duty may very well be found without any further legislation or common law development.

1. *Physicians, suicidal patients, and firearms*

Historically, even as states increasingly decriminalized suicide, tort law still considered suicide an intentional act and therefore one that “broke the chain of causation between the defendant’s negligence and the plaintiff’s death.”²³⁴ But the law also imposed an affirmative duty in some situations, including upon hospitals, to prevent patients from attempting or completing suicide.²³⁵ “Two key facts are common in the cases finding that third parties have assumed a suicidal person’s duty of care: (1) the defendant exercised custody or control over the suicide victim, and (2) the defendant knew or had reason to know that the suicide victim was a danger to himself.”²³⁶

This notion of restricting the duty to patients under direct custodial control used to be pervasive; psychiatrists treating outpatients “essentially enjoyed legal immunity from liability for their negligence in treating such patients who did commit suicide or were injured in a suicide attempt.”²³⁷ Courts have increasingly found that outpatient status does not necessarily mean that a treating physician is relieved of a duty to treat. Rather, “the relevant inquiry is whether a physician failed to provide treatment for the patient and that failure proximately resulted in the patient taking his or her life.”²³⁸ This concept grows out of the more general duty of a physician to “exercise the degree of skill ordinarily employed under similar circumstances by medical specialists in his field in the same or similar communities.”²³⁹ Today, medical malpractice claims based on suicide make up the largest number of claims (20%) against psychiatrists, and the largest percentage of dollars paid in settlement (40%).²⁴⁰

234 SUSAN STEFAN, *RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW* 22 (2016).

235 Victor E. Schwartz, *Civil Liability for Causing Suicide: A Synthesis of Law and Psychiatry*, 24 VAND. L. REV. 217, 245 (1971); see also Charles J. Williams, *Fault and the Suicide Victim: When Third Parties Assume a Suicide Victim’s Duty of Self-Care*, 76 NEB. L. REV. 301, 302, 305–06 (1997).

236 Williams, *supra* note 235, at 309.

237 Wilkinson, *supra* note 145, at 63.

238 *Id.* (quoting *Edwards v. Tardif*, 692 A.2d 1266 (Conn. 1997)).

239 Schwartz, *supra* note 235.

240 MARTIN BLINDER, *PSYCHIATRY IN THE EVERYDAY PRACTICE OF LAW* §

The issue of whether assessing suicidality is part of a routine duty of care that a physician owes to a patient is rooted in malpractice law and therefore varies from state to state.²⁴¹ But a few cases are illustrative of the principle that failure to treat a patient known to be at risk for suicide constitutes a failure of the duty of care. In 1978—just two years after the seminal *Tarasoff* decision—the California Court of Appeals held in *Bellah v. Greenson* that a psychiatrist owed a duty of care to a patient to take appropriate preventive measures when that patient was potentially suicidal, even when not in a hospital or custodial setting.²⁴² Tammy Bellah was a patient of psychiatrist Daniel Greenson when she died by suicide from an overdose of pills.²⁴³ Greenson had “concluded that Tammy was disposed to suicide” and her parents sued him for wrongful death, based on his failure to prevent her suicide.²⁴⁴ Tammy had been an outpatient of Dr. Greenson, and California, up to that point, had only ever found a duty to take precautions to prevent the suicide of a patient admitted to an institutional setting.²⁴⁵ Here, however, the court found that a similar duty of care existed for an outpatient-psychiatrist relationship as well; whether such duty had been breached was a question of fact.²⁴⁶ Explicitly refusing to extend *Tarasoff*, however, the court held that this duty was owed directly and solely to the patient, and did not require the psychiatrist to break confidentiality to inform third parties of a patient’s potential suicide.²⁴⁷ Failing to take precautions for the patient, however, fell below the professional standard of care and could therefore form the basis of a malpractice claim.²⁴⁸

Similarly, in 2016, the Florida Supreme Court ruled that a primary care physician’s regular duty of care to a patient could be breached if that patient dies by suicide. In *Chirillo v. Granicz*,²⁴⁹ a primary care physician had been prescribing Jacqueline Granicz an anti-depressant for about three years when she requested a change in prescription because she was experiencing unpleasant

13:1 (4th ed. 2016).

241 See B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLINICAL ORTHOPEDIC RELATED RES. 339, 340 (2009).

242 *Bellah v. Greenson*, 81 Cal.App.3d 614 (1978) (dismissed on other grounds).

243 *Id.* at 618.

244 *Id.*

245 *Id.* at 620.

246 *Id.*

247 *Id.* at 620–21.

248 Wilkinson, *supra* note 145, at 63.

249 *Chirillo v. Granicz*, 199 So.3d 246, 248 (2016).

side effects. Dr. Chirillo prescribed a new medication; the day after picking up her new pills, Granicz died by suicide.²⁵⁰ Her husband sued Dr. Chirillo, claiming he breached his duty of care to treat Mrs. Granicz appropriately and that breach had resulted in her suicide.²⁵¹ Unlike in *Bellah*, Dr. Chirillo had never observed nor noted that his patient seemed suicidal.²⁵² The Florida Supreme Court held that a patient's suicide could be considered a breach, amounting to medical malpractice, of the regular duty of care owed to a patient; whether or not such a breach occurred is a factual inquiry.²⁵³

Liability for patient suicide still remains a matter that varies from state to state. In Massachusetts, for example, a psychiatrist clearly has a legal duty to treat a patient according to the standard of care, but has no additional specific legal duty to safeguard the patient from serious danger to himself.²⁵⁴ Importantly, unlike the legislative proliferation that followed *Tarasoff*, few statutes exist that spell out a provider's duty owed directly to a suicidal patient. Some states, like New York, do include reporting whether a patient is at risk of serious harm to themselves in their *Tarasoff*-esque laws.²⁵⁵ Essentially no cases exist that specifically address firearms in terms of a physician's duty of care owed to a potentially suicidal patient. In fact, only one published case appears to exist that even raises a claim of "failing to give appropriate warnings and precautions reasonably calculated to prevent [decedent's] access to firearms."²⁵⁶ In *Scheidt v. Denney*, Mr. Scheidt had been committed to a psychiatric hospital for several weeks, under the care of Dr. Denney.²⁵⁷ After discharge, he failed to continue to see Dr. Denney and died by suicide, using a firearm, one week later.²⁵⁸ Mr. Scheidt's wife sued Dr. Denney for wrongful death and, among other things, a common law claim of "failing to give appropriate warnings and precautions reasonably calculated to prevent Mr. Scheidt's access to firearms."²⁵⁹ The case, however, does not ever address the firearm claim specifically. The jury found that Dr. Denney had breached standards of care, but did not specify which

250 *Id.*

251 *Id.*

252 *Id.*

253 *Id.* at 251.

254 *See* *Stepkakoff v. Kantar*, 473 N.E.2d 1131, 1135 (Mass. 1985).

255 *See* N.Y. MENTAL HYG. Law § 9.46 (McKinney 2013).

256 *Scheidt v. Denney*, 644 So. 2d 813 (La. Ct. App. 1994).

257 *Id.* at 814–15.

258 *Id.* at 815.

259 *Id.*

standards or how they were breached.²⁶⁰ The jury also concluded that those breaches did not actually cause Mr. Scheidt's death.²⁶¹ The Louisiana Court of Appeals upheld the verdict, stating simply that the record could have supported a "finding of improper post-discharge care and/or failure to give appropriate firearms warnings and precautions."²⁶² So, while possible that the jury could have not only found but supported a common law claim for a physician's failure to give warnings to a suicidal psychiatric patient, neither the verdict nor the decision in the appeal solidified that finding.

As part of a general duty of care, however, reducing access to firearms should be a primary focus for suicide prevention,²⁶³ and physicians should prioritize asking about such access.²⁶⁴ Physicians should utilize "lethal means counseling" as a routine part of emergency and primary care,²⁶⁵ though particularly "when a patient provides information or exhibits behavior suggesting an acutely increased risk for violence, such as explicit or implicit endorsement of suicidal or homicidal intent or ideation."²⁶⁶ Such counseling includes suicide risk assessment and creating a plan to remove certain objects from the patient's home, such as firearms and other weapons, in addition to medications, alcohol and other potential poisons.²⁶⁷

For older children and adolescents, suicide should be of particular concern. Children who die by suicide using a firearm are most often experiencing "acute crises and life stressors such as relationship, school, and crime problems."²⁶⁸ This age group tends to be impulsive and therefore access to firearms poses a particular risk.²⁶⁹ Pediatricians can potentially reduce such deaths not only by

260 *Id.*

261 *Id.*

262 *Id.* at 817.

263 Carol W. Runyan et al., *Law Enforcement and Gun Retailers as Partners for Safely Storing Guns to Prevent Suicide: A Study in 8 Mountain West States*, 107 AM. J. PUB. HEALTH 1789, 1789 (2017).

264 See Alexander D. McCourt & Jon S. Vernick, *Law, Ethics, and Conversations Between Physicians and Patients About Firearms in the Home*, 20 AMA J. ETHICS 69, 70 (2018).

265 Runyan et al., *supra* note 263, at 1789.

266 Garen J. Wintemute et al., *Yes, You Can: Physicians, Patients, and Firearms*, 165 ANNALS INTERNAL MED. 205, 207 (2016).

267 Runyan et al., *supra* note 263, at 1789.

268 Katherine A. Fowler et al., *Childhood Firearm Injuries in the United States*, 140 PEDIATRICS 1, 8 (2017).

269 Miller et al., *supra* note 75, at 1031.

screening for depression and other behavioral health risks, but also by inquiring about the access to firearms at times when children may be experiencing crisis.²⁷⁰ These inquiries should include questioning both the child and the parent/guardian about the presence of firearms in the home, the storage of those firearms, and whether the firearms can be removed from the home temporarily.

The most difficult barrier to implementing these conversations is the reluctance of physicians themselves:

The fact is that most clinicians, including those who routinely encounter suicidal patients, rarely, if ever, provide firearm-safety counseling. This reticence predated the FOPA and has persisted since its passage, despite evidence that physicians believe that they have a right and a responsibility to engage in firearm-injury prevention, that authoritative medical societies have recommended counseling at-risk patients, and that the majority of gun owners agree that such counseling may be appropriate.²⁷¹

Even though they have the legal right to discuss firearms, some physicians may simply feel uncomfortable or anxious about these conversations.²⁷² Some may be concerned about the conversation becoming political, or the potential of the conversation to offend the patient.²⁷³ A risk assessment, particularly if the patient has indicated a potential for harming themselves or others, must include questions about guns, including the types of guns owned and how the guns are stored.²⁷⁴ Encouragingly, most patients are receptive to and comfortable with physicians “initiating discussions about firearms in the home in the context of depression, suicidality, or cognitive impairment, and that physician counseling can exert a substantial positive impact on firearm safety practices in the patient’s home.”²⁷⁵

270 See Fowler et al., *supra* note 268, at 9.

271 Wendy E. Parmet et al., *Physicians, Firearms, and Free Speech – Overturning Florida’s Firearm Safety Gag Rule*, 376 NEW ENG. J. MED. 1901, 1902–03 (2017).

272 Amy Barnhorst et al., *How Should Physicians Make Decisions about Mandatory Reporting When a Patient Might Become Violent?*, 20 AMA J. ETHICS 29, 31 (2018).

273 *Id.*

274 *Id.* at 31–32.

275 Marshall B. Kapp, *The Physician’s Responsibility Concerning Firearms and Older*

Easy scripts also exist for those physicians who may be reluctant to broach the subject:

Lots of families in my practice keep guns at home. Sometimes when a gun owner is struggling . . . and has thoughts of suicide, they'll temporarily store their guns such that they can't get to them in a moment of desperation. For example, some people will ask their friends to hold onto their guns, others will store their guns locked up and keep the key in a safe deposit box at the bank until they've recovered. Are these strategies you might consider?²⁷⁶

The emphasis should be on collaboration and support, focusing on the patient making the right choice.²⁷⁷

2. *Pediatricians and firearms*

In addition to the duties specific to suicide discussed above, pediatricians have a heightened duty to discuss firearms with the parents of their patients. “The American Academy of Pediatrics (AAP) . . . recommends that conversations about guns and gun safety start during a prenatal visit and be repeated every year as part of anticipatory guidance. Those conversations start with a question: ‘Do you own a gun?’”²⁷⁸

The improper storage of firearms significantly increases the chances that a child will access it.²⁷⁹ Although 19 states have laws

Patients, 25 KAN. J.L. & PUB. POL'Y 159, 175 (2016); see also Erin Renee Morgan et al., *Firearm Ownership, Storage Practices, and Suicide Risk Factors in Washington State, 2013–2016*, 108 AM. J. PUB. HEALTH 882, 887 (2018) (“A nationally representative survey of adults in the United States found that 2 in 3 adults agree that it is sometimes appropriate for clinicians to discuss firearms with their patients.”).

276 Catherine Barber et al., *How Physicians Can Reduce Suicide – Without Changing Anyone’s Mental Health*, 129 AM. J. MED. 1016, 1016–17 (2016).

277 See *id.* Physicians do need to be aware of the relevant state laws about, for example, transferring firearms from one person to another. See McCourt & Vernick, *supra* note 18, at 70–71.

278 Rho, *supra* note 189.

279 NAT'L PHYSICIANS ALL. & LAW CTR. TO PREVENT GUN VIOLENCE, *GUN SAFETY & PUBLIC HEALTH: POLICY RECOMMENDATIONS FOR A MORE SECURE AMERICA* 7 (2013), http://npalliance.org/wp-content/uploads/Gun_Safety_Public_Health_Joint_Report-092513.pdf.

aimed at preventing firearm access by children,²⁸⁰ an estimated two million children live in households with loaded, unlocked guns.²⁸¹ Only 39% of parents believed that their children even knew where guns were kept in the home, but in reality, 73% of children knew and 36% had even handled the guns.²⁸² The AAP recommends that physicians should have a “tailored safe storage counseling approach,” including a discussion with parents not only about ownership, but also about the number and types of guns in the home.²⁸³ The AAP guidelines for parents recommend that all firearms in a household be stored locked and unloaded, but fewer than one in three new gun owners with children actually adhere to that practice.²⁸⁴ Promisingly though, even brief counseling in the office by a pediatrician has positive effects: one study found families with firearms who received such counseling were three times more likely to make safety changes than those who did not have a discussion.²⁸⁵

Improved storage practices are easy to implement and effective in reducing the access that children have to guns.²⁸⁶ The U.S. General Accounting Office has estimated that 31% of accidental deaths caused by firearms might be prevented by the addition of two devices: (1) a child-proof safety lock, and (2) a loading indicator.²⁸⁷ Another study found that keeping firearms locked, unloaded, and stored separately from locked ammunition has a “protective effect” and may reduce youth suicide and “unintentional injury.”²⁸⁸

280 McCourt & Vernick, *supra* note 18, at 71; *see also National Data, ST. FIREARM LAWS*, <https://www.statefirearmlaws.org/national-data> (choose Category: Child Access Prevention) (last visited Oct. 1, 2018).

281 Renee M. Johnson et al., *Are Household Firearms Stored Less Safely in Homes With Adolescents*, 160 JAMA PEDIATRICS 788, 788 (2006).

282 NAT’L PHYSICIANS ALL. & LAW CTR. TO PREVENT GUN VIOLENCE, *supra* note 41, at 7.

283 Foody, *supra* note 198, at 241.

284 Joseph Wertz et al., *Differences Between New and Long-Standing U.S. Gun Owners: Results From a National Survey*, 10 AM. J. PUB. HEALTH 871, 871 (2018); *see also* Deborah Azrael et al., *Firearm Storage in Gun-Ownning Households with Children: Results of a 2015 National Survey*, 95 J. URB. HEALTH 295, 296 (2018).

285 *See* Foody, *supra* note 198, at 241; *see also* Paul J. D. Roszko et al., *Clinician Attitudes, Screening Practices, and Interventions to Reduce Firearm-Related Injury*, 38 EPIDEMIOLOGIC REV. 87, 104 (2016).

286 *See* McCourt & Vernick, *supra* note 18, at 71.

287 U.S. GENERAL ACCOUNTING OFFICE, GAO/PEMD-91-9, ACCIDENTAL SHOOTINGS: MANY DEATHS AND INJURIES CAUSED BY FIREARMS COULD BE PREVENTED 17, 17 (1991).

288 NAT’L PHYSICIANS ALL. & LAW CTR TO PREVENT GUN VIOLENCE, *supra* note 41, at 7 (citing Mark A. Schuster et al., *Firearm Storage Patterns in U.S.*

3. *Primary care and firearms*

In a primary care or family practice setting, a physician should routinely ask,²⁸⁹ as part of the basic duty of care owed to a patient: whether the patient has firearms in the home, how those firearms are stored, what training the patient has in firearms, who else is in the household, and whether there is a history of any violence or suicidal behavior in the patient's or in any household members' pasts.²⁹⁰ Such discussion could include "speaking freely to patients in a nonjudgmental way, giving them safety-related factual information, answering patients' questions, advising them about behaviors that promote health and safety, and documenting these conversations in the patient's medical record (just as the physician would document conversations . . . regarding other kinds of health-related behaviors)."²⁹¹ This questioning should also continue at regular intervals, as the "dynamic nature of firearm ownership" means that a patient's status as a non-gun owner may change by the next visit.²⁹²

Physicians may also be reluctant to discuss firearms as part of routine care, whether because of unfamiliarity with the subject, uncertainty about wording, anxiety about harming the relationship with the patient, or not wanting to wade into a "political" topic.²⁹³ Basic training, assistance of example scripts (as discussed above), and guidance from other practitioners can address and ease many of these physician concerns.²⁹⁴

4. *Potentially dangerous patients and firearms*

Inquiring about firearms should be paramount when a *Tarasoff*-like situation arises and a patient poses a potential danger to another person. Indeed, determining access to firearms (and other potentially lethal means) in such situations is self-evident.²⁹⁵ As soon as a physician has reason to believe that the patient may pose a threat to another person, he or she must, if at all possible,

Homes with Children, 90 AM. J. PUB. HEALTH 588, 590 (2000)).

289 See Wintemute et al., *supra* note 231, at 211.

290 See *id.* at 207, 209.

291 Kapp, *supra* note 274, at 174–175.

292 See Wertz et al., *supra* note 283.

293 See Wintemute et al., *supra* note 231, at 208.

294 *Id.* at 208–09.

295 *Id.* at 207.

immediately inquire about the patient's access to firearms. This determination could be crucial, not only in deciding whether the threat rises to the level of required reporting, but also in gauging the seriousness of the threat. The lethality associated with firearms could transform an otherwise empty threat into a deadly one. Taking firearms into account is especially crucial if the required duty has an element about whether the patient has the “. . . ability to carry out the threat.”²⁹⁶

VII. Conclusion

Physicians clearly have a right to discuss firearms with patients, and generally have a professional duty to do so as well. While no legal duty has yet been articulated, such a duty could easily be read into existing duties of care. However, doing so would inevitably lead to an increase in malpractice claims, an issue that the medical community already bemoans.²⁹⁷ Mandating these conversations—either by law or by instilling fear of malpractice—could have a positive impact in terms of educating patients about the dangers of firearms, proper storage techniques, and the like. Though, largely due to the dearth of research funding, that impact is far from certain. Looking at the issue of firearm violence from a perspective of getting fewer people to die, adding to the legal burden of physicians is not the best way to accomplish that. Imposing an articulated duty would risk creating hostility from the medical community, which may very well view another requirement as a hassle, inconvenience, added expense, or imposition on their relationships with their patients. But, doctors play far too crucial a role in fighting gun violence to risk that rift.²⁹⁸ The idea should be to get doctors to adopt these inquiries and discussions as part of routine care, not because they are ordered to do so by legislatures, courts, or attorneys, but because these inquiries could literally save lives. A partnership between the medical community, the public health community, and the legal community should remain the ideal alliance. Imposing an explicit, mandated duty on physicians to discuss firearms with their patients would risk causing resentment and fear of litigation. Instead, the

296 See MASS. GEN. LAWS ch. 123, § 36B(1) (2018).

297 See Joseph Bernstein, *Malpractice: Problems and Solutions*, 471 CLINICAL ORTHOPAEDICS & RELATED RES. 715 (2013).

298 See Priya Joshi, *Doctors Need to Discuss Firearm Safety and Gun Violence with Their Patients*, STAT (Nov. 13, 2017), <https://www.statnews.com/2017/11/13/gun-violence-firearms-doctors-patients/>.

focus should be squarely on reducing the number of injuries and deaths, by encouraging physicians to talk to their patients about guns. This simple update would put physicians in the best position to start moving toward the goal of losing fewer lives to guns, all with a simple conversation.

Deputizing Family: Loved Ones as a Regulatory Tool in the “Drug War” and Beyond

*Matthew B. Lawrence**

Many laws use family members as a regulatory tool to influence the decisions or behavior of their loved ones, i.e., they deputize family. Involuntary treatment laws for substance use disorder are a clear example; such laws empower family members to use information shared by their loved ones to petition to force their loved ones into treatment without consent. Whether such deputization is helpful or harmful for a patient’s health is a crucial and dubious question discussed in existing literature, but use of family members as a regulatory tool implicates important considerations beyond direct medical impacts that have not been as fully explored. These include the potential for interference with underlying family relationships, the invisibility of care worker burdens, and the inequality of both the burdens and the benefits of care work.

This Article shows how these difficult-to-quantify social consequences of deputizing family can and should be incorporated into the evaluation of laws that use loved ones as a tool of public health. It develops a normative framework for doing so and demonstrates the usefulness of this framework by applying it to the question of how and when patients may permit family members to access and authorize disclosures of protected health information. That analysis reveals the desirability of an “active choice” approach to such deputization; as compared to an “isolation by default” approach, active choice holds the promise to better and more fairly encourage, recognize, support, facilitate, and perhaps even compensate the uniquely valuable care work by loved ones that many who suffer from substance use disorder rely upon as a crucial support in their battle with illness. Specific administrative changes to effectuate that conclusion are recommended. Finally, the broader promise and pitfalls of the Article’s “deputization” frame for understanding certain forms of care work are also discussed.

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I. Introduction

The United States regulatory framework for preventing, treating, and reducing the harms of substance use disorder (“SUD”) increasingly relies upon loved ones of those who suffer from the disease. In some cases the law explicitly and intentionally deputizes family in addressing SUD; for example, “accessory” drug laws enlist family in efforts at prevention-by-prohibition by making them liable for involvement in their loved ones’ drug use.¹ And involuntary treatment laws enacted by numerous states and under consideration in many others explicitly empower a person’s “physician, spouse, blood relative, [or] guardian” to petition a court to have them sent to treatment.²

In other cases, the SUD regulatory framework deputizes family implicitly and perhaps unintentionally, though nonetheless foreseeably. In many counties and states today, accessing treatment for SUD entails days or weeks of phone calls and car trips looking for open beds, especially for those hoping to have treatment covered by insurance or Medicaid. In economics and ethics, this is referred to as rationing by “ordeal”—rather than prices separating those who receive the good from those who do not, a person’s ability to complete an arduous task does so.³ When it comes to addiction, the ordeal our regulatory framework puts between self-diagnosis of

1 See, e.g., *United States v. Jenkins*, 928 F.2d 1175, (D.C. Cir. 1991) (upholding conviction based on inference that one who owns and maintains a house knows about drug and other illegal activities her son and other occupants engage in inside the home); *United States v. Johnson*, 769 F. Supp. 389, 394 (D.D.C. 1991) (holding that “Johnson’s status as the lessee alone is a sufficient basis upon which to find Ms. Johnson guilty of possession with intent to distribute” in violation of 21 U.S.C. §§ 841(a)(1) (2018)).

2 E.g., S. 391, Gen. Assemb., 2017–18 Reg. Sess. (Pa. 2017) (“A spouse, relative or guardian of the respondent must file the [involuntary treatment] petition.”). See also MASS. GEN. LAWS ch. 123, § 35 (2018) (showing that a proceeding may be initiated by a “police officer, physician, spouse, blood relative, guardian, or court official”). See generally *Involuntary Commitment for Individuals with a Substance Use Disorder or Alcoholism*, NAT’L ALLIANCE FOR MODEL STATE DRUG LAWS (Aug. 2016), <http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf>.

3 See Benjamin A. Olken, *Hassles Versus Prices: How Can Subsidized Health Products Best Target Those Who Value Them?*, 353 SCIENCE 864 (2016). See generally Vivi Alatas et al., *Ordeal Mechanisms in Targeting: Theory and Evidence from a Field Experiment in Indonesia* (National Bureau of Economic Research, Working Paper No. 19127, 2013).

suspected SUD and life-saving treatment can effectively conscript involved loved ones in helping a person with SUD find and obtain care, unpaid.

These are only examples. For many sufferers, loved ones play a vital and often personally costly role in almost every aspect of their battle with SUD. Families devote countless hours to reducing the harms of illness, accessing and navigating treatment, and assisting their loved ones in their recovery. They provide support, shelter, food, counseling, oversight, transportation, encouragement, love, advocacy, and care, among other things.⁴

Scholarship addressing specifically the role of family in fighting disease, including SUD, has appropriately focused on the crucial and pressing question of whether family involvement helps or hurts patients' (or, sometimes, caregivers') health outcomes (meta-analyses of existing studies report that social relationships significantly improve health outcomes on net),⁵ with some exceptions.⁶ On this frame, whether deputization is a good idea or not depends exclusively on whether it improves the health of those directly impacted or not. This Article shows how our understanding of the wisdom vel non of laws that deputize family members can

4 See generally BEVERLY CONYERS, *ADDICT IN THE FAMILY: STORIES OF LOSS, HOPE, AND RECOVERY* (2003); BONNIE KAYE, *JENNIFER NEEDLE IN HER ARM: HEALING FROM THE HELL OF MY DAUGHTER'S DRUG OVERDOSE* (2014); CHLOE SILVERMAN, *UNDERSTANDING AUTISM: PARENTS, DOCTORS, AND THE HISTORY OF A DISORDER* 235–36 (2012).

5 See Julianne Holt-Lunstad et al., *Social Relationships and Mortality Risk: A Meta-Analytic Review*, 7 *PUB. LIBR. OF SCI.* 9 (2010) (discussing that, in a meta-analysis of 148 independent studies, social relationships (including living alone, marital status, perceptions of loneliness, and so on) were found to “significantly predict mortality” with an overall effect corresponding to “a 50% increase in odds of survival as a function of social relationships”); J. S. House et al., *Social Relationships and Health*, 241 *SCIENCE* 540, 541 (1988) (“Social relationships, or the relative lack thereof, constitute a major risk factor for health—rivaling the effect of well-established health risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity”); Candyce H. Kroenke et al., *Social Networks, Social Support, and Survival After Breast Cancer Diagnosis*, 24 *J. CLINICAL ONCOLOGY* 1105 (2006) (66% increased mortality among breast cancer patients who were socially isolated, i.e., reported not having a “confidant”).

6 See Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 *YALE J. HEALTH POL'Y, L. & ETHICS* 147 (2016) (addressing care work burdens on family in the context of long-term care). This Article seeks to build on Hoffman's study of long-term care by applying the focus on family care takers to SUD, elaborating upon impacts care work has, and developing a welfare economic framework to balance social consequences with health impacts.

be improved by broadening our perspective to encompass not only medical effects but also social consequences for patients and their families.

Specifically, this Article draws from a line of feminist legal scholarship problematizing “care work” in other contexts—in particular childcare and long-term care—to identify considerations other than health impacts that can affect the desirability of deputizing family. These include the potential for interference with existing family relationships, invisibility of the burden of care work on loved ones, and inequality in the distribution of burdens and benefits of care work. The Article then explores the real-world implications of such difficult-to-quantify considerations, arguing that their existence necessitates more cautious, research-informed regulation; drawing from literature on cost-benefit analysis to offer a normative framework for the weighing of such considerations given incomplete evidence; and demonstrating the usefulness of that framework by applying it to lay out the case for adopting an “active choice” approach to deputizing family to obtain and share private information about SUD treatment.

In short, the Article illustrates through its study of SUD how assessment of laws that deputize family in health care can be improved by considering the interference with family relationships, invisible burdens, and inequality entailed in some such laws. The Article then touches upon implications for deputizing family and the development of family law beyond health care.

The Article proceeds in four parts. Part II offers background and motivation. It shows how the addictions crisis and associated “drug war” is a ready topic through which to explore laws that deputize family because laws in this domain increasingly use family as a regulatory tool and because family are a particularly potent tool for diseases of despair such as addiction.

Part III draws from existing scholarship on care work in other contexts to develop consequential normative considerations for assessing laws that deputize family that include considerations beyond direct health impacts. It argues that while health impacts are of course a primary consequential concern, when weighing laws that deputize family we must also consider the potential for interference with family relationships, and the potential invisibility of care work, the potential inequality of care work.

Part IV explores implications. In light of the behavioral “knowledge problem,” it may be difficult to know for sure whether

social consequences like those identified in Part III outweigh potential health impacts to counsel against (or in favor of) any particular reform. As a first step, new laws deputizing family should include information-gathering provisions to enable ongoing assessment of any social and health impacts that might support subsequent revision, and policymakers should be hesitant to adopt reforms that may interfere with family relationships without an evidentiary basis for believing that such interference is medically justified. Furthermore, “break-even” analysis employed to incorporate hard-to-quantify variables into cost-benefit analysis in administrative law and regulation can be used to account for social consequences. Part IV shows how employing this approach supports a change to the choice architecture of consent to disclosure of protected SUD health information; patients should be given an “active choice” about whether they consent to disclosure of their information to loved ones. As compared to an “opt in” approach that favors isolation by default, such an active choosing regime recognizes and encourages underlying family relationships, brings family burdens to light, and mitigates inequality in access to and burdens of family support.

Finally, the conclusion summarizes and discusses implications beyond substance use disorder and beyond health care. While the Article’s launching-off point and focus is the increasing deputization of family in the “drug war,” its narrative framework and discussion offer broader insights. Its normative approach is broadly applicable, though additional variables for break-even analysis will depend on context. More fundamentally, the “deputizing” frame that emerges from a focus on the utilization of family as a regulatory tool in public health helpfully collapses the public/private distinction that has contributed to invisibility of care work in other contexts, but problematically may do so by bringing all family life into the “public” sphere.

II. Loved Ones as a Regulatory Tool in Public Health: the Case of SUD

A. Leverage Points for Regulating SUD

Health law scholarship traditionally separated, for purposes of analysis, laws’ impacts on health care cost, access, and quality (in addition to ethical considerations).⁷ Scholarship in public health

⁷ E.g., Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law*, 41 WAKE

in recent years has shown us that we must consider also the social determinants of health and the impact of health laws on harm reduction.⁸ Thus, analyzing the consequences of law for health or a disease requires at least considering a law's impacts on social determinants, harm reduction, access to health care, quality of care, and cost.

In addressing SUD as with other chronic illnesses, this framework for understanding a law's potential impacts on health maps roughly onto four key leverage points at which laws seek to or foreseeably change behavior and outcomes. These leverage points are prevention, harm reduction, access, and quality.⁹

First, prevention. The likelihood of contracting addiction in the first place, which might be thought of as a person's baseline "health," is a function not only of their vital characteristics but also of their behaviors, access to transportation, housing, and other social determinants. One engrained legal effort at reducing the risk of addiction is criminal prohibition on drug use and sale associated

FOREST L. REV. 365, 379 (2006) (describing textbook separation of cost, access, and quality, as well as ethics or autonomy, as considerations in health law).

8 See generally Nancy E. Adler et al., *Addressing Social Determinants of Health and Health Inequalities*, 316 JAMA 1641 (2016); Mary C. Brucker, *Social Determinants of Health*, NURSING FOR WOMEN'S HEALTH 7 (2017); Victor R. Fuchs, *Social Determinants of Health: Caveats and Nuances*, 317 JAMA 25 (2017). Harm reduction can be conceptualized within "quality," and is included under the umbrella of "health impacts" in the framework I utilize below. However, it is valuable to recognize the distinct importance of harm reduction because "quality" in this context can too easily be assumed to mean "quality of medical care," i.e., to refer only to the treatment received from the provider itself.

9 Analyzing the legal framework for regulating any chronic illness by addressing impacts on risk of disease, the harms of disease, access to treatment, and quality of treatment does not track perfectly with the underlying health concerns of social determinants, harm reduction, access, quality, and cost. Social determinants of health impact every leverage point, from contraction of disease to quality of treatment. And "cost" is not a single decision-making or leverage point, but rather a consideration distinct from health that must be accounted for in evaluating the effectiveness of a legal intervention at any such point. Under conditions of scarcity, where funds are finite, it is particularly important to consider cost as a "pro" or "con" of any given regulatory approach, in addition to other considerations discussed below including health impacts and social consequences. In such a case, "cost" in dollars can be roughly translated into "opportunity cost" in terms of foregone alternative policies or efforts. See Matthew J.B. Lawrence, *Procedural Triage*, 84 FORDHAM L. REV. 79, 99 (2015) (discussing this state of affairs).

with the “drug war,”¹⁰ but housing policy, early intervention efforts, medical prescribing and reimbursement policy, and insurance coverage should not be overlooked as they play a significant role.¹¹ For example, it is now well understood that a legal framework that makes it more profitable for providers to treat apparent pain with a simple opioid prescription than with more time-intensive approaches contributes significantly to the spread of addiction.¹²

Second, harm reduction is an additional point of leverage at which laws influence behavior to impact SUD outcomes. Some laws seek to reduce the risk of fatal overdose, infection, or other harms associated with addiction. Laws facilitating naloxone distribution are a positive example of such harm reduction;¹³ by making it more likely bystanders or first responders have access to this overdose-reversing drug, such laws reduce the likelihood that an overdose is deadly. But other laws arguably exacerbate the harms associated with addiction. Prohibitions on drug use may push sufferers to use in secret and unsafe environments, increasing the risk of infection or

10 See Benjamin Levin, *Guns and Drugs*, 84 FORDHAM L. REV. 2173, 2174 nn. 3–4 (2015) (collecting sources problematizing the “war on drugs”).

11 See generally Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom*, 62 S.C. L. REV. 261 (2010) (comparing both historical and recent drug policies between the United States and Britain); Sara Gordon, *The Use and Abuse of Mutual-Support Programs in Drug Courts*, U. ILL. L. REV. 1503 (2017) (highlighting drug courts as an important but incomplete tool in drug addiction efforts); Laurie C. Malkin, Comment, *Troubles at the Doorstep: The Fair Housing Amendments Act of 1988 and Group Homes for Recovering Substance Abusers*, 144 U. PA. L. REV. 757 (1995) (encouraging group homes for recovering substance addicts despite community opposition); Ellen Weber, *Equality Standards For Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179 (2013) (explaining the prohibition of discriminatory health insurance coverage for persons with mental health and substance use disorders in large employer health plans).

12 E.g., Beth Han et al., *Prescription Opioid Use, Misuse, and Use Disorders in U.S. Adults: 2015 National Survey on Drug Use and Health*, ANNALS OF INTERNAL MED. (2017), <https://www.doh.wa.gov/Portals/1/Documents/2300/2017/AnnalsInternalMed.pdf> (discussing role of prescription opioid availability and misuse); Katie Thomas & Charles Ornstein, *Amid Opioid Crisis, Insurers Restrict Pricery, Less Addictive Painkiller*, N.Y. TIMES (Sept. 17, 2017), <https://www.nytimes.com/2017/09/17/health/opioid-painkillers-insurance-companies.html> (“Opioid drugs are generally cheap while safer alternatives are often more expensive . . . doctors are given incentives to use less expensive treatments that provide fast relief.”).

13 ARIZ. DEPT’ OF HEALTH SERVS, 50 STATE REVIEW ON OPIOID RELATED POLICY 26–29 (2017) (providing overview of such laws).

unsupervised overdose.¹⁴

Third, laws impact access to care. Access to treatment for SUD depends on the interaction of a person seeking treatment, having a way to pay for that treatment, and finding a provider available. As an illustration, Medicaid reimbursement rates and conditions for inpatient treatment have an obvious impact on the availability of providers and, so, access to such treatment.¹⁵

Fourth, laws impact behavior and outcomes by influencing the quality of treatment. This, in turn, influences the likelihood and length of recovery for one who is able to access treatment. Laws directly limiting or encouraging Medication Assisted Treatment (“MAT”) have an impact on quality, because studies show MAT has positive outcomes relative to other forms of treatment.¹⁶ Other laws play a more subtle role. Current regulatory guidance interpreting the Anti-Kickback Statute makes it difficult (though not impossible) for providers to offer free transportation to get patients to treatment.¹⁷ Yet transportation is a factor in adherence to treatment and so quality.¹⁸

14 Cf. Leo Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in the United States*, 98 AM. J. PUB. HEALTH 231, 232 (2008) (“In multivariate analyses of an IDU cohort in Vancouver, S[afe]I[n]jection]F[acilities] use was negatively associated with needle sharing . . . and positively associated with less frequent reuse of syringes . . .”).

15 See Note, *Congressional Intent to Preclude Equitable Relief – Ex Parte Young After Armstrong*, 131 HARV. L. REV. 828, 832 (2018) (“The significance of the *Armstrong* Court’s holding for the Medicaid providers seeking to enforce the Medicaid Act was clear: their claims could not move forward”); Peter Cunningham & Ann O’Malley, *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?*, HEALTH AFF.: HEALTH AFF. BLOG (Jan. 1, 2009), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.28.1.w17#R3> (“Low Medicaid reimbursement rates relative to those of Medicare and private payers are usually considered to be the primary reason for low physician participation in Medicaid.”).

16 See W. VA. DEPT. OF HEALTH AND HUMAN SERVS., No. 11-W-00307/3, WEST VIRGINIA CONTINUUM OF CARE FOR MEDICAID ENROLLEES WITH SUBSTANCE USE DISORDERS 7 tbl.1 (2017) (Sec. 1115 Waiver to expand Medicaid reimbursement to IMD with fewer than 16 beds); Luis Sordo et al., *Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies*, 357 BMJ 1, 12 (2017).

17 See 42 C.F.R. § 1001.952(bb)(1)(i-v) (2018) (incorporating the language from: Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Safe Harbors Under the Anti-Kickback Statute, 81 Fed. Reg. 88368 (Dec. 7, 2016) (to be codified at 42 C.F.R. pts. 1001 and 1003)).

18 See, e.g., Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976 (2013).

B. *Explicit Deputization*

The United States public health regulatory framework for addressing the addictions crisis uses many traditional regulatory tools. These include information campaigns, prohibition of some substances and regulation of others in an effort to reduce consumption, and partially-subsidized health care for some sufferers.¹⁹ Increasingly, however, efforts to prevent, treat, and reduce the harms of drug addiction work through loved ones, explicitly using family members as a regulatory tool to influence the behavior of their loved ones.²⁰ That is, the law deputizes family in achieving public health ends.²¹

19 See Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUBLIC HEALTH 182 (2018) (discussing aspects of framework); Fernando D. Simoes, *Paternalism and Health Law: Legal Promotion of a Healthy Lifestyle*, 4 EUR. J. RISK. REG. 347, 356–65 (2013) (surveying and evaluating traditional tools of public health regulation in the context of tackling obesity).

20 This Article uses the definition of “family” articulated in SAMHSA’s family therapy treatment protocol: “While the definition of family may change according to different circumstances” it includes “traditional families,” “extended families,” and “elected families, which are self-identified and are joined by choice and not by the usual ties of blood, marriage, and law” such as godparents or close friends. In other words, “[f]or practical purposes, family can be defined according to the individual client’s closest emotional connections.” U.S. DEP’T OF HEALTH AND HUMAN SERVS., TREATMENT IMPROVEMENT PROTOCOL 39, SUBSTANCE ABUSE TREATMENT AND FAMILY THERAPY, at xvi, 2 (2015).

21 By “deputize” this Article means intentionally or foreseeably using a third party to influence a subject’s behavior. This may include laws that empower/disempower third parties with formal legal responsibilities or obligations as well as laws that influence the incentives of third parties, encouraging them to intervene to alter others’ behavior. In seeking to capture pragmatically the breadth of situations in which the law utilizes third parties as a regulatory tool, this understanding is intentionally broader than the traditional understanding of a sheriff “deputizing” some locals when need/emergency pressed. Cf. Steven Lubet, *The Forgotten Trial of Wyatt Earp*, 77 U. COLO. L. REV. 1, 20 n.76 (2001) (describing significance in trial of the fact that while Earp had formally deputized his brothers, Doc Holliday may not have actually been deputized “when he joined Virgil Earp’s posse”). Rather, its use of the term is closer to the use in federalism scholarship on federal laws that “deputize” states. E.g., David R. Hodas, *Enforcement of Environmental Law in a Triangular Federal System: Can Three Not Be a Crowd When Enforcement is Shared by the United States, the States, and Their Citizens?*, 54 MD. L. REV. 1552, 1571 (1995) (“As a result, essentially all the modern major environmental laws provide uniform, minimum national standards with the states ‘deputized,’ to a greater or lesser degree, to do the permitting and enforcing for the federal government.”). See generally Shirly Lin, Comment, *States of Resistance: The Real ID Act and Constitutional Limits Upon*

Prevention: Prohibition laws are a core, controversial aspect of current federal and state efforts to reduce the harms of SUD.²² Laws that forbid or restrict use or sale of certain addictive substances seek to prevent people from developing SUD by preventing misuse. But in some cases, such laws seek to enlist family in prevention-by-prohibition by exposing them to liability for failing to intervene in and halt prohibited uses or sales in their home or presence. Drug possession laws and associated civil forfeiture penalties are an example, putting a person's home at risk if she fails to halt certain drug activity engaged in by those staying with her, as a means to use the homeowner to seek to alter her co-occupants' behavior.²³

Harm reduction: Efforts to reduce the harm of SUD, too, increasingly operate through loved ones. Naloxone is a life-saving drug that is relatively easy to administer and can prevent the death of a person who is overdosing from opioids. Understandably, increasing access to and utilization of Naloxone is a significant focus of regulators and reformers. One way this is done is by prescribing Naloxone prophylactically not only to those suffering from SUD but also likely bystanders to an overdose, including family members or friends. Hence the American Medical Association's guidance encouraging providers to prescribe naloxone to "a family member or close friend" of SUD patients.²⁴ Consistent with that recommendation, many states have standing orders that explicitly identify "family members" as eligible for third-party prescriptions of Naloxone.²⁵

Federal Deputization of State Agencies in the Regulation of Non-Citizens, 12 N.Y. CITY L. REV. 329 (2009) (exploring the post-9/11 deputization of state and local authorities to investigate and detain undocumented immigrants). For reflections on the narrative implications of labeling even family members who the law foreseeably enlists in achieving government ends as "deputies," see *infra* Part V.

22 See Levin, *supra* note 10 (collecting sources expressing skepticism about "war on drugs").

23 21 U.S.C. § 844(a) (1994 & Supp. III 1997); 42 PA. STAT. AND CONS. STAT. ANN. § 5803 (West 2018); (discussing civil forfeiture penalty).

24 Am. Med. Ass'n Opioid Task Force, *Help Save Lives: Co-Prescribe Naloxone to Patient's at Risk of Overdose*, END THE EPIDEMIC (2017), <https://www.end-opioid-epidemic.org/wp-content/uploads/2017/08/AMA-Opioid-Task-Force-naloxone-one-pager-updated-August-2017-FINAL-1.pdf>.

25 E.g., PA. DEP'T OF HEALTH, STANDING ORDER DOH-002-2018, NALOXONE PRESCRIPTION FOR OVERDOSE PREVENTION (2018). See generally Legal Science, *Naloxone Overdose Prevention Laws*, PRESCRIPTION DRUG ABUSE POLICY SYSTEM (July 1, 2017), <http://pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139> (providing a 50-state survey of

Treatment: One of several challenges to providing treatment to those suffering from SUD is that the nature of the illness, coupled with the stigma surrounding it, makes sufferers less likely to pursue treatment voluntarily.²⁶ Involuntary treatment laws are a controversial attempt to address this challenge. Such laws create a mechanism through which SUD sufferers can be forced into treatment without their consent. For present purposes, it suffices to note that such laws often explicitly deputize family, limiting the class of persons eligible to initiate the involuntary treatment process to guardians and family members.²⁷

Quality: Finally, treatment protocols that call for incorporating family into the recovery process are an example of policies that seek to impact the quality of care through the behavior of family members. For example, the “Recovery Oriented Community” program calls upon family members to take a formal, active, and ongoing role in their loved one’s recovery,²⁸ in recognition of years of research indicating that social relationships such as family involvement are a significant positive influence on recovery.²⁹ Family members are actively incorporated in developing the treatment protocol and enrolled in a communication program through which they and

Naloxone access laws).

- 26 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6053 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (noting concern that “individuals with substance use disorders [fail to] seek needed treatment” due to concern about negative consequences of the disclosure of such treatment to employers, landlords, law enforcement, and others).
- 27 *E.g.*, S.B. 391, Gen. Assemb., 2017–18 Reg. Sess. (Pa. 2017) (“A spouse, relative or guardian of the respondent must file the [involuntary treatment] petition.”). Indeed, such laws are occasionally referred to as “Casey’s Laws,” named after the first such law in Kentucky which was motivated in part by one family’s story of their son dying of a drug overdose after the legal system rebuffed the family’s efforts to force their son into involuntary treatment. For an example of the use of this term and discussion of the Kentucky law, see Bradley J. Steffen, *Battling the Heroin Epidemic with Involuntary Treatment*, 12 J. L. & SOC. DEVIANCE 181, 204–13 (2016).
- 28 Lori Simons et al., *A Promising Approach for Families of and Young Adults with Opioid-Related Disorders: The Recovery Oriented Community (ROC) Program*, 2 J. DRUG ABUSE 1 (2016).
- 29 *See supra* note 5 and accompanying text (discussing the impact of social relationships on recovery in other contexts); Ellen M. Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631, 653 n.79 (2005) (“Sustaining recovery is also more difficult for individuals who do not have access to . . . a family support system.”).

medical providers maintain contact through telephone, text, online support, and weekly meetings.

C. *Implicit Deputization*

In many areas the deputization of family is implicit rather than explicit, though no less important. Family are on the front lines of each leverage point of SUD—prevention, harm reduction, treatment, and recovery, though their role as an aspect of our public health system is sometimes not appreciated.³⁰ Family can discourage substance misuse, help to identify and encourage treatment for comorbidities of addiction such as mental illness, and help to identify and encourage early treatment of SUD, thereby reducing the risk and severity of addiction.³¹

Moreover, for those who suffer from SUD, family can play a key role in harm reduction. Family may provide relatively safe housing and, often, a place to use drugs with some sort of supervision and help nearby.³²

Similarly, family can play a key role in facilitating access

30 See U.S. DEPT OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 1-3 (2016) [hereinafter SURGEON GENERAL'S REPORT] (providing exhaustive list of "public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction" and make up the "Public Health System" but not mentioning role of family in provision of such services); see also *id.* at 1-4 (same).

31 Jeffrey M. Jones, *Poll: Only About Half of Addicted Family Members Sought Treatment*, GALLUP NEWS SERV. (Aug. 18, 2006), <http://news.gallup.com/poll/24196/poll-only-about-half-addicted-family-members-sought-treatment.aspx> (showing that pressure from family was among the most common factors in SUD patients' decisions to seek treatment).

32 E.g., Sarah M. Bagley et al., *Overdose Education and Naloxone Rescue Kits for Family Members of Individuals Who Use Opioids: Characteristics, Motivations, and Naloxone Use*, 36 SUBSTANCE ABUSE 149, 151 tbl. 1 (reporting successful Massachusetts program to train family members in use of naloxone); Alexandra Rockey Fleming, *For Families of Addicts, Narcan Has Truly Been a Lifesaving Drug*, WASH. POST (Jan. 7, 2018), https://www.washingtonpost.com/national/health-science/for-families-of-addicts-narcan-has-truly-been-a-lifesaving-drug/2018/01/05/75ffb206-d469-11e7-b62d-d9345ced896d_story.html?utm_term=.03703597a46d (telling story of mother who revived her 22-year-old son from an overdose in the home they shared using Narcan; he then entered an inpatient treatment program); Anna V. Williams et al., *Training Family Members to Manage Heroin Overdose and Administer Naloxone: Randomized Trial of Effects on Knowledge and Attitudes*, 109 ADDICTION 250 (2013) (reporting positive educational outcomes from take-home naloxone administration training).

to treatment for those with SUD. Family may press sufferers to seek treatment.³³ They may help to arrange or apply for insurance coverage, or provide financial support where coverage is lacking.³⁴ They help to find available (and covered) treatment and get their loved ones into such treatment.³⁵

Finally, SUD patients often invite their family to play a key role in maintaining recovery from SUD as well. Recovery may be aided by not just traditional medical care but transportation (for possible probation check-ins, MAT, or work), housing, meaningful employment or other engagement, help navigating the criminal justice system, child care, and above all community. Whether motivated by love, altruism, or even filial support requirements, family provide all of these things.³⁶

33 See W.R. Miller et al., *Engaging the Unmotivated in Treatment for Alcohol Problems: A Comparison of Three Strategies for Intervention Through Family Members*, 67 J. CONSULTING & CLINICAL PSYCHOL. 688 (1999). Particularly for adolescents “family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment.” SURGEON GENERAL’S REPORT, *supra* note 30, at 4-14.

34 E.g., Liz Navratil, *Tell Them My Story: Ross Woman’s Obituary Sheds Light on Addiction*, PITTSBURGH POST-GAZETTE (Jan. 22, 2017), <http://www.post-gazette.com/news/overdosed/2017/01/22/Tell-them-my-story-Maybe-it-would-help-somebody-Ross-Pittsburgh-overdose-obituary-addiction/stories/201701220121> (describing fatal overdose of young woman while she and her mother were working to find a treatment facility covered by their insurance after calendar-year change in insurance led to dropped coverage at originally-planned treatment center); Jeanne Whalen, *After Addiction Comes Families’ Second Blow: The Crushing Cost of Rehab*, WALL STREET J. (Mar. 8, 2018), <https://www.wsj.com/articles/after-addiction-comes-families-second-blow-crushing-cost-of-rehab-1520528850>.

35 For a story of a mother buying heroin for her daughter to help wean her during a self-detox in order for her to be admitted to a treatment program that did not accept those in active addiction, see Anonymous, *Why I Bought My Daughter Heroin*, BBC NEWS (Mar. 10, 2017), <http://www.bbc.com/news/magazine-39212295>.

36 “[F]indings from focus groups of counselors in rural areas noted . . . reliance on friends or family for transportation.” U.S. DEP’T OF HEALTH & HUMAN SERVS., THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS 34 (2017) [hereinafter COMMISSION REPORT]. On the reasons family engage in care work see Hoffman, *supra* note 6, at 175 (discussing reasons family members engage in care work); “All fifty states have statutes that obligate certain adults to care for or financially support certain other family members.” Katherine C. Pearson, *Filial Support Laws in the Modern Era: Domestic and International Comparison of Enforcement Practices for Laws Requiring Adult Children to Support Indigent Parents*, 20 ELDER LAW J. 269, 270 (2013). However, these are limited, for example, while “parents can [] be

It would be a mistake to think of this range of family involvement in SUD prevention, harm reduction, treatment, and recovery as independent of law, separate from and outside of our public health framework for regulating (and aspirationally reducing the cost of) SUD. Quite the opposite, our legal framework calls upon family to serve this role in ways that are at least foreseeable, if not intentional.

SUD is an example of a chronic illness for which resources available through traditional public health, health care, and government entities are, at this writing, tragically insufficient. Institutional actors do not come close to ensuring that those who need treatment for SUD receive it; according to recent estimates, roughly 20% of the 20 million who need treatment for SUD receive it.³⁷ As a result, for many sufferers, loved ones are both the first responders and the last resort.

Meanwhile, family members are not only a stopgap; they are well positioned to assist with many aspects of prevention, harm reduction, treatment, and recovery. Family members are often close to SUD patients which brings a special perspective and insight into their loved ones' behaviors and needs.³⁸ Moreover, the emotional connection that defines "family" makes family members particularly well suited to provide the community that many see as essential to preventing and treating addiction.³⁹ And family can be (even if they

obligated to pay support for adult-aged children . . . usually that obligation is tied to a continuing disability that preexisted age eighteen." *Id.*

37 "[O]nly one in five people who currently need treatment for opioid use disorders is actually receiving it." SURGEON GENERAL'S REPORT, *supra* note 30, at III.

38 See SILVERMAN, *supra* note 4, at 9 ("To care well, Kittay argues, caregivers must not only go through the motions of care, but they must also care about the person who depends on them . . . to do a good job with the rational, arduous, daily labor of caring, an 'affective bond' is necessary."); *id.* at 96 (identifying three comparative advantages of parents in assisting in a child's treatment: "a familiarity with their child's developmental trajectory and current behaviors . . . the continuous therapeutic opportunities offered by the activities of daily life, and their own biological kinship with the child, including shared personality traits and milder forms of the same symptoms"); *id.* at 137 ("As parents enter into professional areas of authority they do so by claiming that their love helps them determine how best to understand and treat their children. These claims about love are strong and sometimes risky.").

39 See Dasgupta et al., *supra* note 19, at 184 ("[R]esearchers agree that such structural factors as lack of economic opportunity, poor working conditions, and eroded social capital in depressed communities, accompanied by

are not always) powerful sources of acceptance.⁴⁰

As a result of the confluence of a shortage of social services and family's unique ability to assist in addressing SUD, it is difficult to identify a way in which family currently assist their loved ones with SUD that is not predictably influenced by one or more aspects of our existing legal framework. Among other legal factors, the Anti-Kickback Statute limits providers' ability to provide patients in recovery with free transportation and payer reimbursement policies that fail to compensate such arrangements often leave those in recovery with no way to obtain necessary, daily treatment, other than reliance on loved ones with legal access to a car.⁴¹ Shortages of Medicaid-eligible inpatient and outpatient treatment providers— itself a function of Medicaid reimbursement rates⁴²—often leave family members with the choice to either pay out of pocket themselves for their loved ones' care or see them go without care. Lack of housing and job support for those in recovery,⁴³ as a matter of logic and inevitable necessity, can leave family invested in their loved ones' health as the patient's last resort.

The goal of this discussion has been to call attention to such implicit deputization and encourage researchers and policymakers

hopelessness and despair, are root causes of the misuse of opioids and other substances”) (quoting NAT'L ACAD'S OF SCI'S, ENG'G, AND MED. ET AL., PAIN MANAGEMENT AND THE OPIOID EPIDEMIC 1–9 (Richard J. Bonnie et al. eds., 2017)).

40 Cf. SILVERMAN, *supra* note 4, at 236 (“Devotion is ideally an experimental procedure. It is especially so when, as parents often feel in the case of autism, it impels us to consider the object of our love as both a biological being, subject to manipulation and harm, and a person, precious and complete in his or her own right.”).

41 See Robert J. Baror, *Transportation and the Anti-Kickback Statute: A Tortured Route with a New Safe Harbor*, THE FED. LAW., March 2015, at 18–20 (describing challenges entailed in providing transportation); Jeffrey Samet et al., *It's Time for Methadone to Be Prescribed as Part of Primary Care*, STATNEWS (July 5, 2018), <https://www.statnews.com/2018/07/05/methadone-prescribed-primary-care/> (“Stigma and a not-in-my-backyard mentality resulted in the placement of a sizable number of methadone clinics in locations that were hard for many to reach.”).

42 See *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015) (discussing claim that low Medicaid reimbursement rates deterred provider participation).

43 See Richard Littlewood et al., *Housing for People with Substance Use Disorders: One Size Does Not Fit All Tenants—Assessment of 16 Housing Services and Suggestions for Improvement Based on Real World Experience*, 55 COMMUNITY MENTAL HEALTH J., 331 (2019).

to be cognizant of it, not to catalog all instances of deputization. In these areas and the many others in which the law implicitly deputizes family, for those with loved ones who are in a position to be asked for help, the choice is not whether society will provide necessary services or not; the choice is whether it will do so through (usually paid) social workers, medical providers, and navigators or through (always unpaid) family members. As discussed in the next section, whether done implicitly or explicitly, the decision to deputize family is a weighty choice that implicates considerations beyond the health of the patient.

III. The Social Consequences of Deputizing Family

The preceding discussion of the role of family in fighting SUD underscores the importance of directing resources toward family caretakers. Family support groups like Learn to Cope based in Massachusetts, The Partnership for Drug Free Kids, Al Anon, Shatterproof, and others could be supported and spread, and educational resources could be improved in quality and made more readily available.⁴⁴ Moreover, funding directed specifically to educating family members could ensure culturally competent

44 Twelve Massachusetts-area organizations offering peer family support services are listed in the Massachusetts Organization for Addiction Recovery. MASS. ORG. FOR ADDICTION RECOVERY, MOAR MINI-GUIDE WITH MOAR TO COME 15 (2018), http://docs.wixstatic.com/ugd/8256b8_c57f31e039d547cbb67e13fb84c6ceed.pdf. In other communities, such peer family support is not as readily available. See generally ADDICTION RESOURCE HUB, <https://resources.facingaddiction.org> (last visited Nov. 5, 2018). As for the availability of resources, the self-professed struggles of noted addiction reformers and policy experts are illustrative. University of Pennsylvania addiction research psychologist and former Senior Scientist for the Office of National Drug Control Policy Dr. Thomas McLellan explains that despite his expertise he found finding out how best to help care for a family member extremely difficult, observing “[i]f I don’t know, nobody else knows Where does a schoolteacher turn? How about a truck driver? How about a cop?” See *How to Fix Rehab: Expert Who Lost Son to Addiction Has a Plan*, NBCNEWS.COM (Apr. 7, 2014, 5:18 AM), <https://www.nbcnews.com/storyline/americas-heroin-epidemic/how-fix-rehab-expert-who-lost-son-addiction-has-plan-n67946>. Similarly, founder and CEO of Shatterproof Gary Mendell explains how his family “fought to navigate the complex and confusing web of treatment programs and therapies” in trying to care for a family member with SUD. Gary Mendell, *A Father’s Promise, History*, SHATTER PROOF, <https://www.shatterproof.org/about/history> (last visited Feb. 2019). There are some excellent resources available, but particularly for a sufferer or family member new to addiction and its treatment, availability of information does not equal access to information.

resources by linking together families with similar backgrounds.⁴⁵ Such efforts could make family more effective in supporting those with addiction while simultaneously reducing the personal financial and emotional burdens of providing such support.

For some, this broader policy implication—that family of patients play a huge role in fighting disease and so are a promising target for resources, funding, and regulation—may not need further elaboration. It is important, however, to focus on the costs and benefits of deputizing family in fighting disease, for four reasons.

First, family involvement may in some cases be a negative rather than a positive; it may do more harm than good. A stark example is that of an abusive spouse—the law should neither empower an abusive person nor force their spouse to rely on them for support or care in seeking treatment for illness.⁴⁶ Teasing out the costs and benefits of deputizing family makes it possible to explore whether current and proposed regulatory approaches do more harm than good.

Second, funding and manpower are finite; this is particularly true for SUD. We must sometimes decide not only which laws or approaches are beneficial, but which are sufficiently beneficial to justify the investment of scarce resources.

Third, legal scholars evaluating the wisdom vel non of involuntary treatment laws have begun to explore behavioral, societal, and ethical costs of such laws independent of their medical impacts.⁴⁷ This growing, fuller understanding of the implications of such laws is improved by exploring their impacts on the deputized family members as well.

45 Cf. 42 U.S.C. § 280i-1 (2018) (specific provision for educating families in addressing autism).

46 See generally *Symposium on Reconceptualizing Violence Against Women by Intimate Partners: Critical Issues*, 58 ALB. L. REV. 1193 (1995).

47 See Leo Beletsky et al., *Expanding Coercive Treatment is the Wrong Solution for the Opioid Crisis*, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 11, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160211.053127/full/> (noting risk that threat of involuntary treatment will deter patients from seeking professional help); Leo Beletsky & Elisabeth Ryan, *The Wrong Path: Involuntary Treatment and the Opioid Crisis*, CRIME REP. (Aug. 16, 2017), <https://thecrimereport.org/2017/08/16/the-wrong-path-involuntary-treatment-and-the-opioid-crisis/> (involuntary treatment “shift[s] financial responsibility for substance use treatment from insurers directly to taxpayers”); Ish P. Bhalla et al., *The Role of Civil Commitment in the Opioid Crisis*, 46 J. L. MED. & ETHICS 343 (2018) (discussing medical as well as ethical objections to involuntary treatment).

Fourth, and finally, for those who are interested not only in reducing the harms of SUD but also putting in place structures to better address the next such crisis (which may well also be related to SUD), there are lessons to be taken from the failures and successes of our policy response thus far to the overdose crisis. Unlike researchers and policymakers, sick people do not have the luxury of waiting on political processes or scientific debates. Again, patients and their families are the first responders for any illness and, unless and until government or institutional resources are brought to bear, the last resort. By better understanding this default, double-edged weapon in the public health arsenal it may be possible to design policies that make family better at the job that illness, indifference, or choice force them to do, or at least to avoid hampering family in such work when desired by their loved ones. The addictions crisis reveals numerous ideas, examples, and potential pitfalls that can serve as lessons for the future.

Part A below discusses the health impacts of laws deputizing family to address SUD. Part B discusses the need to consider impacts beyond direct consequences on patient health, namely, the social consequences of deputization, then discusses such impacts that are particularly implicated by laws deputizing family: interference, invisibility, and inequality. The next Part will offer and apply a framework for weighing such social consequences against health impacts in evaluating or crafting laws that deputize family from a welfare economic standpoint.

A. Health Consequences of Deputization

In addressing a disease—particularly one as widespread, debilitating, and deadly as SUD—it is natural and appropriate to focus on the health impacts of any reform or regulatory tool. So it is understandable that most scholarship that focuses on the role of family in the treatment of disease generally and in the treatment of SUD in particular has focused on medical impacts rather than on other potential benefits or costs of deputizing family.⁴⁸ This is in

48 See D.W. Best et al., *Patterns of Family Conflict and Their Impact on Substance Use and Psychosocial Outcomes in a Sample of Young People in Treatment*, 9 *VULNERABLE CHILD. & YOUTH STUD.* 114, 114–22 (2014); Viviana E. Horigian et al., *A Cross-Sectional Assessment of the Long Term Effects of Brief Strategic Family Therapy for Adolescent Substance Use*, 24 *AM. J. ON ADDICTION* 637 (2015) (discussing the specific outcomes of therapy focused on familial intervention and strengthening of familial bond in the aftermath of substance use). See generally Holt-Lunstad et al., *supra* note 5. Family Law textbooks address drug and alcohol use insofar

contrast to scholarship on the provider-patient relationship, which has problematized laws that deputize doctors in bringing about particular policy outcomes.⁴⁹

This health-focused research has tended to find that social relationships are a significant positive for SUD outcomes,⁵⁰ though

as they may be implicated in divorce or custody proceedings but do not directly address the role or use of the family in prevention and treatment of SUD, chronic illness, or public health. *See generally* JOHN DEWITT GREGORY ET AL., UNDERSTANDING FAMILY LAW (4th ed. 2013); IRA MARK ELLMAN ET AL., FAMILY LAW: CASES, TEXT, PROBLEMS (5th ed. 2010).

- 49 *See generally* Janet L. Dolgin, *Physician Speech and State Control: Furthering Partisan Interests at the Expense of Good Health*, 48 NEW ENG. L. REV. 293, 294, 318–19 (2014) (describing Drudge Report headline that “Obama Deputizes Doctors” in response to Executive Order interpreting ACA provision as leaving doctors free to ask patients about guns and gun safety” (citing Affordable Care Act, 42 U.S.C. § 300gg-17 (2012)); Carol Gosain, Case Note, *Protective Custody for Fetuses: A Solution to the Problem of Maternal Drug Use? Casenote on Wisconsin ex rel. Angela v. Kruzicki*, 5 GEO. MASON L. REV. 799, 817 (1997) (discussing state law, complaining that “[b]y ‘deputizing’ doctors, the state interferes in the physician-patient relationship”); Derk B.K. VanRaalte IV, Note, *Punitive Policies: Constitutional Hazards of Non-Consensual Testing of Women for Prenatal Drug Use*, 5 HEALTH MATRIX 443, 455 (1995) (criticizing requirement that physicians disclose pre-natal drug test results as “effectively ‘deputiz[ing] doctors to be police informers”); Kathleen M. Sullivan, *The Justices of Rules and Standards*, 106 HARV. L. REV. 22, 34 (1992) (describing requirements that physicians inform a woman seeking abortion of certain information as “deputiz[ing] doctors” in framing choice); *id.* at 94 (noting that *Casey* essentially held that “the state could no more deputize doctors than husbands as anti-abortion advocates”).
- 50 SURGEON GENERAL’S REPORT, *supra* note 30, at 3-11 (“A number of family-focused, universal prevention interventions show substantial preventive effects on substance use.”); *id.* at 4-30 (“Mainstream health care has long acknowledged the benefits of engaging family and social supports to improve treatment adherence and to promote behavioral changes needed to effectively treatment many chronic illnesses. This is also true for patients with substance use disorders.”); *id.* at 4-25 (“Adherence to” naltrexone “increases under conditions where it is administered and observed by a trusted family member.”); *see* Simons et al., *supra* note 28, at 1–2 (“Most treatment research indicates that a family component is necessary for treatment to be effective, particularly with opiate addicts aged 15 to 25 years old.”) (collecting sources); *see also id.* at 2 (describing study as indicating “that families play a crucial role in the recovery process for adults with concurrent disorders”); Dasgupta et al., *supra* note 19, at 184 (providing evidence that social isolation contributes to drug misuse and substance misuse disorder and, conversely, that “protective family and social structures generate resilience that mitigates negative impacts from the collision of economic hardship, substance use, and depression”) (collecting sources); U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 20, at 1 (“The family has a central role to play in the treatment of any health problem, including substance abuse.”); *id.* (“[E]vidence from the research that

scholars have questioned the health benefit of empowering family in specific areas such as involuntary treatment.⁵¹ The finding that family involvement has a salutary effect on SUD health outcomes is consistent with meta analyses addressing the health impacts of family involvement generally, which have found family to be a significant and positive social determinant of health.⁵² That said, none of these studies compared family support to other forms of social services, so the identified benefits may indicate only that family may fill a void where other social services are lacking, not that family are better than other more traditionally “public” sources of social services at promoting health when both are available.⁵³

B. Social Consequences of Deputization

It is appropriate for health impacts to be a primary focus of inquiry in consequential evaluation of laws directed at disease, but they should not be the only impacts considered. Such laws can have social, educational, employment, and financial consequences beyond their medical impacts. For a concrete example of such a “social consequence” of health care policy, look no further than the well-documented phenomenon of medical bankruptcy: bankruptcies that result ultimately from our regulatory framework for managing illness.⁵⁴

has been conducted . . . indicates that substance abuse treatment that includes family therapy works better than substance abuse treatments that do not”) (collecting sources); U.S. DEP’T OF HEALTH AND HUMAN SERVS., TREATMENT IMPROVEMENT PROTOCOL 38, INTEGRATING SUBSTANCE ABUSE TREATMENT AND VOCATIONAL SERVICES, at xv (2000) (“Years of research show that the best predictors of successful substance abuse treatment are gainful employment[,] adequate family support[, and] lack of coexisting mental illness”); cf. Kay Hymowitz, *Opioid Deaths Are Surging Among Single and Divorced Americans, Especially Men*, INST. FOR FAMILY STUDIES (Nov. 6, 2017), <https://ifstudies.org/blog/opioid-deaths-are-surging-among-single-and-divorced-americans-especially-men> (finding lower overdose rate among married population than non-married population, but noting that assuming causative connection would be problematic).

51 See, e.g., Dasgupta et al., *supra* note 19 (arguing for an approach that addresses the root causes of the opioid crisis).

52 See sources cited *supra* note 5.

53 Cf. MARTHA FINEMAN, *THE AUTONOMY MYTH: A THEORY OF DEPENDENCY*, at xviii (2004) (“It is very important to understand the roles assigned to the family in society—roles that otherwise might have to be played by other institutions, such as the market or the state.”).

54 See Matthew J. Lawrence, *Health Insurance’s Social Consequences Problem and How to Solve It*, HARV. L. & POL’Y REV. (forthcoming 2019) (collecting and

A strand of feminist legal scholarship problematizing “care work” largely in the context of child care and long-term care for the elderly—unpaid labor by family caring for one another—has unpacked social consequences that such labor implicates independent of health impacts.⁵⁵ These considerations apply as well to laws that deputize family in fighting SUD, in many cases raising the possibility of new objections to or problems with such laws as discussed below. Understood in welfare economic terms, such considerations include: the potential for interference with the underlying family relationship; the invisibility of and lack of compensation for or societal recognition of the care work; and the inequality of relying on care work, particularly when its performance or availability is heterogeneous across genders, race, or class.

1. *Interference*

It is prudent to proceed with caution in using existing family relationships as a regulatory tool because family relationships themselves can be endogenous to the law, that is, family relationships can be shaped by the law. As Fineman puts it, “[f]ar from being separate and private, the family interacts with and is acted upon by other societal institutions . . . the very relationship is not one of separation, but of symbiosis.”⁵⁶ Indeed, a motivating insight of the field of family law is that the formation of romantic partnerships and child rearing units is in some ways determined by legal recognition and treatment, so laws may be tailored to facilitate those relationships that society deems valuable.⁵⁷

describing sources).

55 See Hoffman, *supra* note 6, at 172–73 nn.125–29 (collecting sources and surveying); ANNE L. ALSTOTT, *NO EXIT: WHAT PARENTS OWE THEIR CHILDREN AND WHAT SOCIETY OWES PARENTS* (2005); FINEMAN, *supra* note 53; JOAN WILLIAMS, *UNBENDING GENDER: WHY FAMILY AND WORK CONFLICT AND WHAT TO DO ABOUT IT* (2001); Sylvia A. Law, *Women, Work, Welfare, and the Preservation of Patriarchy*, 131 U. PA. L. REV. 1249 (1983); Katherine B. Silbaugh, *Turning Labor into Love: Housework and the Law*, 91 NW. U. L. REV. 1 (1996); Noah Zatz, *Supporting Workers by Accounting for Care*, 5 HARV. L. & POL’Y REV. 45 (2011)

56 FINEMAN, *supra* note 53. For a multi-layered example of the interaction between legal and institutional arrangements, on the one hand, and affective relationships on the other, in the context of a particular disorder, see generally SILVERMAN, *supra* note 4, at 1–5 (framing love as a complicated and sometimes problematic resource).

57 FINEMAN, *supra* note 53 (“It is very important to understand the roles assigned to the family in society—roles that otherwise might have to be played by other

The spousal evidentiary privilege serves as an enduring acknowledgement of this potential for the law to interfere with family relationships. This potential is a primary underlying rationale for the privilege. The reasoning is that if spouses could be compelled to testify against each other, then open communication between them would be chilled. So, courts provide an evidentiary privilege to such communications, protecting against disclosure in order to ensure that open communication between spouses is not deterred by the shadow of civil or criminal discovery.⁵⁸

In the context of SUD, this concern can be thought of as one of interference. Supportive family relationships are desirable both in the abstract and for their generally positive impact on SUD outcomes.⁵⁹ Laws that interfere with the formation or maintenance of such relationships—that make it more costly for those with SUD to maintain close contact with their loved ones—could carry an interference cost that might itself outweigh any hypothetical medical benefit.

The collateral consequences of civil forfeiture drug laws are a concrete illustration of this problematic interference effect associated with certain forms of deputization. Criminal accessory laws can make families vulnerable to civil forfeiture actions against their homes for unlawful sales conducted by loved ones living with them. Several families in Philadelphia, for example, had their homes seized and were forced to vacate after the police arrested non-minor children on

institutions, such as the market or the state.”); LINDA McCLAIN, *THE PLACE OF FAMILIES: FOSTERING CAPACITY, EQUALITY, AND RESPONSIBILITY* 3, 8 (2006) (“[F]amilies have a place in the project of forming persons into capable, responsible, self-governing citizens. . . . [G]overnment properly takes an interest in families in light of the goods associated with families, the functions that families serve, and the political values at stake.”); Vivian Hamilton, *Will Marriage Promotion Work?*, 11 J. GENDER, RACE & JUSTICE 1 (2007) (providing survey of government policies promoting marriage).

58 See *Trammel v. United States*, 445 U.S. 40, 44 (1980) (“The modern justification for this privilege against adverse spousal testimony is its perceived role in fostering the harmony and sanctity of the marriage relationship.”); see also *Development in the Law: Privileged Communications*, 98 HARV. L. REV. 1450, 1579 (1985) (“Advocates of the privileges argue that privileges encourage intrafamily communications that are more valuable to the family than the evidence shielded from the courts is to society.”); cf. Julia Cardozo, Note, *Let My Love Open the Door: The Case for Extending Marital Privileges to Unmarried Cohabitants*, 10 U. MD. L.J. RACE RELIGION GENDER & CLASS 375 (2010) (arguing for expansion of marital communications privilege to unmarried cohabitants).

59 *Supra* Part III.A.

possession and sale charges that the families had permitted to live with them. Eventually, the police permitted the families to return to their homes—but allegedly only upon the condition that they would not let their SUD-patient loved ones return.⁶⁰

Deputization and interference are both crystallized in this example. Drug laws conscript family members in the effort to prevent SUD by prohibition by subjecting them to penalties if they do not themselves ensure compliance with such prohibitions within their homes. Regardless whether this deputization carries medical benefits or costs, it also interferes directly with family relationships by discouraging sufferers from seeking housing with loved ones, and discouraging loved ones from permitting sufferers to live with them while using. By doing so, in turn, drug laws may undercut the ability of the family home to act as a sort of *de facto* safe injection site, potentially undermining health in turn.⁶¹

2. *Invisibility*

A second consideration presented by laws that deputize family is that the burdens of care work are often invisible, neither compensated nor recognized as a valuable form of work. In turn, because such efforts are invisible, policymakers can easily fail to take burdens on care workers into account. Benefits programs, for example, often fail to acknowledge the value, time, or effort of care work.⁶² In the context of childcare, the care work literature has “made compelling arguments for state support of caregiving based on the idea of caregiving as a public responsibility, a public good, a basic

60 See Class-Action Complaint for Declaratory and Injunctive Relief at ¶ 116, *Sourovelis v. City of Philadelphia*, 103 F. Supp. 3d 694 (E.D. Pa. 2015) (No. 14-4687) (alleging that the ADA “informed Mr. Sourovelis that in order for his house to be unsealed so his family could return home, he and his wife would have to agree to a number of conditions, including agreeing that [their son] would not be permitted to enter his home for any reason for an indefinite period of time”). See generally *Sourovelis v. City of Philadelphia*, 103 F. Supp. 3d 694 (E.D. Pa. 2015). The case was later the subject of a civil lawsuit that partially settled. See Jeremy Roebuck, *D.A.’s Office Reaches Partial Settlement in Forfeiture Suit*, THE PHILADELPHIA INQUIRER (June 24, 2015), http://www.philly.com/philly/news/20150625_Philadelphia_District_Attorney_reaches_partial_settlement_in_civil_forfeiture_suit.html?mobi=true.

61 See Jennifer Ng et al., *Does Evidence Support Supervised Injection Sites?*, 63 CANADA FAM. PHYSICIAN 866 (2017) (providing data supporting the positive outcomes of safe injection sites); cf. *supra* Part II.A (collecting sources reporting positive results from providing family members with access to Naloxone).

62 See Zatz *supra* note 55, at 46; see also Hoffman, *supra* note 6, at 196.

household need, or in order to help preserve women's attachment to the workplace."⁶³ Moreover, when it comes to helping in a loved one's battle with illness, the invisibility of care work can mean an under-supply of educational resources and supports, which can leave care workers to teach themselves, even where minimal educational resources and support could go a long way in reducing the burdens on such care givers and improving the quality of their help.⁶⁴

Helping a loved one in his or her medical struggle can be no less burdensome than child rearing or long-term care.⁶⁵ For example, family caregivers of terminal cancer patients may suffer from "substantial psychological, occupational and economic burdens associated with caregiving."⁶⁶ Stenberg's literature review of 164 articles found similar burdens on caregivers of cancer patients.⁶⁷

The burdens of care work are weighty in the treatment of SUD as well, though not yet studied as significantly. Caring for a loved one with SUD can be personally, psychologically, emotionally, and financially devastating—even if it also can be tremendously rewarding.⁶⁸ Notably, many of these impacts stem not from having a loved one who is ill, but from the care work that comes with the diagnosis.⁶⁹ As discussed above, the work loved ones do includes

63 Hoffman, *supra* note 6, at 172–73 nn.125–130 (collecting and surveying sources).

64 SILVERMAN, *supra* note 4, at 94 (describing "parents during the 1960s and 1970s who often found themselves with few resources other than each other in learning to treat their children"); *id.* at 96 ("[U]ntil the professional community can offer us more effective programs, we will often have to take matters into our own hands . . .").

65 *Id.* at 179–80 ("It is a full-time job driven by love, but accomplished through reason and experience, because '[t]his is our work. Everything else vanishes.'").

66 Eva Grunfeld et al., *Family Caregiver Burden: Results of a Longitudinal Study of Breast Cancer Patients and Their Principal Caregivers*, 170 CAN. MED. ASSOC. J. 1795, 1800 (2004).

67 See Una Stenberg et al., *Review of the Literature on the Effects of Caring for a Patient with Cancer*, 19 PSYCHOONCOLOGY 1013 (2010) (reviewing 164 research-based articles finding significant problems borne by family caregivers of cancer patients, including physical, social, and emotional problems and job and financial impacts).

68 See generally CONYERS, *supra* note 4; KAYE, *supra* note 4.

69 Dennis C. Daley, *Family and Social Aspects of Substance Use Disorders*, 21 J. FOOD & DRUG ANALYSIS S73 (2013) (discussing emotional burden, economic burden, relationship distress, and other adverse impacts of SUD on family members); see also *id.* (collecting sources). Daley's encapsulation of the range of effects of SUD on family members warrants repeating in full: "Emotional burden. Members may feel anger, frustration, anxiety, fear, worry, depression,

transportation, advocacy, oversight, treatment, research, scheduling, and counseling. Yet the costs associated with these efforts are too often overlooked. Indeed, even while the President's Opioid Commission counted impacts on family members among the "inestimable" costs of the opioid epidemic, it acknowledged only their "suffering . . . as witnesses to addiction," not the time, effort, money, or lead role in care that family members often take on.⁷⁰ Family can in some ways be participants, not just witnesses, in their loved ones' battle with addiction.

It should not be surprising, then, that public programs may fail to recognize the burden of care work to support those with SUD. Medicaid state waiver guidance published by the Centers for Medicare and Medicaid Services ("CMS") on January 11, 2018 is a recent example. Medicaid is a federal program by which states provide health insurance, subsidized by the federal government, to low income persons pursuant to federal standards. Under section 1115 of the Medicaid statute, states may seek a "waiver" permitting them to alter eligibility, reimbursement, and other statutorily mandated criteria for their state Medicaid programs.

Several states have publicly expressed interest since the beginning of the Trump Administration in using the 1115 waiver process to create some form of a "work requirement," also called "community engagement," that would make a person's eligibility for

shame and guilt, or embarrassment. Economic burden. This may be caused by money spent on substances, or money problems associated with the loss of jobs or reliance on public assistance. Relationship distress or dissatisfaction. Families may experience high rates of tension and conflict related to the SUD and problems it causes in the family instability. This may result from abuse or violence, or family breakup due to separation, divorce, or removal of children from the home by Children and Youth Services. Effects on the developing fetus and children. Alcohol use during pregnancy can harm fetal development causing birth defects and problems in child development. Infants born to opioid-dependent mothers are at increased risk for neonatal abstinence syndrome, which can contribute to developmental or cognitive delays. Children of parents with SUDs are at increased risk for abuse or neglect, physical problems, poor behavioral or impulse control, poor emotional regulation, conduct or oppositional disorders, poorer academic performance, psychiatric problems such as depression or anxiety, and substance abuse. Effects on parents. Mothers with SUDs may show less sensitivity and emotional availability to infants. Parents of a child with a SUD may feel guilty, helpless, frustrated, angry, or depressed." *Id.*

70 The President's Comm'n on Combating Drug Addiction and the Opioid Crisis, Opinion Letter on Recommendations to Combat the Addiction Crisis (Nov. 1, 2017), at 31.

Medicaid contingent on her maintenance of gainful employment or other community engagement.⁷¹

In its January 11, 2018 guidance, CMS described how it recommends a state craft a waiver with some form of employment requirement in order to maximize the likelihood of CMS approval.⁷² The document recognized that many who receive Medicaid are “engaged as caregivers for young children or elderly family members” and encourages states to recognize such care work. And the document explicitly addresses treatment of those “with opioid addiction and other substance use disorder,” again encouraging states to accommodate such individuals. But its list of potentially accommodating measures is focused exclusively on the Medicaid eligibility of the SUD patients themselves.

Absent from the CMS guidance’s policy recommendations on care work and SUD is recognition of the time and effort many family members put into caring for loved ones with SUD. This invites state requirements that fail to recognize the value of such work and, counter-productively, force low-income family members to choose between either devoting daily attention and time to their loved ones’ illness or continuing to receive Medicaid.⁷³ In other words, it invites state requirements that have a blind spot for care work.

71 Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare for?*, 70 STAN. L. REV. 1689, 1743 (2018) (“Like Indiana’s, Pennsylvania’s, and those of other states before it, Kentucky’s waiver proposal included work requirements for the population Governor Bevin called the ‘able-bodied,’ which the Obama Administration consistently refused to allow.”).

72 Letter from Brian Neale, Dir., Ctrs. For Medicare & Medicaid Servs., to state Medicaid Dir. (Jan. 11, 2018) (available at Medicaid.gov).

73 Under the granted Kentucky waiver, caregiving for a person with a “disabling medical condition” counts toward the community engagement requirement. CTRS. FOR MEDICARE & MEDICAID SERVS., KENTUCKY HELPING TO ENGAGE AND ACHIEVE LONG TERM HEALTH (KY HEALTH) APPROVAL PACKAGE, 32 (2018). It is not apparent whether and under what circumstances Kentucky will include substance use disorder in this provision. The ADA excludes those who are “currently engaging” in illegal drug use from its definition of qualified individuals. That said, those in recovery may be considered disabled depending whether the addiction is considered a substantially limiting impairment. U.S. EQUAL EMP. OPPORTUNITY COMM’N, EEOCMIA, A TECHNICAL ASSISTANCE MANUAL ON THE EMPLOYMENT PROVISIONS (TITLE 1) OF THE AMERICANS WITH DISABILITIES ACT §§ 8.2, 8.5 (1992); see *Hartman v. City of Petaluma*, 841 F. Supp. 949, 949 (N.D. Cal. 1994); see also U.S. Comm’n on Civil Rights, *Sharing the Dream: Is the ADA Accommodating All?*, Chapter 4 (Oct. 2000), <https://www.usccr.gov/pubs/ada/ch4.htm>.

3. *Inequality*

Perhaps the main focus of the care work literature “has been to highlight the undervaluation and gendered nature of care work.”⁷⁴ Heavy reliance on care work—on family members’ uncompensated efforts—often poses profound inequality concerns because of gender imbalances in who performs this work. In short, “[c]aring labor most frequently falls to women.”⁷⁵ Research exploring the role of family in fighting SUD should be attentive to identifying and perhaps exploring the possibility that gender imbalances are endemic in this area as they are in care work on child care.⁷⁶

Furthermore, the nature of care work on SUD creates the potential for a different form of inequality, in who benefits from such work rather than who performs it. Many of the tasks that family may assist with require cultural competence, time, and organization. Finding treatment providers that take insurance is an onerous task that—insofar as it entails navigating complex systems and bureaucracies and interacting with numerous strangers on the phone and in person—depends on cultural capital that may be less available based on race, class, or country of origin.⁷⁷ In the somewhat related context of families’ abilities to advocate on behalf of children with autism in seeking special education resources, Baldwin-Clark found precisely this sort of structural inequality.⁷⁸

74 Hoffman, *supra* note 6, at 172.

75 SILVERMAN, *supra* note 4, at 6.

76 While not the purpose, design, or subject of the study, the fact that 78% of family members not themselves reporting substance use who obtained precautionary Naloxone access and training in Massachusetts were female in Bagley’s study is consistent with the possibility of gender disparities in the burden of care work on SUD. Bagley et al., *supra* note 32, at 151. In the future researchers should consider designing such studies to develop insight into the distribution of care work burdens.

77 See, e.g., Emily Corwin, *Shortage Of Addiction Counselors Further Strained By Opioid Epidemic*, NPR: SHOTS (Feb. 24, 2016), <https://www.npr.org/sections/health-shots/2016/02/24/467143265/shortage-of-addiction-counselors-further-strained-by-opioid-epidemic>; Binghui Huang, *Medication could be key to addiction recovery, but in the Lehigh Valley few doctors prescribe such treatment*, THE MORNING CALL (May 4, 2018), <http://www.mcall.com/business/health-care/mc-nws-nhclv-mat-program-20180129-story.html>; Beth Leipholtz, *Shortage of Treatment Providers For Opioid Addiction Remains Issue For Many States*, THE FIX (Feb. 28, 2018), <https://www.thefix.com/shortage-treatment-providers-opioid-addiction-remains-issue-many-states>.

78 See generally Latoya Baldwin-Clark, *Beyond Bias: Cultural Capital in Anti-Discrimination Law*, 53 HARV. CIV. RTS-CIV. LIBERTIES L. REV. 281 (2018)

Access to health insurance coverage for SUD treatment and services is a potential example of inequality of the benefits of care work. Historically, mental health and addiction treatments and services have been subject to coverage exclusions and especially vigorous utilization review. The federal parity law seeks to counteract this tendency, forbidding insurers from treating mental health and addiction differently from other illnesses in coverage policies and decision-making.⁷⁹ But enforcement of this law is uneven, and many advocates believe that access to addiction treatment is often barred by inappropriate coverage limitations.⁸⁰

Under the Affordable Care Act (“ACA”), all claimants who seek and are denied coverage for a treatment or service by their insurer have the right to appeal that decision both to the insurer and to an independent, external reviewer.⁸¹ Available statistics show that such appeals are successful as much as 40% of the time,⁸² so appealing coverage denials is a promising way to overcome this potential barrier to treatment.

All patients are not equally positioned to appeal, however. Rather, a person’s functional ability to appeal an adverse coverage decision depends on her awareness of the appeals process, her cultural competence, her trust in institutions like the appeals process, her free time (or ability to hire help) to devote to the appeal, and so on.⁸³ As scholars of civil procedure have long recognized, these variables can be correlated with income, education, age, race, and class, among other variables.⁸⁴ Thus, our “system” for ensuring the

(discussing sources on and describing racial and class-based disparities in access to special education services, linking these disparities to underlying disparities in cultural competence and capital in addition to bias).

79 29 U.S.C. § 1185a (2018).

80 See Valerie A. Canady, *Ten States to Embark on New Campaign to Ensure Parity Lives Up to its Promise*, 27 MENTAL HEALTH WEEKLY, Nov. 20, 2017, at 5; Alex Gertner, *Blue Cross Should Cover More Opioid Treatment*, THE NEWS & OBSERVER (June 8, 2018), <https://www.newsobserver.com/opinion/article212771774.html> (“I called several . . . programs and was told that BCBS rarely pays for this type of treatment.”).

81 See Katherine Vukadin, *Hope or Hype?: Why the Affordable Care Act’s New External Review Rules for Denied ERISA Healthcare Claims Need More Reform*, 60 BUFF. L. REV. 1201 (2012) (describing ACA rules).

82 U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-11-268, PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS 22, 23 (2011) (finding that appeals were successful in reversing coverage denial 39 to 59% of the time).

83 Baldwin-Clark, *supra* note 78, at n.27.

84 Marc Galanter is generally cited as the origin of this insight about the nature

accuracy of insurance coverage determinations may entail differential treatment, providing more “accurate” (however defined) favorable coverage determinations to those whose family connections have the capacity and wherewithal to appeal.

IV. Addressing Social Consequences

Whatever their theoretical relevance, actually measuring social consequences like interference, invisibility, and inequality and weighing them against more easily ascertained impacts—in particular medical impacts—is hard to do, as discussed in Part A. This “knowledge problem” is a reason to invest in evaluation and research that is open to social consequences when implementing new laws that deputize family, as Part B illustrates with the case of involuntary treatment laws. Moreover, the “break-even” analysis approach used to incorporate hard-to-quantify variables in administrative law cost-benefit analysis provides a framework for assessing laws that deputize family, as discussed in Part C. And that framework can and should be employed to evaluate the wisdom of a legal change from a welfare economic perspective, as Part D’s discussion of the choice architecture of consent to disclosure of protected information related to SUD treatment demonstrates.

A. Health, Love, and Knowledge

Incorporating the problems of interference, invisibility, and inequality in crafting laws that regulate health (or other behaviors) is challenging, in two ways. First is the problem of measurement, that is, of predicting how likely a legal change is to influence a behavior that it might theoretically influence.

Measurement is a particular problem for assessing interference with family relationships.⁸⁵ It is difficult enough to predict and measure the medical impact of a law that operates through third parties such as family members, even though health is a concrete and relatively measurable outcome.⁸⁶ Assessing the

of procedural rules. See generally Marc Galanter, *Why the ‘Haves’ Come Out Ahead: Speculations on the Limits of Legal Change*, 9 L. & SOC’Y REV. 95 (1974).

85 As for invisibility and inequality, observing unseen labor and identifying disparities in the provision or availability of such unobserved labor pose challenges of their own, though when it comes to measurement these challenges are not as imposing as those for measuring interference. The more policymakers bring care work into the visible realm, the more it will be possible to assess inequality in its burdens and benefits.

86 See U.S. DEPT OF HEALTH AND HUMAN SERVS., *supra* note 20, at 12

impact of such a law on the formation of caring relationships is much harder. While a promising history of scholarship seeks to track family relationships,⁸⁷ such relationships are not as readily measured as health status indicators or health outcomes. Moreover, measuring the causal effect of law on such relationships is complicated by the fact that such effects are unlikely to be instantaneous, necessitating long-term observation.⁸⁸ While it is possible and desirable that researchers might combine scholarship tracking family relationships with scholarship tracking the effect of law on behavior,⁸⁹ such work is not readily available.⁹⁰ In short, interference impacts are difficult to measure and predict.

A related problem for incorporating social consequences is

(explaining that “federally funded research into substance abuse treatment has focused on . . . individual-specific treatments” in part because “research with families is difficult and costly”); Simons et al., *supra* note 28, at 2 (“Methodological limitations and challenges associated with implementing family interventions in treatment settings may contribute to the mixed findings about the effectiveness of family components for adult substance abusers.”).

87 E.g. Susan M. McHale et al., *Sibling Relationships and Influences in Childhood and Adolescence*, 74 J. MARRIAGE & FAM. 913 (2012); Clare M. Stocker et al., *Sibling Relationships in Early Adulthood*, 11 J. FAM. PSYCHOL. 210 (1997).

88 The positive impacts of an intervention in this space may flow directly from the intervention itself and so be direct and immediate; for example, any benefit associated with involuntary treatment for the patient is immediately observable in the patient themselves and comes straight from the intervention. But upstream (or downstream, depending on one’s point of view) behavioral impacts of such interventions may be largely a function of the incorporation of knowledge of the rule into public awareness. In order for a bystander’s decision whether to call for help when a friend overdoses to be influenced by “immunity” laws, she must know about those laws, so too, in order for a patient to avoid family for fear of involuntary treatment she must know about involuntary treatment laws. Such long-run behavioral impacts will presumably take time and widespread adoption and implementation (or education) to develop, so it will be very difficult to pick up in a typical study population.

89 See D. James Greiner & Andrea Matthews, *Randomized Control Trials in the United States Legal Profession*, 12 ANN. REV. L. & SOC. SCI. 295 (2016) (discussing the usefulness of incorporating randomized control trials into the legal profession).

90 Researchers might use the fact that a person must know about a law for it to affect her behavior to measure interference with family relationships. Specifically, researchers might consider randomizing disclosures to patients about particular laws in their state—such as involuntary treatment laws, civil forfeiture laws, or immunity laws—in order to assess any differential downstream behavioral implications for family relationships, consistent of course with governing ethical requirements and IRB approval.

that of quantification, that is, of converting a particular concern into terms by which it might be weighed against traditionally financial or medical impacts. This quantification challenge is a particular problem for inequality, which is recognized as difficult- if not impossible-to-quantify.⁹¹ Some have argued that it would be better to have an equal system than an unequal one so, ⁹² for example, we should not have an appeals process for insurance coverage decisions at all unless we can design one that is equally accessible in practice to all and so does not exacerbate inequality. Tradeoffs that permit unequal treatment of anyone, or of any vulnerable group, may simply be intolerable and not susceptible to quantification and comparison with more fungible values.

On the other hand, Kaplow and Shavell have argued that rather than incorporate some distributional considerations in regulatory design, regulators should design the optimal regulatory apparatus, then somehow repay or offset any inequities through taxes or subsidies for those subject to them. It is possible to envision this approach being used to better account for inequality in consequential analysis of deputization; the value of unpaid labor (and hypothetical cost of repaying those who perform it) might be used to quantify unequal distribution of burdens, and the value of assistance (and hypothetical cost to provide it through state-sponsored navigators or other supports) might be used to quantify unequal distribution of benefits.⁹³

In any event, the fact of measurement and quantification challenges in assessing social consequences like interference, invisibility, and inequality does not mean that such consequences do not exist or that scholars or policymakers should not consider them in weighing laws or reforms.⁹⁴ To the contrary, this quantification challenge creates a risk that such impacts will be ignored, and so a danger that policymakers will adopt policies that appear to be beneficial or at least neutral in the short-term data capable of and

91 See CASS R. SUNSTEIN, *VALUING LIFE* (2014) (discussing the difficulty of quantifying human dignity).

92 See generally LOUIS KAPLOW & STEVEN SHAVELL, *FAIRNESS VERSUS WELFARE* (2006) (discussing such arguments).

93 See *id.* (making such an argument).

94 Jonathan S. Masur & Eric A. Posner, *Unquantified Benefits and the Problem of Regulation Under Uncertainty*, 102 *CORNELL L. REV.* 87, 122 (2016) (“The problem with this argument [that difficult-to-quantify values should be ignored] is that the zero probability is even more arbitrary than the regulator’s prior.”).

subject to measurement, like impact on a particular patient's health, even while being problematic or counter-productive overall or in the long run.⁹⁵

B. The Need for Research into the Social Consequences of Deputization: The Case of Involuntary Treatment Laws

Consideration of the risk of interference, invisibility, and inequality in deputization—the “social consequences” of deputization—can, even in the face of the knowledge problem discussed above, reveal the need for and guide further research before concluding that a policy is beneficial. Indeed, fear that efforts to regulate family will ultimately backfire is one of the reasons for the “[t]radition of [n]oninterference” in family law.⁹⁶ In other words, the possibility of social consequences can at a minimum provide a reason for restraint before concluding that any particular reform that deputizes family is desirable, or for including in such laws provisions to ensure the development of better information regarding their full range of impacts and revisitation as necessary. Involuntary treatment laws offer an example of such a reform as to which there is enough reason for concern about social consequences to justify continuing research.

A growing body of state legislative reforms empower family members to petition to have their loved ones sent for involuntary treatment. Such laws generally empower family or doctors to ask a court to force a person into treatment for SUD on the ground that the disorder creates a “likelihood of serious harm.”⁹⁷ Pennsylvania's proposed statute is illustrative: it would empower a “spouse, guardian, or relative” to bring a petition.⁹⁸

The claim that such laws actually carry a benefit in terms of health is dubious. For example, Beletsky and Ryan survey concerns with these laws, noting that voluntary treatment is more effective than involuntary treatment, particularly for those with mental illness or other health needs and that involuntary treatment passes costs from insurers to the state.⁹⁹ Along the same lines, Bhalla and

95 See SUNSTEIN, *supra* note 91; Masur & Posner, *supra* note 94.

96 See Carl E. Schneider, *Moral Discourse and the Transformation of American Family Law*, 83 MICH. L. REV. 1803, 1837 (1985) (“The law not only suspects that intervention will do harm; it doubts that intervention will do good . . .”).

97 Beletsky & Ryan, *supra* note 47 (citing MASS. GEN. LAWS c. 123, § 35 (2018)); see also *id.* (describing 33 related state laws).

98 S. 391, 2017–18 Leg., Reg. Sess. (Pa. 2017); Bhalla et al., *supra* note 47, at 2.

99 See Beletsky & Ryan, *supra* note 47; see also Leo Beletsky et al., *Expanding Coercive*

co-authors express doubts about the medical consequences of these laws and also express ethical objections.¹⁰⁰

Such laws may also have social consequences that weigh against their adoption. In theory, empowering family members to force their loved ones into involuntary commitment could raise precisely the same concern that motivates the spousal privilege and the enhanced privacy protection provided to SUD treatment-related medical information, namely, concern about chilling communication.¹⁰¹ If awareness and utilization of such laws were widespread, they could theoretically discourage those with SUD from disclosing the extent of their addiction to loved ones, disclosing their location to loved ones, acknowledging a relapse to loved ones, and so on, for fear that such information would prompt and/or be used against them in an involuntary treatment proceeding.¹⁰²

This potential concern is connected to the fact that in many states, involuntary treatment laws not only explicitly limit the class of petitioners to family, but also make information the family might have gleaned from their loved one the primary focus of the court's decision whether to order the patient into treatment. For example, Pennsylvania's proposed involuntary treatment law requires the petition assert:

The petitioner's belief, *including the factual basis for the belief*, that the respondent is suffering from alcohol and other drug abuse and presents an imminent danger or imminent threat of danger to self, family or others, or that there exists a substantial likelihood of such a threat in the near future, if the respondent is

Treatment is the Wrong Solution for the Opioid Crisis, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 11, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160211.053127/full/> (making similar finding).

100 See Bhalla et al., *supra* note 47 (offering survey of medical and ethical objections to civil commitment).

101 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6053 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (The spousal privilege is motivated by a desire to encourage communication between spouses, enhanced privacy for SUD medical information by a desire to encourage communication with providers.).

102 Cf. *Why I Abandoned Tough Love Instead of My Child*, WOMAN'S DAY (July 1, 2016), <https://www.womansday.com/health-fitness/wellness/a55379/help-for-parents-of-drug-addicts/> (discussing one mother's perspective that her prior "tough love" approach had interfered with her son's efforts at recovery).

not treated for alcohol or other drug abuse.¹⁰³

Accordingly, to someone who does not wish to pursue treatment, family in a state with an involuntary treatment law could theoretically present a double threat: the law directly empowers the family member to petition to force the patient into involuntary treatment, and the law makes whatever information the family member might have learned from his loved one central to the court's willingness to initiate involuntary treatment proceedings. This poses the risk of twin chills: first, against one's willingness to even tell family that they may have SUD or, if they know, inform family of their location; and second, against one's willingness to disclose details of their addiction to family for fear those details might be used against them.

Involuntary treatment laws also may pose invisibility and inequality concerns. Family usually must pay for the treatment received, and going through the petition process poses significant logistical and emotional burdens for family, who are of course not paid for their efforts. As for inequality, as a means to identify and push into treatment those who need it such laws pose a real risk of disparities: as discussed above, civil procedure scholars have observed in other contexts that the meaningfulness of such an opt-in procedural mechanism can vary significantly across the population.

To be sure, these are only *potential, theoretical* concerns about the possible social consequences of involuntary treatment laws. It may be that involuntary treatment laws have no impact on underlying family relationships currently and would still have no impact even if their existence became both widespread and widely known. On the other hand, it is accepted that fear of being subject to law enforcement discourages bystanders from calling for help when a friend overdoses; this is the behavioral rationale for immunity laws.¹⁰⁴ It is an open question whether the same sort of fear would tend to discourage a person who is aware that a loved one might initiate involuntary treatment proceedings from informing that loved one of her illness, relapse, or location.

This concern about potential interference does not shed any additional light on the acute health impacts of involuntary treatment

103 S. 391, 2017–18 Leg., Reg. Sess. (Pa. 2017) (emphasis added).

104 See Corey Davis et al., *Changing Law from Barrier to Facilitator of Opioid Overdose Prevention*, 41 J.L. MED. & ETHICS 33, 34 (2013) (discussing need “to encourage bystanders to summon emergency responders” behind such laws).

on the treated individual. However, it adds the following macro-level caution for further inquiry: such deputization mechanisms may alter the power dynamics within a family and so their widespread adoption and use may change family behaviors broadly. Moreover, any benefits and burdens they create are unpaid and may be distributed unfairly. It is important that legislators and policymakers investigate and assess such possible detrimental impacts on the family's ability to improve health, reduce mortality, improve access, and aid in recovery in considering if any hypothetical benefits for access to treatment in an individual case are worthwhile. Moreover, where policymakers prefer to enact legislation despite uncertainty, they should include in such legislation provisions facilitating information gathering and policy re-assessment, such as providing funding for an agency report upon the health and social consequences of the law.¹⁰⁵

This is not to say that gleaning quality information about social consequences by tracking a reform's effects would be easy. Assessing the impact of a state policy change never is.¹⁰⁶ But while perfect information may be unattainable, laws and studies can be designed to provide helpful information and, so, facilitate better policy.¹⁰⁷

C. Accounting for the Social Consequences of Deputization with Break-Even Analysis

No amount of feasible research will remove all uncertainty surrounding the social consequences of deputization. Extensive literature in administrative law on the theory and practice of cost-benefit analysis, however, discusses how policymakers can and should incorporate uncertain costs and benefits into their decision-making.¹⁰⁸ This scholarship on the theory and practice of "cost-benefit analysis" discusses how administrative agencies should make evidence-informed decisions about hard-to-quantify or qualitative

105 *C.f.* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1946, 124 Stat. 119, 582 (2010) (mandating Secretary of HHS to evaluate data collection regarding health disparities and submit report to Congress recommending ways to improve such data collection).

106 *See* Kristin Madison, *Building a Better Laboratory: The Federal Role in Promoting Health System Experimentation*, 41 PEPP. L. REV. 765, 777–83 (2014) (discussing impediments to such knowledge gathering).

107 For general discussion of the construction of reforms to encourage knowledge development, see *id.* at 784 n.84.

108 *E.g.*, SUNSTEIN, *supra* note 91; Masur & Posner, *supra* note 94; Amy Sinden, *Formality and Informality in Cost-Benefit Analysis*, 2015 UTAH L. REV. 93 (2015).

considerations. The insights of this line of scholarship can be applied to incorporate the social consequences of deputization as well.

Specifically, “break-even analysis” is a normative framework for decision-making in the face of hard-to-quantify costs or benefits.¹⁰⁹ This is an approach cost-benefit scholars and policymakers employ when, as occurs “[m]uch of the time, we cannot quantify the benefits of potential courses of action, or the costs, or both, and we must nonetheless decide whether and how to proceed.”¹¹⁰ In essence, breakeven analysis “quantifies what can be quantified, acknowledges what cannot, and adopts a specific framework to help regulators decide how to proceed in the way of limited information.”¹¹¹ In practice, it entails establishing reasonable upper and/or lower “bounds” as thresholds that benefits would have to reach to be justified (or that costs would have to reach to counsel caution), then utilizes all available evidence to estimate whether the benefits (or costs) are sufficient to meet that threshold.¹¹² In short, break-even analysis simply dictates that “when an agency faces uncertainty, it should ask itself, ‘how small could the value of the non-quantified benefits be (or how large would the value of the non-quantified costs need to be) before the rule would yield zero net benefits.’”¹¹³

None of this is to say that policymaking should not be evidence based; it’s quite the opposite. Break-even analysis provides a framework through which policymaking can be *more* informed by evidence and also helps in determining where and how evidence should be developed.

D. Application: The Choice Architecture of Disclosure to and by Family

This subpart demonstrates how the above framework can be used to evaluate and demonstrate the desirability of laws that deputize family in health care, weighing and comparing health

109 See Cass R. Sunstein, *The Limits of Quantification*, 102 CAL. L. REV. 1369 (2014).

110 *Id.* at 1369.

111 *Id.* at 1372.

112 *Id.* at 1385–87 (illustrating the factors of break-even analysis and unquantifiable factors in analysis). See also Pranav Kumar Choudhary et al., *Break-Even Analysis in Healthcare Setup*, 1 INT’L J. OF RES. FOUND. HOSP. & HEALTHCARE ADMIN. 29, 30–32 (2013) (describing break-even analysis in the healthcare world).

113 Masur & Posner, *supra* note 94, at 124 (quoting OFFICE OF MGMT. & BUDGET, CIRCULAR A-4, REGULATORY ANALYSIS 2 (2003)).

impacts with social impacts including interference, invisibility, and inequality. It does so by evaluating two potential changes to the choice architecture of privacy deputization for disclosure of SUD information: an active choice approach (as compared to an opt-in or opt-out approach) and supported decision-making.

Private information pertaining to SUD treatment is protected from disclosure by both HIPAA and 42 C.F.R. Part 2, itself a creature of 42 U.S.C. § 1395dd. This protection restricts applicable providers' ability to share medical information with those other than the patient. The Department of Health and Human Services ("HHS") and the President's Commission have each recognized that misunderstandings about HIPAA can lead to "obstacles to family support that [are] crucial to the proper care and treatment" of SUD sufferers.¹¹⁴

While restricting disclosure of SUD treatment information carries a downside when it prevents a doctor from informing a family member that the patient would like informed, it carries a significant benefit when the promise of privacy encourages a person to come forward and seek treatment for SUD despite the heavy stigma surrounding the illness. The judgment—not questioned here—that the benefits of privacy under current requirements outweigh the associated costs is reflected in the statutory and regulatory protection currently afforded under HIPAA and Part 2.

This subpart focuses on a discrete but nonetheless important aspect of the *experience* of privacy for SUD patients distinct from the privacy requirements themselves: the choice architecture of deputization. As discussed in subsection 1, below, both HIPAA and Part 2 permit patients to authorize disclosures to family members, that is, to deputize family as eligible recipients of protected medical information. Yet the "choice architecture" of such deputization—how and when patients may enlist (or recognize) the help of family in navigating their treatment by authorizing disclosure to them—varies significantly between HIPAA and Part 2.

114 HHS Offices for Civil Rights Issues *Guidance on How HIPAA Allows Information Sharing to Address the Opioid Crisis*, U.S. DEPT OF HEALTH & HUM. SERVS. (Oct. 27, 2017), <https://www.hhs.gov/about/news/2017/10/27/hhs-office-civil-rights-issues-guidance-how-hipaa-allows-info-sharing-address-opioid-crisis.html>. COMMISSION REPORT, *supra* note 36, at 122 (noting 42 C.F.R. Part 2 as a barrier and modification to that regulation "to permit the sharing of this type of information among health care providers and the loved ones of those suffering from SUDs").

1. *Choice Architecture of Deputization for SUD Disclosures*

HIPAA applies broadly to medical providers to limit the disclosure of protected health information.¹¹⁵ HIPAA's privacy protections are a creature of privacy regulations promulgated by HHS under a broad delegation of statutory authority, and so all aspects of these protections can be changed through the administrative process.¹¹⁶

Because of concern that SUD sufferers avoid treatment for fear of their illness being exposed to employers, family, or others, Part 2 offers additional protections for the disclosure of protected health information collected by certain SUD treatment providers.¹¹⁷ Part 2 is largely a creature of regulation that can be changed through the administrative process, but the underlying statutory delegation is not as broad and so constrains both the breadth of the agency's discretion to alter the rules through the administrative process and the scope of the agency's permissible authority.¹¹⁸

Current HIPAA and Part 2 rules permit patients to deputize family, empowering them to receive protected information or even consent to additional disclosures.¹¹⁹ The manner and context of such deputization differs markedly between the programs, however.

When it comes to family involved in a patient's treatment, HIPAA generally leaves it to providers to decide case-by-case whether

115 45 C.F.R. § 164.104(a)(1)–(3) (2018); 45 C.F.R. § 164.500 (2018); 45 C.F.R. § 164.502 (2018).

116 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936; 42 U.S.C. § 1320d-2(a) (2018).

117 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6053 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (“The laws and regulations governing the confidentiality of substance use disorder records were written out of great concern about the potential use of substance use disorder information against individuals, causing individuals with substance use disorders not to seek needed treatment. The disclosure of records of individuals with substance use disorder has the potential to lead to a host of negative consequences, including: Loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.”).

118 42 U.S.C. § 290dd-2 (1992) (amended 1998).

119 See 45 C.F.R. § 164.502(g) (2018); 45 C.F.R. 164.510(b) (2018); 42 C.F.R. 2.31 (2018); Office for Civil Rights Headquarters, Guidance: Personal Representatives, Health Information Privacy (Sept. 19, 2003), <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/personal-representatives/index.html>; Elizabeth Snell, *Do HIPAA Regulations Need Updates on Patient Privacy?*, HEALTH IT SECURITY (Aug. 15, 2017), <https://healthitsecurity.com/news/do-hipaa-regulations-need-updates-on-patient-privacy>.

the patient's consent to disclosure should be opt-in or opt-out and how opt-in or opt-out should occur.¹²⁰ In other words, providers choose whether and how to seek patients' input about consenting to disclosure to family—at the start of treatment, the end, verbally, in writing, explicitly, implicitly, etc. HHS did not discuss the decision to leave this choice architecture to the discretion of providers at length in the privacy rule but did explain that this approach permits providers to use their medical judgment about the best course.¹²¹

Part 2, on the other hand, makes deputization opt-in. A patient must affirmatively agree to disclosure in writing, and this agreement must satisfy certain regulatory criteria for duration, specificity, and so on.¹²² Consistent with the underlying concern about encouraging patients with SUD to seek treatment without fear of discovery or embarrassment given societal stigma, this makes the default presumption one of non-disclosure to friends and family, i.e., of isolation.

Turning to the scope of deputization, HIPAA allows patients to empower their family or friends to permit further disclosures under very limited circumstances.¹²³ Specifically, if a patient has granted authority to “mak[e] decisions related to health care” to another, then that deputy is also authorized under HIPAA to permit disclosures of protected information, for example, to an additional provider.¹²⁴ The regulations do not permit patients to empower a loved one to authorize such disclosures without taking the further step of also empowering the loved one to make medical decisions.

The scope of deputization under Part 2 is even more limited. A patient can only empower another to help coordinate her care by authorizing disclosure or re-disclosure by making that person her legal guardian. Moreover, the regulations include a requirement, not included in the statute, prohibiting re-disclosure of protected information by its recipient.¹²⁵

120 45 C.F.R. § 164.510 (a)(2) (2018) (provider can either seek patient's affirmative consent or disclose when patient does not take advantage of an “opportunity to object” provided that such disclosure is within the patient's best interest and consistent with any prior expressed preference he or she may have).

121 Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82462, 82664 (Dec. 28, 2000).

122 42 C.F.R. § 2.31(a) (2018).

123 45 C.F.R. § 164.502(g)(2) (2018).

124 *Id.*

125 *Compare* 42 C.F.R. § 2.32 (2018) (prohibition on re-disclosure), *with* 42 U.S.C.

2. *The Preferability of Break-Even Analysis over HHS's Regulatory Approach*

HHS substantially revised Part 2 in 2017.¹²⁶ The agency focused exclusively on operational costs of changes to the rule in its Regulatory Impact Analysis, as if Part 2 did not have important impacts on the health of SUD sufferers as well.¹²⁷ This is in contrast to the effort of other agencies to pull apart and carefully consider even uncertain benefits and costs in rulemaking.¹²⁸ This is characteristic of HHS, however; a recent study of the use of cost-benefit analysis in rulemaking showed HHS as the agency that most frequently failed to engage in cost-benefit analysis ostensibly called for by Executive Order.¹²⁹

It would have been preferable for HHS to engage in some form of cost-benefit analysis, perhaps including break-even analysis, that grappled with the various costs and benefits of Part 2 as they related to the revised rule, for four reasons. First, Part 2 implicates a host of important considerations and analysis of these considerations would reduce the likelihood that current rules might fail to accurately balance them.

Foremost, of course, is the benefit that protecting the privacy of SUD treatment information may encourage individuals to seek treatment who would otherwise fear adverse consequences from unwanted disclosure to employers, law enforcement, loved ones, and so on. HHS mentioned this motivating benefit of Part 2 in the preamble to its rule.¹³⁰

§ 290dd-2(a) (1992) (amended 1998) (limiting disclosures by treatment providers).

126 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2).

127 *Id.* at 6109 (“When estimating the total costs associated with changes to the 42 C.F.R. part 2 regulations, we assumed five sets of costs: updates to health IT systems costs, costs for staff training and updates to training curriculum, costs to update patient consent forms, costs associated with providing patients a list of entities to which their information has been disclosed pursuant to a general designation on the consent form . . . and implementation costs associated with the List of Disclosures requirements.”).

128 See generally SUNSTEIN, *supra* note 91 (discussing such efforts); Masur & Posner, *supra* note 94, at 124 (same).

129 Masur & Posner, *supra* note 94, at 124 (describing the HHS as “dominat[ing]” list of agencies that produced regulations for which “either benefits or costs (or both) were not quantified at all).

130 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg.

While encouraging patients to seek treatment is paramount, a countervailing concern is that Part 2 imposes a cost by making coordination among providers more difficult.¹³¹ Again HHS mentioned this countervailing cost of Part 2 in the preamble to its rule in describing the underlying protection, but did not either quantify or purport to weigh it in relation to its proposed revision, despite emphasizing the importance of balancing it with the access-promoting purposes of Part 2.¹³² Moreover, various commentators have identified, implicitly or explicitly, additional considerations: Part 2 helps lower the likelihood of employment, law enforcement, custody, or other discrimination on the basis of SUD. Such discrimination can be intrinsically bad above and beyond its relationship to chilling treatment and associated health impacts.¹³³ And Part 2 makes it harder for law enforcement to identify and prosecute those with SUD to the extent their SUD brings illegal activity; some believe that such law enforcement activity can itself be harmful rather than helpful for a variety of reasons and on that view any policy change that makes it easier as a cost rather than a benefit.¹³⁴

Second, a more fulsome analysis explaining whether and why

6052, 6053 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (“The laws and regulations . . . were written out of great concern about . . . causing individuals with substance use disorders not to seek needed treatment.”).

131 See Jennifer K. Manuel et al., *Confidentiality Protections Versus Collaborative Care in the Treatment of Substance Use Disorders*, 8 ADDICTION SCI. CLINICAL PRAC. 13 (2013).

132 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6077 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (“With respect to obstacles to information sharing, one of SAMHSA’s goals for this rulemaking is to ensure that patients with substance use disorders have the ability to participate in and benefit from new integrated health care models without fear of putting themselves at risk of adverse consequences.”); *id.* at 6089 (“SAMHSA acknowledges the legitimate concerns of commenters regarding how care coordination relates to patient safety. However, SAMHSA must consider the intent of the governing statute [], which is to protect the confidentiality of substance use disorder patient records.”).

133 See, e.g., Karla Lopez & Deborah Reid, *Discrimination Against Patients with Substance Use Disorders Remains Prevalent and Harmful: The Case for 42 C.F.R. Part 2*, HEALTH AFF.: HEALTH AFF. BLOG (Apr. 13, 2017) (“The confidentiality law is often the only shield between an individual in recovery from addiction and the many forms of discrimination and prejudice that could destroy their lives.”).

134 See *id.* (describing “arresting, prosecuting, and incarcerating people because of their illness” as a cause of stigma surrounding SUD).

the agency's experts saw chilling concerns as outweighing medical coordination benefits from loosening Part 2 would go further toward persuading proponents of medical coordination that HHS had struck the right balance. Numerous provider groups support changes to Part 2, presenting the law as an "outdated" barrier to information sharing among providers.¹³⁵ A fuller explanation of costs and benefits of these changes from HHS might persuade proponents they are not worthwhile, and would provide a greater foundation upon which any future Congressional consideration could be built to be sure that Congress does not miss tradeoffs, predictions, or valuations that might have been implicit but unarticulated in HHS's rulemaking.

Third, even when costs and benefits are inevitably uncertain, teasing them out to the extent possible in a systemic way facilitates subsequent research and revisitation of crucial policy assumptions. As will be discussed at greater length below, a strength of break-even analysis is that it helps to pinpoint questions on which further research might be both possible and determinative, and so encourages regulators continually to reassess policies as new information comes to light.¹³⁶

Fourth, a break-even analysis would increase the likelihood that the agency identified and considered viable alternatives and tweaks to its chosen approach.¹³⁷ The following sections will illustrate this with regard to the consent provisions of the rule.

All that said, cost-benefit analysis of the Part 2 rule would not have been without downsides. Paramount, perhaps, is the risk of overestimating costs of Part 2 and underestimating benefits. The costs of Part 2—interfering with care coordination—are highly visible to health care providers. Its benefits, however—an increased likelihood that patients will seek treatment—are not as visible. Providers are plainly much less likely to encounter people who were deterred from seeking treatment by fear of disclosure; relatedly, the population of people that providers do meet are likely to be those for whom fear of disclosure did not wind up being determinative.

135 See generally PARTNERSHIP TO AMEND 42 CFR PART 2, www.helpendopioidcrisis.org (last visited Nov. 11, 2018).

136 See Masur & Posner, *supra* note 94, at 126 (noting that "[t]his review of priors could take place as part of the broader retrospective review of regulations").

137 For example, "[s]everal commenters expressed concerns that the prohibition on re-disclosure did not improve patient privacy protections," Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6090 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2), but HHS did not respond to that comment or explain why it disagreed.

And providers themselves experience the inconvenience and harms of Part 2 to the extent that it limits coordination. As such, a large, well-informed and connected constituency for Part 2 may tend to underestimate the benefits of Part 2 and overestimate its costs.¹³⁸ This presents the risk that this bias would infect break-even analysis as well.

Concern that some benefits or costs may be overemphasized is a reason to be careful in engaging in break-even analysis, or even to endorse a presumption in such analysis in favor of the likely-underexposed value. It is not, however, a reason to refuse to admit the possibility that the value might not be worthwhile in some cases or to explain analytically how and why benefits of a rule outweigh the costs. Indeed, that approach might be counterproductive because, as explained above, it could lead to the propagation through the administrative process of a suboptimally tailored rule that lacks the support of a large constituency.

3. Break-Even Analysis Indicates that Providers Should Be Encouraged to Offer an Active Choice About Part 2 Consent

Of course, performing the break-even analysis that was lacking from HHS's revision of Part 2 is beyond the scope of this Article. This section's focus is instead on the more narrow question of how family are deputized as able to receive and authorize disclosure of a person's otherwise protected medical information. Break-even analysis of the first question—how family are deputized as able to receive a loved one's protected information under Part 2—reveals that providers should be encouraged to present patients with an “active choice” about such deputization. Rather than make non-disclosure the assumed, default option, providers should affirmatively ask patients in each case whether they would like to identify one or more loved ones as able to obtain their health information.

As discussed above, HIPAA does not mandate a single default rule for permitting disclosure of protected medical information to patients' friends or family. Instead, the current privacy rule leaves it to doctors to use their judgment to decide whether to employ an opt-in or opt-out approach or, indeed, to decide whether to present the choice at all. This makes HIPAA's privacy rule an example of a

¹³⁸ See SUNSTEIN, *supra* note 91 (discussing such bias).

“tailored default”¹³⁹ in which the determination of the default is left to the provider.

The choice architecture of Part 2 consent is in some sense a tailored default as well, except that doctors do not have the option of making consent “opt-out” when it comes to SUD information protected by Part 2 as they do when it comes to HIPAA.¹⁴⁰ Specifically, Part 2 requires a detailed, written consent form.¹⁴¹

The default rule for consent is important because default rules can be a powerful influence on decision-making; in organ donation, studies have shown the default determining a person’s choice approximately 16%–22% of the time.¹⁴² Defaults stick for several reasons: some individuals see defaults as communicating policymakers (or doctors’) judgment about the “best” option for them, and so take the default as a signal of the preferred approach.¹⁴³ Others follow the default due to the decisional burden of departing from it—not making a choice is easier than making a choice, especially when making the choice requires involved steps.¹⁴⁴ And finally, due to the “endowment effect,” some value the default state of affairs more highly simply because it is the default.¹⁴⁵

This “status quo bias” can be avoided using an “active choice” approach in which decision-makers are forced to decide one way or the other, without a default option. An active choice approach avoids signaling one option as the “best one” and neutralizes the endowment effect, potential benefits bought at the “price” of forcing

139 For an explanation of tailored defaults, see Ariel Porat & Lior Jacob Strahilevitz, *Personalizing Default Rules and Disclosure with Big Data*, 112 MICH. L. REV. 1417, 1420–27 (2014) (discussing advantages of personalized default rules).

140 See Omri Ben-Shahar & John A. E. Pottow, *On the Stickiness of Default Rules*, 33 FLA. ST. L. REV. 651 (2006).

141 42 C.F.R. § 2.31(a) (2018).

142 See Kendrick T. Van Dalen & Kène Henkens, *Comparing the Effects of Defaults in Organ Donation Systems*, 106 SOC. SCI. & MED. 137, 139 (2014) (reporting opt-in rate of 50% to organ donation as compared to 66% participation rate under active choice regime in survey-based study); Richard H. Thaler, *Opting In vs. Opting Out*, N.Y. TIMES, Sept. 26, 2009, at BU6 (reporting 60% organ donation participation rate in Illinois under active choice regime, as compared to 38% rate nationally); Stan Dorn et al., *Making Health Insurance Enrollment as Automatic as Possible (Part 1)*, HEALTH AFF.: HEALTH AFF. BLOG (May 2, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180501.141197/full/>.

143 See Lawrence, *supra* note 9, at 115–16 (collecting sources addressing reasons defaults stick).

144 *Id.*

145 *Id.*

the decisional burden of making a choice on everyone.¹⁴⁶ In short, active choice deprives people of the freedom not to decide, but frees their decision of the encumbrances of a perhaps undesired signal about the “best” option and the endowment effect.¹⁴⁷

Is it right to leave providers on their own in deciding whether to make consent to Part 2 disclosure “opt-in” or instead to present patients with an “active choice” about such disclosure?

Health: From the perspective of patient health, it is not clear that one or the other (opt-in or active choice) is preferable. The health concern underlying privacy protection for such information is that the threat of unwanted disclosures would deter someone from seeking treatment.¹⁴⁸ But it is not apparent that asking a person affirmatively to decide whether to permit disclosure to a loved one or not would increase or decrease this threat. Indeed, Part 2 regulations require an early notice be given to patients regarding protections; inquiring about consent at the same time might helpfully underscore that the patient’s information is private if she wants it to be. In other words, concern that the threat of disclosure will discourage patients from seeking medical care in the first place is a reason not to disclose private information without the patient’s consent, not a reason to choose a default of non-disclosure over an active choice regime. In either case medical information is disclosed only with the patient’s consent.

Interference: In contrast to health impacts, active choice has several potential social benefits over an opt-in regime. First, to the extent that people follow the status quo because they perceive it as a signal of the preferred alternative by policymakers,¹⁴⁹ an opt-in regime signals that policymakers see going it alone as the best course. But research indicates that, quite the contrary, involving family in care

146 See generally Cass R. Sunstein, *Deciding by Default*, 162 U. PA. L. REV. 1, 39–43 (2013) (discussing arguments in favor of active choosing).

147 See Cass R. Sunstein, *Foreword* to NUDGING HEALTH, at xi (Glenn Cohen et al. eds., 2016).

148 See Paul N. Samuels & Patty McCarthy Metcalf, *Relaxing Patient Privacy Rules Would Worsen the Opioid Epidemic*, STAT (Nov. 24, 2017), <https://www.statnews.com/2017/11/24/opioid-epidemic-patient-privacy/> (arguing based on logic that Part 2 privacy protections significantly increase patients’ willingness to seek treatment such that relaxing such protections would cause “immeasurable and immediate” harm).

149 See John Beshears et al., *The Importance of Default Options for Retirement Saving Outcomes: Evidence from the United States*, in SOCIAL SECURITY POLICY IN A CHANGING ENVIRONMENT 167 (Jeffery R. Brown et al. eds., 2009).

is a positive.¹⁵⁰ Accordingly, an opt-in approach may send the wrong signal and an active choice regime would be a preferable alternative because it would avoid sending any signal at all.

Invisibility: Second, as to invisibility, an opt-in regime creates a significant risk that due to lack of awareness or inertia, a person whose loved ones are actively involved in her care will simply not go through the trouble of signing (or be unaware they can sign) a consent to permit her provider to disclose information to the loved one. Indeed, HHS encourages this common work-around.¹⁵¹ In such a case, the patient may simply communicate protected information to the loved one herself. While this is a lawful workaround and may be a functional one as well, it increases the likelihood that the role of family in assisting with a person's treatment will go unobserved by policymakers or providers.

Moreover, this invisible workaround for informing loved ones involved in a SUD patient's care creates the risk of an additional adverse health impact of an opt-in regime. Even closely involved family may then be cut off from pivotal information if for any reason, such as a relapse, their loved one becomes unavailable to share information themselves. In such a case, the loved one who has been serving as a navigator and the provider themselves would be unable to collaborate, simply because they did not take the preemptive step of getting a consent on file when they had the chance due to an opt-in regime.

Inequality: Finally, inequality favors active choice because the effect of a default is not the same for all influenced by it.¹⁵² A well-informed patient or family member with experience or competence navigating complicated health care regimes is relatively better able and more likely to learn of and find ways to overcome a default rule.

150 See *supra* Part II.A.

151 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6070 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2) (“[I]t is permissible [under part 2] for a *patient to disclose* information to a personal health record or similar consumer application but if a part 2 program or lawful holder of patient identifying information discloses that information to the personal health record or similar consumer application on behalf of the patient, consent would be required.”).

152 See Jessica L. Roberts, *Nudge-Proof: Distributive Justice and the Ethics of Nudging*, 116 MICH. L. REV. 1045, 1055 (2018) (“[N]udges do not work equally well for all citizens”); Lawrence, *supra* note 9, at 115–17 (discussing “status quo bias as a sifting mechanism” based on predictable variation among the population in the stickiness of defaults).

In concrete terms, this means that a person's ability to authorize a family member to discuss treatment options with his doctor depends on her cultural capital, educational, and competing decision burdens. So, the goal of equal treatment favors fewer burdens and active choice.

Weighing: As compared to an opt-in regime, active choice about disclosure of protected SUD treatment information to loved ones involved in a person's care carries a reduced risk of interference with family relationships, makes care work more visible, reduces inequality inherent in an opt-in system, and has potential health benefits. It therefore appears to be the preferable way to present patients with the question of whether to consent to disclosure of their protected SUD information to loved ones.

Moreover, leaving providers with the unguided decision of whether and when to present an active choice about consent risks that they will not do so often enough. By training and by perspective, providers are positioned to focus on medical effects. This creates a risk that providers will tend to give too little weight to systemic, social consequences that are both beyond their expertise and beyond their immediate view.

Accordingly, regulators should at a minimum consider issuing guidance encouraging providers to present patients with an active choice about disclosure to loved ones as a matter of course unless they perceive some concern that counsels against doing so. Such guidance might also suggest logistics for when and how to ask patients to make this choice.

Moreover, it might be that any health benefits of allowing providers to decline to present patients with a choice about deputization are outweighed by the costs of this "tailored default" approach. This question should be explored further and, with it, the possibility of mandating rather than merely encouraging providers to present an active choice about consenting to disclosure of SUD information to loved ones in all cases.¹⁵³

153 Recently enacted federal legislation explicitly empowers family caregivers and requires that they be given support and resources. But this legislation was motivated by proponents of long-term care for the elderly, and so is triggered only upon a patient's discharge from inpatient treatment at the hospital. H.B. 1329, 199th Gen. Assemb., 2015–16 Reg. Sess. (Pa. 2016) (Caregiver Advise, Record, and Enable Act allows for a patient to choose their caregiver following discharge from a hospital, upon signed consent; hospitals are obligated to provide all instructions to care to the caregiver in question); Recognize, Assist, Include, Support and Engage Family Caregivers Act of

4. *Break-Even Analysis Indicates that Permitting Supported Decision-Making for Part 2 Consent is a Difficult Judgment Call*

In addition to pointing to reforms that are desirable (or undesirable), inclusion of social consequences in break-even analysis can promote understanding of laws that deputize family even where it does not ultimately counsel in favor a potential reform. The extent to which patients may deputize family to authorize disclosure of their Part 2-protected information is an example.

A patient's ability to permit a loved one to do more than receive protected information is very limited under both HIPAA and Part 2. If a patient wants to permit a loved one to authorize disclosures to third parties, she must give that loved one the power to make health care decisions for her through at least a power of attorney or, in the case of Part 2, formal guardianship.¹⁵⁴ No in-between option is available whereby a loved one can be acknowledged and empowered as a care partner, both receiving information and authorizing further disclosures to additional providers or care workers.

Supported decision-making is an alternative approach that has been gaining ground in other contexts. It is a rights-based alternative

2017, Pub. L. No. 115–119, 132 Stat. 23 (2018) (establishing benefits for home health caretakers who assist their family members outside of a hospital setting, including a new position that coordinates with several agencies to devise a specific plan to ensure the education and development of positive outlooks for family caregivers); Mindy Fetterman, *Family Caregivers Finally Get a Break — and Some Coaching*, NPR: SHOTS (Apr. 27, 2018, 5:00 AM), <https://www.npr.org/sections/health-shots/2018/04/27/606054065/family-caregivers-finally-get-a-break-and-some-coaching>. The same considerations that justify mandating attention to family caregivers in that context—at the time of discharge, case-specific medical considerations may become relatively less weighty and systemic questions about how entities beyond the provider will care for the patient going forward become more weighty—may justify requiring providers to inquire whether SUD patients would like to authorize disclosures to their own care-givers, if any, and the provision of institutional and educational resources to such caregivers, at the time of discharge from inpatient or outpatient SUD treatment.

154 See Office for Civil Rights Headquarters, *supra* note 119 (“State or other law should be consulted to determine the authority of the personal representative to receive or access the individual’s protected health information.”); cf. Daniel L. Walbright, *Recent OCR Action Provides HIPAA Guidance Related to Opioid Crisis and Privacy Rule in Research*, NAT’L L. REV. (Jan. 3, 2018), <https://www.natlawreview.com/article/recent-ocr-action-provides-hipaa-guidance-related-to-opioid-crisis-and-privacy-rule> (describing recent HHS OCR release of tools designed to assist patients and family members in situations of opioid abuse and overdose and mental health crises).

to guardianship in the disability and elder law fields.¹⁵⁵ Supported decision-making provides “legal recognition to relationships of trust” by empowering a person’s “advocate” to discuss her health care and other options with providers and otherwise participate in the care decision-making process.¹⁵⁶ The key insight of supported decision-making is to create an interim legal recognition, short of power of attorney or other forms of actual decision-making control, for advocates who participate in a person’s health care.¹⁵⁷ A number of states have passed legislation explicitly empowering patients to acknowledge supported decisionmakers, ensuring that such supporters be given enhanced participation in their loved ones’ medical decision-making.¹⁵⁸

Such an in-between approach, in which patients could empower their loved ones to participate in their care, including receiving, sharing, and authorizing the disclosure of protected health information, without giving their loved ones the power to make health care decisions for them, holds promise for SUD. That said, break-even analysis indicates that such a reform may not be desirable and points to open questions that must be explored (or about which informed judgments must be made) to decide that question.

Health: From the perspective of patient health, supported decision-making in SUD carries potential benefits and costs. One benefit would be that such an approach would mitigate the difficulties currently posed by care coordination in SUD; loved ones empowered to authorize disclosures could help a diverse network of providers, social workers, and others involved collaborate on a patient’s care.

On the other hand, empowering a third party to authorize disclosures on a patient’s behalf creates an inevitable risk that such disclosure will be undesired by the patient, and so of chilling the patient from sharing information in the first place. As avoiding such a chill is a purpose of Part 2, such a potential cost should be given

155 See generally Rebekah Diller, *Legal Capacity for All: Including Older Persons in the Shift from Adult Guardianship to Supported Decision-making*, 43 *FORDHAM URB. L.J.* 495 (2016).

156 *Id.* at 512, 516.

157 See *id.* at 514 (describing an interim legal recognition that uses the “best interpretation of will and preferences” when making substituted decisions on behalf of a person whose will and preferences cannot otherwise be ascertained).

158 *E.g.*, DEL. CODE ANN. tit. 16 §9401A (2018) (“This chapter may be cited as the ‘Supported Decision-Making Act.’”).

substantial weight.

Interference: The current all-or-nothing approach to empowering third parties under Part 2 has clear downsides from the perspective of interference. Some patients may feel compelled to grant a loved one who is closely involved in their care power of attorney to facilitate that involvement. On the other hand, other patients may be forced to navigate aspects of treatment themselves despite their desire to involve family because they are unwilling to go so far as to give their loved one power of attorney (or enter guardianship). In such a case, the current approach isolates patients even when they have access to family supports who they would like to make more involved.

Equality: Finally, it is possible that the current approach has equality benefits in this limited sense: by effectively forbidding some forms of care work, the current approach ensures that the burdens of such work are equally distributed.

Implementing some form of supported decision-making for personal information protected by Part 2 would carry potential benefits: it could facilitate collaboration between providers and others involved in a person's treatment while both recognizing and encouraging the close participation of loved ones in the treatment of patients who want such support. On the other hand, such a reform poses some risk of unwanted disclosures, and the burdens of supported decision-making might not be unfairly distributed.

Having identified these tradeoffs, the next step in break-even analysis is to construct upper or lower bounds for both (or either) the uncertain costs and benefits of supported decision-making for SUD. Effect on fatal overdose rates is a logical starting point for setting these bounds. SUD sufferers enrolled in evidence-based treatment have an all-cause mortality rate that is about 1/3 of those who are not.¹⁵⁹ So, it is fair to say that for each person who is chilled from treatment, there will be 24.8 additional deaths per 1000 life years.¹⁶⁰ On the other hand, meta-analysis of studies exploring the relationship between social relationships and health generally reveals a non-disease-specific 50% increased risk of survival associated with such

159 See Sordo et al., *supra* note 16, at 4 (noting a mortality rate of 11.3 per 1000 person years for SUD sufferers in methadone treatment and 36.1 per 1000 person years for SUD sufferers not in methadone treatment).

160 This number subtracts the ineffective-treatment mortality rate from the out-of-treatment rate from the prior footnote; $36.1 - 11.3 = 24.8$, see Sordo et al., *supra* note 16, at 4.

relationships, and studies on the SUD impacts of such relationships are consistent with this finding.¹⁶¹ Based on this, we can estimate a reasonable upper bound for the impact of family involvement in SUD may be ~5.65 fewer deaths per 1000 life years.¹⁶² If we attribute supported decision-making as capturing 10% of this by facilitating more family involvement and coordination among providers, then supported decision-making would mean .0565 (or .057) fewer fatal overdoses per extra supported decision-making arrangement.

Setting bounds in this way reveals the following tradeoff: in order to be worthwhile from the perspective of health, approximately 44 individuals would have to make use of supported decision-making for every 1 individual who was deterred from seeking treatment due to supported decision-making.¹⁶³ This tradeoff makes it difficult to say whether such a reform would be worthwhile or not from the perspective of health; if the ratio were 1000:1 it might be easy to say that supported decision-making is unlikely to be worth it, and if the ratio were 1:1 it would be easy to say that it is. Thus, breakeven analysis reveals that to be justified based on medical benefit alone a reform applicable to patients who are in treatment must be strong indeed if it comes with any increased risk of chilling patients from seeking treatment in the first place, because the risk of chill applies to all patients and the cost of such chill is very high.

Furthermore, this analysis reveals where additional information or tough judgments are needed to decide about the desirability of supported decision-making in SUD care. In the final analysis, the desirability of supported decision-making in the SUD context depends crucially on whether and to what degree such a reform could lead to more patients being chilled from seeking treatment for fear of unauthorized disclosures. This depends, in turn, crucially on the mechanism by which some SUD sufferers' fear of disclosure should they seek treatment comes to be. If this fear is in some sense rational—based on the actual likelihood of disclosure—then supported decision-making poses little risk of chill. A SUD patient concerned about unauthorized disclosure by her supported decisionmaker would have an option to avoid

161 See Holt-Lunstad et al., *supra* note 5 (reporting 50% increased likelihood of survival for those with stronger social relationships); *supra* note 50 (discussing SUD-specific evidence).

162 This number multiplies the in-treatment mortality rate by .5; $11.3 * .5 = 5.65$.

163 This number reflects the ratio of the bound for the potential health harm (24.8) to the bound for the potential health benefit (.57); $24.8/.57 = 43.5$.

such disclosure short of avoiding treatment altogether: she could simply decline to empower such a decisionmaker (or revoke the deputization). On the other hand, if the fear that chills patients from seeking treatment—and that Part 2 is designed to mitigate—is based purely on anecdotal stories of unwanted disclosures, then the possibility of such disclosures resulting from a supported decision-making regime alone would give cause for concern. Further research might helpfully explore this mechanism, and in the interim this is a key question on which policymakers considering such a reform must make a judgment.

5. *Patient Deputies*

The two preceding suggestions—active choice about patient consent to disclosure of SUD information coupled with a new option for patients to empower someone short of a guardian to obtain and authorize disclosure of their medical information—could be coupled at the state or federal level with a systematic “patient deputy” program. A state or federal database (perhaps building on prescription drug monitoring program infrastructure) could permit patients to appoint a “patient deputy” who would presumptively be empowered to obtain and share their health care information. Such an approach would carry the potential benefits and potential costs of the two separate choice architecture changes discussed above. Publicity and centralization associated with such a program would carry several additional positive implications.

From the standpoint of health, regulators could use registration as a health care deputy as an opportunity to provide educational materials tailored to help loved ones do their care work more effectively. At the same time, such a program would be a conduit through which to take steps to protect the health of such care takers, who too often suffer their own health or financial issues from their focus on their loved ones’ needs.¹⁶⁴

From the standpoint of interference, state recognition of the paramount but in some sense emergent, non-traditional role that loved ones other than spouses play in many patients’ lives would both encourage and provide recognition and validation to such relationships.¹⁶⁵ The state could use its expressive power to endorse

164 See Grunfeld et al., *supra* note 66.

165 Compare *U.S. Dep’t of Agric. v. Moreno*, 413 U.S. 528, 538 (1973) (endorsing inclusive understanding of family in case involving participation of “‘hippies’ and ‘hippie communes’” in food stamp program), with Melissa Murray, *The*

the role that so many already take on, thereby potentially facilitating the formation of additional such relationships.

From the standpoint of invisibility, a centralized patient deputy program would permit state regulators to begin to develop a better-informed understanding of the extent of care work performed by loved ones. Moreover, with this understanding in hand, regulators could begin to address such work and relationships in social programs that currently ignore them. For example, the Family and Medical Leave Act currently excludes siblings from its protections; a person is not entitled to protected time off to care for a sibling. A patient deputy program would provide a ready basis on which to expand these protections to all care takers, recognizing the evolving nature of caring relationships today.¹⁶⁶

Lastly, from the standpoint of inequality, a patient deputies program would permit regulators to better track the benefits and burdens of care work. Given a current scarcity of resources, it may be too much to imagine that patient deputies would be properly compensated for their labors, but observing labors that are currently going un-recognized would be a first step. Moreover, as to burdens, if such tracking revealed that those able to make use of the patient deputies program reflected an uneven sample of the overall patient population, then regulators should explore directing available resources—such as funding for navigator programs—to counteract the imbalance in hopes of a more just health care system.

V. Conclusion: Deputizing Family in SUD and Beyond

While the health impacts of any legal intervention may be paramount, when assessing the desirability of an intervention that makes foreseeable use of loved ones such as family it is important to consider the possibility that the health reform has adverse social

Networked Family: Reframing the Legal Understanding of Caregiving and Caregivers, 94 VA. L. REV. 386, 398–99 (“The law effectively has constructed a parent/stranger dichotomy in which one is either a parent . . . or one is a legal stranger . . .”).

¹⁶⁶ Cf. Murray, *supra* note 165, at 388 (“By characterizing caregiving as the exclusive province of parents, the law overlooks the considerable efforts of caregivers who are not parents”); *see id.* (“[I]n order to better support caregiving as it is practiced, I call for a broader legal understanding of caregiving that would acknowledge a wider range of caregiving efforts . . .”); Barbara Bennett Woodhouse, “*It All Depends on What You Mean by Home*”: *Toward a Communitarian Theory of the “Nontraditional” Family*, 1996 UTAH L. REV. 569, 576–84.

consequences. Even the mere possibility of such consequences may turn the balance against adoption of a reform with questionable health impacts.

Consideration of the social consequences of deputization in the prevention and treatment of SUD—in particular, of interference, invisibility, and inequality posed by laws that deputize family in this context—counsels in favor of greater choice regarding such deputization. The desirability of some changes, such as supported decision-making or a patient deputy program, may be a matter of judgment, but providers, insurers, and regulators should at least favor an “active choice” approach when it comes to patients’ decisions to deputize their own family members in their care. In health care and especially in the treatment of SUD, isolation should not be the default.

There are also lessons that extend beyond SUD and beyond healthcare. The “deputization” framework this Article has employed offers a way of thinking about the burdens of care work generally that makes such work more visible and more readily understood. Scholars in family law have lamented that the public/private narrative generally applied to care work—in which such work takes place in the “private” sphere, as distinct from the “public” world of regulation and government—facilitates the invisibility of care work.¹⁶⁷ Understanding all laws that foreseeably rely on care work in addressing a regulatory problem as “deputizing family”—and so understanding loved ones as analogous to social workers, doctors, bureaucrats, or other regulatory tools rather than as *sui generis*, independent, and invisible providers of care—breaks down this public/private distinction.

This narrative shift may not be without cost—“deputization” entails someone doing the deputizing, implying that the work is on some level done for another. When deputization comes from the state, “collapsing” the public and private actually means the public absorbing the private. That understanding could interfere with family relationships in unexpected and presumably (though perhaps not necessarily) undesirable ways. On the other hand, when deputization comes through the patient—when a law permits a patient to empower a loved one vis a vis disease or third parties—this risk

167 Murray, *supra* note 165, at 436 (“Emphasizing the private character of caregiving, they argued, absolved the state of any responsibility to assist families in providing care, and, critically, contributed to the devaluation of caregiving and caregivers.”).

is not present. Relatedly, the examples and analyses in this Article have revealed a similar tendency that separates laws that empower a loved one vis a vis the patient and laws that permit the patient to empower a loved one vis a vis third parties. Patient-disempowering deputizations have tended to pose a risk of negative interference with family relationships, while patient-empowering deputizations have tended to raise the possibility of positive interference. That dynamic is not unique to healthcare, so further research might explore whether the character of deputization is as determinative of its desirability in other contexts.

Health, Housing, and the Law

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I. Introduction

A decent dwelling is necessary for health and well-being—but not actually sufficient. The community in which the dwelling stands matters, too: access to transportation, good schools, shops, parks, socioeconomic mixture, social capital and collective efficacy, and economic opportunity are all features necessary for both a high-level and equitable distribution of well-being. These goods are basic human needs that any society should ensure to its members for both moral and practical reasons. This article assumes that increasing the proportion of Americans who live in healthy homes in socially and racially heterogeneous communities with the features we describe would be good for individual and collective well-being alike.

Both healthy homes and diverse communities are consistent with the stated values and preferences of most Americans,¹ and the law has done much to promote them. For 50 years, the Fair Housing Act has stood as a ban on discrimination and a mandate to affirmatively foster integration. Since the 1970s, most states have read into residential leases an implied warranty of habitability to promise that every rental unit has the basic requirements for safe living, and these have been supported by housing codes and specific rules on lead and other domestic hazards. Since the 1980s, the Low-Income Housing Tax Credit program (LIHTC) funded millions of new units of long-term affordable housing. Federal housing subsidy programs have put billions of dollars every year into low income rental assistance. Dedicated lawyers, community organizations, and bureaucrats work with these tools every day, and every day they win battles. It is not their fault we have lost the war.²

1 See J. Rosie Tighe, *Public Opinion and Affordable Housing: A Review of the Literature*, 25 J. PLAN. LITERATURE 3, 7 (2010).

2 The failure of the U.S. to deliver on the promise of equitable housing has not come cheap. In fiscal year 2017 HUD spent more than \$28 billion on public and Indian housing (including the Housing Choice Voucher Program), almost \$7 billion on community development programs including the Homeless Assistance Grants and Housing Opportunities for Persons with AIDS, and \$11 billion in housing programs including project-based vouchers. See U.S. DEPT OF HOUS. & URBAN DEV., FISCAL YEAR 2017 CONGRESSIONAL JUSTIFICATIONS (2017), https://www.hud.gov/sites/documents/FY_2017_CJS_COMBINED.PDF. In addition, the U.S. treasury spends \$8 billion annually on the Low Income Housing Tax Credit program and \$77 billion on the mortgage interest deduction. JOINT COMM. ON TAXATION, JCX-34-18, ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2017-2021 (May 25, 2018), <https://www.jct.gov/publications.html?func=startdown&id=5095>.

The promise of fair housing law has more often been honored in the breach than the observance, and the United States remains segregated by race and class. Poor tenants remain largely powerless in conflicts with their landlords, facing tragic choices between housing and exposure to toxins, such as lead and mold. For the poorest, eviction is a common, devastating experience. The country has a shortage of affordable units. Vouchers remain a perpetual pilot, available to only a small proportion of those who need them. Sadly, law was much more successful in promoting segregation in the first 70 years of the 20th century than it has been in remedying the problems in the last 50 years.

There are many explanations for the collective failure to achieve a higher standard of healthy, integrated housing. One is that law has never stopped promoting and preserving segregation. Affirmative tools of zoning (which can impede the diffusion of affordable housing in suburbs, towns, and urban neighborhoods), or the incentives written into LIHTC (which can nudge developers to build new units in or on the edges of poor neighborhoods), as well as broader policy actions and inactions around gentrification and urban development have all played a role. Supplying enough affordable housing to all citizens is a huge challenge. Going beyond simply building healthy affordable units and reaching toward fostering and maintaining diverse, equitable neighborhoods runs counter to decades of deliberate segregationist policy, enduring stigmas of race and class, widespread enmity toward immigration, NIMBYism, and the rising inequality in the U.S. It counts as a “wicked problem”—a complex problem with so many elements that there is even a dispute about its definition, and that has no clear set of solutions.³ The best strategies for addressing “wicked problems” are adaptive, collaborative, and informed by a systems perspective.⁴

In this article, we take three preliminary steps that strike us as necessary for using law more effectively in the adaptive, system-oriented process of promoting healthier, more equitable communities. In Part II, we propose (and defend) a broad goal of health equity in housing. In Part III, we offer a heuristic model of the system of legal levers that are arguably instrumental to that goal. We hope that such a model can be a useful tool for breaking the

3 Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL'Y SCI. 155, 161 (1973).

4 Nancy Roberts, *Wicked Problems and Network Approaches to Resolution*, 1 INT'L PUB. MGMT. REV. 1, 2–15 (2000).

wicked problem into a set of tamer ones. Finally, in Part IV of this article, we grapple with what we actually know about these legal levers. Despite the importance of housing, the effects and operation of many of the primary legal levers have not been studied. While research cannot produce definitive answers to wicked problems, it can serve to help define problem elements, narrow the range of solutions, and improve implementation. We conclude in Part V with some early thoughts about next steps for a renewal of systematic efforts toward housing equity.

II. A Goal of Health Equity in Housing

“The connection between health and the dwellings of the population is one of the most important that exists” – Florence Nightingale⁵

We have asserted that increasing the proportion of Americans living in racially and socioeconomically mixed communities—a condition we will call “health equity in housing”—will make us a happier, healthier nation. This part reviews scientific evidence that supports our claim. We do not assert that heterogeneous communities are the only kind of healthy communities; we know, on the contrary, that cohesive, ethnically concentrated neighborhoods can be very healthy indeed.⁶ Nor do we believe that some sort of statistically complete integration is either possible or necessary to yield substantial social benefits. Rather, as the evidence we present below will suggest, we believe that pursuing more diversity in residential conditions in America is a powerful way to deal with a variety of ills.

A broad vision plays a crucial role in an adaptive systems change, by providing an attractive endpoint around which an account of the system and its dynamics can cohere. For lawyers and others working for a healthier America, it provides both accountability and a point of reference linking tactics with strategies: it is a way to ensure that we do not only win battles but also the war itself. A broad vision is important politically for many of the same reasons: it helps reclaim the credibility of the idea of working for major social change, and that idea has to be fairly clear and broadly attractive.

5 Florence Nightingale, *cited in* S. Lowry, *Housing*, 303 BRITISH MED. J. 838 (1991).

6 Brenda Egolf et al., *The Roseto Effect: A 50-Year Comparison of Mortality Rates*, 82 AM. J. PUB. HEALTH 1089 (1992).

In the remainder of Part II, we make the case for why this goal is desirable, from a health and health equity standpoint.⁷

Housing is crucial to health. A house provides shelter, protection against the elements, and a locus for maintaining personal identity and family life. Financially, it is often a family's biggest investment (or monthly expense). Moreover, as sociologist Douglas Massey and his colleagues describe,

In selecting a place to live, a family does much more than simply choose a dwelling to inhabit; it also selects a neighborhood to occupy. In doing so, it chooses the crime rate to which it will be exposed; the police and fire protection it will receive; the taxes it will pay; the insurance costs it will incur; the quality of education its children will receive; the peer groups they will experience; the goods, services, and jobs to which the family will have access; and the relative likelihood a household will be able to build wealth through home appreciation; not to mention the status and prestige, or lack thereof, family members will derive from

7 In 2013, the Robert Wood Johnson Foundation announced an endeavor to promote a “Culture of Health . . . that enables all members of our diverse society to lead healthy lives, now and for generations to come.” LAURIE T. MARTIN ET AL., HOW CULTURAL ALIGNMENT AND THE USE OF INCENTIVES CAN PROMOTE A CULTURE OF HEALTH (2017) (quoting Alonzo L. Plough, *Building a Culture of Health*, 47 AM. J. OF PREVENTIVE MED. S388 (2014)). As we understand it, the idea of a “culture of health” is a way to recast the epidemiological concept of the social determinants of health—a set of conditions and causal processes in the world—as a matter of beliefs, knowledge and actions in communities. Speaking in terms of a culture of health highlights our interdependence and suggests that we as a society can choose to attach greater value to promoting health in “[t]he contexts in which people live, learn, work, and play.” See Paula A. Braveman et al., *Broadening the Focus: The Need to Address the Social Determinants of Health*, 40 AM. J. PREVENTIVE MED. S4 (2011); see also WHY ARE SOME PEOPLE HEALTHY AND OTHERS NOT? (Robert G. Evans et al. eds., Aldine de Gruyter 1994); Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, WORLD HEALTH ORGANIZATION [WHO] (2008). See generally Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, Extra Issue, J. HEALTH & SOC. BEHAV. 80, 81 (1995) (providing evidence, frameworks and action recommendations for addressing social determinants of health). Our work on housing, supported by the Foundation, aspires to identify ways in which Americans can improve health through action on housing.

living in the neighborhood.⁸

The epidemiology connecting housing and health can be divided into four elements: (1) the relationship between housing hazards and health; (2) the relationship between housing *affordability* and health; (3) the relationship between housing *stability* and health; and (4) neighborhood effects on health. These elements are captured in Figure 1.



Figure 1: A simple model of the synergistic effect of all housing aspects on health

A. *Safe Housing Without any Hazards*

Home is the epitome of a safe place—or at least it ought to be. Diseases associated with hazards such as lead and mold persist at high numbers and rates. According to the most recent American Housing Survey, 1,505,000 households in the U.S. were living in units that were severely inadequate and 5,184,000 were in moderately inadequate units.⁹ These statistics reflect that up to six

8 DOUGLAS S. MASSEY ET AL., *CLIMBING MOUNT LAUREL: THE STRUGGLE FOR AFFORDABLE HOUSING AND SOCIAL MOBILITY IN AN AMERICAN SUBURB 1* (2013).

9 U.S. CENSUS BUREAU, *AMERICAN HOUSING SURVEY* (2015).

percent of housing units are inadequate to some degree.¹⁰

The most notorious housing hazard is lead. “The most common source of childhood lead poisoning is lead-based paint (LBP) in older homes and buildings, and the primary exposure pathway is ingestion of lead-contaminated dust.”¹¹ According to the Centers for Disease Control and Prevention (CDC), there is no safe amount of lead in a child’s blood.¹² Although lead had been a high-profile policy concern for decades and its toll has declined,¹³ in 2016, the CDC still reported elevated blood-lead levels in approximately 500,000 children.¹⁴ Even low blood-lead levels are associated with intellectual impairment,¹⁵ academic performance deficits,¹⁶ attention deficits,¹⁷ and anti-social behavior.¹⁸

Lead is not the only housing hazard. Cockroaches, rats, and other vermin have been shown to contribute to the development of asthma, particularly in children.¹⁹ Indoor dampness and water leaks can produce mold that leads to asthma and other respiratory

10 *Id.*

11 STEPHANIE P. BROWN, FEDERAL LEAD-BASED PAINT ENFORCEMENT BENCH BOOK 11 (2009).

12 Ctrs. for Disease Control and Prevention, *Childhood Blood Lead Levels in Children Aged <5 Years – United States, 2009–2014*, 66 SURVEILLANCE SUMMARIES 1, 6 (2017).

13 The difficult battle to protect Americans from lead is thoroughly explained in GERALD E. MARKOWITZ ET AL., LEAD WARS: THE POLITICS OF SCIENCE AND THE FATE OF AMERICA’S CHILDREN 6 (2013).

14 NAT’L CTR. FOR ENVTL. HEALTH/AGENCY FOR TOXIC SUBSTANCES & DISEASE REGISTRY, MEETING OF THE LEAD POISONING PREVENTION SUBCOMMITTEE OF THE NCEH/ATSDR BOARD OF SCIENTIFIC COUNSELORS: RECORD OF THE PROCEEDINGS 9 (Sept. 9, 2016).

15 David C. Bellinger & Herbert L. Needleman, *Intellectual Impairment in Blood Lead Levels*, 349 NEW ENG. J. MED. 500 (2003).

16 David C. Bellinger et al., *Low-Level Lead Exposure, Intelligence and Academic Achievement*, 90 PEDIATRICS 855, 860 (1992).

17 Joel T. Nigg et al., *Confirmation and Extension of Association of Blood Lead with Attention-Deficit/Hyperactivity Disorder (ADHD) and ADHD Symptom Domains at Population-Typical Exposure Levels*, 51 J. CHILD PSYCHOL. & PSYCHIATRY 58, 58 (2010).

18 Kim N. Dietrich et al., *Early Exposure to Lead and Juvenile Delinquency*, 23 NEUROTOXICOLOGY TERATOLOGY 511, 514 (2001).

19 Virginia A. Rauh et al., *Deteriorated Housing Contributes to High Cockroach Allergen Levels in Inner-City Households*, 110 ENVTL. HEALTH PERSP. 323, 323 (2002); Augusto A. Litonjua et al., *Exposure to Cockroach Allergen in the Home is Associated with Incident Doctor-Diagnosed Asthma and Recurrent Wheezing*, 107 J. ALLERGY & CLINICAL IMMUNOLOGY 41, 41 (2001).

problems.²⁰ Radon, a radioactive gas prevalent in some homes, is the second leading cause of lung cancer in the U.S.²¹ Improper sanitation, extreme temperatures, pesticide residues, and risk of injury due to poor conditions (particularly for children and the elderly) are all hazards that one can be exposed to in the home.²²

B. Housing Affordability and Instability

The six percent of households that live in structurally inadequate housing are paying a steep health price for shelter—but they are not getting off easy on the rent.²³ The rising cost of housing is a problem for Americans, ranging from the poorest all the way to the middle class; millions of Americans face a monthly struggle to pay their rent or mortgage. Almost one in three households—mostly renters—in the U.S. is cost-burdened, defined as paying more than 30% of annual income for housing.²⁴ About half of those are *severely* cost-burdened, paying more than *half* of annual income for shelter.²⁵ The U.S. Department of Housing and Urban Development (HUD) estimated that in 2015, 8.3 million low-income households were cost-burdened, received no government assistance, and/or lived in severely inadequate conditions—a significant increase from 5.9 million households in 2005.²⁶ While the housing market of a global city like San Francisco cannot be compared to a poor city like Milwaukee, cost-burdened households are scattered all across America.²⁷

20 W. J. Fisk et al., *Meta-Analyses of the Associations of Respiratory Health Effects with Dampness and Mold in Homes*, 17 J. INDOOR AIR 284, 284 (2007).

21 R. William Field, *A Review of Residential Radon Case-Control Epidemiologic Studies Performed in the United States*, 16 REV. ENVTL. HEALTH 151, 151 (2001).

22 Edmond D. Shenassa et al., *Social Disparities in Housing and Related Pediatric Injury: A Multilevel Study*, 94 AM. J. PUB. HEALTH 633, 633–39 (2004); Stephen R. Lord et al., *Home Environment Risk Factors for Falls in Older People and the Efficacy of Home Modifications*, 35 AGE & AGEING ii55, ii55–59 (2006); Muhammad Sarwar, *Indoor Risks of Pesticide Uses are Significantly Linked to Hazards of the Family Members*, 3 COGENT MED., Dec. 22, 2016, at 1. For a review of housing standards see Thomas D. Matte & David E. Jacobs, *Housing and Health—Current Issues and Implications for Research and Programs*, 77 J. URB. HEALTH 7, 7 (2000).

23 MATTHEW DESMOND, *EVICTED: POVERTY AND PROFIT IN THE AMERICAN CITY* 5 (2016).

24 See JOINT CTR. FOR HOUS. STUDIES OF HARVARD UNIV., *THE STATE OF THE NATION'S HOUSING* 5 (2017).

25 *Id.*

26 NICOLE ELSASSER WATSON ET AL., *WORST CASE HOUSING NEEDS 2017 REPORT TO CONGRESS* 1–2 (2018).

27 According to the National Low-Income Housing Coalition, “in no state can a

Struggling to pay for housing has significant consequences for health. An individual who is cost-burdened must constantly make tradeoffs that are harmful for health. A report published by the Center for Housing Policy Leadership finds that “[c]ompared with working families in more affordable housing, families that pay more than half of household expenditures for housing reduce expenditures for other essentials such as food, clothing, and healthcare.”²⁸ For cost-burdened households, “the rent eats first.”²⁹ In addition, housing cost-burden is a source of stress,³⁰ which has a powerful, lifelong impact on health.³¹ Furthermore, social epidemiology studies find

person working full time at the federal minimum wage afford a two-bedroom at the Fair Market Rent [as determined by HUD].” Some states/municipalities enacted “living wages” that are higher than the federal minimum wage, however these too are far from the hourly wage needed to pay fair market rents. In San Francisco, the most expensive metropolitan area in 2018, the effective minimum wage is the state’s wage of \$11 an hour while the needed hourly-wage for a two bedroom is \$38.13. In 2018, a person earning minimum wage in San Francisco would need to work 218 hours a week to pay only 30% of annual income. This is not only a coastal problem. The lowest hourly minimum wage that would allow someone working full time to not be cost burdened is \$13.84, which would prevent a minimum wage earner from being cost burdened in Arkansas only. Additionally, in only 22 counties in the entire nation a full-time worker earning the federal or state minimum wage can pay less than 30% of annual income on rent. NAT’L LOW INCOME HOUS. COAL., OUT OF REACH 2017 (2017). Further analysis from the Coalition reveals that the wages are not the only problem: “The U.S. has a shortage of 7.4 million rental homes affordable and available to extremely low-income renters, whose income is at or below the poverty guideline or 30% of their area median income.” NAT’L LOW INCOME HOUS. COAL., THE GAP: A SHORTAGE OF AFFORDABLE HOUSING 6 (2017).

- 28 BARBARA J. LIPMAN, SOMETHING’S GOTTA GIVE: WORKING FAMILIES AND THE COST OF HOUSING 7 (2005).
- 29 DESMOND, *supra* note 23, at 303; See also Elizabeth J. Mueller & J. Rosie Tighe, *Making the Case for Affordable Housing: Connecting Housing with Health and Education Outcomes*, 21 J. PLAN. LITERATURE 371, 378 (2007).
- 30 Joseph Harkness & Sandra J. Newman, *Housing affordability and children’s well-being: Evidence from the national survey of America’s families*, 16 HOUSING POL’Y DEBATE 223, 225 (2005); M. Sandel & R.J. Wright, *When Home is Where the Stress Is: Expanding the Dimensions of Housing That Influence Asthma Morbidity*, 33 ARCHIVES OF DISEASE IN CHILDHOOD 942–48 (2006).
- 31 See Robert N. Buschmann, et al., *Stress and Health Behaviors as Potential Mediators of the Relationship Between Neighborhood Quality and Allostatic Load*, 28 ANNALS OF EPIDEMIOLOGY 346 (2018); Karen A. Matthews & Linda C. Gallo, *Psychological Perspectives on Pathways Linking Socioeconomic Status and Physical Health*, 62 ANN. REV. PSYCHOLOGY 501 (2010); Pilyoung Kim et al., *How Socioeconomic Disadvantages Get Under the Skin and into the Brain to Influence Health Development Across the Lifespan*, in HANDBOOK OF LIFE COURSE HEALTH

that stress is unequally distributed, affecting populations of low-income and people of color at higher rates. The “stress gap” is thought to be an important cause of the health gap between advantaged and disadvantaged groups.³²

One source of stress for people struggling to pay the rent or the mortgage is the brooding threat of losing their dwelling to eviction or foreclosure.³³ Matthew Desmond’s *Evicted: Poverty and Profit in the American City* rendered visible to Americans the magnitude of eviction as a part of life for the poor—and the serious harm widespread eviction causes. Eviction leads to an increase in the likelihood of material hardship, depression in mothers, and worsened health outcomes for mothers and children.³⁴ Additionally, eviction increases the likelihood that a low-income worker will be laid off.³⁵ A systematic literature review confirms Desmond’s findings that forced moves lead to poor physical and mental health.³⁶ The negative health outcomes have a disparate impact on families with children, and hence women.³⁷

Eviction seems to be hard on both children and adults. Research from Milwaukee shows that the majority of tenants facing eviction lived with children. More than half of those evicted children were school-aged,³⁸ and each eviction leads to a higher risk of future forced moves.³⁹ Research suggests that moves are associated with poorer academic performance,⁴⁰ meaning that there is a high

DEVELOPMENT 463 (Neal Halfon et al., eds., 2018); Vincent Felitti et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. PREVENTIVE MED. 245–58 (1998).

32 See generally Jacob Bor et al., *Population Health in an Era of Rising Income Inequality: USA, 1980-2015*, 389 THE LANCET 1475, 1485–86 (2017); Peggy A. Thoits, *Stress and Health: Major Findings and Policy Implications*, 51 J. HEALTH & SOC. BEHAV. S41, S49 (2010).

33 Matthew Desmond & Rachel Tolbert Kimbro, *Eviction’s Fallout: Housing, Hardship, and Health*, 94 SOC. FORCES 295, 299 (2015).

34 See generally DESMOND, *supra* note 23.

35 Matthew Desmond & Carl Gershenson, *Housing and Employment Insecurity among the Working Poor*, 63 SOC. PROBS. 47 (2016).

36 Hugo Vásquez-Vera et al., *The threat of home eviction and its effects on health through the equity lens: A systematic review*, 175 SOC. SCI. & MED. 199, 205 (2017).

37 Matthew Desmond et al., *Evicting Children*, 92 SOC. FORCES 303, 314, 320 (2013).

38 *Id.* at 314.

39 Matthew Desmond et al., *Forced Relocation and Residential Instability Among Urban Renters*, 89 SOC. SERV. REV. 227, 255 (2015).

40 Shana Pribesh & Douglas B. Downey, *Why Are Residential and School Moves*

likelihood that evicted children will have to switch schools, and are thus more likely to drop out.⁴¹ Often, eviction leads to moves to neighborhoods with higher crime rates,⁴² which are associated with lower quality schools and poorer academic performance.⁴³ Poor health, material hardship, and parenting stress—all associated with eviction⁴⁴—have also been associated with lower performance in school.⁴⁵ Finally, eviction is associated with increased risk of homelessness,⁴⁶ which produces lower test scores.⁴⁷

The evidence based on foreclosure's health toll is even larger. Mirroring eviction effects, foreclosure disproportionately affects already-vulnerable populations and leads to both higher incidence and exacerbation of poor health.⁴⁸ There is ample evidence that foreclosure is correlated with a decline in mental health,⁴⁹ including an increase in the likelihood of suicide.⁵⁰

Associated with Poor School Performance?, 36 DEMOGRAPHY 521, 521 (1999).

- 41 See Russell W. Rumberger & Katherine A. Larson, *Student Mobility and the Increased Risk of High School Dropout*, 107 AM. J. EDUC. 1, 3, 19–22. (1998).
- 42 Desmond et al., *supra* note 39, at 230, 254.
- 43 Dana Charles McCoy et al., *Neighborhood Crime and School Climate as Predictors of Elementary School Academic Quality: A Cross-Lagged Panel Analysis*, 52 AM. J. COMMUNITY PSYCHOL. 128, 128–40 (2013).
- 44 DESMOND, *supra* note 23, at 1.
- 45 Edward A. Frongillo et al., *Food Stamp Program Participation is Associated with Better Academic Learning Among School Children*, 136 J. NUTRITION 1077, 1077–80 (2006); Steven R. Shaw et al., *The Relationship Between Student Health and Academic Performance: Implications for School Psychologists*, 36 SCH. PSYCHOL. INT'L 115, 115–34 (2015); Kathryn Soltis et al., *Associations Among Parental Stress, Child Competence, and School-Readiness: Findings from the PACE Study*, 24 J. CHILD & FAM. STUD. 649, 649–55 (2015).
- 46 See generally Maureen Crane & Anthony M. Warnes, *Evictions and Prolonged Homelessness*, 15 HOUSING STUD. 757, 757–73 (2000); MATTHEW DESMOND, *EVICTED: POVERTY AND PROFIT IN THE AMERICAN CITY* (2016).
- 47 See, e.g., Joshua M. Cowen, *Who Are the Homeless? Student Mobility and Achievement in Michigan 2010–2013*, 46 EDUC. RESEARCHER 33, 33–43 (2017).
- 48 Craig Evan Pollack & Julia Lynch, *Health Status of People Undergoing Foreclosure in the Philadelphia Region*, 99 AM. J. PUB. HEALTH, 1833, 1833, 1838 (2011); Alexander C. Tsai, *Home Foreclosure, Health, and Mental Health: A Systematic Review of Individual, Aggregate, and Contextual Associations*, 10 PLOS ONE 1 (2015); Craig Evan Pollack et al., *Foreclosure and Health Status*; LEONARD DAVIS INST. HEALTH ECON. ISSUE BRIEF, Jan.–Feb. 2010, at 2–3.
- 49 Jason N. Houle, *Mental Health in the Foreclosure Crisis*, 118 SOC. SCI. & MED. 1 (2014); Janelle Downing, *The Health Effects of the Foreclosure Crisis and Unaffordable Housing: A Systematic Review and Explanation of Evidence*, 162 SOC. SCI. AND MED. 88, 95 (2016).
- 50 Katherine A. Fowler et al., *Increase in Suicides Associated with Home Eviction and*

High rent burdens, eviction, and foreclosure are all facets of residential instability which, in addition to forced moves, has been associated with poor health outcomes and with loss of employment and possessions that could lead to material hardship. The trauma of forced moves is also associated with more punitive parenting.⁵¹ In addition, families often find it difficult to find housing after eviction or foreclosure, and are forced into homelessness,⁵² inadequate housing,⁵³ and/or a move to a neighborhood with more crime and poverty.⁵⁴

C. *Healthy Neighborhoods*

There are many aspects of a neighborhood that contribute to health, but in this article, we focus on four related elements: poverty rate, racial segregation, public amenities, and social mobility.

Concentrating poor people in poor neighborhoods does not have positive effects, so it is concerning that between 2010 and 2014, the number of Americans living in an extreme poverty census tract (poverty rate greater than 20%) doubled, reaching 13.5% of the population.⁵⁵ The demographic of those concentrated in poverty is also unequal: only 5.5 percent of white people live in extreme poverty tracts, while 25.1% of black people and 17.6% of Hispanic people do.⁵⁶ The Moving to Opportunity (MTO) demonstration, a large randomized controlled trial funded by HUD to test the impact of moving from a poor neighborhood, produced experimental evidence that growing up in a neighborhood with a low poverty rate

Foreclosure During the US Housing Crisis: Findings From 16 National Violent Death Reporting System States, 2005–2010, 105 AM. J. PUB. HEALTH 311, 314–15 (2015); Jason N. Houle & Michael T. Light, *The Home Foreclosure Crisis and Rising Suicide Rates, 2005 to 2010*, 104 AM. J. PUB. HEALTH 1073, 1073 (2014); see Tsai, *supra* note 48, at 6–12.

51 See Robert H. Bradley & Robert F. Corwyn, *Socioeconomic Status and Child Development*, 53 ANN. REV. PSY. 371, 384 (2002).

52 See generally Crane & Warnes, *supra* note 46; Robin Phinney et al., *Housing Instability Among Current and Former Welfare Recipients*, 97 AM. J. PUB. HEALTH 832 (2007).

53 Matthew Desmond et al., *Forced Relocation and Residential Instability Among Urban Renters*, 89 SOC. SERV. REV. 227, 256 (2015).

54 *Id.* at 234, 254.

55 Elizabeth Kneebone & Natalie Holmes, *U.S. Concentrated Poverty in the Wake of the Great Recession*, BROOKINGS (Mar. 31, 2016), <https://www.brookings.edu/research/u-s-concentrated-poverty-in-the-wake-of-the-great-recession/>.

56 *Id.*

improves well-being on multiple dimensions.⁵⁷ Low neighborhood poverty rates led to less distressed parents and male children,⁵⁸ healthier adults,⁵⁹ reduction in the prevalence of obesity and diabetes,⁶⁰ and higher incomes in adulthood for children who grew up in these neighborhoods.⁶¹ Moving toward opportunity is also moving toward better health.

Living in a highly racially segregated neighborhood also has effects on health. Segregation is by no means a relic of the past and the cities with the largest black populations are still highly segregated.⁶² An economic analysis of the effects of segregation on schooling, employment, and single parenthood finds that “blacks in more segregated areas have significantly worse outcomes than blacks in less segregated areas.”⁶³ The authors of the analysis concluded that “a one standard deviation decrease in segregation would eliminate one-third of the black-white differences in most of our outcomes.”⁶⁴ Living in a racially segregated neighborhood is associated with almost every illness one could think of, such as heart disease, obesity, tuberculosis, reduced life expectancy, depression, and infant mortality.⁶⁵

Part of the story is that poor, segregated neighborhoods are often less salubrious places to live. Urban planners tend to use areas with high minority populations for land use that exposes communities to environmental hazards.⁶⁶ Further, these areas tend to

57 Tama Leventhal & Jeanne Brooks-Gunn, *Moving to Opportunity: An Experimental Study of Neighborhood Effects on Mental Health*, 93 AM. J. PUB. HEALTH 1576, 1576 (2003).

58 *Id.*

59 Jens Ludwig et al., *Neighborhood Effects on the Long-Term Well-Being of Low-Income Adults*, 337 SCIENCE 1505 (2012).

60 Jens Ludwig et al., *Neighborhoods, Obesity, and Diabetes — A Randomized Social Experiment*, 265 NEW ENG. J. MED. 1509, 1509 (2011).

61 Raj Chetty et al., *The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment*, 106 AM. ECON. REV. 855, 899 (2016).

62 JOHN R. LOGAN & BRIAN J. STULTS, *THE PERSISTENCE OF SEGREGATION IN THE METROPOLIS: NEW FINDINGS FROM THE 2010 CENSUS* 6–7 (2011).

63 David M. Cutler & Edward L. Glaeser, *Are Ghettos Good or Bad?*, 12 Q.J. ECON. 827, 827 (1997).

64 *Id.*

65 Dolores Acevedo-Garcia et al., *Future Directions in Residential Segregation and Health Research: A Multilevel Approach*, 93 AM. J. PUB. HEALTH 215, 215–16 (2003).

66 An example of this can be seen in an analysis of zoning changes over four

lack basic amenities such as healthcare facilities, stores with healthy foods, and transportation centers.⁶⁷ There is even research to suggest that urban trees could reduce crime,⁶⁸ while vacant properties are associated with crime and reduced collective efficacy⁶⁹—the social glue that helps maintain community health.

If this were all there was to it, public policy might plausibly focus its attention on improving conditions in areas of concentrated poverty and racial segregation—except for the fact that, as the Supreme Court at least temporarily grasped in *Brown v. Board of Education*, separate is inherently unequal.⁷⁰ The political and other benefits of having the better-off on your team in campaigns for good schools, parks, and transportation are obvious. Less obvious, but apparently equally real, are the benefits that come (to rich and poor of all races) of rubbing shoulders at work, school, and home.⁷¹ Studies of school integration found that students in integrated schools have higher average test scores, are less likely to drop out, and are more likely to enroll in college.⁷² Integrated classrooms encourage critical thinking, problem solving, and creativity for all students.⁷³

The benefits of integration at the population level have been documented in Raj Chetty's influential work.⁷⁴ His work has been

decades in NYC that found that major manufacturing zones, which bring with them environmental hazards, were generally characterized with a “higher percentage of minority populations than borough or city averages” and “lower than average incomes and rates of home ownership.” Juliana Maantay, *Zoning, Equity, and Public Health*, 91 AM. J. PUB. HEALTH 1033, 1037 (2001).

67 NAT'L RESEARCH COUNCIL & INST. OF MED., U.S. HEALTH IN INTERNATIONAL PERSPECTIVE: SHORTER LIVES, POORER HEALTH 192–206 (Steven H. Woolf & Laudan Aron eds., 2013).

68 Michelle C. Kondo et al., *The Association Between Urban Trees and Crime: Evidence from the Spread of the Emerald Ash Borer in Cincinnati*, 157 LANDSCAPE URB. PLAN. 193, 198 (2017).

69 Eugenia Garvin et al., *More Than Just an Eyesore: Local Insights and Solutions on Vacant Land and Urban Health*, 90 J. URB. HEALTH 412, 413 (2012).

70 *Brown v. Board of Educ.*, 347 U.S. 483, 495 (1954).

71 See SCOTT E. PAGE, *THE DIFFERENCE: HOW THE POWER OF DIVERSITY CREATES BETTER GROUPS, FIRMS, SCHOOLS, AND SOCIETIES* (2008).

72 AMY STUART WELLS ET AL., THE CENTURY FOUND., *HOW RACIALLY DIVERSE SCHOOLS AND CLASSROOMS CAN BENEFIT ALL STUDENTS* 8, 10–11, 14 (2016), https://s3-us-west-2.amazonaws.com/production.tcf.org/app/uploads/2016/02/09142501/HowRaciallyDiverse_AmyStuartWells-11.pdf.

73 *Id.*

74 See generally Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States, 2001–2014*, 315 J. AM. MED. ASS'N 1750 (2016); Raj Chetty

particularly useful in its focus on social mobility and long-term access to economic opportunity.⁷⁵ Mobility, defined as the ability to financially fair better than one's parents, has, on average, been either flat or declining (depending on the measure used) throughout the majority of the 20th century in the U.S.⁷⁶ Additionally, mobility is distributed unevenly across the U.S., with some areas having more upward mobility than others.⁷⁷ Research on the characteristics of neighborhoods shows that both racial and economic segregation impede social mobility.⁷⁸ Where MTO showed the benefits of leaving a poor neighborhood, further geographically granular analysis finds that black people living in racially segregated neighborhoods⁷⁹ and neighborhoods with high levels of racial bias⁸⁰ pay a high price in social mobility compared to those living in more affluent and integrated areas with less bias.⁸¹

III. Legal Levers for Health Equity in Housing

The problem of housing in America reflects a variety of factors, such as: market issues, a history of affirmative legal support for segregation, stagnating wages, rising inequality, and a decline in government investment and regulatory capacity. Since housing-related problems are a reflection of a system, tackling them as if they were discreet problems has a low chance of having a substantial impact on the overall problem. The first step toward a more cross-

et al., *Relationships Between Income, Health Behaviors, and Life Expectancy: Reply*, 316 J. AM. MED. ASS'N 880 (2016); Raj Chetty et al., *The Fading American Dream: Trends in Absolute Income Mobility Since 1940*, 356 SCI. 398 (2017); Raj Chetty & Nathaniel Hendren, *The Impacts of Neighborhoods on Intergenerational Mobility II: County-Level Estimates*, 133 Q.J. ECON. 1163 (2018).

75 Raj Chetty et al., *The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment*, 106 AM. ECON. R. 855, 899 (2016); Raj Chetty & Nathaniel Hendren, *The Impacts of Neighborhoods on Intergenerational Mobility I: Childhood Exposure Effects*, 133 Q.J. ECON. 1107 (2018).

76 Raj Chetty et al., *The Fading American Dream: Trends in Absolute Income Mobility Since 1940*, 356 SCI. 398, 398 (2017).

77 Raj Chetty et al., *Where is the Land of Opportunity? The Geography of Intergenerational Mobility in the United States*, 129 Q.J. ECON. 1553, 1620 (2014).

78 *Id.* 1604.

79 *Id.* 1553–1623.

80 See Raj Chetty et al., *Race and Economic Opportunity in the United States: An Intergenerational Perspective* (Nat'l Bureau of Econ. Research, Working Paper No. 24441, 2018).

81 Chetty & Hendren, *supra* note 74.

cutting campaign is to describe the system to be influenced, and to specify the legal levers that may be used to do the influencing. Our model is a heuristic tool to help people interested in a systematic approach promote greater health equity in housing. It aims to pull together, in one picture, the key factors many have identified serially. As we will canvas in Part IV there is very little research evidence addressing whether most of the individual levers actually do the specific things they purport to do, let alone whether they operate in synergy with other levers. The figure below depicts the model we use in this article.

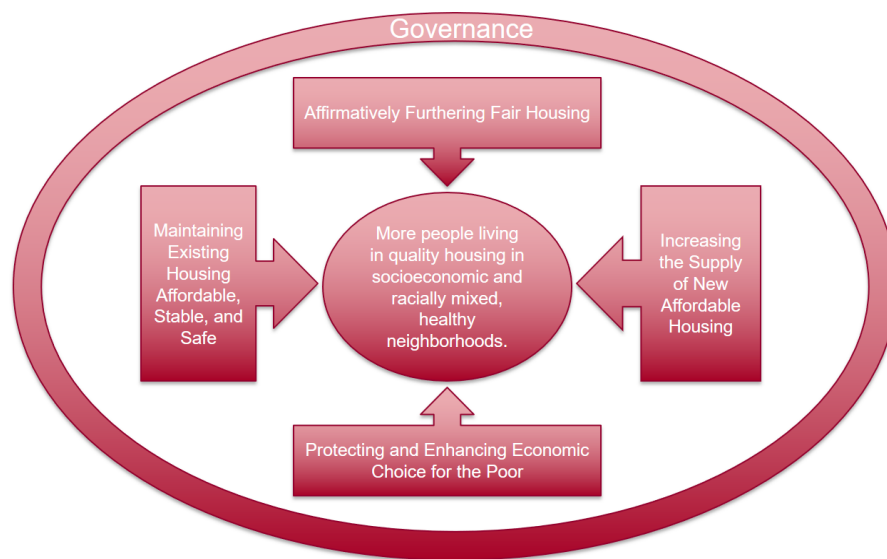


Figure 2: A Legal Levers Model for Health Equity

The domain of increasing the supply of new, affordable housing covers legal tools that influence financing, location, cost, and character of new housing. The levers that we identified as key in this domain are as follows.

Low-Income Housing Tax Credit program (LIHTC): Established by the Tax Reform Act of 1986, the LIHTC is administered by the U.S. Department of Treasury and is intended to incentivize financial institutions to invest in affordable housing developments. Through the program, developers can compete for tax credits, which they can “sell” to the banks in return for project financing. LIHTC authorizes state housing finance agencies to issue tax credits to developers through a competitive process, which involves a call for proposals from developers.⁸² The key legal element is the Qualified Allocation

82 U.S. DEPT OF TREASURY, OFFICE OF THE COMPTROLLER OF THE CURRENCY, LOW-INCOME HOUSING TAX CREDITS: AFFORDABLE

Plan (QAP) that each state agency must have to establish eligibility priorities and criteria for awarding tax credits.⁸³ QAPs are usually drafted annually.

Land use regulations (zoning): These rules are set by localities regulating what can and cannot be built on specific land parcels. A key feature of land use regulation is whether the parcel is zoned for commercial or residential purposes. If the parcel is used for residential purposes, regulations may address occupancy limits, types of housing (single family housing, multifamily housing, etc.), lot sizes, and architectural features.

Land banks: Land banks facilitate temporary management and disposal of problem properties through mechanisms specific to local and state law. Problem properties include those that have been abandoned or are tax-delinquent.⁸⁴ Land banks assure that land is properly titled and unencumbered by liability, and organize transfer to new owners consistent with community development plans.

Anti-Vacancy Laws: Some distressed units have deteriorated to a point that it might be cheaper for the owner to abandon them than to fix them. Since vacant properties can negatively affect the community in the form of decreasing property values of neighboring homes, some states allow neighbors to sue the abandoning property owner and seek damages for the lost value.⁸⁵ These suits could theoretically have a deterrent effect on abandonment, and may be seen as a lever to maintain existing housing. In practice, these laws seem to kick in only once a property is a total loss, and to operate along with land banks as a mechanism for redevelopment. Many jurisdictions also have vacant property registration ordinances, which require owners of vacant properties to pay a fee and register their property.⁸⁶

Land trusts: The land trust is a device for maintaining the long-term affordability of new housing. The basic idea behind a land trust is the separation of home ownership and land ownership. Community land trusts acquire land and lease parcels to low-income home seekers through a long-term, renewable lease. When the

HOUSING INVESTMENT OPPORTUNITIES FOR BANKS (2014).

83 26 U.S.C. § 42(m)(1) (2018).

84 FRANK S. ALEXANDER, *LAND BANKS AND LAND BANKING* (2d ed. 2015).

85 *See, e.g.*, TENN. CODE ANN. §§ 13-6-101, 13-6-104(a) (2018).

86 U.S. GOV'T ACCOUNTABILITY OFF., GAO-12-34, *VACANT PROPERTIES: GROWING NUMBER INCREASES COMMUNITIES' COSTS AND CHALLENGES* 59-61 (2011).

homeowner wants to move and sell the house, he or she is obligated to sell the property back to the land trust or to another low-income family under conditions that insure affordability. This way, the parcel remains affordable for the next owner. Some municipalities support existing trusts through funding, through reduced tax burdens on resale-restricted homes built on a trust's land, or through waiving administrative/impact fees.⁸⁷

Building codes: The bundle of regulations specifying standards for new building construction is commonly known as a building code. These codes, usually set by localities and states but based on models created by independent standards organizations, could cover a slew of issues including: building structure, fire safety, environmental hazards, water and electricity systems, materials that can and cannot be used, energy efficiency standards, and accessibility requirements. Since the 1990s, the leader of the building code industry has been the International Code Council (ICC). The majority of states use the model codes released by the ICC as their building codes.⁸⁸

The second action domain in our model that tackles the health and affordability problem head on is: maintaining existing housing as affordable, stable, and safe, which covers a variety of legal levers that govern housing quality and the willingness and capacity of tenants and owners to stay in their dwellings.⁸⁹ The levers in this

87 JOHN EMMEUS DAVIS & RICK JACOBUS, LINCOLN INST. OF LAND POLICY, *THE CITY-CLT PARTNERSHIP: MUNICIPAL SUPPORT FOR COMMUNITY LAND TRUSTS* (2008), <https://www.lincolninst.edu/sites/default/files/pubfiles/the-city-clt-partnership-full.pdf>.

88 David Listokin & David B. Hattis, *Building Codes and Housing*, 8 *CITYSCAPE* 21, 29–31 (2005).

89 This domain encompasses efforts to manage the problems of gentrification (the process of redesigning lower-income neighborhoods to suit middle-class preferences) and “globalization” (the phenomenon of cities becoming magnets for overseas residential investment). Both push up rents and housing prices, imperiling the tenancy of existing residents. Because this Article focuses on the housing struggles of low-income people, we do not address the globalization issue and its legal levers per se. See, e.g., Conor Dougherty, *In Vancouver, a Housing Frenzy That Even Owners Want to End*, N.Y. TIMES (June 2, 2018), <https://www.nytimes.com/2018/06/02/business/economy/vancouver-housing.html> (reporting on legal efforts of Canadian global city to suppress rise in housing presses). By contrast, gentrification and its management present both challenges and opportunities for health equity in housing. Legal levers for gentrification management, like housing code enforcement, stronger regulation of condo conversion, use of transfer taxes to deter speculation, and property tax relief for existing home owners, have been identified. Donald C. Bryant, Jr. & Henry W. McGee, Jr., *Gentrification and the*

domain are as follows.

Housing code enforcement: Housing codes concern the function, condition, and maintenance of housing.⁹⁰ Housing code enforcement is the activity, usually conducted on the municipal level, to ensure that units are kept up to code.⁹¹ In general, housing code enforcement efforts start with something that ignites an inspection (complaint, strategic choice of municipality, point of sale/rent), then proceeds to an inspection, remediation, and an abatement process.

Landlord-tenant law: A lease is a contract, and the body of law regulating the residential lease is usually referred to as “landlord-tenant” law. During the late 1960s, a “revolution” in landlord-tenant law emerged.⁹² In 1970, the court in *Javins v. First National Realty Corp.* confirmed the existence of an implied warranty of habitability.⁹³ A warranty of habitability promises that the premises will be suitable and safe for residential use, and in theory gives tenants a legal basis to demand repairs or to take self-help measures, such as withholding rent.⁹⁴ Since the *Javins* decision, courts in many other states have adopted the warranty, and state legislators have enacted statutory warranties. All states but Arkansas now recognize a general implied warranty of habitability in residential leases.⁹⁵ Further, all states have enacted some form of landlord-tenant statutes. These laws provide a

Law: Combatting Urban Displacement, 25 WASH. U. J. URB. & CONTEMP. L. 43 (1983); see also Leila Ghaffari et al., *Toward a Socially Acceptable Gentrification: A Review of Strategies and Practices Against Displacement*, GEOGRAPHY COMPASS, Feb. 2018, at 1 (reviewing strategies to protect existing residents). For purposes of this Article, we do not treat gentrification as an independent problem or domain, but as one expression of the problems of segregation, housing shortage, lack of economic agency, and poor governance.

90 H. Laurence Ross, *Housing Code Enforcement and Urban Decline*, 6 J. AFFORDABLE HOUSING & COMMUNITY DEV. L. 29, 31 (1996).

91 Code enforcement agencies should accomplish the following three goals in order to be effective: (1) identify code violations; (2) monitor properties that violate the code, and take action when the issue is not remediated; and (3) engage in a remediation process to either restore or demolish the property. Marilyn L. Uzdavines, *Barking Dogs: Code Enforcement is all Bark and No Bite (Unless the Inspectors Have Assault Rifles)*, 54 WASHBURN L.J. 161, 163 (2014).

92 Edward H. Rabin, *The Revolution in Residential Landlord-Tenant Law: Causes and Consequences*, 69 CORNELL L. REV. 517, 520–21 (1984).

93 *Javins v. First Nat’l Realty Corp.*, 428 F.2d 1071, 1072–73 (D.C. Cir. 1970).

94 Corey Mostafa, *The Implied Warranty of Habitability, Foreseeability, and Landlord Liability for Third-Party Criminal Acts Against Tenants*, 54 UCLA L. REV. 971, 980–81 (2007).

95 Melissa T. Lonegrass, *Convergence in Contort: Landlord Liability for Defective Premises in Comparative Perspective*, 85 TUL. L. REV. 413, 423 (2010).

varying degree of protection, depending on the jurisdiction.

Nuisance (or “crime free”) property ordinances: These ordinances are municipal in nature and generally label some type of conduct (e.g., calling the police or other emergency services) a nuisance. They require the landlord or homeowner to abate the nuisance or suffer penalties such as fines, loss of rental permits, condemnation of property, or even incarceration.⁹⁶ The typical mechanism to abate is eviction.

Just-cause (or “good-cause” or “no-fault”) eviction laws: These laws mandate that landlords may evict tenants only for a good reason, such as damage to the property, non-payment of rent, or other lease violations.⁹⁷ While just-cause eviction is a standard protection in federally subsidized housing, many tenants in the private rental market do not enjoy the same safeguard.⁹⁸ As of 2008, only three states and the District of Columbia have a just-cause eviction law that protects some, if not all, tenants.⁹⁹ Several cities, including Oakland, San Francisco, and Los Angeles have just-cause eviction laws.¹⁰⁰

Free legal representation in housing court: When low-income tenants meet their landlords in court, usually the landlord is armed with a lawyer while the tenant is not. Mostly, legal help for tenants is accomplished through a fund that pays for representation. However, in New York City, a law was enacted to require that, as of July 31, 2022, all low-income tenants receive legal representation.¹⁰¹

Rent control: This lever consists of legal schemes that prevent

96 AMERICAN CIVIL LIBERTIES UNION WOMEN’S RIGHTS PROJECT, SILENCED: HOW NUISANCE ORDINANCES PUNISH CRIME VICTIMS IN NEW YORK 3 (2015), https://www.aclu.org/sites/default/files/field_document/equ15-report-nuisanceord-rel3.pdf [hereinafter ACLU].

97 Marc Jolin, *Good Cause Eviction and the Low Income Housing Tax Credit*, 67 U. CHI. L. REV. 521, 522, 529–30 (2000).

98 *Id.* at 522. For tenants receiving federal housing assistance, the illegal drug-related activity of other household members or guests may be considered good cause for evicting the entire household. 24 C.F.R. § 5.858 (2018).

99 Aleatra P. Williams, *Real Estate Market Meltdown, Foreclosures and Tenants’ Rights*, 43 IND. L. REV. 1185, 1204–05 (2010); Florence Wagman Roisman, *The Right to Remain: Common Law Protections for Security of Tenure: An Essay in Honor of John Otis Calmore*, 86 N.C. L. REV. 817, 834–35 (2008).

100 Roisman, *supra* note 99, at 836–37; Williams, *supra* note 99, at 1205; POLICYLINK, EQUITABLE DEVELOPMENT TOOLKIT: JUST CAUSE EVICTION CONTROLS 2 (2002), <http://www.policylink.org/sites/default/files/just-cause-eviction-controls.pdf>.

101 N.Y.C., ADMIN. CODE §§ 26-1301 to -1302 (2018).

excessive increases in rent, either by creating a strict rent ceiling, or in softer, more sophisticated, ways. Rent control can help maintain the affordability of housing units without depriving landlords of the incentive to maintain the property.¹⁰² Rent control has been widely used since the 1940s, but has gone out of fashion.¹⁰³ Today, only four states and the District of Columbia have rent control laws, and the majority of states preempt localities from enacting rent control measures.¹⁰⁴

The domain of affirmatively furthering fair housing covers the legal levers used to actively promote racial and socio-economic diversity in housing.

Fair housing protections: Fair housing law might be traced back to the *Shelley v. Kraemer* case, which held racially restrictive covenants legally unenforceable,¹⁰⁵ but was symbolically launched in April 1968 when Lyndon B. Johnson signed the Fair Housing Act into law. The Act, as amended in 1988 by the Fair Housing Amendments Act, prohibits housing discrimination based on race, color, religion, national origin, sex, disability, and familial status.¹⁰⁶ In 2015, the U.S. Supreme Court affirmed that the Act protects not only against intentional discrimination, but also against facially neutral policies that have a disparate impact on one of the protected classes.¹⁰⁷ Fair housing laws regulate not only the rental and sale of housing, but also insurance and lending transactions, such as prohibiting predatory mortgage lending based on race¹⁰⁸ (“reverse redlining”¹⁰⁹). As of August 1, 2017, all states except Mississippi have enacted a fair housing law of their own, either reiterating federal protections or expanding upon them.¹¹⁰

102 See Blair Jenkins, *Rent Control: Do Economists Agree?*, 6 *ECON J. WATCH* 73, 79–83 (2009) (reviewing history and economic opinion on rent control).

103 Matthew Desmond & Monica Bell, *Housing, Poverty, and the Law*, 11 *ANN. REV. L. SOC. SCI.* 15, 16–17 (2015).

104 *Rent Control Laws by State*, NAT’L MULTIFAMILY HOUSING COUNCIL (Aug. 29, 2018), <https://www.nmhc.org/research-insight/analysis-and-guidance/rent-control-laws-by-state/>.

105 *Shelley v. Kraemer*, 334 U.S. 1 (1948).

106 42 U.S.C. §§ 3601–3619 (2012).

107 *Texas Dep’t of Hous. and Cmty. Affairs v. Inclusive Cmty. Project, Inc.*, 135 S. Ct. 2507, 2518 (2015).

108 42 U.S.C. § 3605 (2012).

109 RICHARD ROTHSTEIN, *THE COLOR OF LAW* 109–13 (2017).

110 The Policy Surveillance Program, *State Fair Housing Protections*, CTR. FOR PUB. HEALTH LAW RESEARCH, TEMPLE UNIV. BEASLEY SCHOOL OF LAW (Aug. 1, 2017), <http://lawatlas.org/datasets/state-fair-housing->

Affirmatively Furthering Fair Housing rule: The Fair Housing Act not only prohibits housing discrimination, but also imposes a duty on HUD and its program participants to affirmatively further fair housing (AFFH)—to take meaningful steps to promote integration.¹¹¹ This duty applies to state and local governments that receive funds from HUD.¹¹² The AFFH obligation is the broadest potential legal lever for achieving integration over the long term. The law, now specified through a 2015 regulation (the AFFH rule),¹¹³ provides a mechanism to induce systematic local and regional planning, monitor implementation, and use the threat of withholding funds to ensure that the mandate is carried out. The 2015 rule required about 1,200 municipalities to conduct an assessment of their fair housing needs to be submitted by October 31, 2020, but the rule has effectively been suspended by HUD as explained in Part IV. Eight states have an AFFH requirement in their state fair housing law.¹¹⁴

Inclusionary zoning: By limiting the amount of space in a community that can be used for affordable, multi-family housing through devices like minimum lot requirements and density limits, conventional zoning schemes exclude lower-income people.¹¹⁵ Inclusionary zoning is a legal lever that municipalities can use to require that a specified proportion of new housing units be affordable. It can incentivize or force developers to include affordable units in their projects, or to contribute funds toward the construction of affordable units elsewhere in the community. As of 2017, almost 900 jurisdictions have inclusionary zoning schemes.¹¹⁶

State-level mandates: In some states, various legal devices have been used to counter zoning and planning barriers to affordable housing. These requirements are based on income and not on race, but given how closely associated race and income are, the

protections-1498143743.

111 42 U.S.C. § 3608(e)(5) (2012).

112 Timothy M. Smyth et al., *The Fair Housing Act: The Evolving Regulatory Landscape for Federal Grant Recipients and Sub-Recipients*, 23 J. AFFORDABLE HOUSING & COMMUNITY DEV. L. 231, 235 (2015); 24 C.F.R. §§ 91.225(a)(1), 91.325(a)(1) (2018); 24 C.F.R. §§ 570.487(b), 570.601(a)(2) (2018).

113 24 C.F.R. §§ 5.150–5.168 (2018).

114 The Policy Surveillance Program, *supra* note 110.

115 DOUGLAS S. MASSEY ET AL., CLIMBING MOUNT LAUREL 18-19 (2013).

116 Emily Thaden & Ruoniu Wang, *Inclusionary Housing in the United States: Prevalence, Impact, and Practices* 11 (Lincoln Inst. of Land Policy, Working Paper No. WP17ET1, 2017), https://www.lincolninst.edu/sites/default/files/pubfiles/thaden_wp17et1_0.pdf.

requirements theoretically could work as a force against racial segregation as well as poverty concentration. The most explicit requirement came out of litigation in Mt. Laurel, New Jersey and led to a still-unique legal lever: a requirement that all municipalities in the state develop/accommodate their “fair share” of affordable housing. Other states have taken action to make the development of affordable housing in all neighborhoods easier by: simplifying permit processes (Massachusetts),¹¹⁷ speeding appeals of adverse zoning decisions (Connecticut),¹¹⁸ or requiring municipalities to plan for and assist the development of affordable housing (California).¹¹⁹

The domain of protecting and enhancing economic choice for the poor addresses the factors that influence the ability of poor people to get, hold, and spend resources sufficiently to have healthy options in the housing market. It reflects the fact that people struggling for housing are not passive objects of policy and market forces, but are people who can and do strive with determination and creativity to find suitable places to live.

Housing Choice Vouchers: Established in 1974,¹²⁰ the Housing Choice Voucher (HCV) program is administered by public housing agencies (PHAs), and allows low-income individuals to rent private housing while generally paying no more than 30% of their income in rent, unless the rent is higher than the local payment standard.¹²¹ Voucher holders select units that meet the program’s housing quality standards, and if the PHA approves the unit, it will enter a contract with the owner to pay the remainder of the rent on behalf of the tenant.¹²² Other voucher or housing support funding may be provided through special programs for veterans or the homeless.¹²³

The Mortgage Interest Deduction: First included in the income

117 See, e.g., MASS. GEN. LAWS ch. 40B, §§ 20–23 (2018).

118 CONN. GEN. STAT. § 8-30g(f) (2017).

119 CAL. GOV’T CODE § 65583(c) (West 2018).

120 12 U.S.C. § 1706e (1988) (repealed 1991); 42 U.S.C. § 1437f (2018).

121 24 C.F.R. § 982.1 (2018).

122 *Id.*

123 42 U.S.C. § 1437f(o)(19) (2018). This includes Medicaid. There is a movement of physicians who argue that housing is the “prescription” that they want to write for their patients. Since 2015 Medicaid funds can be used to pay for housing for the chronically homeless. Michael Ollove, *States Freed to Use Medicaid Money for Housing*, STATELINE (Nov. 20, 2015), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/11/20/states-freed-to-use-medicaid-money-for-housing>; Kathy Moses & Rachel Davis, *Housing Is a Prescription for Better Health*, HEALTH AFFAIRS (July 22, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150722.049472/full/>.

tax code in 1913, the mortgage interest deduction (MID) is currently one of the largest tax deductions in the tax code and the largest housing subsidy. In its current form, the MID is intended to promote homeownership by allowing homeowners to deduct their mortgage interest on a principle of up to \$750,000 and up to two residences.¹²⁴

Consumer protections against predatory lending: There is a slew of law that is intended to protect low and middle-income borrowers from predatory practices. The Fair Housing Act¹²⁵ and the Equal Credit Opportunity Act (ECOA)¹²⁶ prohibit lending discrimination based on race, color, national origin, religion, sex, and other protected classes. Predatory lending can be a discriminatory practice if members of protected classes are required to pay higher costs or interest rates than others. The law gives the Department of Justice (DOJ) authority to take action against financial institutions that engage in discriminatory lending practices. Since 2011, the Consumer Financial Protection Bureau (CFPB) has assumed the role of point agency for all matters of compliance with federal consumer protection laws, including the enforcement of fair lending laws.¹²⁷ In the context of housing, fair lending is often thought of as relating to mortgages, but we take a more holistic view and include payday lending. Storefront payday lending is legal in 36 states.¹²⁸ Some states enacted interest rate limits intended to protect consumers.¹²⁹

Minimum wage: The federal minimum wage currently stands at \$7.25 per hour of work.¹³⁰ As of 2016, all but five southern states enacted minimum wage laws of their own, and in seven states the minimum wage is lower than the federal minimum wage, and as such, is non-binding.¹³¹

Earned Income Tax Credit: The Earned Income Tax Credit

124 26 U.S.C. § 163(h) (2018). See Roberta F. Mann, *The (Not So) Little House on the Prairie: The Hidden Costs of the Home Mortgage Interest Deduction*, 32 ARIZ. ST. L.J. 1347, 1348–49 (2000).

125 42 U.S.C. § 3605 (2018).

126 15 U.S.C. § 1691 (2018).

127 12 U.S.C. §§ 5511, 5514 (2018).

128 PEW CHARITABLE TRS., HOW STATE RATE LIMITS AFFECT PAYDAY LOAN PRICES 1 (2014), https://www.pewtrusts.org/~media/legacy/uploadedfiles/pes/contentlevel_pages/fact_sheets/stateratelimitsfactsheetpdf.pdf.

129 *Id.*

130 *Minimum Wage Tracker*, ECON. POL'Y INST., <https://www.epi.org/minimum-wage-tracker/> (last visited Jan. 2, 2019).

131 Policy Surveillance Program, *Minimum Wage Laws Map*, LAWATLAS, <http://legacy.lawatlas.org/query?dataset=minimum-wage-laws-1457972234> (last visited Jan. 2, 2019).

(EITC) is another lever intended to directly impact the income of the working poor. The EITC was designed to support low- and moderate-income working families with children. Like minimum wage, the EITC is a federal program, but states can expand on it and provide more generous payments. Twenty-nine states and the District of Columbia do expand on EITC. In 2016, the program assisted almost 26 million households. Unlike other benefits, EITC is most often dispersed once per year, in a lump sum.¹³²

Finally, surrounding the other domains is the element of governance. This domain addresses the fact that all of the laws and practices we have discussed operate within larger, overlapping systems. Governance can be defined as “the management of the course of events in a social system.”¹³³ In its public management sense, governance refers to the set of “meta-levers” (like regional planning authority) through which government can try to strategically coordinate the many individual legal and policy levers for housing development, preservation, and equity. In a broader sense, governance encompasses how policymakers, citizens, businesses, and other individuals and organizations manage the law (and each other) to attain their ends.

Regional governance law: Regional governance focuses on institutional approaches to implement regional plans, and has been defined as “deliberate efforts at collective action in environments of multiple governmental jurisdictions.”¹³⁴ Intergovernmental approaches can take various forms, such as informal cooperation, inter-local service contracts, joint power agreements, or regional planning commissions.¹³⁵ Regional planning commissions are generally “empowered to gather and distribute information, to prepare a regional plan, and to provide . . . technical services to local planning boards.”¹³⁶ However, the commission does not generally

132 *Policy Basics: State Earned Income Tax Credits*, CTR. ON BUDGET & POL’Y PRIORITIES, <https://www.cbpp.org/research/state-budget-and-tax/policy-basics-state-earned-income-tax-credits> (last updated Aug. 23, 2017); *Policy Basics: The Earned Income Tax Credit*, CTR. ON BUDGET & POL’Y PRIORITIES, <https://www.cbpp.org/research/federal-tax/policy-basics-the-earned-income-tax-credit> (last updated Apr. 19, 2018).

133 Scott Burris et al., *Nodal Governance*, 30 AUSTL. J. LEGAL PHIL. 30 (2005).

134 Brian W. Ohm, *Is There a Law of Regional Planning?*, 4 BELMONT L. REV. 35, 38 (2017) (quoting ETHAN SELTZER & ARMANDO CARBONELL, *REGIONAL PLANNING IN AMERICA* 10 (2011) (citation omitted)).

135 *Id.* at 38.

136 PATRICIA SALKIN, *AMERICAN LAW OF ZONING* § 10:9 (5th ed. 2018).

have authority to require municipalities to implement the regional plan.¹³⁷

Governance elements of other legal levers: Many of the legal levers that were identified above relate to the governance of housing markets. For example, the LIHTC QAP is a lever for shaping the character and location of a substantial proportion of new affordable housing, as are fair share laws and other mechanisms for overcoming zoning barriers. The federal AFFH Rule can likewise be understood as a compulsory planning mechanism backed by federal financial incentives. In the governance section below, we describe some examples of those interactions.

IV. The Many Things We Do Not Know About the Impact of Basic Housing Laws

While there are many laws influencing housing, there are still many unknowns regarding the impact of these laws. This form of ignorance is dangerous. It fosters and supports the belief that problems that have been addressed in law have been solved, or at least are in the process of being solved, when in fact the “solutions” may be flawed in design, implementation, or both.

This part explores research into the workings and effects of the most prominent legal levers in our heuristic model. Most studies are peer-reviewed, but not-for-profit groups’ reports comprise much of the literature in some domains. Aside from MTO, we did not find randomized controlled trials on the impact of law on housing related outcomes. Rather, the literature is largely comprised of what would ordinarily be considered low-quality evidence: observational studies of one or a few instances over short time spans without strong design elements to support causal inferences.¹³⁸ There are few studies exploiting changes in policy as a rigorous, natural experiment over time. We therefore do not explicitly rate the strength of evidence, but start with the general caveat that virtually all of our knowledge of the workings of the legal levers we describe should be approached with caution.

¹³⁷ *Id.*

¹³⁸ See L Rychetnik et al., *Criteria for Evaluating Evidence on Public Health Interventions*, 56 J. EPIDEMIOLOGY & COMMUNITY HEALTH 119, 120 (2002); see generally PUBLIC HEALTH LAW RESEARCH: THEORY AND METHODS 93 (Alexander Wagenaar & Scott Burris eds., 2013) (reviewing research methods in legal evaluation).

A. Domain 1: Increasing the Supply of New Affordable Housing

1. The Low-Income Housing Tax Credit Program (LIHTC)

Between 1987 and 2015, the federal government subsidized the building of more than three million housing units through LIHTC.¹³⁹ The program has an annual budget of nearly \$8 billion per year and between 1995 and 2016 has created an average of 108,810 units per year.¹⁴⁰ Unfortunately, demand for affordable housing continues to outpace supply.¹⁴¹ It is plausible that more tax credits would lead to more units but the “big” empirical policy question is whether a system of tax credits is the most efficient way to build the affordable housing we need.¹⁴² That question is extremely difficult, if not impossible to answer. The decentralized, public-private approach to affordable housing finance, of which LIHTC is the fulcrum, emerged from a more traditional government production model that was itself not meeting the need, and was vigorously attacked by proponents of a more conservative, free-market approach.¹⁴³

In the matter of health equity in housing, we ask how and to what extent LIHTC contributes to greater economic and racial integration. The majority of LIHTC developments are sited in low-income neighborhoods,¹⁴⁴ which often means predominantly non-white neighborhoods with fewer jobs, more pollution, and

139 *Low-Income Housing Tax Credits*, OFF. POL’Y DEV. & RES., <https://www.huduser.gov/portal/datasets/lihtc.html> (last updated June 6, 2018).

140 *Id.*

141 U.S. DEPT OF HOUS. & URBAN DEV., *WORST CASE HOUSING NEEDS: 2017 REPORT TO CONGRESS ix-xi* (2017), <https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Housing-Needs.pdf>.

142 That is, assuming that LIHTC survives. By slashing the corporate tax dramatically enough to seriously reduce what corporations owe, the Tax Cuts and Jobs Act dramatically decreased the demand for tax credits, but since LIHTC has bi-partisan support, Congress may yet maintain historical funding levels by other means. Conor Dougherty, *Tax Overhaul Is a Blow to Affordable Housing Efforts*, N.Y. TIMES (Jan. 18, 2018), <https://www.nytimes.com/2018/01/18/business/economy/tax-housing.html>.

143 For a historical view of housing policy and the “revolution” in approach of which LIHTC is a part, see DAVID JAMES ERICKSON, *THE HOUSING POLICY REVOLUTION: NETWORKS AND NEIGHBORHOODS xi-xiv* (Urban Institute Press. 2009).

144 See Jean L. Cummings & Denise DiPasquale, *The Low Income Housing Tax Credit: An Analysis of the First Ten Years*, 10 HOUSING POL’Y DEBATE 251, 268–69 (1999).

lower performing schools.¹⁴⁵ The decision regarding where to site a LIHTC development is based on the QAP. The Internal Revenue Code requires that the QAP give preference to projects located in high poverty census tracts and gives developers in those tracts a tax credit increase of up to 30%. Developers respond to this incentive by building more in high-poverty neighborhoods.¹⁴⁶

The program also incentivizes building developments that are not mixed income. LIHTC requires that 20% or 40% of units in a development be affordable, depending on the level of affordability.¹⁴⁷ However, states reward developments that have more affordable units by giving more tax credits to those developers.¹⁴⁸

These rules of the game raise concern that LIHTC contributes to racial segregation and poverty concentration.¹⁴⁹ Overall, studies of LIHTC's impact on segregation show mixed results with modest effects either way. While LIHTC might not contribute actively to increased racial segregation and poverty concentration, it is clear that it is not a major force of racial and socioeconomic integration.¹⁵⁰

145 Ingrid Gould Ellen et al., *Gateway to Opportunity? Disparities in Neighborhood Conditions Among Low-Income Housing Tax Credit Residents*, 28 HOUSING POL'Y DEBATE 572, 573 (2018).

146 Nathaniel Baum-Snow & Justin Marion, *The Effects of Low Income Housing Tax Credit Developments on Neighborhoods*, 93 J. PUB. ECON. 654 (2009).

147 See 26 U.S.C. § 42(g) (2018).

148 EDWARD L. GLAESER & JOSEPH GYOURKO, RETHINKING FEDERAL HOUSING POLICY 107 (2008).

149 The Inclusive Communities Project, a fair housing litigation group based in Texas, brought a law suit against the U.S. Department of Treasury claiming that LIHTC is "perpetuating racial segregation" and "relegating minority families to unequal conditions of slum, blight, and distress." See Complaint at 6, *Inclusive Cmty. Project, Inc. v. U.S. Dep't of Treasury*, No. 3:14-CV-3013-D, 2016 WL 6397643 (N.D. Tex., Oct. 28, 2016). In 2010, Philip Tegeler, the President Executive Director of the Poverty and Race Research Action Council sent a letter to the department of the Treasury arguing that LIHTC "create[s] and perpetuate[s] racial segregation in assisted housing." Letter from Philip Tegeler et al., President Exec. Dir., Poverty & Race Research Action Council, to Michael S. Barr, Assistant Sec'y for Fin. Insts., Dep't of the Treasury (Oct. 26, 2010), http://www.prrac.org/pdf/civil_rights_letter_to_Michael_Barr_10-26-10.pdf.

150 See Ingrid G. Ellen et al., *Poverty Concentration and the Low Income Housing Tax Credit: Effects of Siting and Tenant Composition*, 34 J. HOUS. ECON. 49, 50, 58 (2016); Keren M. Horn & Katherine M. O'Regan, *The Low Income Housing Tax Credit and Racial Segregation*, 21 HOUS. POL'Y DEBATE 443, 467 (2011); Matthew Freedman & Tamara McGavock, *Low-Income Housing Development, Poverty Concentration, and Neighborhood Inequality*, 34 J. POL'Y ANALYSIS & MGMT. 805 (2015); Lance Freeman & William Rohe, *Subsidized Housing*

There are efforts to make LIHTC a stronger force for socioeconomic integration. Some states have been working on including provisions in the QAP that encourage siting of developments outside of high-poverty areas. For example, in 2009, Texas's QAP started awarding points to developments that are in "high opportunity" areas. A pre-post analysis of LIHTC developments in San Antonio found that after the provision was put in place, more LIHTC units were sited in low-poverty neighborhoods.¹⁵¹ Similarly, since 2013, New Jersey's QAP requires 60% of the tax credits to be allocated in areas with low poverty, such as prosperous suburbs.¹⁵² This change to the QAP has been shown to increase the number of LIHTC developments next to public transit, placing half of the credits in "job-center municipalities," and in "proficient school districts."¹⁵³

Authors of a HUD report published in 2015 analyzed changes in the QAPs of 21 states between 2002 and 2010, and found that various types of opportunity provisions impact the siting outcomes of LIHTC developments.¹⁵⁴ The report shows considerable variation in how states define an opportunity area, the mechanism through which the state incorporates opportunity in the QAP (set asides, point changes, or others), and the impact of the change on locational outcomes.

While some of the rules that govern LIHTC come from the treasury, every state program with its QAP is a different program in a sense. Since early 2002, there is a growing recognition of the importance of the QAP and, as such, we need research to help direct state agencies in their efforts to use LIHTC as a force for racial and social economic integration.

and Neighborhood Racial Transition: An Empirical Investigation, 11 HOUS. POL'Y DEBATE 67–89 (2000); Nathaniel Baum-Snow & Justin Marion, *The Effects of Low Income Housing Tax Credit Developments on Neighborhoods*, 93 J. PUB. ECON. 654 (2009).

151 Rebecca J. Walter, et al., *Comparing Opportunity Metrics and Locational Outcomes in the Low-Income Housing Tax Credit Program*, 38 J. PLAN. EDUC. & RES. 449 (2018).

152 TIM EVANS, NEW JERSEY FUTURE, ASSESSMENT OF THE NEW JERSEY LOW INCOME HOUSING TAX CREDIT PROGRAM 12–13 (2017), <http://www.njfuture.org/wp-content/uploads/2017/05/New-Jersey-Future-Assessment-of-the-NJLIHTC-program.pdf>.

153 *Id.*

154 U.S. DEPT OF HOUS. & URBAN DEV., EFFECT OF QAP INCENTIVES ON THE LOCATION OF LIHTC PROPERTIES (2015), https://www.novoco.com/sites/default/files/atoms/files/pdr_qap_incentive_location_lihtc_properties_050615.pdf.

2. *Land Use Regulation*

Land use regulation has potential effects on health equity in housing across all of the domains of our model. It can influence the cost of new housing, and can be a means of affirmatively encouraging or preventing integration. It is a primary instrument of planning. The classical economic case against zoning is that it raises costs, which constricts the supply of affordable housing. The most expeditious way to get people the housing they need is not to help tenants pay rent, but to relax regulations that restrict supply, and allow the invisible hand to achieve equilibrium. There is evidence to support this theoretical position, although it varies both in significance and magnitude.¹⁵⁵ In its broadest form, the claim ignores the potential benefits of land use regulation, and its many particular forms.

Land use regulations can be divided into five categories: (1) limits of density and intensity; (2) design and performance standards; (3) moving costs (such as sewerage) from locality to developer; (4) banning development on specific lots; and (5) controls on growth.¹⁵⁶ The majority of studies that attempt to estimate the impact of land use regulation use crude measures to capture the regulation, so we remain in the dark as to the costs and benefits of particular elements of regulation. A review of empirical evidence concluded that “the most promising strategy for improving our understanding of the economic effects of zoning and land use restrictions would be to devote resources to measuring regulatory conditions systematically in a large cross-section of cities and metropolitan areas.”¹⁵⁷

A few years after this recommendation, researchers from the Wharton School of the University of Pennsylvania conducted a survey of land use regulations in over 2,000 jurisdictions. The survey results, with additional data, were used to create a measure of the stringency of the regulatory environment in each community, called

155 For a review of the literature see John M. Quigley & Larry A. Rosenthal, *The Effects of Land Use Regulations on the Price of Housing: What Do We Know? What Can We Learn?*, 8 *CITYSCAPE* 69, 69–70 (2005), and Ralph B. McLaughlin, *Land Use Regulation: Where Have We Been, Where Are We Going?*, 29 *CITIES* S50, S54 (2012).

156 Elizabeth Deakin & Douglas R. Porter, *Growth Controls and Growth Management: A Summary and Review of Empirical Research*, in *UNDERSTANDING GROWTH MANAGEMENT: CRITICAL ISSUES AND A RESEARCH AGENDA* 5–6 (David J. Brower & David R. Godschalk eds., 1989).

157 Quigley & Rosenthal, *supra* note 155, at 89, 100.

the Wharton Residential Land Use Regulatory Index (WRLURI).¹⁵⁸ Using the WRLURI, the researchers found that coastal markets are more highly regulated,¹⁵⁹ and were able to model a demand curve for housing¹⁶⁰ and correlate housing elasticity to the amount of developable land.¹⁶¹ Further, since the index was used in a rigorous and scientific manner, it is now used as a benchmark for indexing regulation.¹⁶²

The WRLURI was a large step in the right direction. There are two next steps that will progress the research on land use regulations. The first is moving from indexes to observable elements of the law. This move will enable evaluation of what parts of land use regulation drive supply effect, if any at all. Second, a longitudinal dataset of regulations must be built to increase the ability of studies to achieve causal inference.

3. *Vacant Properties, Land Banks, and Land Trusts*

Vacant properties are a problem in cities throughout the U.S. In 2017, 9.3% of housing units in the U.S. were estimated to be vacant year-round.¹⁶³ Vacant lots and properties are associated with neighborhood crime, illicit drug use, and a reduced perception of safety.¹⁶⁴ As of 2011, “439 jurisdictions have enacted vacant property registration ordinances.”¹⁶⁵ Another effort to estimate the prevalence of these ordinances coded more than 500 ordinances to a database.¹⁶⁶ The popularity of these ordinances does not translate to research and evaluation. We found only one study that suggests

158 Joseph E. Gyourko et al., *A New Measure of the Local Regulatory Environment for Housing Markets: Wharton Residential Land Use Regulatory Index*, 45 *URB. STUD.* 693–729 (2008).

159 *Id.*

160 Christian A.L. Hilber & Frédéric Robert-Nicoud, *On the Origins of Land Use Regulations: Theory and Evidence from US Metro Areas*, 75 *J. URB. ECON.* 29–43 (2013).

161 Edward Glaeser et al., *Housing Supply and Housing Bubbles*, 64 *J. URB. ECON.* 198–217 (2008).

162 Kristoffer Jackson, *Do Land Use Regulations Stifle Residential Development? Evidence from California Cities*, 91 *J. URB. ECON.* 45–56 (2016).

163 U.S. CENSUS BUREAU, *QUARTERLY RESIDENTIAL VACANCIES AND HOMEOWNERSHIP, FOURTH QUARTER 2017* (2018), <https://www.census.gov/housing/hvs/files/qtr417/Q417press.pdf>.

164 Eugenia Garvin et al., *More Than Just an Eyesore: Local Insights and Solutions on Vacant Land and Urban Health*, 90 *J. URB. HEALTH* 413, 420–21 (2013).

165 U.S. GOV'T. ACCOUNTABILITY OFF., *supra* note 99, at 61.

166 Yun Sang Lee et al., *New Data on Local Vacant Property Registration Ordinances*, 15 *CITYSCAPE* 289 (2013).

that these registration requirements actually reduce vacancy rates.¹⁶⁷

Once the property is vacant, the challenge is to acquire and dispose of the land with reasonable dispatch. Land banks are a popular mechanism to do so. Along with securing a marketable title, land banks can (or should) become integral to the community development and planning process, helping to define and promote desirable uses of vacant property.¹⁶⁸

A limited evaluation of literature finds mostly positive results. An implementation study of five land banks shows how “a land bank can operate as a local government authority to transcend the legal and structural impediments to conversion” of vacant properties to “assets.”¹⁶⁹ The challenge in major land banking cities, where tens of thousands of properties may be vacant, is scaling up disposition. Although the land banks reviewed in the study held large amounts of land, the rate of disposition was much lower.¹⁷⁰ While land banks can have measurable success locally,¹⁷¹ there is a question of whether they can be scaled to address the magnitude of the vacancy problem. For example, if the Philadelphia Land Bank disposed of 500 vacant parcels per year, and not a single new parcel became vacant, it would take about 83 years for Philadelphia to dispose of all 40,000 vacant properties.¹⁷² Scaling up is possible in theory, and would be expected to increase the magnitude of benefits compared to mechanisms like sheriff’s sales, but it also increases administrative costs considerably.¹⁷³ Interviews with more than 40 land bank officials show that the challenge for land banks is funding.¹⁷⁴ While there is general agreement, mainly from non-peer reviewed evaluations, that

167 Thomas J. Fitzpatrick et al., *The Effect of Local Housing Ordinances* (Fed. Reserve Bank of Cleveland, Working Paper No. 1240, 2014).

168 PAYTON HEINS & TARIK ABDELAZIM, CTR. FOR CMTY. PROGRESS, TAKE IT TO THE BANK: HOW LAND BANKS ARE STRENGTHENING AMERICA’S NEIGHBORHOODS (2014), <http://www.communityprogress.net/take-it-to-the-bank--how-land-banks-are-strengthening-america-s-neighborhoods-pages-466.php>.

169 Frank S. Alexander, *Land Bank Strategies for Renewing Urban Land*, 14 J. AFFORDABLE HOUS. & COMMUNITY DEV. L. 140 (2005).

170 *See id.* at 156.

171 TYLER BOROWY ET AL., LAND POL’Y INST. MICH. ST. U., ECONOMIC IMPACTS OF THE INGHAM COUNTY LAND BANK: 2006–2012 (2013).

172 PHILA. LAND BANK, 2017 STRATEGIC PLAN & PERFORMANCE REPORT 22 (2017), <http://wp.philadelphialandbank.org/wordpress/wp-content/uploads/2015/01/philadelphia-land-bank-strategic-plan-february-2017.pdf>.

173 *Id.* at 34.

174 HEINS & ABDELAZIM, *supra* note 168, at 18.

land banks are a force for good in communities, it is unclear if they can be scaled up to address systemic vacancy in cities with distressed housing stock.

Another mechanism to increase the utilization of vacant land parcels is a community land trust. Similar to land banks, community land trusts show a lot of promise, but not to scale. Compared to other homeowners, community land bank homeowners had much lower rates of completed foreclosures throughout the foreclosure crisis of 2008–2010.¹⁷⁵ This occurrence was due, in part, to the fact that the land trust helped delinquent homeowners sell their houses and avoid foreclosure.¹⁷⁶ A few case studies on specific land trusts show that they were able to help low-income people achieve homeownership, while retaining affordable housing.¹⁷⁷ A national study of community land trusts in 2006 found that nearly 190 land trusts throughout the U.S. held 6,495 units.¹⁷⁸

4. Building Codes

Like land-use regulations, building codes are mechanisms to promote safety¹⁷⁹ and support rational planning, but they may also affect the cost of new housing.¹⁸⁰ Empirical interest in the basic costs and benefits of codes seems to have peaked in the 1970s

175 Emily Thaden, *Stable Home Ownership in a Turbulent Economy: Delinquencies and Foreclosures Remain Low in Community Land Trusts* 11 (Lincoln Inst. of Land Policy, Working Paper No. WP11ET1, 2011), https://www.lincolnst.edu/sites/default/files/pubfiles/1936_1257_thaden_final.pdf.

176 *Id.* at 16.

177 KENNETH TEMKIN ET AL., THE URBAN INST., *BALANCING AFFORDABILITY AND OPPORTUNITY: AN EVALUATION OF AFFORDABLE HOMEOWNERSHIP PROGRAMS WITH LONG-TERM AFFORDABILITY CONTROLS*, at iii (2010), <https://www.urban.org/sites/default/files/publication/29291/412244-Balancing-Affordability-and-Opportunity-An-Evaluation-of-Affordable-Homeownership-Programs-with-Long-term-Affordability-Controls.PDF>.

178 Yesim Sungu-Eryilmaz & Rosalind Greenstein, *A National Study of Community Land Trusts* 16 (Lincoln Inst. of Land Policy, Working Paper No. WP07YS1, 2007), <http://cltnetwork.org/wp-content/uploads/2014/01/2007-A-National-Study-of-CLTs.pdf>.

179 A clear example of this comes from seismic building codes that are intended to mitigate the impact of an earthquake on buildings. A review by the World Bank Group concludes that “[b]uilding code implementation has a crucial role to play in disaster risk reduction.” World Bank Group, *Building Regulation for Resilience: Managing Risks for Safer Cities*, at 13 (2015), <https://www.gfdrr.org/sites/default/files/publication/BRR%20report.pdf>.

180 David Listokin & David B. Hattis, *Building Codes and Housing*, 8 CITYSCAPE 21, 42 (2005).

and 80s, including the publication of a 1969 report to the Douglas Commission on Urban Problems.¹⁸¹ This report identified several building codes as wasteful practices.¹⁸² While multiple early studies found that more restrictive building codes (often unclear how defined) led to an increase in cost of construction and as such are restrictive,¹⁸³ a study that aimed to determine the magnitude of the increase found that “the effects of local building codes on housing costs is, at most, small.”¹⁸⁴

Building codes are often discussed in monolithic terms but can be separated into various types. Although specific requirements may be debatable, fire codes, plumbing codes, and general safety codes are directly related to public health.¹⁸⁵ On the other hand, regulations on room dimensions, though they may reflect older notions of public health, are harder to justify epidemiologically and may unnecessarily inflate housing costs; the general trend is for these types of codes to reduce in scope in recent years.¹⁸⁶

A review of the current literature suggests that there is a need for an update to address today’s code and technology. As in the broader land use law literature, the majority of existing studies utilize a more or less fuzzy measure of restrictiveness, and measure cost without consideration of the potential benefits of these codes. For the policymaker, it is imperative to know if the increased cost of codes has a greater societal benefit, but thorough evaluation to estimate the benefit is not available.¹⁸⁷ One study helped distinguish

181 Cty. of Santa Clara Planning Dep’t., Summary: The Douglas Commission Report (1969), <https://searchworks.stanford.edu/view/4038271>.

182 Sharon M. Oster & John M. Quigley, *Regulatory Barriers to the Diffusion of Innovation: Some Evidence from Building Codes*, 8 THE BELL J. OF ECON. 361, 361–68 (1977).

183 *Id.*; Eli M. Noam, *The Interaction of Building Codes and Housing Prices*, 10 AM. REAL EST. & URB. ECON. ASS’N J. 394, 394–95 (1983).

184 Richard F. Muth & Elliot Wetzler, *The Effect of Constraints on House Costs*, 3 J. URB. ECON. 57, 64 (1976).

185 See James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758, 763 (2002).

186 See generally PAUL BOUDREAUX, THE HOUSING BIAS: RETHINKING LAND USE LAWS FOR A DIVERSE NEW AMERICA (Palgrave Macmillan 1st ed. 2011) (cataloging the harms of traditional zoning); Listokin & Hattis, *supra* note 180, at 25.

187 A few studies do conduct these types of cost-benefit analysis for building codes. JAMES K. HAMMIT ET AL., HARVARD UNIVERSITY, RESIDENTIAL BUILDING CODES, AFFORDABILITY, AND HEALTH PROTECTION: A RISK-TRADEOFF APPROACH 2 (1999) (“We estimate that a code change that increases the nationwide cost of constructing and maintaining homes by

code requirements that improve safety (fire codes/structural requirements) from those that are outdated or reflect self-interested pressures of a professional or commercial group.¹⁸⁸

B. Domain 2: Maintaining Existing Housing Affordable, Stable, and Safe

1. Housing Code Enforcement and Landlord-Tenant Law

Approximately one-third of Americans rent their homes.¹⁸⁹

High transaction costs and the dynamics of the rental market can result in unequal bargaining power between landlords and tenants. In addition, renters may be particularly vulnerable, as they are more likely than homeowners to have low incomes or to be minorities.¹⁹⁰ A variety of laws regulate the relationship between landlords and tenants, including the implied warranty of habitability and state landlord-tenant laws.

The implied warranty of habitability has long been seen in academic writing as an extremely weighty development. An abundance of articles discuss, praise, or critique the warranty, but virtually none empirically evaluate its actual use or impact. A recent article used historic rent data to estimate the effect of the implied warranty on rents.¹⁹¹ The author found that there is reason to believe that the implied warranty of habitability achieves its goal of improving housing conditions, but also leads to an increase in rents.¹⁹² The last study that took place before this 2010 study dates back to 1975.¹⁹³ Neither article was peer-reviewed, and neither provides strong support for claims about the effect of the warranty

\$150 (0.1% of the average cost to build a single-family home) would induce offsetting risks yielding between 2 and 60 premature fatalities or, including morbidity effects, between 20 and 800 lost quality-adjusted life years (both discounted at 3%) each year the code provision remains in effect.”).

188 Listokin & Hattis, *supra* note 180, at 21 (providing a strong framework on how to assess building codes as well as a breakdown of codes that should be used in future research).

189 Megan E. Hatch, *Statutory Protection for Renters: Classification of State Landlord-Tenant Policy Approaches*, 27 HOUSING POL’Y DEBATE 98, 98 (2017).

190 *Id.*

191 Michael A. Brower, *The “Backlash” of the Implied Warranty of Habitability: Theory vs. Analysis*, 60 DEPAUL L. REV. 849, 851–52 (2011).

192 *Id.* at 887.

193 Werner Z. Hirsch et al., *Regression Analysis of the Effects of Habitability Laws upon Rent: An Empirical Observation on the Ackerman-Komesar Debate*, 63 CALIF. L. REV. 1098, 1098 (1975).

on quality or affordability.

The state of the evaluation of other landlord-tenant law is not much better. A 1980 study using mixed methods to evaluate the utilization of landlord-tenant laws in two cities found that legislation has had little effect on landlord and tenant litigation.¹⁹⁴ Since then, we found no evaluation of landlord-tenant litigation or the effect of law on their relations, and experts know little about its effect.¹⁹⁵ A study of the Milwaukee market powerfully demonstrates the failure of landlord-tenant law in giving some leverage to tenants.¹⁹⁶ Aside from Desmond's recent work, there has been little research on what really happens in landlord-tenant disputes. It is unclear to what extent states enforce landlord-tenant laws, and to what extent tenants know about these laws or how to use them to protect their rights. Additionally, it is unknown how parties typically operate in the shadow of these laws where many, if not most, evictions are handled informally.

The "revolution" in landlord-tenant law sparked a vigorous debate about the effects that housing code enforcement, tenant rights, and the implied warranty of habitability have on the poor. Two camps of legal scholars formed at the time, with Bruce Ackerman leading one and Neil Komesar leading the other, in a debate about whether housing code enforcement hurts the poor.¹⁹⁷ However, "[d]espite all the ink spilled in this debate, little empirical research has been conducted to inform either position."¹⁹⁸

While there is a small body of literature suggesting that code enforcement achieves the goal of improving housing quality¹⁹⁹ and reducing incidence of childhood lead poisoning,²⁰⁰ the effects on the housing market are still largely unevaluated. Publicly available data from Rochester, New York suggests that concentrated efforts

194 Samuel Jan Brakel & Donald M. McIntyre, *The Uniform Residential Landlord and Tenant Act (URLTA) in Operation: Two Reports*, 5 AM. B. FOUND. RES. J. 557, 557, 566 (1980).

195 Hatch, *supra* note 189.

196 DESMOND, *supra* note 23. The tenants he followed in Milwaukee were consistently bullied by their landlords, and found little help in court.

197 Hirsch, et al., *supra* note 189, at 1116–17.

198 Desmond & Bell, *supra* note 103, at 22.

199 See, e.g., Carla Campbell et al., *Philadelphia's Lead Court Is Making a Difference*, 38 J. HEALTH POL., POL'Y & L. 709, 709 (2013).

200 See Chinaro Kennedy et al., *Primary Prevention of Lead Poisoning in Children: A Cross-Sectional Study to Evaluate State Specific Lead-Based Paint Risk Reduction Laws in Preventing Lead Poisoning in Children*, 13 ENVTL. HEALTH 1, 8 (2014).

to address lead did not result in a negative impact on housing markets.²⁰¹ A case study from Minneapolis supports these results.²⁰² However, an older study of three cities found that strict housing code enforcement contributed to urban blight.²⁰³

Given the different results from cities and a small body of empirical research, the debate remains open and policymakers who want to improve the adequacy of the rental housing stock without increasing rents are left in the dark. Research is needed on the impact strict housing code enforcement may have on factors such as rent levels, eviction rates, and number of rental units on the market. In addition, evaluation is needed on the effectiveness and impacts of potentially promising models, such as strategic code enforcement.²⁰⁴

2. Nuisance Property Ordinances

It is estimated that more than 2,000 municipalities have nuisance and crime-free property ordinances.²⁰⁵ However, policy surveillance of these ordinances in the 40 most populous U.S. cities shows that there is wide variation regarding the type of conduct the city defines as a nuisance, along with other key elements.²⁰⁶

There has been little research on the effects of these laws.

201 Katrina Smith Korfmacher et al., *Rochester's Lead Law: Evaluation of a Local Environmental Health Policy Innovation*, 120 ENVTL. HEALTH PERSP. 309, 309, 313 (2012).

202 Robin Powers Kinning, *Selective Housing Code Enforcement and Low-Income Housing Policy: Minneapolis Case Study*, 21 FORDHAM URB. L.J. 159, 197 (1993).

203 H. Laurence Ross, *Housing Code Enforcement as Law in Action*, 17 LAW & POL'Y 133, 158 (1995).

204 The Center for Community Progress, a leader in code enforcement and anti-blight efforts, defines strategic code enforcement as, “[c]ode enforcement that goes beyond complaint response to strategically address systemic targets and focus on bringing properties into compliance with codes.” They further explain that the rationale is that “[c]omplaint-driven code enforcement, while necessary, is inefficient and leads to scattered outcomes rather than systematic compliance and neighborhood stabilization.” ALAN MALLACH, CTR. FOR CMTY. PROGRESS, RAISING THE BAR: A SHORT GUIDE TO LANDLORD INCENTIVES AND RENTAL PROPERTY REGULATION 4 (2015), http://mayorscaucus.org/wp-content/uploads/2016/01/SSMMA_landlord-incentives_how-to-guide_final-am-12-28-15.pdf.

205 Kate Walz, *Let's Stop Criminalizing Victims of Domestic Violence*, THE SHRIVER BRIEF (Oct. 27, 2017), <https://theshriverbrief.org/lets-stop-criminalizing-victims-of-domestic-violence-a72a06b50e42>.

206 *City Nuisance Property Ordinances*, THE POL'Y SURVEILLANCE PROGRAM: A LAW ATLAS PROJECT (Aug. 1, 2017), <http://lawatlas.org/datasets/city-nuisance-property-ordinances>.

An analysis of nuisance citations distributed in Milwaukee in 2008 and 2009 finds that almost one in three citations were generated by domestic violence incidents, and that most property owners abated the nuisance by evicting abused women.²⁰⁷ Properties in predominantly black neighborhoods have the highest likelihood of receiving a nuisance designation. The authors concluded that a nuisance property ordinance “has the effect of forcing abused women to choose between calling the police on their abusers (only to risk eviction) or staying in their apartments (only to risk more abuse)” and could explain “why women from poor black neighborhoods are evicted at significantly higher rates than men.”²⁰⁸ An analysis of two cities in New York State finds that “domestic violence was the single largest category of enforcement” under both cities’ nuisance ordinances,²⁰⁹ adding to the concern that the results from Milwaukee are generalizable to other settings.

The experience of domestic violence survivors reinforces the results from the statistics. A qualitative study interviewing 27 low-income African American women who survived domestic violence finds the ordinances hinder access to safe and secure housing, as well as “discourag[e] them from calling 911.”²¹⁰ Multiple states have enacted laws protecting the right to call for emergency assistance,²¹¹ but we found no empirical evaluation of these laws and whether they affect enforcement efforts on the ground.

The harm of nuisance property ordinances may not be limited to people in need of emergency intervention. Some argue that these ordinances reduce the supply of rental housing by revoking property rental licenses, or by discouraging homeowners from providing rental housing because they do not want to be exposed to the possibility of nuisance enforcement.²¹² While the intuition behind the argument

207 Matthew Desmond & Nicol Valdez, *Unpolicing the Urban Poor: Consequences of Third-Party Policing for Inner-City Women*, 78 AM. SOC. REV. 117, 118 (2013).

208 *Id.*

209 ACLU, *supra* note 96.

210 Gretchen W. Arnold, *From Victim to Offender: How Nuisance Property Laws Affect Battered Women*, 2016 J. INTERPERSONAL VIOLENCE 1, 1.

211 NAT’L HOUS. LAW PROJECT, HOUSING RIGHTS OF DOMESTIC VIOLENCE SURVIVORS: A STATE AND LOCAL LAW COMPENDIUM (2016), <http://nhlp.org/files/CombinedD-HousingStateLawCompendium.pdf>.

212 EMILY WERTH, THE COST OF BEING “CRIME FREE”: LEGAL AND PRACTICAL CONSEQUENCES OF CRIME FREE RENTAL HOUSING AND NUISANCE PROPERTY ORDINANCES 5, 9, 24 (2013), <http://www.povertylaw.org/files/advocacy/housing/ShriverCenter.HousingReport.08-2013.cost-of->

is plausible, we found no empirical evaluation to support it.

There is a need for further research on the effects nuisance property ordinances have on victims of domestic violence, people with disabilities, and on the rental market in general.

3. Preventing Eviction—“Just-Cause” and Free Legal Representation

In response to what some have called an eviction crisis, cities and states are looking for solutions to help protect renters. One solution is the enactment of “just-cause” eviction laws. Opponents of “just-cause” argue that just-cause evictions, like other tenant protections, hurt low-income renters by raising the cost of low-income housing, and reducing the number of affordable units that can be built.²¹³ Proponents assert that any costs are justified by the decrease in unjust and costly evictions.²¹⁴ Just-cause protections, proponents argue, promote housing stability, particularly in areas where landlords might want to evict tenants to get higher rents.²¹⁵

Just-cause and other changes in landlord-tenant law do not eliminate, and may increase, the need for legal services. For those parties negotiating in the shadow of law, there must be awareness of the protection and, between both landlords and tenants, some sense that courts truly police the justice of the cause.²¹⁶ As of now, despite the salience of both the just-cause approach and eviction generally, we remain evidence-free.

In recent years there has been a push for free legal representation of low income tenants in housing courts. At least one jurisdiction, New York City, has established a program in which free legal representation in housing court will be provided for all low-income tenants facing eviction.²¹⁷ Some studies—including a randomized controlled trial—suggest that, unsurprisingly, lawyers

being-crime-free.report.pdf.

213 Jolin, *supra* note 97, at 532. Legal scholars have also analyzed just-cause evictions in the context of the takings clause. See Karl Manheim, *Tenant Eviction Protection and the Takings Clause*, 1989 WIS. L. REV. 925, 927, 929 (1989); Laura L. Westray, *Are Landlords Being Taken by the Good Cause Eviction Requirement?*, 62 S. CAL. L. REV. 321, 323, 366 (1988) (considering whether just-cause protections constitute a taking).

214 Jolin, *supra* note 97, at 534.

215 POLICYLINK, *supra* note 100, at 1, 6.

216 See generally *id.*; Roisman, *supra* note 99, at 851–52.

217 N.Y.C., ADMIN. CODE §§ 26-1301 to -1302 (2017).

improve outcomes for tenants,²¹⁸ but there is no existing evaluation of what happens when a city starts providing these services to all low-income residents. Key questions include: whether representation reduces informal evictions, how much added cost the measure creates for legitimate evictions, and whether a case-by-case system of dispute resolution at the point of eviction is the best use of public resources for helping poor tenants.

4. *Rent control*

The idea of rent control has been heavily debated in economics literature. The classical economist argues that for the prices between the market rent and the lower rent imposed by rent control, there are tenants who are willing and able to pay, and landlords who are willing and able to supply. A large survey conducted in the 1990s found that 76.3% of economists working in the U.S. generally agree with the proposition “a ceiling on rents reduces the quantity and quality of available housing.”²¹⁹ None of the other 40 propositions in the questionnaire had a higher consensus rate.²²⁰

Generally, rent control can be divided into strict price ceilings and the softer rent stabilization models. A comprehensive literature review of economic studies finds that indeed rent control “creates many more problems than it solves.”²²¹ The author of the review finds negative impacts for strict and soft rent controls. The negative impacts go beyond housing supply. For example, one study finds that “far from eliminating segregation, at least in New Jersey, rent control has appeared to increase it.”²²² Reflecting on rent control, Desmond comments that the literature on this topic has largely

218 See generally Carroll Seron et al., *The Impact of Legal Counsel on Outcomes for Poor Tenants in New York City’s Housing Court: Results of a Randomized Experiment*, 35 L. & SOC’Y REV. 419 (2001); D. James Greiner et al., *The Limits of Unbundled Legal Assistance: A Randomized Study in a Massachusetts District Court and Prospects for the Future*, 126 HARV. L. REV. 901 (2013); BOS. BAR ASS’N TASK FORCE ON THE CIVIL RIGHT TO COUNSEL, THE IMPORTANCE OF REPRESENTATION IN EVICTION CASES AND HOMELESSNESS PREVENTION (Mar. 2012), <http://www.bostonbar.org/docs/default-document-library/bba-crtc-final-3-1-12.pdf>.

219 Richard M. Alston et al., *Is There a Consensus Among Economists in the 1990’s?*, 82 AM. ECON. REV. 203, 204 (1992).

220 *Id.*

221 Blair Jenkins, *Rent Control: Do Economists Agree?*, 6 ECON. J. WATCH 73, 105 (2009) (quoting Peter Navarro, *Rent Control in Cambridge, Massachusetts*, 78 PUB. INT. 83 (1985)).

222 Edward L. Glaeser, *Does Rent Control Reduce Segregation?*, 10 SWEDISH ECON. POL’Y REV. 179, 198 (2003).

ignored the “increasing professionalization of urban landlords” Understanding the power dynamics behind rent control could help gauge whether the rare occasions that seem to show benefits from rent control could be replicated.²²³

C. Domain 3: Affirmatively Furthering Fair Housing

1. Fair Housing Protections and the AFFH Rule

Though officially outlawed, housing discrimination persists in the rental, sales, and lending markets (see the Predatory Lending section below for further discussion of discrimination in lending).²²⁴ The persistence of discrimination is reported both by official HUD studies²²⁵ and by not-for-profit groups helping homeseekers with their complaints—tens of thousands every year.²²⁶ The actual magnitude of discrimination based on race is probably understated in complaint statistics. A 2017 Robert Wood Johnson Foundation-Harvard survey reported that 45% of African Americans, 25% of Asian-Americans, and 31% of Hispanic Americans report having been discriminated against when seeking housing.²²⁷ Furthermore, there is reason to believe that many people of color are so discouraged by the persistence of segregation, and expect discrimination, that they do not seek housing in predominantly white areas at all.

There is reason to believe that the problem is not the fair housing laws but rather, their enforcement. There are several ways enforcement is deficient. First, many or most victims may not come forward because they do not realize they have experienced discrimination, may not trust the remedy or wish to invest time and energy in litigation, or simply because their focus is on trying to fill their housing needs. Second, the system may not process claims

223 Desmond & Bell, *supra* note 103, at 17.

224 Jacob S. Rugh & Douglas S. Massey, *Racial Segregation and the American Foreclosure Crisis*, 75 AM. SOC. REV. 629, 629 (2010); NAT'L FAIR HOUS. ALL., THE CASE FOR FAIR HOUSING: 2017 FAIR HOUSING TRENDS REPORT 76–82 (2017), <https://nationalfairhousing.org/wp-content/uploads/2017/04/TRENDS-REPORT-4-19-17-FINAL-2.pdf>.

225 E.g., U.S. DEPT' OF HOUS. & URBAN DEV., OFFICE OF POLICY DEV. & RESEARCH, HOUSING DISCRIMINATION AGAINST RACIAL AND ETHNIC MINORITIES 2012, at xi–xii (2013), https://www.huduser.gov/portal/Publications/pdf/HUD-514_HDS2012.pdf.

226 NAT'L FAIR HOUS. ALL., *supra* note 224, at 77–78.

227 *Discrimination in America*, ROBERT WOOD JOHNSON FOUND., <https://www.rwjf.org/en/library/research/2017/10/discrimination-in-america-experiences-and-views.html> (last visited Dec. 2, 2018).

efficiently, which could reduce the incentives for victims to complain and providers to abstain from discrimination.²²⁸ Only a small proportion of HUD complaints result in a charge of discrimination (2.5% of completed cases in 2016), about one-third are settled, and nearly half are dismissed or withdrawn.²²⁹ There is also a considerable backlog of incomplete cases.²³⁰

Third, the enforcement system may not use its investigatory mechanisms optimally. Fair housing law has been enforced in part by funding non-governmental fair housing organizations to assist people who suffer discrimination, investigate claims, and conduct proactive efforts like testing. The National Fair Housing Alliance (NFHA) reports on these activities, and supports organizations across the country to investigate potential discrimination in dozens of cities and states. For its part, the federal government brings a small but impactful number of pattern and practice cases each year. While these efforts successfully identify discriminatory activity, and produce positive legal outcomes, NFHA has also said that “this work receives neither the support nor respect it deserves.”²³¹

The persistence of discrimination in housing markets is evidence that half a century after the enactment of the Fair Housing Act, the law did not achieve significant social norm changes, nor a significant deterrence effect to make landlords stop discriminating.

Although the evidence raises concerns about the anti-discrimination project,²³² there is a dearth of literature evaluating the impact of fair housing law on racial residential segregation. There is almost no empirical evaluation of either federal or state fair housing laws’ effect on residential segregation, and the little evidence that does exist suggests that such laws may be insufficient as a tool of integration.²³³ There is some evaluation of city-level

228 Cary Coglianese & Evan Mendelson, *Meta-Regulation and Self-Regulation*, in *THE OXFORD HANDBOOK OF REGULATION* 147–49 (Oxford Univ. Press ed. 2010) (ebook).

229 U.S. DEP’T OF HOUS. & URBAN DEV., OFFICE OF FAIR HOUS. & EQUAL OPPORTUNITY, ANNUAL REPORT TO CONGRESS FY 2016, at 21 (2017), <https://www.hud.gov/sites/documents/FY2016FHEOANNUALREPORT.PDF>.

230 *Id.* For a comparison, see Kathryn Moss et al., *Unfunded Mandate: An Empirical Study of the Implementation of the Americans with Disabilities Act by the Equal Employment Opportunity Commission*, 50 U. KAN. L. REV. 1 (2001).

231 NAT’L FAIR HOUS. ALL., *supra* note 224, at 75.

232 Nancy A. Denton, *Half Empty or Half Full: Segregation and Segregated Neighborhoods 30 Years After the Fair Housing Act*, 4 CITYSCAPE 107, 113 (1999).

233 Richard A. Smith, *The Effects of Local Fair Housing Ordinances on Housing*

initiatives, with mixed results. In case studies, efforts to increase black homeownership in New York City in the 1990s had some of the desired results,²³⁴ while St. Louis, Missouri showed no impact of city-level desegregation efforts.²³⁵

The Fair Housing Act not only prohibits discrimination in housing-related transactions, but it also imposes a duty on HUD and its program participants to affirmatively further fair housing.²³⁶ This duty applies to state and local governments that receive HUD funds.²³⁷ In the 1990s, HUD issued regulations and published a Fair Housing Planning Guide to clarify the AFFH mandate and provide guidance on how to comply. However, some recipients have not complied with their AFFH obligation, either to conduct a serious analysis of fair housing barriers, or to take concrete and meaningful steps to overcome identified barriers.²³⁸

Despite significant litigation on this issue,²³⁹ noncompliance remained a significant problem in many jurisdictions. This noncompliance led the U.S. Government Accountability Office (GAO) to publish a report highlighting HUD's general ineffectiveness in enforcing the AFFH mandate.²⁴⁰ The GAO report prompted HUD to promulgate new regulations to clarify the AFFH process and standards for grantees. Published in 2015, the new rule requires grantees to submit an Assessment of Fair Housing (AFH) to HUD that identifies integration and segregation patterns, racially or ethnically concentrated areas of poverty, significant disparities in access to opportunity for any protected class, and disproportionate housing needs for any protected class.²⁴¹ The AFH must include

Segregation: Their Impact is Small, but It's an Important Positive Change Toward Integration, 48 AM. J. ECON. & SOC. 219, 219 (1989).

234 Lance Freeman, *Black Homeownership: The Role of Temporal Changes and Residential Segregation at the End of the 20th Century*, 86 SOC. SCI. Q. 403 (2005).

235 Dennis R. Judd, *The Role of Governmental Policies in Promoting Residential Segregation in the St. Louis Metropolitan Area*, 66 J. NEGRO EDU. 214, 214–15 (1997).

236 42 U.S.C. § 3608(e)(5) (2012).

237 24 C.F.R. § 5.154 (2018).

238 Smyth et al., *supra* note 112, at 238–39.

239 *See, e.g., U.S. ex rel. Anti-Discrimination Ctr. of Metro N.Y., Inc. v. Westchester Cty.*, 668 F. Supp. 2d 548 (S.D.N.Y. 2009); *see also* Stipulation & Order of Settlement & Dismissal, *U.S. ex rel. Anti-Discrimination Ctr. of Metro N.Y., Inc. v. Westchester County*, 668 F. Supp. 2d 548 (S.D.N.Y. 2009) (No. 06 Civ. 2860), http://prrac.org/pdf/2009-08-10_order_settlement_signed.pdf.

240 Smyth et al., *supra* note 112, at 243–44.

241 24 C.F.R. § 5.154(d) (2018).

goals to overcome fair housing issues, and the public must be given an opportunity to participate in the development of the AFH.²⁴² Program participants are encouraged to collaborate and submit a single AFH for two or more jurisdictions.²⁴³

In May of 2018, HUD withdrew the Assessment Tool to be used by local governments in conducting their AFH, claiming that the tool is deficient.²⁴⁴ Because the Assessment Tool must be used to complete the AFH, HUD in effect has suspended the AFH submission requirement. As of the publication of this article, HUD is in the process of developing a proposed rule to amend the existing AFFH regulations.

It is too soon to know what, if any, amendments will be made, or if there will be a substantial change in the quality of assessments under the new rule. Questions remain as to whether states, cities, and PHAs will identify real fair housing issues that need to be addressed, and if they will take concrete and meaningful steps to overcome barriers to integration. It also remains to be seen how strongly HUD will enforce the AFFH mandate going forward. To what extent will HUD review the AFHs? Will HUD withhold funds from jurisdictions that are not working to affirmatively further fair housing? In addition to the federal mandate, eight states have an AFFH requirement in their state fair housing law.²⁴⁵ However, the impact of the state requirement on segregation levels is unknown.

2. *Inclusionary Zoning*

There is ample evidence that “density zoning is now the most important mechanism promoting class and racial segregation” in the U.S.²⁴⁶ Inclusionary zoning is a legal lever that could be used to reduce the exclusionary impact of density zoning. In considering the evidence of its impact, it is important to recognize that inclusionary zoning is a nuanced legal mechanism that can be tailored to the needs of a specific community given the market pressures, housing resources, and the regulatory environment. The main elements of inclusionary zoning ordinances are the required share of affordable

242 24 C.F.R. §§ 5.154, 5.158 (2018).

243 24 C.F.R. § 5.156 (2018).

244 83 F.R. § 23922 (2018).

245 The Policy Surveillance Program, *supra* note 110.

246 Jonathan T. Rothwell & Douglas S. Massey, *The Effect of Density Zoning on Racial Segregation in U.S. Urban Areas*, 44 URB. AFF. REV. 779, 779–806 (2009); Jonathan T. Rothwell & Douglas S. Massey, *Density Zoning and Class Segregation in U.S. Metropolitan Areas*, 91 SOC. SCI. Q. 1123, 1140–41 (2010).

units in the development, target income level, duration of the affordability requirements, and exemptions and buyout options. Some inclusionary zoning ordinances are mandatory, while others are voluntary and use incentives such as additional density.²⁴⁷ Inclusionary zoning is still zoning: it functions as a form of exception to density or other requirements that operate to limit affordable housing.

From an economic theory perspective, inclusionary zoning operates as a tax to raise the costs of housing construction. Developers must build some units below the market price, which results in affordable housing that is smaller or of lower quality, and market-rate housing that is more expensive than it otherwise would have been. The predicted result would, in theory, be fewer affordable units and higher prices than would have been attained by leaving matters to the invisible hand. The specific effects—marginally higher prices for market rate houses and smaller affordable units—have been observed, but the size of the effect varies depending on location and study design, and often the overall effect on the market is small.²⁴⁸

The economic critique of inclusionary zoning is merely a variant of the argument against zoning itself. The more important question is whether inclusionary zoning provides the promised gains in social welfare: as many (or perhaps more) affordable units as the market or other mechanisms would supply, in locations that create racial and social integration. A recent review judiciously, but credibly, cuts the baby in half: inclusionary zoning can increase affordable housing production and integration, though there may be trade-offs between these two goals.²⁴⁹ The real issue for research and practice is to better identify what particular elements of inclusionary zoning—i.e. which regulatory strategies—are most effective in producing both goals without significant adverse effects. Such

247 See Vinit Mukhija et al., *Can Inclusionary Zoning Be An Effective And Efficient Housing Policy? Evidence from Los Angeles and Orange Counties*, 32 J. URB. AFF. 229, 234 (2010) (reporting heterogeneity in effects of inclusionary zoning policies).

248 Vinit Mukhija et al., *The Tradeoffs of Inclusionary Zoning: What Do We Know and What Do We Need to Know?*, 30 PLAN. PRAC. & RES. 222, 228–29, 230 (2015); Antonio Bento et al., *Housing Market Effects of Inclusionary Zoning*, 11 CITYSCAPE, no. 2, 2009, at 10, 20–21.

249 Mukhija et al., *supra* note 247, at 226–30. Notably, the review reports that inclusionary zoning “programs produce as much affordable housing as the Low Income Housing Tax Credits (LIHTC) program.” *Id.* at 227.

studies can also inform normative debates about any tradeoffs that inclusionary zoning creates: if there are less overall housing units, but the share of affordable housing increases, do we define that as a net positive or net negative from an equity lens with the goal of promoting a culture of health?²⁵⁰

3. *Fair Share and Other State-Level Mandates*

While zoning is usually left to localities, some states have created inclusionary housing requirements. The requirements are based on income, not race, but given how closely associated race and income are, the requirements theoretically could work as a force against racial segregation as well as poverty concentration. Litigation in Mt. Laurel, New Jersey led to a still-unique legal lever, a requirement that all municipalities develop/accommodate their “fair share” of affordable housing.²⁵¹ The three-decade process of defining, implementing and applying the requirement statewide has involved local governments, courts, and the state legislature. The results of the Mt. Laurel doctrine are “a proof of concept for the further development of affordable family housing, both as a social policy for promoting racial and class integration in metropolitan America and as a practical program for achieving poverty alleviation and economic mobility in society at large.”²⁵² Outcomes for low-income individuals who acquired affordable housing through the Mt. Laurel litigation were better than those for similar people who remained in an area of concentrated poverty on numerous measures, including welfare use, employment, mental health, and income.²⁵³ That said, the doctrine has by no means substantially desegregated New Jersey, nor has the doctrine been adopted elsewhere.

There is some evaluation of other states’ “fair share-ish” laws. For example, there is a small body of literature that argues that Chapter 40B played a role in increasing density, combating exclusionary zoning,²⁵⁴ and generating economic activity in

250 Vinit Mukhija et al., *The Tradeoffs of Inclusionary Zoning: What Do We Know and What Do We Need to Know?*, 30 PLAN. PRAC. & RES. 222, 230, 233 (2015).

251 S. Burlington Cty. NAACP v. Township of Mount Laurel, 456 A.2d 390 (N.J. 1983).

252 MASSEY ET AL., *supra* note 8, at 190 (providing a detailed review of the evidence about the experience of Mt. Laurel, N.J.).

253 *Id.* at 148.

254 See, e.g., Lynn M. Fisher & Nicholas J. Marantz, *Can State Law Combat Exclusionary Zoning? Evidence from Massachusetts*, 52 URB. STUD. 1071 (2014).

Massachusetts.²⁵⁵ In California, New Jersey, and Massachusetts, LIHTC produces more affordable housing units per year than the statewide affordable housing programs.²⁵⁶

D. Domain 4: Enhancing Economic Choice for the Poor

The economic analysis of affordable housing tends to put considerable emphasis on supply-side issues, such as zoning. Likewise, measures like LIHTC, inclusionary zoning, and housing code enforcement aim to primarily influence developers and landlords. We think it is also important to take people with low incomes seriously as agents in the housing market, and therefore to consider how subsidy programs and other measures aimed at increasing the resources at their disposal could or do support the market agency of lower-income people.

1. Housing Choice Voucher Program

Housing vouchers have been shown to reduce homelessness and housing instability.²⁵⁷ Children in homeless families that receive vouchers are 42% less likely to be placed into foster care.²⁵⁸ The MTO experiment showed long-term positive effects for voucher families moving into less poor neighborhoods.²⁵⁹ The HCV program can also benefit property owners. In 2016, owners received \$17.5 billion in voucher payments, which can help to pay property taxes and maintain properties in good condition.²⁶⁰

Given the broad evidence of positive impact, the most obvious defect in the program is that it is chronically, and substantially, underfunded. Although the HCV program is the largest rental

255 LINDSAY KOSHGARIAN ET AL., U. MASS. DONAHUE INST., ECONOMIC CONTRIBUTIONS OF HOUSING PERMITTED THROUGH CHAPTER 40B 6–7, 10 (2010), http://massbenchmarks.org/publications/studies/pdf/Economic_Contributions_of_Housing.pdf.

256 Lance Freeman & Jenny Schuetz, *Producing Affordable Housing in Rising Markets: What Works?* 10 (Sept. 2016) (unpublished working paper), https://pennur.upenn.edu/uploads/media/FreemanSchuetz_PennIUR-Philly_Fed_working_paper_091616v2.pdf.

257 Matthew Desmond & Kristen L. Perkins, *Are Landlords Overcharging Housing Voucher Holders?*, 15 CITY & COMMUNITY 137 (2016).

258 CTR. ON BUDGET & POLICY PRIORITIES, UNITED STATES HOUSING CHOICE VOUCHERS FACT SHEET (2017), https://www.cbpp.org/sites/default/files/atoms/files/3-10-14hou-factsheets_us.pdf.

259 See Ludwig et al., *supra* note 59; Chetty et al., *supra* note 61; LOGAN & STULTS, *supra* note 62; Cutler & Glaeser, *supra* note 63.

260 CTR. ON BUDGET & POLICY PRIORITIES, *supra* note 258.

assistance program in the U.S., with more than five million people in 2.2 million low-income households using vouchers,²⁶¹ the demand for vouchers substantially outweighs the supply: overall, only one in four households eligible to receive a voucher actually gets one.²⁶² “According to a recent survey, 53% of HCV waiting lists were closed to new applicants, and the median list had a wait time of 1.5 years.”²⁶³

It is clear that the HCV program is an invaluable tool to help low-income renters afford housing. However, what is not clear in a broader context is whether or not the program leads to poverty deconcentration and racial integration. In other words, while it is clear that the program achieves the goal of helping voucher holders pay rent, it is unclear whether the program allows for mobility. One study that tackles this question head on finds that, “to a large extent, the residents did not live in places that met their location preferences.”²⁶⁴ Other studies analyze HCV program data to estimate whether voucher holders move to low poverty neighborhoods or if they get stuck in voucher submarkets.²⁶⁵ The Center on Budget and Policy Priorities reports that of the more than 2.2 million households using vouchers, only 399,000 families (18%) use their vouchers to live in neighborhoods with a poverty rate below 20%.²⁶⁶ However, one study found that between 2007 and 2013, there was a notable decline in voucher use in high-poverty areas in Florida.²⁶⁷ Another article suggests that vouchers are working to reduce poverty concentration and racial segregation in Columbus, Ohio.²⁶⁸ Further, one analysis

261 *Id.*

262 Desmond & Bell, *supra* note 103, at 18.

263 NAT’L LOW INCOME HOUS. COAL., *OUT OF REACH 2017: THE HIGH COST OF HOUSING 6* (2017), http://nlihc.org/sites/default/files/oor/OOR_2017.pdf.

264 Ruoniu Wang, *Tracking “Choice” in the Housing Choice Voucher Program: The Relationship Between Neighborhood Preference and Locational Outcome*, 54 *URB. AFF. REV.* 302, 302 (2018).

265 Rebecca J. Walter et al., *Moving to Opportunity? An Examination of Housing Choice Vouchers on Urban Poverty Deconcentration in South Florida*, 30 *HOUSING STUD.* 1064 (2015); Stephanie DeLuca et al., *Segregating Shelter: How Housing Policies Shape the Residential Locations of Low-Income Minority Families*, 647 *ANNALS AM. ACAD. POL. & SOC. SCI.* 268 (2013).

266 *CTR. ON BUDGET & POLICY PRIORITIES, supra* note 258.

267 Ruoniu Wang & Rebecca J. Walter, *Tracking Mobility in the Housing Choice Voucher Program: A Household Level Examination in Florida, USA*, 33 *HOUSING STUD.* 455 (2017).

268 Barbra Teater, *Residential Mobility of Section 8 Housing Choice Voucher Program Recipients: Assessing Changes in Poverty and Racial Composition in Neighborhoods*, 12 *J. POVERTY* 351, 353 (2008).

indicates that some black voucher holders are moving out of low-income, hyper-segregated areas into historically white communities, but that other voucher holders move in clustered patterns, which can lead to reconcentration of race and poverty.²⁶⁹

Given the mixed evidence, one conclusion that can be drawn is that even if there are mobility gains from the HCV program, these gains are not very large. One reason for this, which was documented through qualitative research, is that the voucher is geographically tied to a housing authority. Often, there is a jurisdictional boundary between the high poverty area in which the voucher holder currently lives and the low poverty area to which the holder wishes to move. While it is possible to move the voucher across jurisdictions, arranging the transfer requires “time-consuming steps” that are a barrier for many working poor.²⁷⁰ One region shows that another way to govern the voucher program is possible. Following the *Thompson v. HUD*²⁷¹ desegregation case, the Baltimore Housing Mobility Program (BHMP) was founded. BHMP not only provides intensive housing counseling to voucher holders, but also makes it easier to use a voucher from Baltimore City in the more affluent neighborhoods of Baltimore County. The program shows promise and, compared to other voucher programs, BHMP voucher holders “moved to more integrated and affluent neighborhoods.”²⁷²

Another reason that we do not see more mobility gains from the HCV program is discrimination against voucher holders, known as source of income discrimination.²⁷³ Thirteen states plus the District of Columbia have laws prohibiting discrimination based on source of income, which often protects voucher holders.²⁷⁴ However, in three of those states, housing choice vouchers are excluded as a protected

269 Kelly L. Patterson & Eun-Hye Enki Yoo, *Trapped in Poor Places? An Assessment of the Residential Spatial Patterns of Housing Choice Voucher Holders in 2004 and 2008*, 38 J. SOC. SERV. RES. 637 (2012).

270 Stephanie DeLuca et al., *Why Don't Vouchers Do a Better Job of Deconcentrating Poverty? Insights from Fieldwork with Poor Families*, POVERTY & RACE, Sept./Oct. 2012, at 1, 10–11.

271 *Thompson v. U.S. Dep't. of Hous. and Urban Dev.*, 348 F. Supp. 2d 398 (2005).

272 Stefanie DeLuca & Peter Rosenblatt, *Walking Away From The Wire: Housing Mobility and Neighborhood Opportunity in Baltimore*, 27 HOUSING POL'Y DEBATE 519, 519, 533 (2017).

273 Jessica Luna & Josh Leopold, *Landlord Discrimination Restricts the Use of Rental Vouchers*, URB. INST. (July 22, 2013), <https://www.urban.org/urban-wire/landlord-discrimination-restricts-use-rental-vouchers>.

274 The Policy Surveillance Program, *supra* note 110.

source of income.²⁷⁵ The fact that source of income protections are so rare is disheartening, given the potential efficacy of these laws.²⁷⁶ Studies show not only that source of income protections increase voucher utilization,²⁷⁷ but that they are associated with more voucher holders moving to areas with less poverty—even though the laws do not reduce voucher holder concentration.²⁷⁸ Other barriers to mobility include: (1) documented harassment of voucher holders from community members²⁷⁹; for example, aggressively reporting voucher holders to the housing authority or the police²⁸⁰; (2) lack of financial readiness supports²⁸¹; and (3) poor housing search resources of the HCV program makes finding units hard.²⁸²

Another unknown factor related to the HCV program is how it affects housing prices for voucher holders, and for urban rental markets generally. One recent analysis from Milwaukee found that voucher holders are charged between \$51 and \$68 more in monthly rent than tenants without vouchers in comparable units and neighborhoods.²⁸³ However, more research is needed to confirm that this result is not unique to Milwaukee. Overcharging should be of concern as it leads to fewer vouchers being in circulation.

The structure of the HCV program, at least for many areas, theoretically enables overcharging. Voucher holders select a unit rented for an amount at or below Fair Market Rent (FMR), which is a rent ceiling set by HUD.²⁸⁴ FMRs are generally calculated at the metropolitan level (i.e. Philadelphia's FMR for 2017 applies to the

275 *Id.*

276 J. Rosie Tighe et al., *Source of Income Discrimination and Fair Housing Policy*, 32 J. PLAN. LITERATURE 3, 8 (2017).

277 Lance Freeman, *The Impact of Source of Income Laws on Voucher Utilization*, 22 HOUSING POL'Y DEBATE 297, 297 (2012).

278 Lance Freeman & Yunjing Li, *Do Source of Income Anti-discrimination Laws Facilitate Access to Less Disadvantaged Neighborhoods?*, 29 HOUSING STUD. 88, 88, 101–02 (2014); Molly W. Metzger, *The Reconcentration of Poverty: Patterns of Housing Voucher Use, 2000 to 2008*, 24 HOUSING POL'Y DEBATE 544, 545–46 (2014).

279 Rahim Kurwa, *Deconcentration without Integration: Examining the Social Outcomes of Housing Choice Voucher Movement in Los Angeles County*, 14 CITY & COMMUNITY 364, 364, 380 (2015).

280 *Id.* at 380–85, 387.

281 Laurie A. Walker, *Resident Responses to Section 8 Relocation Outcomes: "If You're Gonna Move, You Want to Move Up"*, 11 J. EVIDENCE-BASED SOC. WORK 97, 97, 99, 104, 107, 110 (2014); DeLuca et al., *supra* note 265, at 268, 289.

282 DeLuca et al., *supra* note 265, at 268, 280–81, 288–89.

283 Desmond & Perkins, *supra* note 257, at 137.

284 *Id.* at 139–40.

entire Philadelphia-Camden-Wilmington Metropolitan Statistical Area (MSA)).²⁸⁵ Due to the large and diverse areas for which FMRs are calculated, FMRs are generally higher than the market rents in high-poverty areas. Since these may be the areas in which voucher holders tend to live, landlords renting to voucher holders can charge them more than the market rate. This practice does not affect most voucher holders because they are generally only paying 30% of their income, and the PHA pays the remainder of the rent via the voucher.²⁸⁶

HUD recently issued a new rule and guidance stating that 24 metropolitan areas must use a small area FMR based on zip code, rather than the entire MSA.²⁸⁷ This rule should help alleviate the issue of landlords overcharging voucher holders. It is suggested that preventing overcharging could make the HCV program more cost-effective and expansive.²⁸⁸ The authors analyzing the Milwaukee study noted that overcharging “voucher holders costs taxpayers an estimated \$3.8 million each year in Milwaukee alone, the equivalent of supplying 620 additional families in that city with housing assistance.”²⁸⁹

Another area in which there is a lack of meaningful research is the impact of housing vouchers on private rents, and the research that does exist is mixed. At least one study found that cities with more vouchers had steeper rent increases, but some studies have found no relationship between the concentration of voucher holders and the price of rental housing in general.²⁹⁰ The impact is unknown.²⁹¹

While the HCV program is underfunded, it is the only major investment in the U.S. regarding rental support. While the literature debates whether or not the program allows for mobility,

285 *FY 2018 Fair Market Rent Documentation System*, U.S. DEPT HOUSING & URB. DEV., https://www.huduser.gov/portal/datasets/fmr/fmrs/FY2017_code/2017summary.odn (last visited Dec. 7, 2018).

286 Desmond & Perkins, *supra* note 257, at 137.

287 Using Small Area Fair Market Rents in the Housing Choice Voucher Program Instead of the Current 50th Percentile FMRs, 81 Fed. Reg. 80,567, 80,568 (Nov. 16, 2016) (to be codified at 24 C.F.R. pt. 888, 982, 983, 985); OFFICE OF PUB. & INDIAN HOUS., U.S. DEPT OF HOUS. & URBAN DEV., NOTICE PIH 2018-01(HA), GUIDANCE ON RECENT CHANGES IN FAIR MARKET RENT (FMR), PAYMENT STANDARD, AND RENT REASONABLENESS REQUIREMENTS IN THE HOUSING CHOICE VOUCHER PROGRAM (2018).

288 Desmond & Perkins, *supra* note 257, at 137.

289 *Id.* at 138.

290 *Id.* at 141.

291 Desmond & Bell, *supra* note 103, at 18.

no one seems to argue that the impact is significant on the extensive margin. The few instances of tinkering with the program, such as requiring small-area FMRs, pursuing regional collaboration such as Baltimore did, or enacting source of income protections, shows that changes can incrementally improve program outcomes. More inventive ideas need to be experimented with, as we continue to evaluate the innovative ideas that are currently in place, so that mobility gains may be maximized.

2. *The Mortgage Interest Deduction*

Tax subsidies can add to the resources of home-seekers. In contrast to vouchers, the support for individual home ownership through the home MID has traditionally been available to virtually all comers. In 2015, the cost of the MID was \$70 billion, more than double the combined cost of LIHTC and the HCV program.²⁹² In 2016, the MID was the fifth largest tax break, at \$77 billion.²⁹³ Despite its popularity, a policy favoring tax-payer subsidized home ownership over rental residency has contributed to poverty concentration and racial segregation, rather than to collective welfare.²⁹⁴

The majority of the MID goes to families with above average income. There are a few reasons for this phenomenon. First, wealthier families have larger mortgages, which translate to larger deductions. Second, the tax filer needs to itemize the deduction in order to claim it, something that the rich are more likely to do. Finally, homeowners are on average wealthier, and the MID does not help with paying a down payment, which is the biggest barrier to homeownership for the poor.²⁹⁵

There are studies to suggest that the MID does not achieve the goal of increasing homeownership.²⁹⁶ Furthermore, some studies

292 CAROL GALANTE ET AL., *THE FAIR TAX CREDIT: A PROPOSAL FOR A FEDERAL ASSISTANCE IN RENTAL CREDIT TO SUPPORT LOW-INCOME RENTERS* 14 (2016).

293 Drew DeSilver, *The Biggest U.S. Tax Breaks*, PEW RES. CTR. (Apr. 6, 2016), <http://www.pewresearch.org/fact-tank/2016/04/06/the-biggest-u-s-tax-breaks/>.

294 BRIAN J. MCCABE, *NO PLACE LIKE HOME: WEALTH, COMMUNITY, AND THE POLITICS OF HOMEOWNERSHIP* 129–133 (2016).

295 Matthew Desmond, *How Homeownership Became the Engine of American Inequality*, N.Y. TIMES (May 9, 2017), <https://www.nytimes.com/2017/05/09/magazine/how-homeownership-became-the-engine-of-american-inequality.html>.

296 Edward L. Glaeser & Jesse M. Shapiro, *The Benefits of the Home Mortgage Interest Deduction*, 17 TAX POL'Y & ECON. 37, 37 (2003).

suggest that eliminating the MID would “[cause] house prices to decline, [increase] homeownership, [decrease] mortgage debt, and [improve] welfare.”²⁹⁷ A policy change in Denmark allowed for a quasi-experiment on what would happen if the MID were to be decreased significantly. The results suggest that the MID has “zero effect on homeownership.”²⁹⁸ Harvard Economist Edward Glaeser called for the “killing (or maiming)” of the MID which he called “a sacred cow.”²⁹⁹ It certainly must be considered when discussing the need for more public investment in affordable housing, integration, and support for low-income renters.

3. *The Earned Income (Housing) Tax Credit*

There is a solid empirical consensus that “the EITC has proved remarkably successful in reducing poverty.”³⁰⁰ There is also some evidence that it is a force for better health (for example, infant health).³⁰¹ Survey research shows that the majority of EITC recipients use the money to pay debts.³⁰² Some who can afford using

297 See generally Kamila Sommer & Paul Sullivan, *Implications of US Tax Policy for House Prices, Rents, and Homeownership*, 108 *AM. ECON. REV.* 241, 241 (2018).

298 Jonathan Gruber et al., *Do People Respond to the Mortgage Interest Deduction? Quasi-Experimental Evidence from Denmark* 19 (Nat. Bureau of Econ. Research, Working Paper 23600, 2017).

299 Edward L. Glaeser, *Killing (or Maiming) a Sacred Cow: Home Mortgage Deductions*, *N.Y. TIMES: ECONOMIX* (Feb. 24, 2009, 7:40 AM), <https://economix.blogs.nytimes.com/2009/02/24/killing-or-maiming-a-sacred-cow-home-mortgage-deductions/>.

300 STEVEN HOLT, THE BROOKINGS INST., *THE EARNED INCOME TAX CREDIT AT AGE 30: WHAT WE KNOW* 13–14 (2006). For a review of the literature, see Richard K. Caputo, *TANF and EITC: A Literature Review*, in *U.S. SOCIAL WELFARE REFORM* 81–103 (2011).

301 Sara Markowitz et al., *Effects of State-Level Earned Income Tax Credit Laws in the U.S. on Maternal Health Behaviors and Infant Health Outcomes*, 194 *SOC. SCI. & MED.* 67, 67, 68 (2017); HILLARY W. HOYNES ET AL., *CTR. FOR POVERTY RESEARCH, THE EITC: LINKING INCOME TO REAL HEALTH OUTCOMES*, https://poverty.ucdavis.edu/sites/main/files/file-attachments/policy_brief_hoyes_eitc_1.pdf (last visited Jan. 4, 2019); *Earned Income Tax Credits*, *CTR. FOR DISEASE CONTROL & PREVENTION*, <https://www.cdc.gov/policy/hst/hi5/taxcredits/index.html> (last updated June 22, 2017).

302 Timothy M. Smeeding et al., *The EITC: Expectation, Knowledge, Use and Economic and Social Mobility*, 53 *NAT’L TAX J.* 1187, 1193, 1202 (2000); see Timothy M. Smeeding, Katherin Ross Phillips & Michael A. O’Connor, *The Earned Income Tax Credit: Expectation, Knowledge, Use, and Economic and Social Mobility*, in *MAKING WORK PAY: THE EARNED INCOME TAX CREDIT AND ITS IMPACT ON AMERICA’S FAMILIES* 1193, 1202 (2001).

the benefit for something other than paying debts use the EITC refund as a down payment for a house.³⁰³ For others, given that missing a monthly rent or mortgage payment can initiate eviction or foreclosure proceedings, using the EITC for housing can be tricky. The ability to use the lump sum benefit toward housing depends upon the beneficiary's ability to save money throughout the year, or upon a landlord's agreement to take a lump sum to cover future months of rent.³⁰⁴ Indeed, a study looking directly to estimate the effect of state EITC expansion on housing stability and foreclosure/eviction for single mothers found no significant relationship.³⁰⁵ While the EITC might not have a direct estimated effect on housing stability, it is plausible to believe that by covering other expenditures it helps families pay rent.³⁰⁶

Because the EITC is a cash transfer mechanism that economists view as less distorting of the market than rent ceilings or minimum wages, and because of the growing need to help poor households pay for housing, some argue that the EITC could be reformed to take housing into account.³⁰⁷ One of these proposals is the Federal Assistance In Rent (FAIR) Tax Credit. The FAIR credit is, in essence, using the tax code to create a universal housing voucher program. One way this proposal could work is by providing each family that earns less than 80% of the area median income the remainder between 30% of the household annual income and the small-area FMR.³⁰⁸

4. *The Minimum Wage*

Inherent to the notion of housing affordability is how much people can pay. Parallel to the effort to reduce the cost burden of

303 See, e.g., Jennifer L. Romich & Thomas Weisner, *How Families View and Use the EITC: Advanced Payment Versus Lump Sum Delivery*, 53 NAT'L TAX J. 1245, 1259 (2000).

304 See *id.* at 1259–60.

305 Natasha Pilkauskas & Katherine Michemore, *The Effect of Income on Housing Instability and Living Arrangements: Evidence from the Earned Income Tax Credit 2*, 5, 24 (Poverty Sols. at the Univ. of Mich., Working Paper No. 1-17, 2018).

306 See MICHAEL A. STEGMAN ET AL., THE BROOKINGS INST. CTR. ON URBAN & METRO. POLICY, *THE EARNED INCOME TAX CREDIT AS AN INSTRUMENT OF HOUSING POLICY* 36 (2003).

307 See *id.*

308 TERNER CTR. FOR HOUS. INNOVATION, *THE FAIR TAX CREDIT: A PROPOSAL FOR A FEDERAL ASSISTANCE IN RENTAL CREDIT TO SUPPORT LOW-INCOME RENTERS* (2016), http://turnercenter.berkeley.edu/uploads/FAIR_Credit.pdf.

renters through decreasing the cost of housing should be an effort to increase disposable household income. One legal lever that was intended to achieve this goal is the minimum wage. However, the minimum wage sparked a heated debate within the discipline of economics about potential negative unintended consequences, mainly an unemployment effect.

The disconnect between the minimum wage and housing costs is striking. In no state does the minimum wage allow a full-time worker to pay less than 30% of annual income on a two-bedroom, at fair market rent.³⁰⁹ Some cities are enacting living wages that are higher than the state minimum wage, with labor activists demanding at least \$15 per hour, typically.³¹⁰

There is some epidemiology to suggest that a higher minimum wage is related to better health. Studies show that a higher minimum wage is associated with a reduced likelihood of unmet medical needs,³¹¹ reduced heart disease,³¹² reduced adolescent births,³¹³ reduced infant mortality,³¹⁴ and no effect on the rate of the uninsured.³¹⁵ We could not, however, find any peer-reviewed studies estimating the impact of an increase in the minimum wage on housing related outcomes—prices, rent, or affordability.³¹⁶

309 See NAT'L LOW INCOME HOUS. COAL., *OUT OF REACH: THE HIGH COST OF HOUSING* (2017), http://nlihc.org/sites/default/files/oor/OOR_2017.pdf.

310 Steven Greenhouse, *How the \$15 Minimum Wage Went from Laughable to Viable*, N.Y. TIMES (Apr. 1, 2016), <https://www.nytimes.com/2016/04/03/sunday-review/how-the-15-minimum-wage-went-from-laughable-to-viable.html>.

311 Kelly P. McCarrier et al., *Associations Between Minimum Wage Policy and Access to Health Care: Evidence from the Behavioral Risk Factor Surveillance System, 1996–2007*, 101 AM. J. PUB. HEALTH 359, 366 (2011).

312 Miriam E. Van Dyke et al., *State-Level Minimum Wage and Heart Disease Death Rates in the United States, 1980–2015: A Novel Application of Marginal Structural Modeling*, 112 PREV. MED. 97 (2018).

313 Lindsey Rose Bullinger, *The Effect of Minimum Wages on Adolescent Fertility: A Nationwide Analysis*, 107 AM. J. PUB. HEALTH 447, 449–50 (2017).

314 Kelli A. Komro et al., *The Effect of an Increased Minimum Wage on Infant Mortality and Birth Weight*, 106 AM. J. PUB. HEALTH 1514, 1514–15 (2016).

315 Kelly P. McCarrier et al., *Associations Between Minimum Wage Policy and Access to Health Care: A Multi-Level Analysis of the 2004 Behavioral Risk Factor Survey*, 21 J. HEALTH CARE FOR THE POOR & UNDERSERVED 729, 744 (2010).

316 An Economic Policy Institute report does make the connection between the minimum wage and housing. The author argues that increasing the minimum wage to \$12 per hour would lead to a \$17 billion annual savings for public assistance spending, “enough to double housing assistance benefits.” DAVID COOPER, ECON. POLICY INST., *BALANCING PAYCHECKS*

5. *Protecting Lower-Income People from Predatory Lending*

While redlining is talked about as an issue of the past, racial bias in lending and access to credit persists.³¹⁷ An analysis of 31 million mortgage records in 61 metro areas in 2015 and 2016 found that black applicants were more likely to be denied a loan in 48 of the cities, and Hispanics were more likely to be denied in 25 cities.³¹⁸ An analysis of mortgages from 2015 conducted by the Pew Research Center found that black and Hispanic borrowers pay higher mortgage rates than white borrowers.³¹⁹

When there is a pattern or practice of discrimination involving mortgage loans or home improvement loans, DOJ may file lawsuits under the Fair Housing Act and ECOA. In recent years, multiple banks entered settlements with DOJ to resolve allegations that they engaged in a pattern or practice of discrimination against African American and Hispanic borrowers in their mortgage lending. These settlements include amounts of \$335 million (Countrywide Financial Corporation),³²⁰ \$175 million (Wells Fargo),³²¹ and \$21 million (SunTrust Mortgage, Inc.), among others.³²²

In addition, the CFPB has enforcement authority related to ECOA violations. CFPB and DOJ have filed multiple joint actions alleging discriminatory mortgage lending practices, at least two of which have been settled in recent years.³²³ However, we are

AND PUBLIC ASSISTANCE 24 (2016), <https://www.epi.org/files/2015/balancing-paychecks-and-public-assistance.pdf>.

- 317 ROTHSTEIN, *supra* note 109, at 109–13; *see generally* Jacob S. Rugh & Douglas S. Massey, *Racial Segregation and the American Foreclosure Crisis*, 75 AM. SOC. REV. 629 (2010).
- 318 Aaron Glantz & Emmanuel Martinez, *Keep Out: For People of Color, Banks Are Shutting the Door to Homeownership*, REVEAL NEWS (Feb. 15, 2018), <https://www.revealnews.org/article/for-people-of-color-banks-are-shutting-the-door-to-homeownership/>.
- 319 Drew DeSilver, *Blacks and Hispanics Face Extra Challenges in Getting Home Loans*, PEW RES. CTR.: FACT TANK (Jan. 10, 2017), <http://www.pewresearch.org/fact-tank/2017/01/10/blacks-and-hispanics-face-extra-challenges-in-getting-home-loans/>.
- 320 Consent Order at 2, 5, U.S. v. Countrywide Fin. Corp., No. 2:11-CV-10540-PSG-AJW (C.D. Cal. Dec. 28, 2011).
- 321 Consent Order at 1, 13, U.S. v. Wells Fargo Bank, N.A., No. 1:12-CV-01150-JDB (D.D.C. Sept. 21, 2012).
- 322 Consent Order at 10, U.S. v. Suntrust Mortgage, Inc., No. 3:12-CV-397 (E.D. Va. May 31, 2012).
- 323 *See e.g.*, Consent Order, Consumer Fin. Prot. Bureau v. Hudson City Sav. Bank, F.S.B., No. 15-7056 (D.N.J. 2015); Consent Order, Consumer Fin.

left wondering if larger banks and lending institutions consider the payment of fines and monetary settlements for discriminatory behavior to be just another cost of doing business.

The lack of accessible credit for the poor brought rise to payday lending—small loans that are repaid in bulk. Twelve million people use payday loans every year, spending much more in interest than in credit.³²⁴ The large expenditure on interest often forces borrowers to forgo a large chunk of their paycheck to repay the loan and have to take another loan to meet other expenses³²⁵—for 1 in 10 borrowers, the first loan is for a housing related expense.³²⁶

Some argue that payday loans, while not ideal, are better than nothing. Without them, the poor would have no ability to borrow at all.³²⁷ House repairs, car repairs, and medical bills are all examples of unforeseen and often unbudgeted expenses. Most Americans do not have the savings to recover from these kinds of budgetary strains.³²⁸ It is for this type of consumption smoothing that loans exist. Internationally, there is ample evidence that small loans for low-income people help with this economic weathering and smooth shocks.³²⁹ Others argue that payday loans harm the poor, and it is the role of law to mitigate that damage.³³⁰ These types of laws that make payday loans less harmful cannot be viewed as out of scope when discussing the impacts of law on housing equity. A comprehensive systems view on housing affordability must take into consideration

Prot. Bureau v. Bancorp South Bank, No. 1:16cv118 (N.D. Miss. 2016).

324 PEW CHARITABLE TRUSTS, PAYDAY LENDING IN AMERICA: POLICY SOLUTIONS (2013), http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2013/pewpaydayoverviewandrecommendationspdf.pdf.

325 *Id.*

326 PEW CHARITABLE TRUSTS, PAYDAY LENDING IN AMERICA: WHO BORROWS, WHERE THEY BORROW, AND WHY 14 (2012), http://www.pewtrusts.org/~media/legacy/uploadedfiles/pcs_assets/2012/pewpaydaylendingreportpdf.pdf.

327 Lisa Servon, *Are Payday Loans Harmful To Consumers?*, 36 J. POL'Y ANALYSIS & MGMT. 240 (2016).

328 PEW CHARITABLE TRUSTS, HOW DO FAMILIES COPE WITH FINANCIAL SHOCKS? 2–3 (2015), http://www.pewtrusts.org/~media/assets/2015/10/emergency-savings-report-1_artfinal.pdf.

329 E.g., Paul Gertler et al., *Do Microfinance Programs Help Families Insure Consumption Against Illness?*, 18 HEALTH ECON. 257, 269 (2009); Asadul Islam & Pushkar Maitra, *Health Shocks and Consumption Smoothing in Rural Households: Does Microcredit Have a Role to Play?*, 97 J. DEV. ECON. 232 (2012).

330 E.g., Alex Horowitz, *Payday Loans Harm Consumers, but Reform is Possible*, 36 J. POL'Y ANALYSIS & MGMT. 248 (2016).

not only the impact of access to credit, but also the financial product that the credit allows access to.

E. Domain 5: Governance and Planning

The governance of housing markets is complex in itself, and the connection of housing as a basic need to other basic needs such as transportation, education, work, and recreation adds many more layers. Public housing is developed and managed by local public housing authorities, which often do not overlap geographically with other governing bodies. While there are 3,007 counties in the U.S.,³³¹ there are close to 3,400 public housing authorities.³³² Other actors, such as land banks and cooperatives, may work with housing authorities, developers, and planners. The AFFH rule was intended to incentivize regional collaboration by allowing multiple jurisdictions to submit an AFH together.³³³ However, it is unknown to what extent this collaboration will occur, or whether any such collaboration will succeed past the AFH submission to HUD.

Some of the legal levers identified in this article are examples of efforts to adopt a regional approach in the housing context. For example, by creating an obligation for municipalities to have a fair share of the region's affordable housing, the Mt. Laurel doctrine brought light to the idea that a regional planning approach could be used to reduce exclusionary zoning practices.³³⁴ In *Hills v. Gautreaux*, the U.S. Supreme Court upheld the Seventh Circuit's order that a comprehensive metropolitan area plan be adopted to desegregate the public housing system in Chicago.³³⁵ As a result of that case, the first major housing mobility program in the U.S. was launched in the Chicago metropolitan area.³³⁶ That program influenced other housing mobility efforts, including the Baltimore Housing Mobility

331 *How many counties are there in the United States?*, U.S. GEOLOGICAL SURV., <https://www.usgs.gov/faqs/how-many-counties-are-there-united-states>.

332 U.S. DEPT OF HOUS. & URBAN DEV., U.S. HOUSING MARKET CONDITIONS SUMMARY (1995), <https://www.huduser.gov/periodicals/ushmc/spring95/spring95.html>.

333 24 C.F.R. § 5.156.

334 *S. Burlington Cty. NAACP v. Mt. Laurel*, 336 A.2d 713 (N.J. 1975); *S. Burlington Cty. NAACP v. Mt. Laurel*, 456 A.2d 390 (N.J. 1983).

335 *Hills v. Gautreaux*, 425 U.S. 284 (1976).

336 *The Supreme Court and the Gautreaux Assisted Housing Program*, BUS. & PROF'L PEOPLE FOR THE PUB. INTEREST: BPI BLOG (May 15, 2015), <https://www.bpichicago.org/blog/the-supreme-court-and-the-gautreaux-assisted-housing-program/>.

Program, which arose from *Thompson v. HUD*,³³⁷ a case similar to *Gautreaux*.³³⁸ These types of mobility programs make it easier for someone to use a housing voucher in the larger metropolitan region, rather than only within the city limits, thus providing opportunity to live in better neighborhoods.

In the U.S., the challenge of integrating action on housing, economic development, transportation, education, population growth, and urban design across city, county, and school district lines is vested, if anywhere, in regional planning entities with varying degrees of legal authority. Most states have laws that enable regional activity.³³⁹ California law provides for the creation of regional planning districts, which prepare regional plans that seek to harmonize the general plans of cities and counties within the region. These districts are authorized to offer facilities and services to help solve problems related to physical development that involve two or more governing bodies, planning commissions, or agencies.³⁴⁰ In Pennsylvania, the governing bodies of two or more municipalities may establish regional planning commissions to provide planning services to any municipality in the region.³⁴¹

The federal government can play a role in helping to build regional collaborations and regional planning efforts.³⁴² In addition to the AFFH rule, HUD has used funds to incentivize collaboration. For example, in its Sustainable Communities Initiative, HUD awarded

337 *Thompson v. U.S. Dep't. of Hous. and Urban Dev.*, 348 F. Supp. 2d 398 (2005).

338 LORA ENGBAHL, *NEW HOMES, NEW NEIGHBORHOODS, NEW SCHOOLS: A PROGRESS REPORT ON THE BALTIMORE HOUSING MOBILITY PROGRAM 11* (2009), <http://www.prrac.org/pdf/BaltimoreMobilityReport.pdf>.

339 Ohm, *supra* note 134, at 41; David N. Bengston et al., *Public Policies for Managing Urban Growth and Protecting Open Space: Policy Instruments and Lessons Learned in the United States*, 69 *LANDSCAPE & URB. PLAN.* 271, 272–73 (2004). Of course, states have potentially many laws that are relevant to local planning, if not helpful. See, e.g., David L. Prytherch, *Where a Subdivision is not a "Subdivision": State Enabling Statutes and the Local Regulation (or not) of Land Division in the United States*, 37 *J. PLAN. EDUC. & RES.* 286 (2017) (mapping state laws on land division that may allow developments that would be differently governed under state law).

340 CAL. GOV'T CODE § 65065.1 (West 2018).

341 53 PA. STAT. ANN. §§ 2341, 2344(a), 2345(b) (2018).

342 Lavea Brachman, *New State and Federal Policy Agendas: Realizing the Potential of America's Legacy Cities and Their Regions*, in *REBUILDING AMERICA'S LEGACY CITIES: NEW DIRECTIONS FOR THE INDUSTRIAL HEARTLAND* 276–77 (Alan Mallach ed., 2012).

Regional Planning Grants and Community Challenge Planning Grants through a competitive process. These grants “supported regional and local planning efforts that helped communities integrate housing, transportation, infrastructure, and environmental goals”³⁴³

There is a long and diverse history of research on urban planning and development, which is beyond the scope of this article to describe. We were unable to locate studies focusing particularly on the efficacy of planning mechanisms on affordable housing as such.

V. Conclusion

Assuring safe and healthy housing to Americans has emerged as an urgent, but wicked problem. The nation has thrown a great deal of law at housing, discrimination, and poor neighborhoods for a generation, with unsatisfying results. We have proposed an approach to the problem rooted in legal epidemiology.³⁴⁴ We have argued that attaining this goal requires a systems approach, and have offered a heuristic model of legal levers that have the potential to promote this goal. Our goal, and our evocation of a systematic approach, can easily be dismissed as inconsistent with current political reality—but that objection misses the point. There is clearly a need to rebuild public faith in collective problem solving and government action—indeed, in the necessity and practicality of rational planning itself. This process is long-term.

A good place to start is with correctness about our prescriptions and deftness with our tools. This is where the overview of evidence in Part IV came in. We looked at a range of legal levers that are often in intense use, and found that the deftness was, in most cases, missing. Some levers, like the implied warranty of habitability, may never have been widely implemented. There are some working levers, like housing code enforcement to preserve affordable units,

343 *Regional Planning Grants and the SCI*, HUD EXCHANGE, <https://www.hudexchange.info/programs/sci/> (last visited May 30, 2018).

344 Legal epidemiology is the growing discipline that is defined “as the scientific study and deployment of law as a factor in the cause, distribution, and prevention of disease and injury in a population.” A methodology that is central to legal epidemiology is “policy surveillance, the ongoing, systematic collection, analysis, and dissemination of information about laws and other policies of importance to health.” Scott Burris et al., *A Transdisciplinary Approach to Public Health Law: The Emerging Practice of Legal Epidemiology*, 37 ANN. REV. PUB. HEALTH 135, 139 (2016).

which may not be working well, suffering from under-investment in enforcement and regulatory innovation. Others, such as housing vouchers, may be working well, but fail perennially to scale. Finally, there are levers, like LIHTC, that succeed splendidly on their own terms, but may not be properly designed or managed to promote other important system goals, highlighting that even more important than the questions about individual levers is the unexplored question of how the levers interact in the system, or could. Governing the many elements of the system so that housing is built in the right places and at the right prices to support healthy and economically vibrant communities is a challenge this country continues to struggle with. Few clearly successful models exist.

Policy debates under these circumstances can easily miss the point. The empirical objection to many of the devices is that they interfere with the market. This point is likely true, but if one allows it to be permissible as a mechanism for advancing social welfare—let alone if one believes that regulating markets is essential for social welfare—the important empirical questions have to do with harmonizing the benefits of market mechanisms with those of regulation. This inquiry, in turn, will tend to turn on questions both of optimal investment—are we spending enough to get the optimal benefits (a question, say, with LIHTC or vouchers)—or whether we are using the right mix of specific regulatory levers, the sort of question that arises with inclusionary zoning and housing code enforcement.

Lack of legal nuance is also a problem in assessing existing options. Many of the legal levers are complicated (housing codes, for example), and can vary from jurisdiction to jurisdiction. We do not know enough about what regulatory approaches or mechanisms work best for, say, inclusionary zoning. That question, rather than whether inclusionary zoning “works,” is the key question now. Likewise, it is stimulating, but not illuminating, to contend over whether housing code enforcement is pro- or anti-tenant. The important challenge is to more assiduously investigate what approaches to enforcement best serve landlords, tenants, and the public under various housing market conditions.

The set of questions raised by reviewing gaps in existing knowledge is a blue-print for strategic thinking and immediate action to develop and test better ways to use and combine legal levers. Two generic practices are, we think, clearly indicated by the current state of play. First, innovation, advocacy, implementation,

and evaluation should be planned together as much as possible.³⁴⁵ If a city or (ideally) a collaborative group of cities undertake to develop new approaches to the content and enforcement of their housing codes (for example), foundations or other funders with an interest in better enforcement (or even the cities themselves) can support the infrastructure and processes needed to develop a plausible approach, overcome opposition to its enactment, and properly implement it. Evaluation should start at implementation, so as to determine what works and what needs to be refined as quickly as possible. Results can feed back into advocacy for scaling up what works. None of this brings change overnight, but if the time to create, identify, and diffuse better legal models can be cut from two decades to one, the savings can be measured in human thriving and prevented harm. The need for this sort of strategic discipline is evident in housing, where large scale legal interventions have gone decades without the evaluation work that would show remediable weaknesses or clear failures. Law that does not work is more than useless; it creates harm by suggesting that problems have been solved. Strategy is only in part a function of thought; it depends to a considerable degree on resources and leadership from committed organizations and individuals. Those resources exist.

Second, research must do more to identify the effects of specific variant features in general legal models, while also building toward rigorous study of the interactions of policies and policy elements within a system. This matter is one of nuance and of the development of knowledge over time. On the one hand, no one is exposed to, say, an “inclusionary zoning policy.” Rather, in each jurisdiction, there is a form of the approach with more particular characteristics—mandatory versus voluntary, density-bonuses or not, etc.—that will influence the program’s outcomes. On the other hand, no one is exposed to just one housing policy at a time. Inclusionary zoning, LIHTC, and regional plans may all interact to produce results that differ across jurisdictions. Tools and methods for this kind of empirical legal research are available and becoming better with the advent of machine-assisted research.³⁴⁶

Wicked problems are not insoluble, any more than well-

345 Cf. Scott Burris et al., *Better Health Faster: The 5 Essential Public Health Law Services*, 131 PUB. HEALTH REP. 747 (2016) (describing essential elements of public health law intervention).

346 See Scott Burris et al., *Policy Surveillance: A Vital Public Health Practice Comes of Age*, 41 J. HEALTH POL., POL’Y & L. 1151 (2016).

funded and systematic efforts to weaken government and prevent collective problem solving are unstoppable. Carefully borrowing from Socrates, we can improve sustained, strategic efforts to promote health equity in housing by owning our own ignorance about the legal levers at hand. From that, we can also perhaps extract enough hope to abstain from drinking the hemlock.

Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*

*Nicolas P. Terry***

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*He went to work when he'd spent his last dime
And Sammy took to stealing
When he got that empty feeling
For a hundred dollar habit without overtime.
And the gold rolled through his veins
Like a thousand railroad trains,
And eased his mind in the hours that he chose,
While the kids ran around wearin' other peoples' clothe . . .
There's a hole in daddy's arm where all the money goes . . .*¹

I. Introduction

Why are more than two and a half million Americans suffering from substance use disorder (“SUD”)?² Why did more than half a million die from drug overdose from 1999–2015³ and an estimated 72,000 in 2017 alone?⁴ Why do so few (maybe only 20%) of those suffering from opioids use disorder (“OUD”) receive treatment?⁵ Why do so many re-entering from prisons relapse and continue their cycles of despair?⁶ Should we be tackling a behavioral health services problem, a substance use epidemic, an opioid epidemic or an opioid overdose epidemic, or all of the above?

Sometimes, explanations to hard problems are found hiding in plain sight. Recently, the academy lost Uwe Reinhardt, one of the finest health policy scholars of his generation.⁷ Reinhardt, an

1 JOHN PRINE, *Sam Stone*, on JOHN PRINE (Atlantic Records 1971).

2 SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, RESULTS FROM THE 2016 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES 1220, tbl.5.1A (2017), <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf>.

3 Puja Seth et al., *Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016*, 67 MORBIDITY & MORTALITY WKLY. REP. 349, 349 (2018).

4 Farida B. Ahmad et al., *Provisional Drug Overdose Death Counts*, NAT'L CTR. FOR HEALTH STATISTICS (Nov. 14, 2018), <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

5 See Olga Khazan, *Why 80 Percent of Addicts Can't Get Treatment*, THE ATLANTIC (Oct. 13, 2015), <https://www.theatlantic.com/health/archive/2015/10/why-80-percent-of-addicts-cant-get-treatment/410269/>.

6 Ingrid A. Binswanger et al., *Return to Drug Use and Overdose After Release from Prison: A Qualitative Study of Risk and Protective Factors*, ADDICTION SCI. & CLINICAL PRAC., Mar. 15, 2012, at 3, <https://ascjournal.biomedcentral.com/track/pdf/10.1186/1940-0640-7-3>.

7 Sam Roberts, *Uwe Reinhardt, 80, Dies; a Listened-to Voice on Health Care Policy*,

economist, wrote extensively about healthcare costs and in one article famously concluded, “It’s the prices, stupid!”⁸ As we examine the opioid crisis (and other diseases of despair), we should recognize that here, also, there are some causes or accelerants hiding in plain sight. Indeed, enough relate to healthcare access, financing, and delivery that we should conclude, “It’s the Healthcare, Stupid!”

In concentrating on the healthcare system, this article is not seeking to oversimplify what is manifestly a wicked problem with multiple, interlocking causes.⁹ Specifically, nothing written here should be misunderstood as minimizing the urgent need for evidence-based harm-reducing public health interventions or denying the fundamental role of social determinants of health upon which addictions attach like parasites. Neither is this concentration on healthcare simply a restatement of the evidence-based medicalization-not-criminalization approach to the opioid crisis. Rather, the article invites critical examination of our healthcare “system” seen through an addictions frame; the way in which it supplies context and the role it plays—or in many ways, fails to play—in crises generally and specifically in the case of the opioid epidemic.

The article paints a picture of a healthcare system that not only has been slow to deliver appropriate treatments but also stands as a structural determinant of this crisis. Structural determinants create barriers that stop or slow the remediation of social determinants while perpetuating others. This paper argues that the healthcare system has failed those struggling with OUD and co-morbidities and is itself a structural determinant that creates barriers to effective behavioral health services.

In some ways (such as poor preventative care and over-prescribing) the healthcare system justifiably can be viewed as a cause of the opioid epidemic. However, its true failing is the way it has amplified the crisis; seemingly unable or unwilling to identify appropriate points of intervention or deliver the necessary services. The root causes of the opioid epidemic must be treated with improved education, better surveillance, and generally addressing

N.Y. TIMES (Nov. 15, 2017), <https://www.nytimes.com/2017/11/15/obituaries/uwe-reinhardt-a-listened-to-voice-on-health-care-policy-dies-at-80.html>.

8 Gerard F. Anderson et al., *It’s the Prices, Stupid: Why the United States is So Different From Other Countries*, 22 HEALTH AFFAIRS 89, 103 (2003).

9 See generally Jonathan C. Lee, *The Opioid Crisis is a Wicked Problem*, 27 AM. J. ON ADDICTIONS 51, 51 (2017).

the social determinants of health. However, the U.S. healthcare system is responsible for many of the symptoms of the opioid crisis and several of the barriers to effective solutions.

The article proceeds as follows. Section II provides context for the current opioid crisis, identifying morphing drug sources to shifting at-risk populations. Section III discusses social and structural determinants of health, arguing that the healthcare system is one of the latter. Section IV is a deeper dive into some of healthcare's flaws relevant to this analysis, critically examining access and benefit stratification, the changing role of Medicaid, and problems associated with fragmentation of care and the lack of wraparound services. Section V provides a brief overview of the extreme healthcare-related structural determinants present in our jails and prisons.

II. Inconvenient Truths

The public health (harm reduction) and medical (treatment) frames for understanding disorders or addictions are widely held.¹⁰ However, many policymakers still cling to a “moral defect” framing.¹¹ Furthermore, although recognized by some as ineffective or worse,¹² many still believe in continuing or reviving the supply-side criminalization seen in the “war on drugs.” The opioid epidemic also pushes some powerful psychological buttons; some of its causes (drug over-prescription by physicians and misleading promotion

10 Scott Burris, *Where Next for Opioids and the Law? Despair, Harm Reduction, Lawsuits, and Regulatory Reform*, 133 PUB. HEALTH REP. 29, 29–33 (2017); Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. OF PUB. HEALTH 182 (2018).

11 Nicole L. Henderson & William W. Dressler, *Medical Disease or Moral Defect? Stigma Attribution and Cultural Models of Addiction Causality in a University Population*, 41 CULTURE, MED., & PSYCHIATRY 480, 492 (2017).

12 See, e.g., Mona Chalabi, *The ‘War on Drugs’ in Numbers: A Systematic Failure of Policy*, THE GUARDIAN (Apr. 19, 2016), <https://www.theguardian.com/world/2016/apr/19/war-on-drugs-statistics-systematic-policy-failure-united-nations>; CHRISTOPHER J. COYNE & ABIGAIL R. HALL, CATO INSTITUTE, *FOUR DECADES AND COUNTING: THE CONTINUED FAILURE OF THE WAR ON DRUGS* (2017), <https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf>; Altaf Rahamatulla, *The War on Drugs has failed. What’s next?*, FORD FOUND. (Mar. 23, 2017), <https://www.fordfoundation.org/ideas/equals-change-blog/posts/the-war-on-drugs-has-failed-what-s-next/>; George P. Shultz & Pedro Aspe, *The Failed War on Drugs*, N.Y. TIMES (Dec. 31, 2017), <https://www.nytimes.com/2017/12/31/opinion/failed-war-on-drugs.html>.

by pharmaceutical manufacturers) are identifiably blameworthy,¹³ sometimes leading to bad actors being shamed in front of Congressional committees.¹⁴ And, at root there are, according to the “moral defect” frame, junkies and their drug lords or kingpins, although this crisis’ kingpins are quite different from those seen before.¹⁵

As befits a “‘wicked’ problem,”¹⁶ reality is somewhat more complicated. An evolving view of the opioid use crisis is that there exists not just one crisis, but two. Shanoor Seervai and colleagues label the first as a “prescription-drug epidemic,” typically impacting older rural whites, but identify the second “emerging epidemic” as impacting non-medical users (increasingly urban communities of color) of heroin and fentanyl.¹⁷

The line drawn connecting these two epidemics is controversial. The so-called “vector model” assigns causality to drug users and suppliers—overprescribing leads to opioid abuse and overdoses caused by whichever opiate is easiest to acquire.¹⁸ Of course, the two crises (prescription and street drugs) are intertwined¹⁹ and it is not hard to conjure up a mental diagram illustrating how changes in supply and prices of (frequently diverted) prescription

13 Barry Meier, *3 Executives Spared Prison in OxyContin Case*, N.Y. TIMES (July 21, 2017), <https://www.nytimes.com/2007/07/21/business/21pharma.html>.

14 See Katie Zezima & Scott Higham, *Drug Executives to Testify Before Congress About Their Role in U.S. Opioid Crisis*, WASH. POST (Apr. 12, 2018), https://www.washingtonpost.com/national/drug-executives-to-testify-before-congress-about-their-role-in-us-opioid-crisis/2018/04/12/89e7ccf2-3db6-11e8-974f-aacd97698cef_story.html?

15 Esmé E. Deprez et al., *Deadly Chinese Fentanyl Is Creating a New Era of Drug Kingpins*, BLOOMBERG (May 22, 2018), <https://www.bloomberg.com/news/features/2018-05-22/deadly-chinese-fentanyl-is-creating-a-new-era-of-drug-kingpins>.

16 See generally Horst W. J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL’Y SCI. 155 (1973).

17 Shanoor Seervai et al., *The U.S. Has Two Opioid Epidemics: The Federal Response Should Consider Both*, THE COMMONWEALTH FUND: TO THE POINT (Mar. 22, 2018), <http://www.commonwealthfund.org/publications/blog/2018/mar/federal-response-to-opioids>.

18 See Dasgupta et al., *supra* note 10, at 183.

19 “And so it went. Oxycontin first, introduced by reps from Purdue Pharma over steak and dessert and in air-conditioned doctors’ offices. Within a few years, black tar heroin followed in tiny uninflated balloons held in the mouths of sugarcane farm boys from Xalisco driving old Nissan Sentras to meet-ups in McDonald’s parking lots.” SAM QUINONES, DREAMLAND: THE TRUE TALE OF AMERICA’S OPIATE EPIDEMIC 269 (2016).

drugs lead to increases in the demand for street drugs.

However, the vector model for comprehending and reacting to the opioid crises cannot stand.²⁰ More closely examined, these two increasingly diverging crises exhibit other and more complicated similarities and differences. White middle-class persons with OUD are more likely to have private insurance, unlike the rural and urban poor, who are more likely to rely on Medicaid. Persons of color are more likely to have been the subject of law enforcement and face additional problems associated with societal re-entry from corrections. Finally, and true to its internal (albeit flawed) logic, the vector model emphasizes supply-side interventions such as limitations on prescribing,²¹ opioid reimbursement reforms,²² and the expansion of Prescription Drug Monitoring Programs (“PDMs”).²³ Some of these reforms may impact the prescription drug epidemic.²⁴ However, they are likely to be of limited help regarding the second epidemic and, obviously, do nothing to address underlying social determinants of health.

A further inconvenience is that the nature of the problem we face is hard to define or, even when defined, is muddied by inconsistent labelling. According to The Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”) “[t]he essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”²⁵ Opioids are included in the list of substances. The core diagnostic criterion for OUD is “[a] problematic pattern of opioid use leading

20 See Dasgupta et al., *supra* note 10 (rejecting “prescribing as the causative vector” and arguing that economic and social upheaval are the primary causes).

21 Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, 65 MORBIDITY & MORTALITY WKLY. REP. 1 (2018), <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.

22 See Dasgupta et al., *supra* note 10; see also *2019 Medicare Advantage and Part D Advance Notice Part II and Draft Call Letter*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 1, 2018), <https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-advance-notice-part-ii-and-draft-call-letter>.

23 See generally Rebecca L. Haffajee et al., *Mandatory Use of Prescription Drug Monitoring Programs*, 313 JAMA 891 (2015).

24 See generally Kelly K. Dineen, *Addressing Prescription Opioid Abuse Concerns in Context: Synchronizing Policy Solutions to Multiple Complex Public Health Problems*, 40 LAW & PSYCHOL. REV. 1 (2016).

25 AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 483 (5th ed. 2013).

to clinically significant impairment or distress.”²⁶ Diagnosis of OUD and its severity depends upon the presence of certain criteria, for example “[r]ecurrent opioid use in situations in which it is physically hazardous” or “[c]ontinued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by substance.”²⁷

Notwithstanding the discrete diagnosis of OUD, government agencies such as the Substance Abuse and Mental Health Services Administration (“SAMHSA”) or the Centers for Medicare & Medicaid Services (“CMS”) tend not to break out OUD from SUD, tending to refer more to the latter, although clearly accepting there is an opioid epidemic.²⁸ When it comes to treatment, the broader phrase “behavioral health services” often is employed referring to both mental health and substance use disorder services.²⁹ The Affordable Care Act (“ACA”) uses the phrase “[m]ental health and substance use disorder services, including behavioral health treatment” to define one of its “essential health benefits.”³⁰ The linkage to mental health is not accidental. As noted in DSM-5, “[a]n important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.”³¹ Finally, some refer to the current epidemic as an opioid overdose crisis,³² a term that is both accurate and perhaps telling in that overdoses, particularly overdose deaths, have elevated this crisis in both public and political consciousnesses.³³

In this article SUD will be used when describing a broader addiction epidemic or when that language is used by agencies.

26 *Id.* at 541.

27 *Id.* In total DSM lists 11 such diagnostic/severity criteria.

28 See MEDICAID INNOVATION ACCELERATOR PROGRAM, *infra* note 211.

29 See, e.g., *Behavioral Health Services*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/benefits/bhs/index.html> (last visited Dec. 9, 2018); see also *Behavioral Health Treatments and Services*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN. (Sept. 20, 2017), <https://www.samhsa.gov/treatment>.

30 Patient Protection and Affordable Care Act, 42 U.S.C. § 18022(b)(1)(E) (2018).

31 AM. PSYCHIATRIC ASS’N, *supra* note 25, at 483.

32 See, e.g., *Opioid Overdose Crisis*, NAT’L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis> (last updated Mar. 2018).

33 See German Lopez, *The Opioid Epidemic: Explained*, VOX (Dec. 21, 2017), <https://www.vox.com/science-and-health/2017/8/3/16079772/opioid-epidemic-drug-overdoses>.

However, the article is concerned primarily with OUD, particularly at the severe end of the scale involving opioid intoxication, withdrawal, or overdose.³⁴

Those definitional issues lead into another inconvenient truth: that our current opioid epidemic is not unique. It is an addiction crisis but is neither the only one we have faced nor likely the last one we will face. Herzberg and colleagues have explained how, at root, the opioid epidemic is part of an addiction problem that stretches back over a century, with each crisis, (methamphetamine in the 1980s, crack cocaine in the early 1990s, and so on) tending to recycle “supply-side and criminal-justice approaches” rather than “an expanded public health response.”³⁵ Until we solve the broader addiction problem, we will be treating somewhat varying symptoms, not root causes.

These root causes *do* require public health responses such as improved education, better surveillance, and tackling social determinants of health. However, many of the adverse *symptoms* of the crisis (its co-morbidities if you like), and barriers to effective solutions, should be laid at the feet of the U.S. healthcare system. The opioid crisis does present as a “wicked problem,”³⁶ however “[e]very wicked problem can be considered to be a symptom of another problem.”³⁷ On a daily basis, many of our fellow citizens must confront problems with our healthcare system. Those with OUD must deal with an amplified problem: a healthcare system that is particularly poor at providing access to, or delivering appropriate and necessary, healthcare services.

III. Structural Determinants and Overlapping Frames

Multiple frames are used to explain the opioids crisis. For example, the linear (or vector) model begins with prescription opioids and their over-prescription causing the crisis, followed by some of the users transitioning over to illegal drugs as the supply

34 See AM. PSYCHIATRIC ASS'N, *supra* note 25, at 546–47; Ayman Fareed et al., *Illicit Opioid Intoxication: Diagnosis and Treatment*, SUBSTANCE ABUSE: RES. & TREATMENT, 2011, at 17.

35 David Herzberg et al., *Recurring Epidemics of Pharmaceutical Drug Abuse in America: Time for an All-Drug Strategy*, 106 AM. J. PUB. HEALTH 408, 409 (2016).

36 Jonathan C. Lee, *The Opioid Crisis is A Wicked Problem*, 27 AM. J. ON ADDICTIONS 51, 51 (2017).

37 Horst W.J. Rittel & Melvin M. Webber, *Dilemmas in a General Theory of Planning*, 4 POL'Y SCI. 155, 165 (1973).

of prescription drugs is slowed.³⁸ In fact, only 3.6% of prescription opioid users transition to heroin, but 79.5% of heroin users previously had used prescription opioids.³⁹ As already noted, concentrating on supply fails to factor in the reasons for demand and tends to over-focus interventions on the supply side.⁴⁰

Increasingly, the opioids crisis has been identified as a “disease of despair,”⁴¹ akin to the “deaths of despair” detailed by Anne Case and Angus Deaton: an increase in mortality and morbidity among non-Hispanic white Americans without college degrees caused in part by “an increasingly difficult labor market.”⁴² Case and Deaton themselves posit the view that “the prescription of opioids for chronic pain added fuel to the flames, making the epidemic much worse than it otherwise would have been.”⁴³ Dayna Matthew takes a similar approach arguing, “social determinants contribute to hopelessness and social trauma that ‘set the stage’ for opioid abuse and dependency.”⁴⁴

Social determinants of health, the “complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities,” are broadly and correctly identified as causative with regard to diseases of despair including the opioid crisis.⁴⁵ Paula Braveman and colleagues define “health

38 See generally Dasgupta et al., *supra* note 10.

39 Pradip K. Muhuri et al., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CBHSQ DATA REV., Aug. 2013, at 2–3.

40 Dasgupta et al., *supra* note 10, at 182–83.

41 Jeff Guo, *The Disease Killing White Americans Goes Way Deeper than Opioids*, WASH. POST (Mar. 24, 2017), https://www.washingtonpost.com/news/wonk/wp/2017/03/24/the-disease-killing-white-americans-goes-way-deeper-than-opioids/?noredirect=on&utm_term=.734ce9f859c2; Michael Meit et al., *Appalachian Diseases of Despair*, APPALACHIAN REGIONAL COMMISSION (Aug. 2017), https://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=139.

42 Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, 2017 BROOKINGS PAPERS ON ECON. ACTIVITY 397, 399 [hereinafter Case & Deaton, *Mortality and Morbidity*]; see also Anne Case & Angus Deaton, *Rising Morbidity and Mortality in Midlife Among White Non-Hispanic Americans in the 21st Century*, 112 PROC. NAT'L ACAD. SCI., Dec. 2015, at 15078 [hereinafter Case & Deaton, *Rising Morbidity*].

43 Case & Deaton, *Rising Morbidity*, at 15078.

44 DAYNA BOWEN MATTHEW, UN-BURYING THE LEAD: PUBLIC HEALTH TOOLS ARE THE KEY TO BEATING THE OPIOID EPIDEMIC 4 (2018), https://www.brookings.edu/wp-content/uploads/2018/01/es_20180123_un-burying-the-lead-final.pdf.

45 NCHHSTP *Social Determinants of Health*, CTRS. FOR DISEASE CONTROL

equity” as “the ethical and human rights principle that motivates us to eliminate health disparities, which are differences in health or its key determinants (such as education, safe housing, and freedom from discrimination) that adversely affect marginalized or excluded groups.”⁴⁶

Structural determinants include architectural, economic, or political frameworks that create barriers to remediating social determinants or perpetuate social determinants such as health inequities. This paper argues that the healthcare system has failed those struggling with OUD and co-morbidities and is itself a structural determinant that creates barriers to effective behavioral health services.

Flaws in the U.S. healthcare system are clearly not the only structural determinants at play in the opioid crisis. As Dayna Matthew notes, “[s]ocial determinants such as poor housing conditions are often accompanied by neighborhood-level conditions that limit access to health care, risk-reduction information, and treatment alternatives, which are protective resources and can disrupt behaviors that ultimately lead to opioid addiction.”⁴⁷ A far more specific example would be adverse policing practices in the vicinity of syringe exchanges.⁴⁸

Two well-known frameworks may help to pinpoint the areas where the healthcare system has failed the opioid epidemic. First, and at a macro level, the Institute for Healthcare Improvement’s *Triple Aim* identifies the key goals of our healthcare system: “Improving the patient experience of care (including quality and satisfaction); Improving the health of populations; and Reducing the per capita cost of health care.”⁴⁹

& PREVENTION, <https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html> (last updated Mar. 21, 2014); see e.g., Dasgupta et al., *supra* note 10, at 182–86.

46 Paula Braveman et al., *What Is Health Equity? And What Difference Does a Definition Make?*, ROBERT WOOD JOHNSON FOUND. 3 (May 2017), https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393 (emphasis omitted).

47 MATTHEW, *supra* note 44.

48 See generally Leo Beletsky et al., *Police Encounters Among Needle Exchange Clients in Baltimore: Drug Law Enforcement as a Structural Determinant of Health*, 105 AM. J. PUB. HEALTH 1872 (2015).

49 *The IHI Triple Aim*, INST. FOR HEALTHCARE IMPROVEMENT, <http://www.ihf.org/Engage/Initiatives/TripleAim/Pages/default.aspx> (last visited Dec. 8, 2018). See generally Donald M. Berwick et al., *The Triple Aim: Care, Health, and Cost*, 27 HEALTH AFF. 759 (2008).

Second, and at the micro opioid treatment level, SAMHSA⁵⁰ and the American Society of Addiction Medicine (“ASAM”) are clear that the standard of care is comprised of the three Food and Drug Administration-approved medication-assisted treatments (“MAT”).⁵¹ Additionally, ASAM recommends certain levels of treatment services for those suffering from OUD: level 1 (outpatient services), level 2 (intensive/partial hospitalization services), level 3 (residential/inpatient services), and level 4 (medically managed intensive inpatient services).⁵²

Failures and frequent barriers to effective interventions are as rampant as they are obvious. At the macro level, they involve familiar health policy tropes: limited access to care, high costs, and failures in healthcare delivery. More specifically, our healthcare system is not providing quality care to those with OUD, failing at the levels of access and the standard of care. Population health (preventative care and public health) continues to be put on a back burner compared to expensive clinical interventions, such as surgery, and our policymakers have completely missed the overwhelming cost-benefit argument for preventative care and wraparound services for those at OUD risk. At the micro level, MAT and appropriate levels of treatment are still unavailable for vast swaths of the population. Moreover, for some cohorts, such as rural populations and those in jails and prisons, the level of neglect is extraordinary.

The healthcare system deserves to be called out as a problem: primarily because of its role in causing the crisis and, more importantly, because for so many affected by opioids the healthcare system should have been a solution while in practice it has failed them and frequently amplified their problems.

Foremost, the healthcare system must take some responsibility for the opioids crisis. There is nothing new about opiate-based treatment for pain; it dates back to the 19th century.⁵³ However, in the

50 *Medication Assisted Treatment (MAT)*, SAMHSA, <https://www.samhsa.gov/medication-assisted-treatment> (last updated Feb. 7, 2018).

51 *Information About Medication-Assisted Treatment (MAT)*, U.S. FOOD & DRUG ADMIN., <https://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm600092.htm> (last updated Oct. 3, 2018).

52 *What are the ASAM Levels of Care?*, ASAM CONTINUUM (May 13, 2015), <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care>. These levels of care are expanded upon at *infra* text accompanying note 92.

53 *See generally* Marcia L. Meldrum, *A Capsule History of Pain Management*, 290 JAMA 2470 (2003).

1990s clinicians were persuaded by the “non-addictive” marketing of Oxycontin.⁵⁴ Meanwhile, the greater expenses associated with multidisciplinary approaches likely led to their disfavor among providers and insurers, even though such methods can be highly useful.⁵⁵ Simultaneously, healthcare organizations were responsible for designating pain as the “fifth vital sign”⁵⁶ and introducing pain management into reimbursement-impacting patient satisfaction scores.⁵⁷

Whatever the specific cause, there was a more liberal outlook with regards to opioid prescribing, particularly for nonmalignant pain.⁵⁸ That prescribing trajectory continued almost as though the 2007 guilty pleas of Purdue Pharma, and three senior executives, to accusations of misleading doctors never happened.⁵⁹ As already noted, the prescribing vector model for explaining the opioid crisis is both flawed as to causation and tends to lead to over-reliance on supply-side interventions.⁶⁰ Notwithstanding this flawed hypothesis, the healthcare system, together with those in the opioid prescription drug supply chain, continues to deserve our disapprobation for doing more to cause a problem than solve it.⁶¹

More fundamentally, the healthcare system has simply failed those who need it most. Persons with SUD face acute problems in accessing healthcare services. In 2016, 19.9 million adults needed substance use treatment but only 10.8% received specialty treatment; 26.9% of those who did not receive specialty treatment,

54 See QUINONES, *supra* note 19, at 124–27.

55 *Id.* at 86–87, 97–98; see also Marcia L. Meldrum, *The Ongoing Opioid Prescription Epidemic: Historical Context*, 106 AM. J. PUB. HEALTH 1365 (2016) [hereinafter Meldrum, *Historical Context*].

56 David W. Baker, *History of The Joint Commission’s Pain Standards: Lessons for Today’s Prescription Opioid Epidemic*, 317 JAMA 1117 (2017); see also Natalia E. Morone & Debra K. Weiner, *Pain as the 5th Vital Sign: Exposing the Vital Need for Pain Education*, 35 CLINICAL THERAPEUTICS 1728 (2013).

57 See generally Jay. S. Lee et al., *Postoperative Opioid Prescribing and the Pain Scores on Hospital Consumer Assessment of Healthcare Providers and Systems Survey*, 317 JAMA 2013 (2017).

58 See *id.*; see also Meldrum, *Historical Context*, *supra* note 55, at 1365–66.

59 Barry Meier, *In Guilty Plea, OxyContin Maker to Pay \$600 Million*, N.Y. TIMES (May 10, 2007), <https://www.nytimes.com/2007/05/10/business/11drug-web.html>.

60 See Rittel, *supra* note 37.

61 See, e.g., Michael E. Schatman & Lynn R. Webster, *The Health Insurance Industry: Perpetuating the Opioid Crisis Through Policies of Cost-Containment and Profitability*, 8 J. PAIN RES. 153, 155–56 (2015).

but perceived that they did need it, cited no healthcare coverage and not being able to afford the cost of treatment as reasons for non-treatment.⁶² The history is plain to see, with the healthcare system (from policymakers, to insurers, to healthcare institutions and clinicians) failing those requiring behavioral healthcare services. It was not until the 2008 passage of The Mental Health Parity and Addiction Equity Act (“MHPAEA”)⁶³ that health insurers had to treat behavioral health benefits on a par with medical or surgical benefits. The ACA⁶⁴ continued its work by, for example, including behavioral health as one of the statute’s essential health benefits (“EHBs”).⁶⁵ However, while there have been modest increases in behavioral health spending,⁶⁶ there have been numerous complaints about its impact and, in particular, its enforcement.⁶⁷

Some of healthcare’s failings are better understood as fundamental systems problems. Nabarun Dasgupta and colleagues catalog some of healthcare’s failures: a system ill-equipped to coordinate a combination of social and clinical ills, fragmentation (and sometimes cessation) of care, limited access to MAT, and an inability to provide wraparound services.⁶⁸ Other issues that may create barriers to treatment range from a lack of culturally competent

62 EUNICE PARK-LEE ET AL., SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., RECEIPT OF SERVICES FOR SUBSTANCE USE AND MENTAL HEALTH ISSUES AMONG ADULTS: RESULTS FROM THE 2016 NATIONAL SURVEY ON DRUG USE AND HEALTH (2017).

63 Emergency Economic Stabilization Act of 2008, Pub. L. 110-343, § 511, 122 Stat. 3765 (2008). See generally *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act> (last updated Jan. 24, 2017).

64 Patient Protection and Affordable Care Act, 42 U.S.C. § 180001 (2018).

65 *Id.* See generally Richard G. Frank et al., *Behavioral Health Parity and the Affordable Care Act*, 13 J. SOC. WORK DISABILITY & REHABILITATION 31 (2015).

66 Sarah Friedman et al., *The Mental Health Parity and Addiction Equity Act Evaluation Study: Impact on Specialty Behavioral Healthcare Utilization and Spending Among Enrollees with Substance Use Disorders*, 80 J. SUBSTANCE ABUSE TREATMENT 67 (2017).

67 Jenny Gold, *Advocates Say Mental Health ‘Parity’ Law is Not Fulfilling its Promise*, KAISER HEALTH NEWS (Aug. 3, 2015), <https://khn.org/news/advocates-say-mental-health-parity-law-is-not-fulfilling-its-promise/>.

68 See Dasgupta et al., *supra* note 10, at 184. Wraparound services are considered to be “non-clinical services that facilitate patient engagement and retention in treatment as well as their ongoing recovery.” U.S. DEP’T OF HEALTH & HUMAN SERVS., OFFICE OF THE SURGEON GEN., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 5–6 (2016).

health services, or professionals, when dealing with the poor, the addicted, or the mentally ill; to concerns about cost; the likelihood of experiencing stigma; or even apprehension about sub-optimal “care” that focuses on detox and potentially painful withdrawal.⁶⁹

IV. Healthcare Structural Determinants Versus Opioid Responses

Most systems, be they industrial, technological, or social services, are designed primarily to function for average use; to respond to the mean. As a result, systems will experience outlying events as stressors. Most will survive such an event, and some are even capable of temporary ramp-ups to handle the outliers. However, the U.S. healthcare ecosystem is uniquely fragile. In large part, because it is not a single “system,” it seems to have particular difficulties responding to stressors whether they be pandemics, syndemics, or natural disasters. For example, problems with healthcare delivery were quite apparent in the aftermath of Hurricane Katrina and during the Ebola outbreak.⁷⁰

Structural barriers to healthcare access and delivery are deeply seated and path dependent—even once-in-a-generation major legislative and funding efforts, such as the ACA,⁷¹ only make incremental changes to a system populated by persons and institutions who lack incentives to change. The U.S. healthcare system is not a particularly good one when measured against metrics such as access, cost, or outcomes.⁷² While it can excel at some tasks

69 Of course, this is something of an oversimplification. Barriers to treatment are multiple, quite complicated, and include a lack of help-seeking behavior. See, e.g., Philip W. Appel et al., *Barriers to Enrollment in Drug Abuse Treatment and Suggestions for Reducing Them: Opinions of Drug Injecting Street Outreach Clients and Other System Stakeholders*, 30 AM. J. DRUG & ALCOHOL ABUSE 129 (2004).

70 See, e.g., Josh Voorhees, *Everything That Went Wrong in Dallas: A Timeline of the Many Missteps Surrounding the First Cases of Ebola Diagnosed in the United States*, SLATE (Oct. 16 2014), http://www.slate.com/articles/health_and_science/medical_examiner/2014/10/dallas_ebola_timeline_the_many_medical_missteps_at_texas_health_presbyterian.html; Alyssa Rege, *How Hurricane Katrina Impacted Healthcare in New Orleans and What That May Mean for Houston*, BECKER'S HOSP. R. (Aug. 29, 2017), <https://www.beckershospitalreview.com/patient-flow/how-hurricane-katrina-impacted-healthcare-in-new-orleans-and-what-that-may-mean-for-houston-5-takeaways.html>.

71 Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2018).

72 See, e.g., Leah A. Burke & Andrew M. Ryan, *The Complex Relationship Between Cost and Quality in US Health Care*, 16 AM. MED. ASS'N J. ETHICS 124, 127 (2014); Cynthia Cox & Bradley Sawyer, *How Does Cost Affect Access to Care?*, KAISER FAMILY FOUND.: PETERSON-KAISER HEALTH SYSTEM TRACKER (Jan. 17, 2018), <https://www.healthsystemtracker.org/chart-collection/cost->

such as complex surgeries, its strength does not lie in diagnostics or treating chronic illnesses⁷³—areas of great need for those with OUD. The U.S. healthcare system's major operational deficiencies are well known. For example, the U.S. spends more on its healthcare than any other economically advanced country yet receives less both in terms of the percentage of the population receiving care and the quality of the care provided.⁷⁴ The list of symptoms and causative factors is long and includes: access problems (particularly for the poor and the near poor), high and increasing costs (including insurance costs, prescription drug costs, and cost-shifting), substandard care coordination, a frequently incoherent healthcare delivery model involving multiple types of entities and or reimbursement models, and severe deficiencies in data management and sharing.⁷⁵ These, among many others, are architectural, financing, or implementation flaws that have presented as barriers to effective responses to the opioid crisis.

This article concentrates on only a few of the myriad defects in our healthcare system; those that play out with particular force in the context of the opioid crisis. First, the difficulty of access to healthcare services is illustrated by examining the stratified manner in which persons are provided access to healthcare insurance: the gateway to healthcare in the U.S. Second, and closely related to the first, is the recent whiplash phenomenon associated with Medicaid, the insurance system arguably best positioned to provide preventative care and treatment for those susceptible to diseases of despair but which increasingly is beginning to act more like a problem than a solution. Third, behavioral and non-behavioral health disciplines have developed with differential architectures, both as to treatment models, locations, and data sharing—defects that highlight the healthcare system's fundamental inability to provide care coordination and wraparound services.

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73 See, e.g., *U.S. Spends More on Health Care Than Other High-Income Nations but has Lower Life Expectancy, Worse Health*, COMMONWEALTH FUND (Oct. 8, 2015), <http://www.commonwealthfund.org/publications/press-releases/2015/oct/us-spends-more-on-health-care-than-other-nations>.

74 See *id.*; Melissa Etehad & Kyle Kim, *The U.S. Spends More on Healthcare Than Any Other Country—But Not with Better Health Outcomes*, L.A. TIMES (July 28, 2017), <https://www.latimes.com/nation/la-na-healthcare-comparison-20170715-htmlstory.html>.

75 See Nicolas P. Terry, *Pit Crews with Computers: Can Health Information Technology Fix Fragmented Care?*, 14 HOUSTON J. HEALTH L. & POL'Y 132 (2014).

A. *The Standard of Care*

The ideal treatment of addiction is to “address the needs of the whole person,” selecting from a menu of services.⁷⁶ Although detoxification and recovery models, such as 12-step programs, are used in the OUD space, the standard of care for severe OUD is MAT,⁷⁷ the use of FDA-approved medications in combination with counseling, and behavioral therapies.⁷⁸ Although more treatment modes are promised,⁷⁹ currently there are three: those using methadone, buprenorphine, or naltrexone.

While all three modes are generally safe, and reduce the risk of overdose, they differ in their chemical effects and, as a result, the conditions imposed on their delivery.⁸⁰ As to the former, methadone is an agonist, buprenorphine a partial agonist, and naltrexone is an antagonist.⁸¹ These labels describe how closely their chemical effects resemble or mimic opioids; an agonist essentially tricks the brain into thinking there is an opioid present (by reducing cravings and delaying withdrawal), while an antagonist blocks an opioid from

76 *Drugs, Brains, and Behavior: The Science of Addiction*, NAT'L INST. ON DRUG ABUSE, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery> (last updated July 2018).

77 Nora D. Volkow et al., *Medication-Assisted Therapies — Tackling the Opioid-Overdose Epidemic*, 370 *NEW ENG. J. MED.* 2063 (2014); see also *Drugs, Brains, and Behavior: The Science of Addiction*, *supra* note 76 (“Research shows that when treating addictions to opioids (prescription pain relievers or drugs like heroin or fentanyl), medication should be the first line of treatment, usually combined with some form of behavioral therapy or counseling.”).

78 *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment> (last updated Feb. 7, 2018); see also *CDER Conversation: Treatment for Opioid Use Disorder*, U.S. FOOD & DRUG ADMIN. (July 28, 2018), <https://www.fda.gov/Drugs/NewsEvents/ucm611659.htm>. See generally Kate Sheridan, *How Effective is Medication-Assisted Treatment for Addiction? Here's the Science*, STATNEWS (May 15, 2017), <https://www.statnews.com/2017/05/15/medication-assisted-treatment-what-we-know/>.

79 Press release, U.S. FDA, FDA Takes New Steps to Encourage the Development of Novel Medicines for the Treatment of Opioid Use Disorder (Aug. 6, 2018), <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm615892.htm>.

80 Sheridan, *supra* note 78.

81 CATHIE E. ALDERKS, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., *TRENDS IN THE USE OF METHADONE, BUPRENORPHINE, AND EXTENDED-RELEASE NALTREXONE AT SUBSTANCE ABUSE TREATMENT FACILITIES: 2003–2015* 1 (Aug. 22, 2017), https://www.samhsa.gov/data/sites/default/files/report_3192/ShortReport-3192.pdf.

having any effect on the brain.⁸² While the agonists, methadone and buprenorphine, are chemically related to opioids, the antagonist naltrexone is not opioid-based⁸³ (and so unlikely to be the subject of diversion).

SAMHSA requires that methadone only be dispensed through an opioid treatment program (“OTP”) accredited by a “federally deemed accrediting body,”⁸⁴ while physicians who have obtained a Drug Enforcement Administration waiver, which requires buprenorphine-specific training, may prescribe buprenorphine,⁸⁵ and any licensed provider can prescribe naltrexone.⁸⁶ Patients should be evaluated to determine the most appropriate individual treatment, typically using the ASAM clinical guidelines.⁸⁷ Methadone is associated with robust long-term recovery but must be carefully calibrated and is prone to abuse or diversion,⁸⁸ while naltrexone should not be administered before full opioid withdrawal.⁸⁹ There is also some evidence that buprenorphine is superior to methadone for use by pregnant women, as fetal outcomes are slightly better.⁹⁰ Different clinical states of patients and their different contexts influence the choice of drug and emphasizes that the standard of

82 Sheridan, *supra* note 78; see also *Medication-Assisted Treatment: Naltrexone*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone> (last visited Dec. 18, 2018).

83 *Medication-Assisted Treatment (MAT)*, *supra* note 78.

84 For background on the accreditation process see *Opioid Treatment Program (OTP) Accreditation*, JOINT COMM’N (Nov. 14, 2018), https://www.jointcommission.org/facts_opioid_treatment_program_otp_accreditation/.

85 See generally *Medication-Assisted Treatment: Buprenorphine Waiver Management*, SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver> (last updated Jan. 18, 2018).

86 *Medication-Assisted Treatment: Naltrexone*, *supra* note 82.

87 Kyle Kampman & Margaret Jarvis, *American Society of Addiction Medicine National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*, 9(5) J. OF ADDICTION MED. 358 (2015).

88 *How effective are medications to treat opioid use disorder?*, NAT’L INST. DRUG ABUSE (June 2018), <https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder>. See generally Herbert D. Kleber, *Pharmacologic Treatments for Opioid Dependence: Detoxification and Maintenance Options*, 9 DIALOGUES CLINICAL NEUROSCIENCE 455 (2007).

89 *Medication-Assisted Treatment: Naltrexone*, *supra* note 82.

90 Barbara K. Zedler, et al., *Buprenorphine Compared with Methadone to Treat Pregnant Women with Opioid Use Disorder: A Systematic Review and Meta-Analysis of Safety in the Mother, Fetus and Child*, 111 ADDICTION 2115 (2016).

care requires the availability of all three forms of MAT.

Assessment of the recommended *levels* of care increasingly also is performed by reference to ASAM guidelines. In general, Level 1 refers to outpatient services; Level 2 intensive outpatient services; Level 3 residential inpatient services; and Level 4 intensive inpatient services.⁹¹ ASAM also recognizes additional point levels. These include Level 0.5 (early intervention), 2.5 (partial hospitalization service), and 3.5 (clinically-managed, high-intensity residential services for adults and medium-intensity for adolescents).⁹²

The standard of care notwithstanding, there are some very obvious examples of structural determinants (and not only in jails and prisons where the standard of care seldom is met). Across the nation, there are a limited number of OTPs certified by SAMHSA, with a few states having none,⁹³ while there are state variations in the number of providers who have applied for the buprenorphine waiver.⁹⁴

B. Stratification and Benefit Indeterminacy

If educational, physical, and economic environments are social determinants of health, then limited access, high costs, and insufficient (limited or poor quality) services are structural determinants. Those with OUD are disproportionately represented in the cohorts without access or faced with social, financial, demonstrative, geographical, or other barriers to health.⁹⁵ These barriers are caused or exacerbated not only by the barriers intrinsic to each stratum (e.g., eligibility, cost-sharing, etc.) but also by the very fact of stratification. The root causes of this stratification are decisions that were made during the Second World War that linked healthcare

91 E. Chuang et al., *Factors Associated with Use of ASAM Criteria and Service Provision in a National Sample of Outpatient Substance Abuse Treatment Units*, 3 J. ADDICTION MED. 139 (2009).

92 *What are the ASAM Levels of Care?*, CONTINUUM: ASAM CRITERIA DECISION ENGINE (May 13, 2015), <https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/>.

93 *Opioid Treatment Program Directory*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <https://dpt2.samhsa.gov/treatment/directory.aspx> (last visited Jan. 27, 2019).

94 *Number of DATA-Waived Practitioners Newly Certified Per Year*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment> (last visited Jan. 27, 2019).

95 Kenneth A. Feder et al., *Trends in Insurance Coverage and Treatment Among Persons with Opioid Use Disorders Following the Affordable Care Act*, 179 DRUG & ALCOHOL DEPENDENCE 271 (2017).

to health insurance and health insurance to employment.⁹⁶ Writing before the ACA, Atul Gawande noted the path-dependence that has resulted.⁹⁷ Today, employer-provided private coverage remains our gold standard, with the constructs, such as managed care, designed to keep it afloat occasionally migrating to public insurance. Worse, health insurance provided outside of that idealized private scenario is viewed as suspect and increasingly as exceptional rather than a foundation on which to embrace and build universality. And, most sadly, the association of health insurance with employment has led to some embracing the perverse mission of curtailing Medicaid for those not working.⁹⁸ While many with OUD work, a large minority of them do not have access to the gold standard of employer group coverage,⁹⁹ the Medicaid that so many rely on is under political attack,¹⁰⁰ and their very eligibility for public health insurance may be at risk because of emerging administrative and work requirements.¹⁰¹

1. *Differentially-Treated Cohorts*

Stratification tends to be based on income (or the lack thereof) expressed in terms of relative variance from the Federal Poverty Level (“FPL”).¹⁰² As these vary, beneficiaries on the edge of the qualification tiers may experience churn between types of insurance, exacerbating indeterminacy of insurance and so healthcare.¹⁰³ There may also be a political cost. Persons on the margins of what are, after all, arbitrary eligibility dividing lines between coverages with different benefits

96 See Dan Gorenstein, *How Did We End Up with Health Insurance Being Tied to Our Jobs?*, MARKETPLACE (June 28, 2017, 4:00 PM), <https://www.marketplace.org/2017/06/28/health-care/how-did-we-end-health-insurance-being-tied-our-jobs>.

97 Atul Gawande, *Getting There from Here*, NEW YORKER: ANNALS PUB. POL’Y, (Jan. 26, 2009), <https://www.newyorker.com/magazine/2009/01/26/getting-there-from-here>.

98 See *infra* text accompanying note 172.

99 *The NSDUH Report*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN. (Aug. 7, 2014), <https://www.samhsa.gov/data/sites/default/files/NSDUH-SP132-FullTime-2014/NSDUH-SP132-FullTime-2014.pdf>.

100 See discussion *infra* Section C.

101 Sara Rosenbaum, *Stewart v. Azar and the Future of Medicaid Work Requirements*, COMMONWEALTH FUND (July 3, 2018), <https://www.commonwealthfund.org/future-of-Medicaid-work-requirements>.

102 See generally *Federal Poverty Level*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/> (last visited Dec. 16, 2018).

103 See generally *Health Insurance Churn: The Basics*, COMMUNITY CATALYST (Nov. 2016), https://www.communitycatalyst.org/resources/publications/document/Health-Insurance-Churn-November-2016_FINAL.pdf.

or premiums, may feel animosity to cohorts “treated better” on the other side of a cut-off (e.g., someone at 200 FPL comparing their premiums with those in the Medicaid expansion cohort).¹⁰⁴

For decades, access to health insurance has been the key to access to healthcare in the U.S.¹⁰⁵ Those who cannot afford insurance are often denied access to healthcare.¹⁰⁶ Notwithstanding the reforms introduced by the ACA, 15.5% of those of working-age remain uninsured.¹⁰⁷ Those most at risk of being uninsured are those with low-income and people of color.¹⁰⁸ Although the majority of nonelderly adults with opioid addiction are employed,¹⁰⁹ they likely have low incomes and are therefore less likely than adults with higher incomes to have employer-provided health insurance. Approximately 10% are unemployed and 13% are disabled, and as a group they tend to suffer from comorbidities.¹¹⁰

When the Supreme Court in *NFIB v. Sebelius*¹¹¹ rendered Medicaid expansion voluntary for the states, it opened up another cleavage in access to healthcare, one based on the accident of state of residence. Over two million of the uninsured cohort lack health insurance because their states of residence (primarily in the south and, typically, correlating with poor social determinants) have decided to forego Medicaid expansion.¹¹²

104 See Louise Norris, *The ACA's Cost-Sharing Subsidies*, HEALTHINSURANCE.ORG (Dec. 11, 2018), <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/>.

105 See generally CHRISTY FORD CHAPIN, *ENSURING AMERICA'S HEALTH: THE PUBLIC CREATION OF THE CORPORATE HEALTH CARE SYSTEM* (2017).

106 See generally BEATRIX HOFFMAN, *HEALTH CARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930* (2012).

107 Sara R. Collins et al., *First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse*, COMMONWEALTH FUND: TO THE POINT (May 1, 2018), <https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse>.

108 JULIA FOUTZ ET AL., *The Uninsured: A Primer 1* (2017), <http://files.kff.org/attachment/Report-The-Uninsured-A-Primer-Key-Facts-about-Health-Insurance-and-the-Uninsured-Under-the-Affordable-Care-Act>.

109 *NSDUH Report*, *supra* note 99.

110 Julia Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KFF (Apr. 11, 2018), <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/>.

111 *NFIB v. Sebelius*, 567 U.S. 519, 585 (2012).

112 Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KFF (June 12, 2018), <https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not>

In the stratified world of health insurance (and so of access to healthcare), the first stratum to recognize is the uninsured. Being uninsured does not preclude *all* access to healthcare. However, safety-net care such as emergency department access courtesy of Emergency Medical Treatment & Labor Act (“EMTALA”)¹¹³ only provides emergency care, not the preventative or chronic care necessary to identify or treat addictions.¹¹⁴ As Julia Foutz and colleagues express the issue: “[h]ealth insurance makes a difference in whether and when people get necessary medical care, where they get their care, and ultimately, how healthy they are. Uninsured people are far more likely than those with insurance to postpone health care or forgo it altogether.”¹¹⁵

Insured versus uninsured status is not a simple binary. The uninsured cohort is relatively cohesive; there may be some wealthy persons who forego insurance, but the overwhelming majority of the uninsured cohort are poor, likely suffering from one or more diseases of despair, and highly unlikely to have access to OUD treatment within the standard of care.¹¹⁶

In contrast, the insured are highly stratified. The largest stratum (approximately 50% of those with health insurance)¹¹⁷ consists of those whose insurance is provided by their employer. In most cases their insurance will provide behavioral health coverage and therefore likely paths to treatment and recovery.¹¹⁸ However, as the President’s Commission recognized, “[t]here are commercial

expand-medicaid/; see also Fredric Blavin et al., *Medicaid Versus Marketplace Coverage For Near-Poor Adults: Effects On Out-Of-Pocket Spending And Coverage*, 37 HEALTH AFF. 299 (2018).

113 Social Security Act of 1935 § 1867, 42 U.S.C. § 1395 (2018).

114 See Sawyer, N. T., *Why the EMTALA Mandate for Emergency Care Does not Equal Healthcare “Coverage”*, 18 WESTERN J. EMERGENCY MED. 551, 551–52 (2017).

115 FOUTZ, *supra* note 108.

116 Feder, *supra* note 95. See also Li-Tzy Wu et al., *Treatment Utilization Among Persons with Opioid Use Disorder in the United States*, 169 DRUG & ALCOHOL DEPENDENCE 117 (2016); Praise O. Iyiewuare et al., *Demographic and Mental Health Characteristics of Individuals Who Present to Community Health Clinics with Substance Misuse*, 4 HEALTH SERV. RES. & MANAGERIAL EPIDEMIOLOGY 1 (2017).

117 HENRY J. KAISER FAMILY FOUNDATION, HEALTH INSURANCE COVERAGE OF THE TOTAL POPULATION (2017), <https://www.kff.org/other/state-indicator/total-population/?>.

118 Jessica M. Harwood et al., *The Mental Health Parity and Addiction Equity Act Evaluation Study*, 55 MED. CARE 164 (2017).

insurance barriers to MAT, such as dangerous fail-first protocols and onerous and frequent prior authorization requirements.”¹¹⁹ Additionally, this predominantly white, middle class group will find their treatment restricted in similar ways to the rest of their healthcare, with limits on types and days of care and massive cost shifting when using out-of-network care¹²⁰ (a real likelihood given the dearth of opioid treatment providers). Looking forward, the actuarial value of employer-provided coverage is in steep decline, creating a new stratum—the underinsured—who increasingly cannot afford to undertake their insured treatment or care because of high deductibles or other cost-shifting.¹²¹

Outside of employer-provided group coverage the insured generally fall into one of four health insurance cohorts: Medicare, Medicaid, Expanded Medicaid, or the Exchange Marketplaces.¹²² Of these, Medicare has the greatest access to OUD care with the fewest barriers. Medicare enrollees, the elderly and near-elderly, do not immediately seem to fit the OUD demographic. However, they make up about 25% of long-term opioid users¹²³ and are among the fastest growing population with diagnosed OUD.¹²⁴

119 GOVERNOR CHRIS CHRISTIE ET AL., *THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS* 70 (2017).

120 INST. OF MED. COMM. ON OPPORTUNITIES IN DRUG ABUSE RESEARCH, *PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH* (2018); see also *A Consumer’s Guide to the Mental Health Parity and Addiction Equity Act*, NAT’L DISABILITY NAVIGATOR, <http://www.nationaldisabilitynavigator.org/wp-content/uploads/resources-links/SAMHSA-Parity-guide.pdf>.

121 See Thomas Beaton, *Health Plan Cost Sharing, Deductibles Outpace Members’ Wage Growth*, HEALTHPAYERINTELLIGENCE (July 12, 2018), <https://healthpayerintelligence.com/news/health-plan-cost-sharing-deductibles-outpace-members-wage-growth>. See generally David Blumenthal, *The Decline of Employer-Sponsored Health Insurance*, THE COMMONWEALTH FUND: TO THE POINT (Dec. 5, 2017), <https://www.commonwealthfund.org/blog/2017/decline-employer-sponsored-health-insurance>.

122 This is an oversimplification because some persons will be insured by small group insurance, Short-Term, Limited-Duration Insurance, Association Health Plans, grandfathered Basic Health Plans in New York and Minnesota, and so on. However, for the purposes of this article these plans are statistically irrelevant.

123 See Ramin Mojtabai, *National Trends in Long-Term Use of Prescription Opioids*, 27 PHARMACOEPIDEMIOLOGY & DRUG SAFETY 526 (2017). See also Audrey J. Weiss et al., *Opioid-Related Inpatient Stays and Emergency Department Visits Among Patients Aged 65 Years and Older, 2010 and 2015*, HEALTHCARE COST AND UTILIZATION PROJECT (Sept. 2018), <https://www.ahrq.gov/news/newsroom/press-releases/seniors-struggles-with-opioids.html>.

124 CTRS. FOR MEDICARE & MEDICAID SERVS., *OPIOID MISUSE STRATEGY*

Medicare provides broad access to MAT, though there are some quirky omissions. In the words of one MAT provider, “[w]hile Medicare pays for the pain medications that are contributing to the OUD epidemic, it does not pay for the full range of treatment options necessary to treat beneficiaries’ addiction.”¹²⁵ Indeed, one of the greatest ironies is that Medicare covers methadone for the treatment of pain but not for the treatment of OUD. This is because Medicare Part D (covering prescription drugs) does not include methadone or buprenorphine when used for treatment of opioid dependence in an opioid treatment program (in large part this is because Part D only applies to retail pharmacy distribution).¹²⁶ MAT is less likely to be covered by traditional Medicare Part C but could be covered by Part C Medicare Advantage if they are part of a “bundled” service.¹²⁷

2. *Acute Stratification on the Exchanges*

After Employer-Group and Medicare insurance, stratification increases apace. Health Insurance Marketplace plans, those established by the ACA,¹²⁸ are sold from online marketplaces or exchanges. The exchanges may be established and managed either by states or, if they are unwilling, by the federal government.¹²⁹ The policies offered on the exchanges are standardized; that is, they all offer the same benefits. However, their premium costs differ.¹³⁰ The plans often are referred to collectively as the “metallics” because

2016, 1 (2017), <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf>.

125 *The Opioid Crisis: Removing Barriers to Prevent and Treat Opioid Abuse and Dependence in Medicare, Hearing Before the H. Comm. on Ways & Means*, 115th Cong. 6 (2018) (statement of Jason Kletter, President, BayMark Health Services), <https://waysandmeans.house.gov/wp-content/uploads/2018/02/20180206-HL-Testimony-Kletter.pdf> [hereinafter Kletter, *Opioid Crisis*].

126 *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 124, at 17.

127 Kletter, *Opioid Crisis*, *supra* note 125. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE COVERAGE OF SUBSTANCE ABUSE SERVICES (2016), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1604.pdf>.

128 Patient Protection and Affordable Care Act § 1311(b), 42 U.S.C. § 18001 (2018).

129 *See generally* Patient Protection and Affordable Care Act, 42 U.S.C. §§ 18031–41 (2018).

130 *The ‘Metal’ Categories: Bronze, Silver, Gold & Platinum*, HEALTHCARE.GOV, <https://www.healthcare.gov/choose-a-plan/plans-categories/> (last visited Dec. 23, 2018) [hereinafter *Metal Categories*].

of their gold, silver, bronze, etc., nomenclature.¹³¹ The plans (and so their premiums) differ according to their actuarial value: that “percentage of total average costs for covered benefits that a plan will cover.”¹³²

At first sight, the choice between the metalics would be based on the level of out-of-pocket risk a person wishes to assume and, assuming a somewhat competitive state marketplace,¹³³ the plan cost. However, that “simple” model becomes more complicated and stratified because of how the ACA made premiums affordable (via tax credits)¹³⁴ and reduced the impact of cost-sharing (via insurance-company provided, but (originally) federal government financed, subsidies) for lower income persons.¹³⁵ In general terms, persons are eligible for financial assistance if their income is between 100% and 400% of the FPL.¹³⁶ In Medicaid expansion states, such assistance would apply to those between <138% and 400% FPL with expanded Medicaid picking up the cohort between 100% and 138% FPL. The premium tax credits are calculated on the basis of a family’s modified adjusted gross income and size and apply to all of the metalics. Cost-sharing subsidies apply only to those enrolled in their state’s

131 *Metal Levels for Health Insurance Plans*, EHEALTH (Oct. 9, 2014), <https://www.ehealthinsurance.com/resources/affordable-care-act/metallic-health-plan-levels>; *Understanding the Healthcare Exchange Plan Offering*, FORBES (Sept. 24, 2013 8:37AM), <https://www.forbes.com/sites/thesba/2013/09/24/understanding-the-exchange-plan-offering/#7942c75f72bc>; see *Metal Categories*, *supra* note 130.

132 *Glossary Definition of Actuarial Value*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/actuarial-value/> (last visited Dec 23, 2018); see, e.g., *What’s the Difference Between Bronze, Silver and Gold Plans?*, BLUE CROSS BLUE SHIELD BLUE CARE NETWORK OF MICH., <https://www.bcbsm.com/index/health-insurance-help/faqs/topics/buying-insurance/metal-tiers.html> (last visited Dec. 23, 2018).

133 See generally Cynthia Cox et al., *Sizing Up Exchange Market Competition*, HENRY J. KAISER FAM. FOUND. (Mar. 17, 2014), <https://www.kff.org/health-reform/issue-brief/sizing-up-exchange-market-competition/>.

134 See generally *King v. Burwell*, 135 S. Ct. 2480 (2015) (holding that the ACA authorized tax credits for health insurance purchased either from state or federally established exchanges).

135 See generally BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., *HEALTH INSURANCE PREMIUM TAX CREDITS AND COST-SHARING SUBSIDIES* (2018), <https://fas.org/sgp/crs/misc/R44425.pdf>.

136 “Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.” *Glossary Definition of Federal Poverty Level (FPL)*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/> (last visited Dec. 23, 2018).

“silver” plan and apply only to those between 100% (or <138% in an expansion state) and 250% FPL.¹³⁷

Another wrinkle and potentially destabilizing occurrence was the 2017 decision by the Trump Administration to stop making the payments (known as Cost-Sharing Reduction Payments) to insurance companies that compensated them for providing the cost-sharing subsidies to their very low-income customers.¹³⁸ However, under the ACA, insurance companies were still responsible for subsidizing the silver plan cost-sharing by increasing the actuarial value of policies purchased by those eligible for cost-sharing subsidies.¹³⁹ Absorbing those costs would cause costs, and hence premiums, to rise. Insurers’ rather clever retort was to disproportionately increase the cost of silver plans.¹⁴⁰ This strategy keeps non-silver plans relatively affordable while essentially passing on to the federal government the increased cost of silver plans.¹⁴¹ Notwithstanding, this strategy may increase insurance costs for the cohort that has income <400% FPL and so lacks tax credits to offset the large premium increases.¹⁴²

Moreover, as the cost of exchange-based insurance for the unsubsidized cohort rises, they are going to be far less likely to purchase insurance, thereby reverting to uninsured status. Cost increases and concomitant declines in the number of insured likely will

137 See *Questions and Answers on the Premium Tax Credit*, IRS, <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit> (last updated Mar. 16, 2018); Louise Norris, *The ACA’s Cost-Sharing Subsidies*, HEALTHINSURANCE.ORG (Dec. 27, 2018), <https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies/>.

138 Much of the (somewhat arcane) history is to be found in the now settled litigation referred to as *U.S. House of Representatives v. Price*, No. 16 –5202, 2017 WL 3271445 (D.C. Cir. Aug. 1, 2017). See also Sarah Lueck, *Trump Move Would Boost Premiums, Raise Federal Costs, Destabilize Insurance Market*, CTR. ON BUDGET & POL’Y PRIORITIES (July 31, 2017, 4:30 PM), <https://www.cbpp.org/blog/trump-move-would-boost-premiums-raise-federal-costs-destabilize-insurance-market>.

139 Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2018).

140 Rabah Kamal et al., *How the Loss of Cost-Sharing Subsidy Payments is Affecting 2018 Premiums*, HENRY J. KAISER FAM. FOUND. (Oct. 27, 2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>.

141 See Margot Sanger-Katz, *Trump’s Attack on Insurer ‘Gravy Train’ Could Actually Help a Lot of Consumers*, N.Y. TIMES (Oct. 18, 2017), <https://www.nytimes.com/2017/10/18/upshot/trumps-attack-on-insurer-gravy-train-could-actually-help-a-lot-of-consumers.html?>

142 See *id.*

be accelerated in 2019 with the demise of the individual mandate,¹⁴³ and the likely further destabilization of the marketplace risk pools as the Trump Administration's favored Short-Term, Limited-Duration Insurance¹⁴⁴ and Association Health Plans ("AHPs") come online.¹⁴⁵

Stratification and persistent questions about affordability aside, marketplace plans do provide coverage for behavioral healthcare as an EHB.¹⁴⁶ Unfortunately, this is one point at which the conventional wisdom that health insurance equals access to healthcare breaks down. The problem is that insurance provides reimbursement, not care, and so is dependent on the insurer having adequate treatment relationships with behavioral healthcare providers. In 2017, Stephen Melek and colleagues published a major study examining relative access to behavioral healthcare, finding both major disparities in the use of out-of-network providers (and so higher-priced or non-reimbursed services) and in reimbursement rates for behavioral healthcare providers. Specifically, the researchers found that for the period from 2013–2015 "the proportion of inpatient facility services for behavioral healthcare that were provided out-of-network was 2.8 to 4.2 times higher than for medical/surgical services, and the proportion of outpatient facility services for behavioral healthcare that were provided out-of-network was 3.0 to 5.8 times higher than for medical/surgical services."¹⁴⁷

143 See Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 424 (2017) (codified at I.R.C. 48 § 5000A) (reducing penalty for not having insurance to \$0); see also Christine Eibner & Sarah Nowak, *The Effect of Eliminating the Individual Mandate Penalty and the Role of Behavioral Factors*, THE COMMONWEALTH FUND (July 11, 2018), <https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors>.

144 See generally Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, HENRY J. KAISER FAM. FOUND. (Apr. 23, 2018), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

145 See John Arensmeyer, *Association Health Plans Will Destabilize Small Group Market*, SMALL BUS. MAJORITY (June 19, 2018), <http://www.smallbusinessmajority.org/press-release/association-health-plans-will-destabilize-small-group-market>.

146 See *What Marketplace Health Insurance Plans Cover*, HEALTHCARE.GOV, <https://www.healthcare.gov/coverage/what-marketplace-plans-cover/> (last visited Feb. 6, 2019).

147 STEPHEN P. MELEK ET AL., MENTAL HEALTH TREATMENT & RESEARCH INST., ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: ANALYZING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT RATES 1 (2017), <http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf>.

Regarding reimbursement, “primary care providers were paid 20.7% to 22.0% higher rates for office visits than behavioral providers, and medical/surgical specialty care providers were paid 17.1% to 19.1% higher rates for office visits than behavioral providers.”¹⁴⁸ Research by Jane Zhu and colleagues that focused on exchange-marketplace plans found “structural barriers” to behavioral healthcare because approximately half of all plans featured behavioral health “narrow networks:” networks where fewer than 25% of providers are “in-network.”¹⁴⁹

The ACA’s EHB requirement may not be an absolute guarantee of affordable mental health services. Nevertheless, it does require *some* services and may deliver better than that in competitive marketplaces. Unfortunately, the Trump Administration has taken issue with EHBs, increasing state discretion in their benchmarking.¹⁵⁰ Further, the Administration’s Short-Term, Limited-Duration Insurance and AHPs online will feature deprecated EHBs.¹⁵¹ Thus, at a time when persons suffering from OUD desperately need coverage for behavioral health services, the Administration is actively promoting “skimpy” policies that frequently will not include coverage for mental health, substance use, or OUD-appropriate prescriptions drugs.

The stratification of health insurance may (for good reason) seem arcane, and its connection to OUD treatment somewhat remote. However, comprehending stratification helps us understand why there is no *one* solution to improving opioids treatment interventions. Rather, each stratum requires separately tailored improvements in the applicable insurance model because those in different strata face different barriers.¹⁵² For a start, there are those who remain uninsured. These include undocumented persons, those

148 *Id.* at 2.

149 Jane M. Zhu et al., *Networks in ACA Marketplaces are Narrower for Mental Health Care Than for Primary Care*, 36 HEALTH AFFAIRS 1624, 1626 (2017).

150 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (Apr. 17, 2018).

151 John Arensmeyer, *Association Health Plans Will Destabilize Small Group Market*, SMALL BUS. MAJORITY (June 19, 2018), <http://smallbusinessmajority.org/press-release/association-health-plans-will-destabilize-small-group-market>. See generally Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, KAISER FAM. FOUND. (Apr. 23, 2018), <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

152 See generally Kathleen Rowan et al., *Access and Cost Barriers to Mental Health Care, by Insurance Status, 1999-2010*, 32 HEALTH AFF. 1723 (2013).

who fall within the Medicaid expansion gap (100% FPL to 138% FPL) in non-expansion states, and those with income <400% FPL who, without tax credits, cannot afford a marketplace plan or could not use one absent cost-sharing subsidies. Then, and more fully described in the next section, are those who should benefit from Medicaid or expanded Medicaid but who either are unaware of the coverage, cannot meet the program's administrative requirements, or (increasingly) fall afoul of new eligibility hurdles such as paperwork or premium requirements.¹⁵³

Stratification based on income was intended to mitigate the impact of poverty on access to healthcare. In actuality, it perpetuates classism and health disparities by shuffling persons into different healthcare systems with different coverages, expectations, and realities. As stressors like the opioids epidemic vividly demonstrate, a stratified system is a poor alternative to a single payer, universal care model.

C. Medicaid's Devolution from Solution to Potential Problem

It is difficult to overestimate Medicaid's potential for alleviating the opioid crisis. Approximately 12% of the adult Medicaid population suffers from a SUD,¹⁵⁴ Medicaid covers nearly 40% of nonelderly adults with OUD,¹⁵⁵ and overall, the program funds more than 20% of all addiction treatment.¹⁵⁶ Additionally, Medicaid offers opportunities for innovation and states have considerable leeway to adopt the kinds of treatments and services urgently needed by those suffering from OUD.¹⁵⁷ States can open up such opportunities

153 See discussion *infra* Section C.1.

154 *Medicaid Works for People with Substance Use Disorders*, CTR. ON BUDGET & POLICY PRIORITIES (Jan. 19, 2018), <https://www.cbpp.org/research/health/medicaid-works-for-people-with-substance-use-disorders>.

155 *Nonelderly Adults with Opioid Addiction Covered by Medicaid Were Twice as Likely as Those with Private Insurance or the Uninsured to Have Received Treatment in 2016*, KAISER FAM. FOUND. (Apr. 12, 2018), <https://www.kff.org/medicaid/press-release/nonelderly-adults-with-opioid-addiction-covered-by-medicicaid-were-twice-as-likely-as-those-with-private-insurance-or-the-uninsured-to-have-received-treatment-in-2016/>.

156 Julia Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, KAISER FAM. FOUND. (Apr. 11, 2018), <http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicoids-Role-in-Facilitating-Access-to-Treatment>.

157 U.S. DEPT OF HEALTH & HUMAN SERVS., *FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 6-35 to 6-38* (2016), <https://addiction.surgeongeneral.gov/>

by applying to the Secretary for a Section 1115 Medicaid waiver to use federal funds for additional services.¹⁵⁸ Indeed, states that have not expanded Medicaid have generally seen their percentage of uninsured persons *increase*.¹⁵⁹

Persistent insurance coverage such as that provided by Medicaid expansion has proven very positive in improving the management of other chronic diseases.¹⁶⁰ As noted in the Surgeon General's report, "Medicaid expansion is a key lever for expanding access to substance use treatment because many of the most vulnerable individuals with substance use disorders have incomes below 138% of the federal poverty level."¹⁶¹ Indeed, after Kentucky expanded Medicaid, it experienced a 700% increase in the utilization of substance use services.¹⁶²

Medicaid was recognized as a key vehicle to increase the health of near-poor adults even before the expansion of behavioral health services by the MHPAEA and, subsequently, the ACA. From 2001, the Bush Administration's Health Insurance Flexibility and Accountability initiative encouraged states to request Section 1115 waivers in an attempt to provide coverage (albeit constrained by budget neutrality) to persons <200% FPL.¹⁶³

Originally, even before the ACA, Section 1115 demonstration projects often were used to *reduce* stratification.¹⁶⁴ The ACA itself

sites/default/files/surgeon-generals-report.pdf.

158 42 U.S.C. § 1315 (2018) (originally enacted by the Social Security Act of 1962, the waiver provision even predated Medicaid).

159 Jennifer Haley et al., *Adults' Uninsurance Rates Increased by 2018, Especially in States That Did Not Expand Medicaid*, HEALTH AFF. BLOG (Sept. 26, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180924.928969/full/>.

160 See, e.g., Rebecca Myerson et al., *Medicaid Eligibility Expansions May Address Gaps in Access to Diabetes Medications*, 37 HEALTH AFF. 1200 (2018).

161 U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 68, at 6–7.

162 *Substance Use and the ACA in Kentucky*, FOUND. FOR A HEALTHY KY. 7, 7 (2016), https://www.healthy-ky.org/res/images/resources/Full-Substance-Use-Brief-Final_12_16-002-.pdf.

163 See generally Hefei Wen et al., *Effect of Medicaid Expansions on Health Insurance Coverage and Access to Care among Low Income Adults with Behavioral Health Conditions*, 50 HEALTH SERVS. RES. 1787 (2015).

164 NAT'L CONFERENCE OF STATE LEGISLATURES, UNDERSTANDING MEDICAID SECTION 1115 WAIVERS: A PRIMER FOR STATE LEGISLATORS 4 (2017), http://www.ncsl.org/Portals/1/Documents/Health/Medicaid_Waivers_State_31797.pdf; THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, A LOOK AT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS UNDER THE ACA: A FOCUS ON CHILDLESS ADULTS 4 (2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/10/8499-a-look->

signaled considerable interest in that model by permitting more ambitious projects under an additional waiver process.¹⁶⁵ Overall, Section 1115 waivers could help in implementing state innovations in behavioral health such as suspending the Institutions for Mental Diseases exclusion,¹⁶⁶ reimbursing care coordination, or paying for services that address health-related social needs such as supportive housing, transportation, and food.¹⁶⁷

1. *Regressive Trends in Section 1115 Waivers*

During the Obama Administration, the waiver process continued much as before until Medicaid expansion stalled because states with conservative administrations declined to opt-in to expansion.¹⁶⁸ The Administration then took a detour from traditionally approved waivers and began approving requests that appealed to generally-held conservative views on health policy. In particular, the Administration allowed waivers that required enrollees to have some “skin in the game;”¹⁶⁹ for example, by paying small premiums, contributing to health savings accounts, or requiring healthy/wellness behaviors.

At least two objections can be levelled at these Obama-era waivers. First, there are serious doubts about the effectiveness

at-section-1115-medicaid-demonstration-waivers.pdf; see, e.g., *Background on Oregon’s 1115 Medicaid Demonstration Waiver*, OR. HEALTH AUTH., <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Background.aspx> (last visited Dec. 18, 2018).

165 See Patient Protection and Affordable Care Act § 1332, 42 U.S.C. § 18052 (2018).

166 Social Security Act § 1905(a)(B), 42 U.S.C. § 1396(d) (2018) (prohibiting Medicaid financing for behavioral care provided in residential treatment facilities with more than 16 beds); see discussion *infra* notes 215–18.

167 See NAT’L ASS’N OF MEDICAID DIR., MEDICAID SECTION 1115 WAIVER TRENDS IN AN ERA OF STATE FLEXIBILITY (2018), <http://medicaiddirectors.org/wp-content/uploads/2018/03/Section-1115-Waiver-Trends-NAMD-Whitepaper-1.pdf>.

168 See generally *Where the States Stand on Medicaid Expansion*, ADVISORY BD. (June 8, 2018), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap>; Sara Rosenbaum, *The Trump Administration Re-Imagines Section 1115 Medicaid Demonstrations – and Medicaid*, HEALTH AFF. BLOG, (Nov. 9, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171109.297738/full/>.

169 See Seema Verma & Brian Neale, *Health Indiana 2.0 is Challenging Medicaid Norms*, HEALTH AFF. BLOG (Aug. 29, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160829.056228/full/>.

of “skin-in-the-game” and wellness initiatives.¹⁷⁰ Second, some of the approved provisions were likely to *decrease* enrollment or service utilization. Because this was a likely result, the Obama Administration likely considered these to be worthy trade-offs in order to make headway in states reticent to expand Medicaid. Equally, conservative-led states could expand Medicaid with a modicum of political cover; what Abbe Gluck and Nicole Huberfeld call the “secret boyfriend model” of federalism.¹⁷¹

An example of a “skin-in-the-game” waiver is found in Indiana’s “Healthy Indiana Plan 2.0.”¹⁷² Under this waiver, Medicaid benefits were tiered; the higher tier included vision and dental coverage and did not impose a co-pay for most services.¹⁷³ To qualify for this higher tier, otherwise-eligible persons had to contribute to a health savings account. Failure to make contributions (or never signing up) had a differential impact depending whether the otherwise-eligible person was in the traditional Medicaid or expanded cohort. In broad terms, failure to contribute would move those at 100% FPL or below to the lower benefits tier, while those in the expanded >138% FPL cohort would not receive those additional benefits, or if they stopped paying would be locked out of benefits for a period of time.¹⁷⁴ Analysis of HIP 2.0 has shown that 55% of those eligible to pay premiums failed to do so, either dropping down to the lower benefits tier (< 101% FPL) or never being enrolled or losing coverage (>100% FPL).¹⁷⁵ “The top two reasons cited by people who never enrolled in or lost HIP 2.0 coverage were affordability

170 See generally JANE B. WISNER ET AL., THE URBAN INST., MEDICAID EXPANSION, THE PRIVATE OPTION, AND PERSONAL RESPONSIBILITY REQUIREMENTS (2015), <https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf>.

171 Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare for?*, 70 STAN. L. REV. 1689, 1767 (2018).

172 Letter from Marilyn Tavenner, Dep’t of Health & Human Serv., to Joseph Moser, Medicaid Dir. for Ind. Family and Soc. Serv. Admin. (Jan. 27, 2015), https://www.in.gov/fssa/hip/files/IN_HIP_2.0_CMS_Approval_Ltr_1_27_15.pdf.

173 ROBIN RUDOWITZ ET AL., KAISER FAM. FOUND., DIGGING INTO THE DATA: WHAT CAN WE LEARN FROM THE STATE EVALUATION OF HEALTHY INDIANA (HIP 2.0) PREMIUMS 3 (2018), <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums>.

174 *Id.* at 2.

175 *Id.* at 3.

and confusion about the payment process.”¹⁷⁶

Overall, the results from these Obama-era waiver approvals undoubtedly show net gains in the number of covered persons.¹⁷⁷ However, the picture seems cloudier with regard to the behavioral health cohort. The Indiana Medicaid population is approximately 1.3 million.¹⁷⁸ Approximately 100,000 (or 7%) suffer from SUD, although under-reporting makes it likely that the number is roughly twice that (or 14%).¹⁷⁹ It seems arguable that programs that lead with paperwork and not treatment will have a disproportionately negative impact on those needing behavioral health services. Either Medicaid eligibility paperwork will not be completed or the staff in emergency rooms or other treatment situations will find themselves pausing from their clinical responsibilities to help fill in forms.

Clearly, the Trump Administration is doubling down on the approach to Section 1115 waivers taken by the Obama Administration. First, it is approving draconian provisions, such as work requirements, that the prior administration rejected.¹⁸⁰ Second, while the Obama Administration used Section 1115 waivers as a carrot offered to states vacillating over expansion, the Trump Administration is using the waiver process to *reform* traditional Medicaid.¹⁸¹ There is, therefore, more going on here than simply

176 *Id.* at 4.

177 *See, e.g.*, Seth Freedman et al., *Learning from Waiver States: Coverage Effects Under Indiana’s HIP Medicaid Expansion*, 37 HEALTH AFF. 936, 939–40 (2018).

178 *See Medicaid in Indiana*, KAISER FAMILY FOUND. (Nov. 2018), <http://files.kff.org/attachment/fact-sheet-medicaid-state-IN> (providing the statistic that 20% of Indiana’s population is on Medicaid, which is approximately 1.3 million).

179 NICOLAS P. TERRY ET AL., LEGAL AND POLICY BEST PRACTICES IN RESPONSE TO THE SUBSTANCE ABUSE CRISIS 32 (2018), <https://grandchallenges.iu.edu/doc/iu-grand-challenges-legal-and-policy-best-practices.pdf>.

180 *See, e.g.*, Michael Ollove, *Should Medicaid Recipients Have to Work?*, PEW (Sept. 30, 2015), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/09/30/should-medicaid-recipients-have-to-work>; Mattie Quinn, *On Medicaid, States Won’t Take Fed’s No for an Answer*, GOVERNING (Oct. 11, 2016), <http://www.governing.com/topics/health-human-services/gov-medicaid-waivers-arizona-ohio-cms.html>; Sara Rosenbaum, *The Trump Administration Re-Imagines Section 1115 Medicaid Demonstrations – and Medicaid*, HEALTH AFF. BLOG (Nov. 9, 2017), <https://www.healthaffairs.org/do/10.1377/hblog20171109.297738/full/>.

181 MARYBETH MUSUMECI ET AL., SECTION 1115 MEDICAID DEMONSTRATION WAIVERS 3–5 (2018), <http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Demonstration-Waivers-The-Current-Landscape-of->

approving more conservative waivers or providing political cover for the most conservative states to expand Medicaid. Rather, it indicates a major shift in philosophy regarding Medicaid.

In 2017, this was laid bare in just the third paragraph of a letter to the country's governors from then-HHS Secretary Tom Price and CMS Administrator Seema Verma (hereinafter the "Price-Verma letter"). Whether conscious or not of their historical revisionism, they wrote, "[t]he expansion of Medicaid through the [ACA] to non-disabled, working-age adults without dependent children was a clear departure from the core, historical mission of the program."¹⁸² It was in this letter that the new Administration also announced its belief that "[t]he best way to improve the long-term health of low-income Americans is to empower them with skills and employment."¹⁸³ In January 2018, then-CMS Director Brian Neale provided more details in a letter to state Medicaid directors (hereinafter the "Neale letter").¹⁸⁴

Predictably, states with conservative leadership applied for new waivers or added work requirements to requests for renewal of existing waivers—that cohort exemplified by Indiana, Kentucky, and Ohio, states that have been hit particularly hard by the opioid epidemic.¹⁸⁵ Both the Price-Verma and the Neale letters reflected on

Approved-and-Pending-Waivers.

182 Letter from Thomas E. Price, Sec'y, U.S. Dep't of Health & Human Servs., and Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to U.S. State Governors 1 (March 14, 2017), <https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf> [hereinafter Price-Verma Letter].

183 *Id.*

184 Letter from Brian Neale, Medicaid Deputy Adm'r & Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. (Jan. 11, 2018), <https://www.medicare.gov/federal-policy-guidance/downloads/smd18002.pdf>; see also Marian Jarlenski et al., *Shaping Health Policy for Low-Income Populations: An Assessment of Public Comments in a New Medicaid Waiver Process*, 42 J. HEALTH POL., POL'Y, & L. 1039, 1047 (2017) (examining whether the comment letters used the rhetoric of "personal responsibility," "consumer choice," or "consumer-driven care" rather than "vulnerable populations").

185 *Indiana Opioid Summary*, NAT'L INST. ON DRUG ABUSE (Feb. 2018), <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/indiana-opioid-summary>; Billy Wynne & Taylor Cowey, *State Waivers as a National Policy Lever*, HEALTH AFF. BLOG (Feb. 6, 2018), <https://www.healthaffairs.org/do/10.1377/hblog20180202.543483/full/>; see, e.g., Kyle Fee, *The Opioid Epidemic and Its Effects*, FED. RES. BANK CLEVELAND (May 31, 2018), <https://www.clevelandfed.org/newsroom-and-events/publications/community-development-briefs/db-20180531-the-opioid-epidemic.aspx>; see *Where the States Stand on Medicaid Expansion*, ADVISORY BOARD (Nov. 5, 2018,

the opioid epidemic. While the former included language pledging CMS's cooperation with the states to provide a "full continuum of care,"¹⁸⁶ the Neale letter included a promise of carve-outs from the work requirements for those with SUD. These included required respect for civil rights protections and "counting time spent in medical treatment towards an individual's work/community engagement requirements."¹⁸⁷ However, whether compliance with the Americans with Disabilities Act ("ADA"),¹⁸⁸ and some requirement that states use some kind of "medical frailty" safe harbor,¹⁸⁹ will be sufficient protections for those with OUD remains an open question.

Again, to use Indiana's Medicaid as an example, the state's 2018 waiver extension includes additional potential barriers to Medicaid enrollment. For example, the extension approves a tobacco surcharge, a work requirement (beginning in 2019), and more process requirements.¹⁹⁰ Persons with OUD likely will have difficulty meeting the accompanying administrative requirements. Many may be transients whose qualifying paperwork fails to reach them,¹⁹¹ and others cycle in and out of relapse,¹⁹² making regular

12:51 PM), <https://www.advisory.com/daily-briefing/resources/primers/medicaidmap>.

186 Price-Verma Letter, *supra* note 182, at 3.

187 Letter from Brian Neale, *supra* note 184, at 6.

188 Title II of the ADA protects qualified individuals with disabilities from discrimination on the basis of disability from services, programs, or activities provided by state and local government entities. A person with OUD may be a "qualified individual with a disability." 28 C.F.R. § 35.130 (2018).

189 MARYBETH MUSUMECI ET AL., APPROVED CHANGES IN INDIANA'S SECTION 1115 MEDICAID WAIVER EXTENSION 5 (2018), <http://files.kff.org/attachment/Issue-Brief-Approved-Changes-in-Indianas-Section-1115-Medicaid-Waiver-Extension>.

190 Letter from Demetrios Kouzoukas, Principal Deputy Adm'r, Ctrs. for Medicare & Medicaid Servs., to Allison Taylor, Medicaid Dir., Indiana Family & Soc. Servs. Admin. (Feb. 1, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>. See generally MUSUMECI ET AL., *supra* note 189, at 1.

191 SUZANNE WIKLE, MEDICAID WORKS: NO WORK REQUIREMENT NECESSARY 6 (2018), <https://www.clasp.org/sites/default/files/Medicaid%20Works-No%20Work%20Requirement%20Necessary%20updated%20December%202018%20final.pdf>; see also Lydia Coutré, *Ohio Hospitals Battle Proposed Medicaid Work Requirements*, MODERN HEALTHCARE (Apr. 30, 2018), <https://www.modernhealthcare.com/article/20180430/NEWS/180439992>.

192 NIH NIDA actually defines drug abuse and addiction as a "relapsing brain disease." See *The Science of Drug Use and Addiction*, NAT'L INST. ON DRUG

employment problematic. The new program will be subject to the ADA, containing a SUD-exception from the work requirement, and a medical frailty care exception to lockout.¹⁹³ However, it is unclear how these will operate and precisely how substantiation burdens will fall on those with SUD. It is at least arguable that these additional requirements will increase the barriers to healthcare among the poor and near-poor in Indiana, and disproportionately impact persons with OUD.¹⁹⁴ While the proportion of those with SUD or OUD is not broken out, new figures from Arkansas, which has imposed an 80-hour-per-month work requirement, suggest that thousands of persons are at risk of being dropped from the state's Medicaid program.¹⁹⁵

If the worst-case scenario plays out with those needing behavioral health services excluded because of a politically-motivated work requirement, the irony will be cruel. Expanding Medicaid should be one of the most effective interventions in the OUD epidemic, extending healthcare to a particularly hard-hit demographic. However, the price for that intervention, a Medicaid expansion "tax," may create new barriers to eligibility for large numbers in the very cohort that needs help. These waivers or waiver extensions are adding increased premiums, work requirements, documentation burdens, and requirements that recipients log onto state computer systems to report employment details; failure to comply with even the minutest requirements leads to lockouts.¹⁹⁶

ABUSE (July 2018), <https://www.drugabuse.gov/publications/media-guide/science-drug-use-addiction-basics>.

193 MUSUMECI ET AL., *supra* note 189, at 4, 8.

194 HANNAH KATCH ET AL., TAKING MEDICAID COVERAGE AWAY FROM PEOPLE NOT MEETING WORK REQUIREMENTS WILL REDUCE LOW-INCOME FAMILIES' ACCESS TO CARE AND WORSEN HEALTH OUTCOMES (2018), <https://www.cbpp.org/sites/default/files/atoms/files/2-8-18health2.pdf>.

195 Erin Brantley & Leighton Ku, *Arkansas's Early Experience with Work Requirements Signals Larger Losses to Come*, THE COMMONWEALTH FUND: TO THE POINT (Oct. 31, 2018), <https://www.commonwealthfund.org/blog/2018/arkansas-early-experience-work-requirements>; Jessie Hellmann, *Arkansas Medicaid Work Requirements Could Cost Thousands Coverage, Data Show*, THE HILL (Aug. 15, 2018), <https://thehill.com/policy/healthcare/401975-new-data-shows-arkansas-medicaid-work-requirements-could-cost-thousands>; *see also* Jessica Greene, *Medicaid Recipients' Early Experience with the Arkansas Medicaid Work Requirement*, HEALTH AFF. BLOG (Sept. 5, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.

196 *See generally* MUSUMECI ET AL., *supra* note 189.

There is particular potential for additional “churn” as those with OUD drop in and out of these programs with complex administrative or work requirements.¹⁹⁷ It is at least arguable that those types of conditions for eligibility would disproportionately harm those with OUD. Many with OUD will likely be unable to handle the administrative burdens and simply walk away.

Re-architecting the Medicaid program around employment is flawed on a number of fronts. First, the policy shift likely is not worth the administrative costs; only a very small number of Medicaid eligible persons who could work choose not to.¹⁹⁸ Sixty percent work and most of those who don’t are disabled, caregivers, or in school.¹⁹⁹ Only seven percent would qualify as not-working and there are many reasons, including lack of jobs in a particular locale, which could explain some of that number.²⁰⁰ Second, the CMS explanation for a work requirement is based on some twisted logic. While it is true that those who are employed generally have better health, it is false to conclude that making people work will increase their health. As Douglas Jacobs observes, “it could just as easily be that poor health causes unemployment” while research suggests “that having Medicaid made it easier to look for a job.”²⁰¹

At present, the impact of imposing work requirements is uncertain. Some programs do not begin until 2019 and the legality of the waivers is under attack. For example, in *Stewart v. Azar*, Medicaid enrollees challenged the section 1115 waiver CMS granted to Kentucky HEALTH which included a work requirement, premiums, additional cost-sharing, and a coverage lockout for failure

197 RACHEL GARFIELD ET AL., IMPLICATIONS OF WORK REQUIREMENTS IN MEDICAID 5 (2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>; see also Letter from Demetrios Kouzoukas, *supra* note 190. See generally MUSUMECI ET AL., *supra* note 189.

198 MARYBETH MUSUMECI ET AL., MEDICAID AND WORK REQUIREMENTS (2018), <http://files.kff.org/attachment/Issue-Brief-Medicaid-and-Work-Requirements-New-Guidance-State-Waiver-Details-and-Key-Issues>.

199 *Id.*

200 *Id.*

201 Douglas Jacobs, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health*, HEALTH AFF. BLOG (Aug. 6, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180730.371424/full/>; see also LARISA ANTONISSE & RACHEL GARFIELD, THE RELATIONSHIP BETWEEN WORK AND HEALTH (2018), <http://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review>.

to promptly renew.²⁰² Kentucky itself admitted that almost 100,000 Kentuckians would lose coverage.²⁰³ In June 2018, the federal district court decided that the Secretary's waiver decision was arbitrary and capricious because he failed to consider the impact of the waiver policies on insuring people (Medicaid's primary purpose) given the estimate of how many would lose coverage.²⁰⁴ Undoubtedly, neither the litigation nor the question of obstructive Medicaid restrictions are over, and reports suggest that CMS is not inclined to change its new embrace of work requirements.²⁰⁵ On a brighter note, there are indications that an increasing number of non-expansion states are now leaning toward expansion²⁰⁶ and, as a result, a net increase in the number of insureds. However, it is unclear how many of these recent converts to expansion will have to adopt draconian conditions to cement the transition.²⁰⁷ Nor, as already discussed, is it clear whether those "skin-in-the-game" policies and work requirements will disproportionately impact those needing behavioral health services.

2. *Medicaid Reimbursement for Behavioral Health Services*

For those needing behavioral health services the stakes are high. Those covered by Medicaid are twice as likely as those who are uninsured or have private insurance to receive treatment for OUD and almost three times more likely to have received outpatient treatment.²⁰⁸ Overall, Medicaid provides access to more

202 *Stewart v. Azar*, 313 F. Supp. 3d 237, 248 (D.D.C. 2018).

203 *Id.* at 263.

204 *Id.* at 259–62; see MARYBETH MUSUMECI, *EXPLAINING Stewart v. Azar* (2018), <http://files.kff.org/attachment/Issue-Brief-Explaining-Stewart-v-Azar-Implications-of-the-Courts-Decision-on-Kentuckys-Medicaid-Waiver>.

205 See Dan Diamond & Rachana Pradhan, *CMS Plots Path Forward for Kentucky Work Requirements After Court Setback*, POLITICO (July 18, 2018), <https://www.politico.com/story/2018/07/18/kentucky-medicaid-work-requirements-cms-court-setback-694575>.

206 Donald Moulds et al., *A New Group of States Looks to Expand Medicaid*, THE COMMONWEALTH FUND: TO THE POINT (Aug. 27, 2018), <https://www.commonwealthfund.org/blog/2018/states-look-expand-medicaid>.

207 See generally *id.*

208 Julia Zur & Jennifer Tolbert, *The Opioid Epidemic and Medicaid's Role in Facilitating Access to Treatment*, THE HENRY J. KAISER FAM. FOUND. (Apr. 11, 2018), <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaid-role-in-facilitating-access-to-treatment/>.

comprehensive behavioral health services than marketplace plans.²⁰⁹ However, while states generally are obliged to provide such services writ large, not all states provide robust services.²¹⁰ Three variables are at work here: first, the extent to which a state provides different modes of treatment; second, the levels of care that are available; and third, the extent to which an individual state has taken advantage of additional coverages (for example, Health Homes) or requested waivers under Section 1115 to address issues that go beyond mainstream clinical care (for example, wraparound services).

While Medicaid (courtesy of the MHPAEA and ACA) requires states to include reimbursement for substance use treatment, it did not require all three forms of MAT until the 2018 opioid legislation.²¹¹ While a majority of states do require such reimbursements, many still do not, the omission frequently being methadone-based treatment, which is absent from numerous state plans.²¹²

Medicaid has approved the ASAM guidelines providing the appropriate levels of care.²¹³ However, yet again, there are considerable state-by-state disparities in the availability of these levels of care under Medicaid. Particular deficiencies are identified in levels 3 (residential inpatient services) and 4 (intensive inpatient

209 *Medicaid Works for People with Substance Use Disorders*, CTR. ON BUDGET & POL'Y PRIORITIES (Jan. 19, 2018), <https://www.cbpp.org/research/health/medicaid-works-for-people-with-substance-use-disorders>.

210 *See id.*

211 *See* MEDICAID INNOVATION ACCELERATOR PROGRAM, OVERVIEW OF SUBSTANCE USE DISORDER (SUD) CARE CLINICAL GUIDELINES: A RESOURCE FOR STATES DEVELOPING SUD DELIVERY SYSTEM REFORMS 1 (2017), <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/asam-resource-guide.pdf>; *see also Insurance and Payments*, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., <https://www.samhsa.gov/medication-assisted-treatment/treatment/insurance-payments> (last updated Sept. 28, 2015); SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 2001 (2018).

212 Colleen M. Grogan et al., *Survey Highlights Differences in Medicaid Coverage for Substance Use Treatment and Opioid Use Disorder Medications*, 25 HEALTH AFF. 2289, 2292 (2016); *States Reporting Medicaid Coverage of Medication Assisted Treatment (MAT) Drugs*, THE HENRY J. KAISER FAM. FOUND., <https://www.kff.org/medicaid/state-indicator/states-reporting-medicoid-coverage-of-medication-assisted-treatment-mat-drugs/> (last visited Dec. 14, 2018).

213 *See* Letter from Vikki Wachino, Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. 7 (July 27, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>; *see also* MEDICAID INNOVATION ACCELERATOR PROGRAM, *supra* note 211, at 2–3.

services), along with other state-by-state variations such as pre-authorization requirements and coverage limitations.²¹⁴

The relative lack of level 3 residential inpatient care is to a large extent because of what is known as the Institutions for Mental Disease (“IMD”) exclusion that applies to reimbursement for adults aged 21–64.²¹⁵ As should be obvious from its name, the IMD exclusion is a relic from the past, prior to the integration of behavioral health services with general medical care. IMDs are hospitals or treatment facilities that have more than 16 beds and that primarily provide mental health or substance use care.²¹⁶ Increasingly, CMS seems willing to approve Section 1115 waivers to the IMD prohibition and allow Medicaid reimbursement²¹⁷ while recent federal opioid legislation brought about the exclusion’s suspension but not its ultimate demise.²¹⁸

Section 1115 waivers are the one part of the third aspect of Medicaid treatment; the potential to reimburse for and so unlock expanded behavioral health services. The other key route for states is to adopt “state plan amendments.” One of these, included in the ACA,²¹⁹ is the Medicaid “health home” that provides time-limited federal funding for creating “homes” for beneficiaries that provide case management, care coordination, and other services that would be of particular utility when dealing with those requiring behavioral health services. Approximately 15 states have adopted some form of this model.²²⁰

In contrast, Section 1115 waiver applications are being adopted broadly to increase reimbursable behavioral health

214 Grogan et al., *supra* note 212, at 2292.

215 42 U.S.C. § 1396d(a)(29)(B) (2018).

216 See generally MaryBeth Musumeci, *Key Questions about Medicaid Payment for Services in “Institutions for Mental Disease,”* THE HENRY J. KAISER FAM. FOUND. (June 18, 2018), <https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/>.

217 See Letter from Brian Neale, Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. 2 (Nov. 1, 2017), <https://www.thenationalcouncil.org/wp-content/uploads/2017/11/smd-17-003.pdf>.

218 SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, §§ 1012-13, 5052, 132 Stat. 3894, 69-70 (2018).

219 See 42 U.S.C. § 256a-1 *et seq.* (2018).

220 KATHY MOSES & BRIANNA ENSSLIN, CTR. FOR HEALTH CARE STRATEGIES, SEIZING THE OPPORTUNITY: EARLY MEDICAID HEALTH HOME LESSONS 1 (2014).

services.²²¹ This route has been encouraged by both the Obama²²² and Trump Administrations.²²³ In addition to IMD waivers (the most popular), a large number of states have applied for waivers to expand community-based services (such as supportive housing or peer coaching), increase the eligible cohort, or finance delivery system reforms (such as integrating services).²²⁴ However, these demonstration projects must be budget neutral,²²⁵ which likely creates difficult decisions for states as they increase their behavioral health services (for example, calibrating the appropriate balance of spending on institutional versus community-based care).

As Jonathan Oberlander has commented, “[t]he ACA is stuck in purgatory, beyond comprehensive repeal but subject to a war of attrition that jeopardizes its gains.”²²⁶ Medicaid expansion, a major component in improving behavioral health services, continues to be under threat, potentially leading to the loss of some or all insurance for hundreds of thousands of persons with behavioral health issues.²²⁷ The worst case scenario is that even traditional Medicaid may be cut back if reformers succeed in moving “welfare” programs to a block grant model.²²⁸

221 MaryBeth Musumeci et al., *Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers*, THE HENRY J. KAISER FAM. FOUND. (Sept. 20, 2018), <https://www.kff.org/medicaid/issue-brief/key-questions-about-medicaid-payment-for-services-in-institutions-for-mental-disease/>.

222 See Letter from Vikki Wachino to State Medicaid Dirs., *supra* note 213, at 4 (replaced by Nov. 1, 2017 letter below).

223 See Letter from Brian Neale to State Medicaid Dirs., *supra* note 217, at 1.

224 MARYBETH MUSUMECI, THE HENRY J. KAISER FAMILY FOUND., KEY THEMES IN MEDICAID SECTION 1115 BEHAVIORAL HEALTH WAIVERS 2 (2017).

225 Letter from Timothy B. Hill, Acting Dir., Ctrs. for Medicare & Medicaid Servs., to State Medicaid Dirs. 1–2 (Aug. 22, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf>.

226 Jonathan Oberlander, *The Republican War on Obamacare — What Has It Achieved?*, 379 NEW ENG. J. MED. 703, 705 (2018).

227 Peggy Bailey, *ACA Repeal Would Jeopardize Treatment for Millions with Substance Use Disorders, Including Opioid Addiction*, CTR. ON BUDGET & POL’Y PRIORITIES (Feb. 9, 2017), <https://www.cbpp.org/research/health/aca-repeal-would-jeopardize-treatment-for-millions-with-substance-use-disorders>; Richard G. Frank & Sherry A. Glied, *Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses*, THE HILL (Jan. 11, 2017), <http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders>.

228 See Aaron E. Carroll, *How Would Republican Plans for Medicaid Block Grants Actually Work?*, N.Y. TIMES (Feb. 6, 2017), <https://www.nytimes.com/2017/02/06/>

Assuming the survival of Medicaid and expanded Medicaid, the practical challenge will be to minimize the impact of “skin-in-the-game” work requirements and increased administrative burdens that will disproportionately have a negative impact on those needing behavioral health services. Philosophically and politically, the greater challenge will be to reverse the current Administration’s “welfare” labelling of these important programs. As Sara Rosenbaum noted regarding the Price-Verma letter’s rollout of work requirements and the Administration’s new objectives, “[i]n all of this there is absolutely no mention of Medicaid as insurance.”²²⁹

D. Differential Architectures, Fragmentation, and a Paucity of Wraparound Services

From the early days of addiction science, those with SUD were viewed as “morally flawed and lacking in willpower . . . which led to an emphasis on punishment rather than prevention and treatment.”²³⁰ Not surprisingly, behavioral and non-behavioral health services developed with differential architectures implicating, inter alia, treatment models, places for care, and data sharing. Deinstitutionalization began decades ago while, more recently, the MHPAEA and the ACA strengthened the integration or mainstreaming of treatments for substance use disorder and mental illness. However, in yet another example of path dependency, the practices and structures of the past haunt the present. The stigma surrounding SUD and mental illness remains as an intermediary determinant of health for those with OUD, while access and treatment differentials play out as structural determinants because patients and providers struggle with fragmentation and lack of care coordination. These flaws in the provision of behavioral healthcare services are amplified by fragmentation problems in healthcare generally and the lack of investment in case management, care coordination, and wraparound services by both healthcare and social welfare services.

upshot/how-would-republican-plans-for-medicaid-block-grants-actually-work.html.

229 Sara Rosenbaum, *The Trump Administration Re-Imagines Section 1115 Medicaid Demonstrations – And Medicaid*, HEALTH AFFAIRS (Nov. 9, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171109.297738/full/>.

230 NAT’L INST. ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION 2 (2018), <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

To a large extent, lack of care coordination or fragmentation of care are defining features of the U.S. healthcare system.²³¹ The need for improved coordination frequently has been cited by organizations such as the National Academies of Science,²³² the Agency for Healthcare Research and Quality,²³³ and the National Quality Forum.²³⁴

Successful care coordination has several key pillars, including “access to a range of health care services and providers,” effective communications and care plan transitions (hand-offs) between providers, a focus on the patient’s needs, the communication of “clear and simple information that patients can understand,”²³⁵ and the effective use of health information technologies.²³⁶ Demonstration projects have identified cost-savings in the Medicaid program from the use of care coordination interventions for those with chronic conditions.²³⁷

1. Fragmentation and the Continuum of Care for Those with OUD

It is broadly recognized that many of the care coordination issues that present in the OUD context follow from the historic segregation of substance use diagnosis and treatment from mainstream healthcare delivery, with the former frequently thought of as social or criminal justice issues that should be dealt with by psychiatric hospitals or prisons.²³⁸ As we now recognize, persons

231 See, e.g., FAMILIES USA, THE PROMISE OF CARE COORDINATION: TRANSFORMING HEALTH CARE DELIVERY 3 (2013).

232 See, e.g., THE NAT’L ACADS. OF SCIS., IMPROVING DIAGNOSIS IN HEALTH CARE 6–9 (2015).

233 *Care Coordination*, AGENCY FOR HEALTHCARE RES. & QUALITY, <https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html> (last visited Dec. 14, 2018).

234 *Care Coordination Measures*, NAT’L QUALITY FORUM, <http://www.qualityforum.org/ProjectDescription.aspx?projectID=73700> (last visited Dec. 14, 2018).

235 *What Is Care Coordination?*, NEJM CATALYST (Jan. 1, 2017), <https://catalyst.nejm.org/what-is-care-coordination/>.

236 *Improved Care Coordination: The Need for Better Improved Care Coordination*, HEALTHIT.GOV, <https://www.healthit.gov/providers-professionals/improved-care-coordination> (last visited Dec. 14, 2018).

237 See, e.g., Jingping Xing et al. *Care Coordination Program for Washington State Medicaid Enrollees Reduced Inpatient Hospital Costs*, 34 HEALTH AFF. 653 (2015).

238 U.S. DEPT OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 1–19, 6–5 (2016).

suffering from OUD are particularly vulnerable populations that in practice require high levels of care coordination. These cohorts also need a well-thought-out continuum of care such that harm reduction or emergency department interventions can lead to treatment or, later, that treatment can lead to recovery services.²³⁹

The insurance policy stratification discussed above relates primarily to access to care, including the near-zero access experienced by the uninsured and the differential levels of care available to cohorts insured within different strata. Fragmentation is less about access and more about the quality of care that is delivered. Of course, those flaws overlap. For example, facilities being detox-only or not offering a full range of evidence-based medication assisted treatments²⁴⁰ exhibit aspects relating both to access and quality. Similarly, the absence of a progressive continuum of care not only frustrates clinical interventions but also other innovative programs. For example, researchers found that, while an innovative police-led referral program²⁴¹ proved effective in referring persons to short-term services, it could not “overcome a fragmented treatment system focused on acute episodic care which remains a barrier to long-term recovery.”²⁴²

Behavioral healthcare frustrates clinical interventions by placing limitations on the number of treatment options at a time when the opposite is required. As already discussed, Medicaid previously maintained an IMD exclusion, prohibiting Medicaid payments for some residential programs.²⁴³ There are also limitations on the number of OTPs that are the requisite location for most MAT treatments.²⁴⁴ By law, OTPs must be accredited

239 See P. Todd Korthius et al., *Primary Care-Based Models for the Treatment of Opioid Use Disorder*, 166 ANNALS INTERNAL MED. 268, 276 (2017).

240 Hannah K. Knudsen et al., *Barriers to the Implementation of Medication-Assisted Treatment for Substance Use Disorders: The Importance of Funding Policies and Medical Infrastructure*, 34 EVALUATION & PROGRAM PLAN. 375, 375–76, 379 (2011), <https://doi.org/10.1016/j.evalprogplan.2011.02.004>. See also Brendan Saloner & Colleen L. Barry, *Ending the Opioid Epidemic Requires a Historic Investment in Medication-Assisted Treatment*, 37 J. POL. ANALYSIS & MGMT. 431 (2018).

241 *Police Assisted Addiction & Recovery Initiative*, <https://paarius.org/> (last visited Sept. 28, 2018).

242 Davida M. Schiff et al., *A Police-Led Addiction Treatment Referral Program in Gloucester, MA: Implementation and Participants' Experiences*, 82 J. SUBSTANCE ABUSE TREATMENT 41, 41 (2017).

243 See *supra* text accompanying notes 215–18.

244 *Medication and Counseling Treatment*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP'T. OF HEALTH & HUMAN SERVS., <https://www>.

by an approved accrediting body and certified by SAMHSA.²⁴⁵ The regulatory model is designed to ensure that medications are accompanied by appropriate “counseling and behavioral therapies, to provide a ‘whole-patient’ approach to the treatment of substance use disorders.”²⁴⁶ Additionally, and with specific applicability to agonists, the regulatory model is intended to prevent diversion.²⁴⁷ An exception applies to the partial agonist buprenorphine, through the waiver structure introduced by the Drug Addiction Treatment Act of 2000.²⁴⁸ Although that waiver program increased the number of physicians permitted to prescribe buprenorphine, it also placed somewhat arbitrary limits on the numbers of patients that physicians with waivers are permitted to treat.²⁴⁹

Those suffering from OUD face a sadly limited view of the continuum of care. For example, there is strong evidence syringe exchange programs open a path to treatment, do not increase rates of addiction,²⁵⁰ and reduce the risk of needle stick injuries among law enforcement officers in the community.²⁵¹ Syringe exchange

samhsa.gov/medication-assisted-treatment/treatment (last updated Sept. 28, 2015); see also SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T. OF HEALTH & HUMAN SERVS., FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS 4 (2015), http://mpcmh.org/wpcontent/uploads/2017/12/SAMHSA_Guidelines_Opioid-Treatment-Programs.pdf.

245 Opioid Treatment Program Certification, 42 C.F.R. § 8.11 (2018).

246 *Medication-Assisted Treatment (MAT)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T. OF HEALTH & HUM. SERVS., <https://www.samhsa.gov/medication-assisted-treatment> (last updated Sept. 28, 2015).

247 FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS, *supra* note 244.

248 *DEA Requirements for DATA Waived Physicians (DWP)*, D.E.A. DIVERSION CONTROL DIV., U.S. DEP’T. OF JUSTICE, https://www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm (last visited Dec. 16, 2018).

249 See generally Andrea G. Barthwell et al., *What’s in a Number? Recommending Practicality in the Data 2000 Patient Limits*, 12 J. OPIOID MGMT. 243 (2016). A situation that was somewhat improved by the 2018 opioid legislation. See SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, § 3201(a) (2018).

250 Steffanie A. Strathdee et al., *Needle-Exchange Attendance and Health Care Utilization Promote Entry into Detoxification*, 76 J. URB. HEALTH 448 (1999), <https://www.ncbi.nlm.nih.gov/pubmed/10609594>; see also INST. OF MED., NAT’L ACAD. OF SCI., PREVENTING HIV INFECTION AMONG INJECTING DRUG USERS IN HIGH-RISK COUNTRIES: AN ASSESSMENT OF THE EVIDENCE 141 (2006), <https://www.nap.edu/read/11731/chapter/6#140>.

251 Samuel L. Groseclose et al., *Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers – Connecticut, 1992-1993*, 10 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUM. RETROVIROL 82,

programs are safe places and a place of re-entry from the streets for those with OUD. They offer persons with OUD a route to a safer life, the minimization of comorbidities such as HIV/AIDS or Hepatitis-C, treatment, and even recovery,²⁵² suggesting they should be more formally recognized as part of the continuum of care.²⁵³ Similarly, emergency department treatment should be recognized as a step toward treatment or at least chronic disease management.²⁵⁴ As noted by Mark Olfson and colleagues, “[t]he high and broadly distributed mortality risks after nonfatal opioid overdose underscore the importance of coordinating medical, substance use, and mental health management after opioid overdose.”²⁵⁵

2. *Non-Aligned Data Protection Models*

Healthcare data enjoy exceptional protection under federal law when compared to data in other domains.²⁵⁶ Some data in healthcare subdomains experience even greater degrees of protection; these include the exceptional protection for process notes taken by psychotherapists²⁵⁷ and the Genetic Information Nondiscrimination Act of 2008’s prohibitions on the acquisition of genetic information.²⁵⁸ Arguably, the strongest protection given to any healthcare data is that applied to behavioral health information by the Confidentiality of Substance Use Disorder Patient Records

86–88 (1995).

252 ELIZABETH TAYLOR, AIDS FOUND., AIDS WATCH: SYRINGE EXCHANGE PROGRAMS (2015), https://www.aidsunited.org/data/files/Site_18/AW2015Syringe_Exchange_Web.pdf.

253 See Michael Kidorf et al., *Benefits of Concurrent Syringe Exchange and Substance Abuse Treatment Participation*, 40 J. SUBSTANCE ABUSE TREATMENT 265 (2011), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056913/> (users of syringe exchange programs also participating in any type of substance abuse treatment reported less drug use).

254 See Andrew Herring, *Addiction Treatment Comes to the Emergency Department*, CAL. HEALTH CARE FOUND. (May 17, 2018), <https://www.chcf.org/blog/addiction-treatment-comes-to-the-emergency-department/>. See generally Gail D’Onofrio et al., *Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial*, 313 JAMA 1636 (2015).

255 Mark Olfson et al., *Causes of Death After Nonfatal Opioid Overdose*, 75 JAMA PSYCHIATRY 821, 821 (2018).

256 See generally Nicolas Terry, *Regulatory Disruption and Arbitrage in Healthcare Data Protection*, 17 YALE J. HEALTH POL’Y L. & ETHICS 143, 162–71 (2017).

257 45 C.F.R. §§ 164.501, 164.508(a)(2) (2018).

258 45 C.F.R. § 164.502(a)(5)(i) (2018).

rule, often referred to as 42 C.F.R. Part 2 (or just “Part 2”).²⁵⁹

The federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) Privacy Rule applies to patient data in most traditional healthcare environments.²⁶⁰ As a result, HIPAA privacy applies to patients being treated for substance use or other mental health issues.²⁶¹ HIPAA permits broad data-sharing between providers without requiring any patient consent.²⁶² The Privacy Rule does not contain any provisions specific to substance use patients.

However, Part 2 provides an *additional* layer of confidentiality for the records of SUD (and therefore OUD) patients.²⁶³ Part 2 applies to federally-assisted programs that provide SUD programs to diagnosis, treat, or refer. Part 2 can apply to personnel or a unit contained within a general medical facility.²⁶⁴ Most importantly, Part 2 has required an additional, highly specific consent from the patient before SUD records may be shared.²⁶⁵

In 2017, SAMHSA updated Part 2 including some changes to the consent process.²⁶⁶ The updated consent provisions allow for a limited “general” consent contained in the “To Whom” section of the consent, under which a SUD patient may designate certain providers to receive certain, specified SUD information.²⁶⁷ Technically, the

259 42 C.F.R. pt. 2 (2018). *See generally* LAURA ASHPOLE ET AL., 42 C.F.R. PART 2 IN RETROSPECTIVE: THE 30-YEAR JOURNEY OF THE ALCOHOL AND DRUG ABUSE TREATMENT CONFIDENTIALITY REGULATIONS (2017), https://www.healthlawyers.org/Members/PracticeGroups/TaskForces/BH/briefings/Documents/42_CFR_Part2_MB.pdf.

260 45 C.F.R. §§ 160, 162, 164 (2018). In general, the HIPAA rules apply to “covered entities,” including most doctors, hospitals, and treatment facilities. *Covered Entities and Business Associates*, U.S. DEP’T OF HEALTH & HUMAN SERVS., <https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html> (last visited June 16, 2017).

261 45 C.F.R. § 164.501 (2018).

262 45 C.F.R. § 164.506 (2018).

263 Susan Awad, *Confused by Confidentiality? A Primer on 42 CFR Part 2*, AM. SOC. OF ADDICTION MED. (Aug. 15, 2013), <https://www.asam.org/resources/publications/magazine/read/article/2013/08/15/confused-by-confidentiality-a-primer-on-42-cfr-part-2>.

264 42 C.F.R. § 2.11 (2018).

265 42 C.F.R. § 2.31 (2018). *See generally* *Substance Abuse Confidentiality Regulations*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T. OF HEALTH & HUMAN SERVS., <https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs> (last updated May 1, 2018).

266 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052 (Jan. 18, 2017).

267 42 C.F.R. §§ 2.31, 2.33 (2018).

new consent rules operate quite differently from HIPAA and bring with them distinct accountability, research, and other provisions. Although the updated disclosure rule does include a new “medical emergency” exception,²⁶⁸ even that is not as permissive as the equivalent HIPAA approach. In 2018, SAMHSA revisited some of these issues but again declined to further align HIPAA and Part 2 provisions.²⁶⁹

There has been a consistent drumbeat to better align these two sets of privacy regulations. For example, The President’s Commission on Combating Drug Addiction and The Opioid Crisis recommended action to “[b]etter align, through regulation, patient privacy laws specific to addiction with the Health Insurance Portability and Accountability Act (HIPAA) to ensure that information about SUDs be made available to medical professionals treating and prescribing medication to a patient.”²⁷⁰

The differential approach to protecting SUD records is blamed for inadequate integration of full SUD patient data in electronic health records, the exclusion of SUD records from statewide sharing through Health Information Exchanges, the perpetuation of stigma by treating SUD patients differently, and the exclusion of SUD patients from potentially beneficial research based on electronic health records data.²⁷¹

Continued data segregation has been justified on the grounds that such data are particularly sensitive and that there has been a history of discrimination against SUD patients.²⁷² For example, The

268 42 C.F.R. § 2.51 (2018).

269 Confidentiality of Substance Use Disorder Patient Records, 83 Fed. Reg. 239, 241 (Jan. 3, 2018).

270 OFFICE OF NAT’L DRUG CONTROL POLICY, THE PRESIDENT’S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS FINAL REPORT 210 (2017), https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf; see also Letter from Rebecca Murow Klein, Chair, P’ship to Amend 42 CFR Part 2, to Orrin Hatch, Chairman, U.S. Senate Comm. on Fin., and Ron Wyden, Ranking Member, U.S. Senate Comm. on Fin. (Feb. 16, 2018), <http://www.helpendopioidcrisis.org/wp-content/uploads/2018/02/Partnership-to-Amend-42-CFR-Part-2-Recommendations.pdf>.

271 See Austin B. Frakt & Nicholas Bagley, *Protection or Harm? Suppressing Substance-Use Data*, 372 NEW ENG. J. OF MED. 1879 (2015).

272 U.S. DEP’T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL’S REPORT ON ALCOHOL, DRUGS, AND HEALTH 6-1, 6-33 to 6-34 (2016), <https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>.

Surgeon General's Report noted, "[c]urrently, persons with substance use disorders involving illicit drugs are not protected under anti-discrimination laws, such as the ADA."²⁷³ This is partially correct; although SUD is recognized by the ADA as a disability, protection is lost if the person is "currently engaging in the illegal use of drugs."²⁷⁴ As noted by SAMHSA, disclosure of SUD information can lead to a host of negative consequences, "including: [l]oss of employment, loss of housing, loss of child custody . . . discrimination by medical professionals and even arrest, prosecution, and incarceration."²⁷⁵ It is arguable that those seeking behavioral health services are less concerned about data sharing between providers but particularly fearful of information about their illness being shared with law enforcement and corrections.

An overarching policy imperative is to normalize or mainstream the treatment of SUD. However, if our healthcare delivery is to move to a position where SUD is treated as a mainstream disease, then segregation of data between SUD populations and other populations must be better managed. There is a very real safety angle here; for example, there is some evidence that patients with a substance use history unknown to treating physicians have been put at risk by opioid prescribing.²⁷⁶

This is not a newly identified problem and there have been unsuccessful attempts to pass legislation to provide regulatory authority to better align the rules.²⁷⁷ As HHS rolls out regulations and policies authorized under the 21st Century Cures Act to

273 *Id.* at 6-34.

274 42 U.S.C. § 12114(a) (2018); *see also* 42 U.S.C. § 12111(6) (2018).

275 Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6053 (Jan. 18, 2017); *see* Paul N. Samuels & Patty McCarthy Metcalf, *Relaxing Patient Privacy Rules Would Worsen the Opioid Epidemic*, STAT NEWS (Nov. 24, 2017), <https://www.statnews.com/2017/11/24/opioid-epidemic-patient-privacy/> (presenting strong defenses of Part 2); *see also* Karla Lopez & Deborah Reid, *Discrimination Against Patients with Substance Use Disorders Remains Prevalent and Harmful: The Case for 42 CFR Part 2*, HEALTH AFF. BLOG (Apr. 13, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170413.059618/full/>.

276 *See* Constance M. Weisner et al., *Trends in Prescribed Opioid Therapy for Non-Cancer Pain for Individuals with Prior Substance Use Disorders*, 145 PAIN 287 (2009).

277 *See, e.g.*, Overdose Prevention and Patient Safety Act of 2017, H.R. 3545, 115th Cong. (2017); Helping Families in Mental Health Crisis Act of 2016, H.R. 2646, 114th Cong. (2016).

promote interoperability,²⁷⁸ discourage “information blocking,”²⁷⁹ and establish a Trusted Exchange Framework,²⁸⁰ more and improved clinical sharing inevitably will result and may, in the future, lead to some consensus on how to proceed with the differential laws.

HHS’s Office of Civil Rights has published FAQs encouraging sharing²⁸¹ and, more recently, issued a “clarifying” Opioid Crisis Guidance that notes the flexibility in the HIPAA rule that permits providers to disclose information to families in dangerous or emergency situations and the fact that a patient’s personal representative (recognized as such by state law) has the same rights as the patient.²⁸² However, the Guidance does not address the relationship between HIPAA and the more stringent Part 2.²⁸³ Equally, SAMHSA has issued a FAQ on the interrelationship of Part 2 and the Health Information Exchange.²⁸⁴ This dichotomous approach is clearly insufficient.

Although the House of Representatives’ version of the 2018 opioid legislation would have amended Part 2’s enabling legislation²⁸⁵ to permit the sharing of SUD records with other treatment providers, as permitted under the HIPAA Privacy Rule,²⁸⁶

278 42 U.S.C. § 300jj (2018). *See generally* Don Rucker, *Achieving the Interoperability Promise of 21st Century Cures*, HEALTH AFF. BLOG (June 19, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180618.138568/full/>.

279 42 U.S.C. § 300jj-52(a)-(b) (2018).

280 THE OFFICE OF THE NAT’L COORDINATOR FOR HEALTH INFO. TECH., DRAFT TRUSTED EXCHANGE FRAMEWORK (2018), <https://www.healthit.gov/sites/default/files/draft-trusted-exchange-framework.pdf>.

281 *FAQ: Disclosures to Family and Friends*, HHS.GOV, <https://www.hhs.gov/hipaa/for-professionals/faq/disclosures-to-family-and-friends/index.html> (last visited Dec. 15, 2018).

282 *HHS Office for Civil Rights Issues Guidance on How HIPAA Allows Information Sharing to Address the Opioid Crisis*, HHS.GOV (Oct. 27, 2017), <https://www.hhs.gov/about/news/2017/10/27/hhs-office-civil-rights-issues-guidance-how-hipaa-allows-info-sharing-address-opioid-crisis.html>.

283 *Id.*

284 LEGAL ACTION CTR. FOR THE SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., U.S. DEP’T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS: APPLYING THE SUBSTANCE ABUSE CONFIDENTIALITY REGULATIONS TO HEALTH INFORMATION EXCHANGE (HIE) (2010), <https://www.samhsa.gov/sites/default/files/faqs-applying-confidentiality-regulations-to-hie.pdf>.

285 42 U.S.C. § 290dd-2 (2018).

286 Overdose Prevention and Patient Safety Act, H.R. 6082, 115th Cong. (2018). *See generally* Mary Butler, *House of Representatives Passes Privacy Law Updates Governing Opioid Abuse Treatment*, J. OF AHIMA (June 20, 2018), <http://journal.ahima.org/2018/06/20/house-of-representatives-passes-privacy-law>

that provision did not survive reconciliation and was omitted from the final legislation.²⁸⁷ Separately, however, on July 26, 2018, HHS Deputy Secretary Hargan tweeted that the agency would soon be issuing Requests for Information on HIPAA and Part 2 and would be “taking regulatory action,”²⁸⁸ a position confirmed by Secretary Azar.²⁸⁹

From harm reduction through treatment and recovery services, together with the accompanying patient data, there needs to be a more global sense of how to improve and coordinate behavioral health services. States need to improve case management, increase the availability of peer coaches, and invest in wraparound services, either through direct service improvements or by incenting stakeholders such as Medicaid managed care providers to step up. The ASAM levels of care discussed above²⁹⁰ should be seen as an important baseline but one to which harm reduction and long-term recovery should be added.

V. The Healthcare Wasteland: Jails and Prisons

*I think we are in rats' alley
Where the dead men lost their bones.*²⁹¹

More than half of state prisoners and two-thirds of sentenced jail inmates meet the diagnostic criteria for SUD.²⁹² A quarter of inmates suffer from both SUD and a co-occurring mental health

updates-governing-opioid-abuse-treatment/.

287 SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2018).

288 Eric D. Hargan (@DepSecHargan), TWITTER (Jul. 26, 2018, 1:05 PM), <https://twitter.com/DepSecHargan/status/1022573758475849728>.

289 Alex M. Azar II, Sec’y, U.S. Dep’t of Health & Human Servs., Remarks to the Heritage Foundation (July 26, 2018), <https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/remarks-to-the-heritage-foundation.html>.

290 See *supra* text accompanying note 52.

291 T.S. ELIOT, *THE WASTE LAND* (1922).

292 JENNIFER BRONSON ET AL., U.S. DEPT’ OF JUSTICE, DRUG USE, DEPENDENCE, AND ABUSE AMONG STATE PRISONERS AND JAIL INMATES, 2007-2009 1 (2017), <https://www.bjs.gov/content/pub/pdf/dudasppi0709.pdf>; THE NAT’L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., BEHIND BARS II: SUBSTANCE ABUSE AND AMERICA’S PRISON POPULATION 3 (2010), <https://www.centeronaddiction.org/addiction-research/reports/behind-bars-ii-substance-abuse-and-america%E2%80%99s-prison-population>.

problem.²⁹³ It has been estimated that between a quarter and a third of those who suffer from heroin addiction pass through the corrections system each year.²⁹⁴ Ironically, however, the criminal justice system is the place where the medicalization of substance use is least likely to be endorsed.²⁹⁵ Worse, the criminal justice system frequently embraces the very opposite of the policy needed to address the opioid epidemic by criminalizing those who need behavioral healthcare services. Just as the Penrose hypothesis played out,²⁹⁶ transforming our corrections facilities into a makeshift mental health system,²⁹⁷ so now the cycle has repeated as prisons and jails now also house a significant population of those with SUD.

A. *The State of Jails and Prisons*

Fewer than 30 of the nation's 5,100 jails and prisons offer methadone or buprenorphine-based MAT.²⁹⁸ This is despite the evidence that those treatments result in significant reduction in

293 THE NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 292, at 3. See generally Roger H. Peters et al., *Co-Occurring Substance Use and Mental Disorders in The Criminal Justice System: A New Frontier of Clinical Practice and Research*, 38 PSYCHIATRIC REHABILITATION J. 1 (2015) (discussing the prevalence of substance use disorders among prison inmates with mental disorders than those without a mental disorder).

294 Amy E. Boutwell et al., *Arrested on Heroin: A National Opportunity*, 3 J. OF OPIOID MGMT. 328, 328 (2007).

295 See *How People with Opioid Addictions are Treated in Prison*, NPR (Aug. 30, 2018), <https://www.npr.org/2018/08/30/643445817/how-people-with-opioid-addictions-are-treated-in-prison>; see also Erin Schumaker, *Inadequate Prison Policies Put Former Inmates at Greater Risk of Opioid Death*, HUFFINGTON POST (July 31, 2018) https://www.huffingtonpost.com/entry/inadequate-prison-policies-put-former-inmates-at-greater-risk-of-opioid-death_us_5b58e0c9e4b0b15aba94c3b6.

296 L.S. Penrose, *Mental Disease and Crime: Outline of a Comparative Study of European Statistics*, 18 BRITISH J. MED. PSYCHOL. 1 (1939). The hypothesis is that there is an inverse relationship between a country's available psychiatric beds and its prison population. See, e.g., Mark Toynbee, *The Penrose Hypothesis in the 21st Century: Revisiting the Asylum*, 18 EVIDENCE-BASED MENTAL HEALTH 76 (2015).

297 Samantha Raphelson, *How the Loss of U.S. Psychiatric Hospitals Led to a Mental Health Crisis*, NPR (Nov. 30, 2017, 1:15 PM), <https://www.npr.org/2017/11/30/567477160/how-the-loss-of-u-s-psychiatric-hospitals-led-to-a-mental-health-crisis>.

298 Timothy Williams, *Opioid Users Are Filling Jails, Why Don't Jails Treat Them?*, N.Y. TIMES (Aug. 4, 2017), <https://www.nytimes.com/2017/08/04/us/heroin-addiction-jails-methadone-suboxone-treatment.html>.

post-release overdoses or deaths²⁹⁹ and decreased recidivism.³⁰⁰ According to Redonna Chandler and colleagues, “the criminal justice system provides a unique opportunity to intervene and disrupt the cycle of drug use and crime in a cost-effective manner,” however they also recognize that “[t]he challenge of delivering treatment in a criminal setting requires the cooperation and coordination of 2 disparate cultures: the criminal justice system organized to punish the offender and protect society and the drug abuse treatment systems organized to help the addicted individual.”³⁰¹

That last reason aside, there are several explanations for the low rate of utilization of MAT in the criminal justice system. In jails the stays are, or should be, brief—rendering effective treatment questionable. However, jails do offer an opportunity for screening and referral to treatment. The situation in prisons is more complicated, with cost issues,³⁰² multiple levels of stigma,³⁰³ and an institutional culture that is oppositional to the use and potential diversion of agonist or partial agonist drugs.³⁰⁴

Nevertheless, methadone treatment has been successfully employed at Rikers Island in New York City for 30 years, resulting in “overall health care cost savings, reduced crime and recidivism, reduced HIV and hepatitis C transmission, and better than average rates of recovery from drug use.”³⁰⁵ A similar success story has

299 John Marsden et al., *Does Exposure to Opioid Substitution Treatment in Prison Reduce the Risk of Death After Release? A National Prospective Observational Study in England*, 112 *ADDICTION* 1408, 1415 (2017).

300 Vincent Tomasino et al., *The Key Extended Entry Program (KEEP): A Methadone Treatment Program for Opiate-Dependent Inmates*, 68 *MOUNT SINAI J. MED.* 14, 19–20 (2001).

301 Redonna K. Chandler, et al., *Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety*, 301 *JAMA* 183, 189–90 (2009) (citation omitted).

302 An issue not limited to SUD. *See, e.g.*, Adam Beckman et al., *Follow California’s Lead: Treat Inmates with Hepatitis C*, *HEALTHAFFAIRS* (July 24, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180724.396136/full/>.

303 German Lopez, *How America’s Prisons are Fueling the Opioid Epidemic*, *Vox* (Mar. 26, 2018, 9:20 AM), <https://www.vox.com/policy-and-politics/2018/3/13/17020002/prison-opioid-epidemic-medications-addiction>.

304 Leah Pope et al., *A New Normal: Addressing Opioid Use Through the Criminal Justice System*, *VERA INST. JUST.*, https://www.vera.org/publication_downloads/new-normal-opioid-use-criminal-justice-system/new-normal-opioid-use-criminal-justice-system.pdf (last visited Sept. 28, 2018).

305 Christine Vestal, *At Rikers Island, a Legacy of Medication-Assisted Opioid Treatment*, *PEW* (May 23, 2016), <http://www.pewtrusts.org/en/research-and-analysis/>

been reported from the Rhode Island Department of Corrections,³⁰⁶ a unified prison/jail system that uses all three forms of MAT that extends the continuum of care such that individuals who are on MAT at intake are not tapered and, upon reentry, connect treated individuals to community-based resources.³⁰⁷

Notwithstanding these successes, at least “28 [states] don’t fully offer *any* medication to prisoners with opioid use disorders.”³⁰⁸ It is hardly surprising, therefore, that there are examples of persons suffering from a diagnosable and diagnosed disease, but who have been denied the accepted standard of care, who have then sought legal redress.³⁰⁹ The courts have adopted a high bar for Eighth Amendment inadequate treatment claims, “medical indifference,” that requires the showing of not only medical malpractice but also animus.³¹⁰

Therefore, as jurisprudence stands today, Title II of the ADA³¹¹ may be a better vehicle for bringing actions against jails and prisons for inadequate OUD treatment. For example, the U.S. Attorney’s office in Massachusetts has initiated an investigation of the Massachusetts Department of Corrections for discontinuing MAT upon incarceration.³¹² A lawsuit filed by the American Civil Liberties Union of Washington State against Whatcom County Jail in Bellingham, Washington goes further, arguing that prisoners

blogs/stateline/2016/05/23/at-rikers-island-a-legacy-of-medication-assisted-opioid-treatment.

306 Andrew Joseph, *One State Takes a Novel Approach to Opioid Addiction: Access to Treatment for All Inmates*, STAT (Aug. 3, 2017), <https://www.statnews.com/2017/08/03/opioid-treatment-prisons/>.

307 Traci C. Green et al., *Postincarceration Fatal Overdoses After Implementing Medications for Addiction Treatment in a Statewide Correctional System*, 75 JAMA PSYCHIATRY 405, 405–407 (2018).

308 Lopez, *supra* note 303.

309 See, e.g., *Gallegos v. Bernarlillo Cty. Bd. of Comm’rs*, No. CIV 16-0127 JB/WPL, 2017 WL 3575883, *1–2 (D. N.M. Aug. 17, 2017); *Niemic v. UMass Corr. Health*, 89 F. Supp. 3d 193, 198–99 (D. Mass. 2015).

310 See, e.g., *Helling v. McKinney*, 509 U.S. 25, 30–35 (1993); *Estelle v. Gamble*, 429 U.S. 97, 103–107 (1976); cf. *Brown v. Plata*, 563 U.S. 493, 510 (2011) (allowing prisoner release after showing of overcrowding and systemic failures related to medical treatment).

311 42 U.S.C. § 12131; 28 C.F.R. pt. 35 (2018) (protecting individuals with disabilities from discrimination on the basis of disability regarding services, programs, and activities provided by State and local government entities).

312 Letter from U.S. Att’y Gen., Dist. of Mass., to Mass. Exec. Office of Pub. Safety & Sec., Gen. Counsel, and Mass. Exec. Office of Health & Human Servs., Gen. Counsel (Mar. 16, 2018).

should be treated with opiate-withdrawal medication rather than being required to go “cold turkey.”³¹³

B. Reentry and Avoiding Recidivism

According to the National Center on Addiction and Substance Abuse, “[r]eleased inmates are more than three times likelier than the general population to meet clinical criteria for substance abuse,”³¹⁴ while “[o]ver half (52.2 percent) of substance-involved inmates have one or more previous incarcerations compared with 31.2 percent of inmates who are not substance involved.”³¹⁵ More specifically, with regard to OUD, and according to German Lopez, “[s]ince so few state prisons offer adequate access to treatment, the days and weeks after a person’s release from prison are perhaps the single deadliest time period in the US’s opioid epidemic.”³¹⁶ Huge numbers of our fellow citizens are therefore trapped in a cycle of imprisonment, untreated OUD, and reincarceration. Many die shortly after release, with one study finding, “[d]uring the first 2 weeks after release, the risk of death among former inmates was 12.7 times that among other state residents.”³¹⁷

This does not have to be the case even in corrections facilities that are opposed to agonists. For example, a pilot study found that treating prisoners with extended-release naltrexone just prior to reentry from jail was associated with significantly lower rates of opioid relapse.³¹⁸ The negative structural determinants go beyond the availability of treatment. The social determinants are equally negative, with released inmates highlighting “the significance of

313 Gene Johnson, *Lawsuit: Washington Jail Must Provide Addiction Treatment*, U.S. NEWS & WORLD REP. (June 7, 2018, 7:53 PM), <https://www.usnews.com/news/best-states/washington/articles/2018-06-07/lawsuit-washington-jail-must-provide-addiction-treatment>.

314 NAT’L CTR. ON ADDICTION AND SUBSTANCE ABUSE AT COLUM. UNIV., *supra* note 292, at 59.

315 *Id.* at 5.

316 Lopez, *supra* note 303.

317 Ingrid A. Binswanger et al., *Release from Prison – A High Risk of Death for Former Inmates*, 356 NEW ENG. J. MED. 157, 161 (2007).

318 Joshua D. Lee et al., *Opioid Treatment at Release from Jail Using Extended-Release Naltrexone: A Pilot Proof-of-Concept Randomized Effectiveness Trial*, 110 ADDICTION 1008, 1012 (2015); cf. Aaron D. Fox et al., *Release from Incarceration, Relapse to Opioid Use and the Potential for Buprenorphine Maintenance Treatment: A Qualitative Study of the Perceptions of Former Inmates with Opioid Use Disorder*, 10 ADDICTION SCI. & CLINICAL PRAC. 2 (Jan. 2015) (reporting multiple factors behind prisoners refusing buprenorphine upon release).

poor social support, medical problems, and inadequate financial resources to support” re-integration while they simultaneously faced “ubiquitous exposure to drugs in the neighborhoods to which they were released.”³¹⁹ There are very few wraparound services that aid prisoner reentry by, for example, assisting with serious issues such as employment and housing,³²⁰ while failure to acquire post-release employment is associated with poverty and recidivism.³²¹

VI. Conclusion

“Between 2001 and 2016, the number of opioid-related deaths in the United States increased by 345% . . . 33.3 to 130.7 deaths per million population;” a public health crisis particularly responsible for the premature deaths of young and middle-aged adults.³²² Estimates suggest that opioids could be responsible for another half million drug-related deaths during the next decade,³²³ becoming this generation’s AIDS epidemic,³²⁴ and likely even exceeding its death toll.³²⁵

Both our current healthcare system and the opioid epidemic deserve to be labelled as wicked problems. In both scenarios we are appropriately warned that wicked problems resist unitary diagnosis or single solutions.³²⁶ Although the epidemic is national in its scope, in the end, the greatest toll of the opioid epidemic likely will fall

319 Ingrid A Binswanger et al., *Return to Drug Use and Overdose After Release from Prison: A Qualitative Study of Risk and Protective Factors*, 7 ADDICTION SCI. & CLINICAL PRAC. 3 (2012) (small qualitative study using semi-structured interviews).

320 See generally Faith E. Lutze et al., *Homelessness and Reentry: A Multisite Outcome Evaluation of Washington State’s Reentry Housing Program for High Risk Offenders*, 41 CRIM. JUST. & BEHAV. 471 (2014).

321 Adam Looney & Nicholas Turner, *Work and Opportunity Before and After Incarceration*, BROOKINGS INST. (Mar. 2018), https://www.brookings.edu/wp-content/uploads/2018/03/es_20180314_looneyincarceration_final.pdf.

322 Tara Gomes et al., *The Burden of Opioid-Related Mortality in the United States*, 1 JAMA NETWORK OPEN, June 2018, at 1.

323 Max Blau, *STAT Forecast: Opioids Could Kill Nearly 500,000 Americans in the Next Decade*, STAT (June 27, 2017), <https://www.statnews.com/2017/06/27/opioid-deaths-forecast/>.

324 Andrew Sullivan, *The Opioid Epidemic is This Generation’s AIDS Crisis*, N.Y. MAG. (Mar. 16, 2017), <http://nymag.com/daily/intelligencer/2017/03/the-opioid-epidemic-is-this-generations-aids-crisis.html>.

325 Carol Levine, *The Statistics Don’t Capture the Opioid Epidemic’s Impact on Children*, STAT (Jan. 2, 2018), <https://www.statnews.com/2018/01/02/opioid-epidemic-impact-children/>.

326 Lee, *supra* note 36, at 51.

disproportionately on the Midwestern and Southern states that exhibit poverty, marginalized populations, poor social determinants of health, underfunded public health, and limited access to healthcare.³²⁷

Starting from the hypothesis that many of the barriers to effective interventions in the opioid crisis are properties of our deficient health access and delivery processes, it is not difficult to suggest some relevant flaws that rise to the level of structural determinants: access and benefit stratification, the changing role of Medicaid, problems associated with fragmentation of care (the lack of behavioral health services integrated into our primary care systems cannot be overemphasized), and the lack of wraparound services. It is not necessary that we all end up agreeing that healthcare is a major cause; that “It’s the Healthcare, Stupid!” However, what we should all be able to agree on is that we will have to re-engineer our healthcare system if we wish to make any headway against this or future addictions crises.

327 *Tobacco Nation: The Deadly State of Smoking Disparity in the U.S.*, TRUTH INITIATIVE, <https://truthinitiative.org/sites/default/files/Tobacco-Nation-FINAL.pdf> (last visited Dec. 17, 2018).

The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis*

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I. Introduction

The United States legislature has historically favored punitive legislative proposals to addressing problem drug use.¹ However, in addressing the current opioid crisis, legislators have been critical of past punitive approaches,² such as arguing that “we cannot arrest our way out of this problem.”³ Federal legislation enacted to address the opioid crisis evidences that legislators are willing to act on this rhetorical shift away from punitive approaches and have done so in a bipartisan manner.⁴ Such a shift in legislative approaches is often preceded by a change in the problem definition, causal theories and aligning proposals supported by administrative agencies and organized interest groups.⁵

The rhetoric supporting recent federal legislation has evidenced an increasing acceptance of the ideas that addiction is a disease and that the opioid crisis is a public health issue.⁶ Addiction has been compared to other chronic health conditions, which require long-term maintenance,⁷ but the comparison has often not

1 See generally Taled El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*. 48 U. MEM. L. REV. (forthcoming 2019).

2 See, e.g., Mike Lee, *We Can Beat the Opioid Epidemic*, MIKE LEE U.S. SENATOR UTAH (May 10, 2018), <https://www.lee.senate.gov/public/index.cfm/2018/5/we-can-beat-the-opioid-epidemic>.

3 *Id.*

4 See, e.g., Comprehensive Addiction and Recovery Act of 2016 (CARA), Pub. L. No. 114-198, 130 Stat. 695 (2016); 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016). CARA is bipartisan legislation that was passed with a 94–1 vote in the Senate and a 400–5 vote in the House. 162 CONG. REC. S1404 (daily ed. Mar. 10, 2016); 162 CONG. REC. H2373 (daily ed. May 13, 2016). CARA includes funding for education, treatment, prescriber training, overdose reversal medication, and prescription drug monitoring programs (PDMPs)—policy solutions that facially appear more aligned with a health approach. The 21st Century Cures Act built on CARA by providing an additional \$1 billion of funding over two years. 21st Century Cures Act.

5 Causal theories are the stated theories of causation of a social problem and are components of causal stories. See DEBORAH A. STONE, *POLICY PARADOX: THE ART OF POLITICAL DECISIONS MAKING* 206–07 (3d ed. 2012). See generally El-Sabawi, *supra* note 1 (providing historic examples of how changes in problem definitions have historically preceded changes in legislative approaches in drug policy).

6 See, e.g., Portman, *Whitehouse, Ayotte, Klobuchar Cheer Final Passage of Comprehensive Addiction and Recovery Act*, ROB PORTMAN U.S. SENATOR FOR OHIO (July 13, 2016) [hereinafter *Portman*], <http://www.portman.senate.gov/public/index.cfm/2016/7/portman-whitehouse-ayotte-klobuchar-cheer-final-passage-of-comprehensive-addiction-and-recovery-act>.

7 *Drug Abuse and Addiction: One of America’s Most Challenging Public Health Problems*

extended to the social determinants of chronic conditions.⁸ As such, federal legislation, like the Comprehensive Addiction and Recovery Act of 2016 (CARA) and the 21st Century Cures Act, does not fully embrace model drug policy⁹ or evidence a substantive attempt to address the psychological-sociological-economic (PSE) factors that contribute to problem drug use.¹⁰

Since organized interest groups and federal administrative agencies have historically been influential in defining problem drug use during nationwide crisis,¹¹ it stands to reason that the manner in which these pressure groups defined the problem may have influenced or, at least, provided support for legislators' decisions to shy away from a criminal justice approach. These pressure groups¹² may have also affected legislators' decisions to resort to a "health" approach that did not comprehensively address demand factors or demonstrate a commitment to reforming U.S. drug policy to meet international standards of best practice.¹³ To date, little scholarly analysis has been conducted on the involvement of organized interests and federal administrative agencies in defining the causes of the opioid crisis and the preferred legislative solutions.

In an effort to provide a snapshot of what such involvement

– *Addiction is a Chronic Disease*, NAT'L INST. DRUG ABUSE (June 2005), <https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease>.

8 See, e.g., *Portman*, *supra* note 6.

9 See TAMYKO YSA ET AL., GOVERNANCE OF ADDICTIONS: EUROPEAN PUBLIC POLICIES 47–48 (2014) (comparing European policies and identifying best practices).

10 See *supra* note 4, and accompanying text.

11 See generally DAVID F. MUSTO, AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL (Oxford Univ. Press, 3d ed. 1999) (1973). See also El-Sabawi, *supra* note 1.

12 For the purposes of this paper, I have defined pressure groups to include all groups that place pressure on legislators to vote for an issue in a specified manner. My definition therefore includes both organized interest groups outside of the government and administrative officials within the government.

13 See ALICE RAP SCIENCE FINDINGS #1–5, #40–51, ALICE RAP (n.d.) [hereinafter ALICE RAP FINDINGS], https://www.alicerap.eu/resources/documents/doc_download/387-alice-rap-science-findings-full-document-55-findings.html. ALICE RAP was a research collaboration by 200 scientists from 25 countries and more than 29 disciplines aimed at compiling evidence to inform European drug policy. *About ALICE RAP: The Project and Results*, ALICE RAP, <https://www.alicerap.eu/about-alice-rap.html#a-governance-of-addictions> (last visited Mar. 28, 2018). The researchers also analyzed existing drug policies in European countries and provided suggestions for how to implement best practices. See generally ALICE RAP FINDINGS, *supra* note 13.

may look like, this article explores the types of narratives used by pressure groups to define the opioid crisis in the congressional hearing discourse prior to the enactment of CARA. In order to do this, I analyzed 144 congressional hearing testimonies¹⁴ discussing the opioid crisis and identified the most common narratives used to explain the causes of the opioid crisis.¹⁵ I also identified the types of legislative proposals supported in these narratives.

Understanding the narratives used by organized interests and federal administrative agencies to define the opioid crisis offers some insight as to the narratives that were used to justify the inclusion of the provisions enacted in CARA, as narratives can be used to narrow down the available alternative legislative solutions. Organized interest groups offer the opportunity for citizens, including invested professionals, researchers, and individuals suffering from a substance use disorder, to engage in the problem definition process and influence the types of legislative proposals enacted. Gaining a better understanding of how organized interests have contributed or shaped the legislative problem definition discourse will better equip activated citizens to navigate the pluralist discourse and advocate for significant change.

14 The corpus, or population, of documents that were analyzed were compiled by conducting a search on Thomas Reuters Westlaw for congressional hearing testimony using the search terms “addict!” and “overdose!” and limiting the dates to hearings occurring in January 2014 to June 2016. I chose to limit the analysis to hearings occurring within these dates because it would capture the discourse that preceded CARA, which was passed in June 2016. I restricted the dataset to 2014 because of resource constraints. Future research will be needed to determine whether the findings of this article are time-limited. The terms addict! and overdose! were chosen because the purpose of my analysis is to capture the discourse on the social problem commonly referred to as the opioid crisis. It has been characterized by rates in overdose and an acknowledgment of the problem of addiction. I then excluded testimony, or parts of testimony, that discussed methamphetamine use, synthetic drug use, and marijuana use, as these problems were characterized differently than the opioid crisis, a difference I hope to capture in a future analysis. The results were then limited to hearings that occurred from 2014 to 2016. Both written and oral testimony were included.

15 To analyze the congressional hearing testimony, I used both qualitative and quantitative text analysis. I used QDAMiner5 for the qualitative coding and Wordstat7 for the quantitative analysis. I used content analysis methodology to create categories of causal stories and proposed solutions. Once the categories were saturated, meaning causal stories I identified fit into the categories created and no additional categories needed to be created, I identified patterns and broader themes evidenced by the categories.

I begin Part II with a discussion of how organized interest groups and federal administrative agencies are theorized to influence legislators, with a short overview of the problem definition and the role of causal stories—a type of policy narrative—in the problem definition process. In Part III, I discuss the types of causal stories that I identified in my analysis of congressional hearing testimony, contrasting these narratives with narratives that were used in the past to support criminal justice legislative approaches. Part IV concludes with suggestions on how pressure groups can utilize this political window of opportunity¹⁶ to shift the narrative discourse from policy narratives based on causal theories of supply to causal theories that acknowledge the sociological, biological, environmental, behavioral, psychological, and economic causes of problem drug use.

II. Theories of Pressure Group Influence

Although for much of this article, I refer to organized interest groups and federal administrative agencies collectively as pressure groups, the literature analyzing their influence on legislative behavior is distinct so I review each separately.

A. *Empirical Evidence of Pressure Groups' Influence on Federal Legislators*

Although organized interest groups are thought to influence federal legislators through their campaign contributions, little empirical evidence exists supporting the contention that money buys groups their preferred legislative outcomes.¹⁷ Since organized interest groups continue to spend millions of dollars funding campaigns, they must believe that the money spent is buying them something of importance. If campaign contributions are not buying legislative outcomes, they may be buying legislators' time. Investigators have

16 I am using “political window of opportunity” here to refer to a phenomenon that is originally described by Dr. John Kingdon as a “policy window,” which occurs when three streams meet: the problem stream, the policy stream, and the politics stream. See JOHN KINGDON, *AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES* 165–66 (2d ed. 1995).

17 See Beth L. Leech, *Lobbying and Influence*, in *THE OXFORD HANDBOOK OF AMERICAN POLITICAL PARTIES AND INTEREST GROUPS* 534–51 (L. Sandy Maisel & Jeffrey M. Berry eds., 2010) for a review of the literature. However, there is literature that shows that groups may contribute to legislators that are on powerful committees. See, e.g., Eleanor Neff Powell & Justin Grimmer, *Money in Exile: Campaign Contributions and Committee Access*, 78 J. POL. 974, 976 (2016).

found that legislators are more likely to meet with groups that contribute to their campaigns.¹⁸ So, although organized interest groups may not be buying votes, they may be buying legislator time and attention.¹⁹

Organized interest groups can use this time to define social problems using causal stories that best align with their desired outcomes.²⁰ Legislators are inclined to listen to organized interest groups, even if the groups have not contributed large sums of money to their campaigns, because interest groups may be privy to specialized, subject-matter-specific information.²¹ This information provides legislators with policy-specific information that they can use to make informed decisions and support their positions. These interest groups subsidize the legislators' costs of acquiring this information, costs that can include time and resources.²² Meanwhile, these groups can use their privileged position to define the problem advantageously.

B. Federal Administrative Agencies as Narrators in U.S. Drug Policy

The idea that organized interest groups use causal narratives to sway legislators may seem more intuitive or believable than the use of causal narratives by federal administrative agency officials to do the same. However, historically, in the U.S., high ranking officials in federal administrative agencies have been dominant

18 Joshua L. Kalla & David E. Broockman, *Campaign Contributions Facilitate Access to Congressional Officials: A Randomized Field Experiment*, 60 AM. J. POL. SCI. 545, *passim* (2016).

19 *See id.* at 545.

20 These outcomes of interest may not necessarily be legislative outcomes. An organized interest group may be interested in changing the dominant problem definition, in and of itself. For example, a group of persons recovering from addiction may be invested in the adoption of the “addiction as a disease narrative”—a narrative that attributes the cause of addiction to a brain disease. Regardless of the legislative outcome, the adoption of such a narrative is a victory in and of itself, as it helps destigmatize addiction by treating it as an illness instead of a moral failing.

21 Richard L. Hall & Alan V. Deardorff, *Lobbying as Legislative Subsidy*, 100 AM. POL. SCI. REV. 69, 74 (2006).

22 *Id.* at 72, 74. In general, citizens' groups' reports are given more credibility than industry reports. *See* JEFFREY M. BERRY, *THE NEW LIBERALISM: THE RISING POWER OF CITIZEN GROUPS* 127–29 (1999); WILLIAM P. BROWNE, *CULTIVATING CONGRESS: CONSTITUENTS, ISSUES, AND INTERESTS IN AGRICULTURAL POLICYMAKING* 241 (1995).

players in the problem definition of drug use.²³ The causal narratives crafted by these agencies, often using data collected by the agencies, supported legislative action that limited alternative legislative solutions to those that utilized existing institutional structures. As such, these solutions were easiest to implement, unlike solutions that require multimodal approaches, agency collaboration, and the strengthening of the welfare state—even if such a multimodal approach was empirically the most successful model for combatting addiction and overdose crises.²⁴ These officials and the agencies that they oversee have influenced the problem definition discourse in a number of ways, including by using their positions as subject matter experts, implementers, and enforcers of legislation to increase the credibility of their definition of the problem when testifying in front of Congress.²⁵ As such, these agencies participate in the problem definition discourse along with organized interest groups and they may even influence the types of causal theories supported by organized interest groups.

In sum, administrative agencies influence the problem definition discourse by contributing scientific information that supports their causal story and providing accompanying rhetoric. These agencies have historically influenced the problem definition discourse, and in doing so, affected the types of legislative solutions proposed and enacted in U.S. drug policy.²⁶ The causal stories used by the agencies to describe the causes of drug problems have been supply-side, focusing on the availability of drugs as the cause for use, with the lack of access to drug abuse treatment coming at a distant second.²⁷ The legislative solution enacted to address the nation's current drug problem is a primarily health-oriented piece

23 See generally DAVID T. COURTWRIGHT, *DARK PARADISE: A HISTORY OF OPIATE ADDICTION IN AMERICA* (enl. ed. 2001) (1982); MUSTO, *supra* note 11. See generally FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE (Jonathan Erlen & Joseph T. Spillane eds., 2004) [hereinafter Erlen & Spillane].

24 For support for this argument, compare COURTWRIGHT *supra* note 23, MUSTO, *supra* note 11, and ERLIN & SPILLANE, *supra* note 23, with ALICE RAP FINDINGS, *supra* note 13.

25 See generally COURTWRIGHT, *supra* note 23; MUSTO, *supra* note 11; Erlen & Spillane, *supra* note 23.

26 See generally Erlen & Spillane, *supra* note 23; COURTWRIGHT, *supra* note 23; MUSTO, *supra* note 11.

27 Federal administrative agencies have been historically incentivized to support supply-side policies that are criminal justice oriented. See El-Sabawi, *supra* note 1. See generally Erlen & Spillane, *supra* note 23; MUSTO, *supra* note 11.

of legislation, and suggests that the causal stories used by federal administrative agencies were more health- or medically-oriented.

III. Causal Stories, Pressure Groups, Congress, and the Opioid Crisis

A. *Types of Causal Stories Used by Pressure Groups in Congressional Hearings*

In order to get at least a partial view of the types of causal stories used by pressure groups to convince Congress of the causes of the opioid crisis, I reviewed a sample of federal congressional hearing testimony on substance abuse and overdoses between 2014 and 2016. I chose this time period because it preceded the enactment of CARA.

The first trend I noticed was that some narratives included an explicit reference to a cause of the problem (explicit causal theory), while others implicitly suggested the cause by supporting a particular solution (implicit causal theory). Implicit causal theories allowed the narrators to support a causal theory that aligned with a policy solution, without having to explicitly blame certain actors for causing the crisis. Even when explicit narratives were used, pressure groups demonstrated a preference for explicitly blaming groups.

The second major trend I identified was that the criminal justice theme that dominated problem definitions in past drug crises²⁸ has been overtaken by a health theme that included attributing the causes of addiction to a disease and calling for health actors to be involved in addressing the crisis. Despite the prevalence of the health theme, however, the idea that drug supply caused addiction and overdoses was still ever-present.²⁹ Finally, only a select few testifiers acknowledged PSE factors³⁰ as causes of drug use, despite the empirical literature supporting their likely contribution and the emphasis placed on these causes in other developed nations.³¹

28 See generally COURTWRIGHT, *supra* note 23.

29 This idea will be discussed in detail in Section III(A)(2)(a), *infra*.

30 In saying psycho-social-economic factors, I am also referencing ideas of despair or lack of hope as factors that contribute to drug use and overdoses. For an overview of the despair hypothesis, see Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY 397, 397–98, 408, 417, 420, 427 (2017). See also CARL L. HART, *HIGH PRICE: DRUGS, NEUROSCIENCE AND DISCOVERING MYSELF* 8, 90–94 (Penguin Books Ltd. 2013).

31 See generally *Technical Reports*, ALICE RAP, <http://www.alicerap.eu/resources/>

1. *Implicit vs. Explicit Causal Stories*

a. *Implicit Causal Stories*

A subset of the hearing testimony that I analyzed did not include explicit causal theories, in that the speakers did not unequivocally state the cause of the opioid crisis, but rather, they implied the cause through their support for a particular solution and often through the types of statistics they chose to highlight. Such testimony often began with a general statement of the scope of the opioid crisis, supported by statistics, and then a call for the proposed solution to be adopted.

For example, during one hearing, the U.S. Department of Health and Human Services proposed solutions aimed at decreasing the supply and availability of prescription opioids, including providing support to states invested in prescription drug monitoring programs (PDMPs) and publishing a “best practices” for prescribing opioids without explicitly stating that over-prescription of opioid prescription pills was the cause of the opioid crisis.³² HHS implicitly communicated that over-prescription was the cause by suggesting solutions that were aimed at decreasing the supply of prescription opioids.

Implicitly referencing the cause of the problem accomplishes more than just supporting the preferred solution. Arguably, the benefit of using such implicit causal stories is that the narrator avoids the political consequences of explicitly blaming a group, while still supporting the desired policy solution. For example, rather than

documents/cat_view/1-alice-rap-project-documents/7-reports.html (providing reports from the ALICE RAP series project) (last visited May 22, 2018). *See, e.g.*, ALICE RAP, DELIVERABLE 9.1: THE DETERMINANTS OF A REDUCTION IN OR CESSATION OF HARMFUL SUBSTANCE USE AND GAMBLING (n.d.), http://www.alicerap.eu/resources/documents/doc_download/206-deliverable-09-1-determinants-of-a-reduction-in-or-cessation-of-harmful-substance-use-and-gambling.html (discussing “the determinants of harmful substance use and gambling from across 11 disciplines within five clusters: social and cultural factors, personal factors, patterns of usage and drug knowledge, cellular and molecular factors, and multidisciplinary models.”).

32 *See Examining Legislative Proposals to Combat Our Nation’s Drug Abuse Crisis: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 114th Cong. 26–34 (2015) (prepared statement of Richard Frank, Ph.D., Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services), 2015 WL 6152905.

directly blaming prescribers for causing the opioid crisis and risking the political ramifications of accusing a relatively politically powerful group of malfeasance or negligence, use of an implicit causal story garners support for a group's preferred policy solution, without alienating prescribers.

Implicit causal stories are strategically beneficial not only because they help narrators avoid the political ramifications of finger-pointing, but also because they shift the discourse away from debating the causes of the opioid crisis to debating the efficacies of the proposed solutions.³³ The implicit cause was assumed to be the true cause, signaling that no discussion was even needed.³⁴ This kept actors from critiquing and, perhaps, theorizing that the causes of the opioid crisis were not only the facially obvious supply-side causal theories that were most frequently referenced, but also included fuzzier concepts of despair,³⁵ lack of hope, or lack of opportunity,³⁶ that were largely omitted from the pressure group discourse. Such a strategy shifts the discourse away from debating the causes of the opioid crisis to debating the merits of the solution. And, a simple before-and-after measurement of drug supply would be a sufficient measure of a solution's efficacy.

b. Explicit Causal Stories

In the congressional hearing testimony analyzed, explicit causal stories most often took the form of narratives rooted in *intentional* and *inadvertent* causal theories.³⁷ Intentional causal theories include causal theories that posit that the actor's action was intentional and that the actor intended the results.³⁸ Inadvertent

33 See, e.g., *id.*

34 See, e.g., *id.* (The focus on the solutions of supply, treatment for drug users, and harm reduction imply that the problem is the supply, lack of treatment, and lack of harm reduction without explicitly stating it as the cause).

35 See generally Case & Deaton, *supra* note 30.

36 See HART, *supra* note 30, at 8, 90–94.

37 Dr. Deborah Stone argues that most causal theories used in policy narratives involve two components: actions and consequences. STONE, *supra* note 5, at 208 (3d ed. 2012). Blame is assigned based on whether or not these actions and consequences were intended (or guided) or unintended (unguided). *Id.* Therefore, causal theories can include (1) unguided actions but with intended results (“mechanical cause”), (2) guided actions with intentional consequences (“intentional cause”), (3) guided actions with unintended consequences (“inadvertent cause”), or (4) a result of a “complex systems.” *Id.* at 208, 214–15.

38 Intentional causes typically include an actor that acted intentionally and

causal theories are theories of causation in which the actor may have intended to commit the act, but did not intend the resulting outcome.³⁹

Although most testimony *implicitly* referred to over-prescription as the cause of the problem, there were instances in which certain actors were *explicitly* blamed for causing the opioid crisis by over-prescribing prescription opioids or for causing the over-prescription of opioids. Actors that were blamed explicitly for over-prescription included the medical profession (in general), pharmaceutical opioid manufacturers, drug seekers, “bad apples” in the medical industry, and foreign drug cartels.⁴⁰

2. Supply-Side vs. Demand-Side Causal Narratives

Aside from the distinction between explicit and implicit causal narratives, narratives could be further divided into supply-side and demand-side causal narratives. Supply-side causal narratives blamed the cause of the opioid crisis on the supply of opioids, while demand-side causal narratives attempted to explain why people demanded drugs.

a. Supply-Side Causal Stories

The idea that the rise of overdoses and addiction in the U.S. was caused by the increased availability of opioids was a common feature of the congressional hearing testimony reviewed.⁴¹

intentionally caused the outcome in dispute. *Id.* at 209. This category includes “conspiracies,” “harmful side effects that are known but ignored,” “bad apples,” and “blaming the victim.” *Id.* at 208. These narratives explicitly blame the victim for causing the social problem that the victim is affected by. *Id.*

39 Inadvertent causal theories include “unanticipated harmful side effects of policy,” “avoidable ignorance,” “carelessness,” and “blaming the victim.” STONE, *supra* note 37. Causal theories that blame the victim within this category are softer than the intentional causal theories outlined in note 38, as the actions could have been well-intentioned but resulted in a poor outcome. *Id.* For example, if physicians, as a profession, prescribed opioids in order to treat pain as a fifth vital sign and ease the pain of the population, although their prescriptions were intentional acts, they did not intend for their patients to become addicted or overdose to the medications. *See infra* p. 390 and note 75.

40 Examples of causal stories used to assign blame will be provided in the following sub-section.

41 *See, e.g., Heroin and Prescription Drug Abuse: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 113th Cong. (2014) (statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse) [hereinafter NIDA 2014], 2014 WL 1990482.

Historically, supply-side causal narratives emphasized the trafficking of illicit psychoactive substances with blame explicitly assigned to foreign and local criminal enterprises.⁴² The 2014–2016 supply-side causal narratives differed from the blatant supply-side narratives of the past because the 2014–2016 narratives involved health actors, the health system, and health terminology.⁴³ For example, while street gangs and Colombian cartels may have been blamed for supplying the crack cocaine responsible for the crack cocaine drug crisis in the late 1980s and early 1990s,⁴⁴ doctors, pharmacists, pharmacies, and drug manufacturers were often blamed for supplying the opioid crisis.⁴⁵ While internal systems at the Federal Bureau of Investigation or the Drug Enforcement Administration may have been touted as the solutions to past drug epidemics, prescription monitoring systems were proposed to identify bad apples in the healthcare system,⁴⁶ as well as to improve quality of care.⁴⁷ The use of health or medical terminology and actors makes the narratives used appear as if the opioid crisis is being defined as a public health issue. However, the causal narratives are classic supply-side narratives attributing the cause of addiction and overdoses to availability of the substance; and they imply that the supply must be limited because the prevalence of the supply itself causes rises of overdose and addiction. Meanwhile, the public health approach to drug policy has been characterized, at least internationally, by solutions that focus on reducing the harms

42 For historic examples, see MUSTO, *supra* note 11; COURTWRIGHT, *supra* note 23.

43 By health terminology, I am referring to the characterization of addiction or overdoses as adverse health consequences or side effects to medication, for example. See, e.g., *Opioid Abuse Among Older Americans: Hearing Before the S. Spec. Committee on Aging*, 114th Cong. (2016) (statement of Katherine Neuhausen, M.D., MPH, Assistant Professor, Department of Family Medicine and Population Health and Associate Director, Office of Health Innovation, Virginia Commonwealth University) [hereinafter *Opioid Abuse Among Older Americans*], 2016 WL 370153.

44 See COURTWRIGHT, *supra* note 23 at 180.

45 See, e.g., *Opioid Abuse Among Older Americans*, *supra* note 43.

46 See, e.g., *Heroin/Prescription Drug Abuse: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Louis J. Milione, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration) [hereinafter *DEA 2016*], 2016 WL 319839.

47 See *VA Opioid Prescription Policy, Practice, and Procedures: Hearing Before the S. Comm. on Veterans' Affairs*, 114th Cong. 12–17 (2015) (prepared statement of John D. Daigh, Jr., M.D., C.P.A., Assistant Inspector General for Healthcare Inspections, Office of Inspector General, U.S. Department of Veterans Affairs) [hereinafter *Daigh, VA Opioid Prescription Policy*], 2015 WL 1348883.

of use and addressing the reasons for users' demand for the drug.

The most dominant supply-side causal narratives in the 2014–2016 legislative discourse can be grouped as follows: (1) narratives that blamed the cause of the opioid crisis on over-prescription of prescription opioids, (2) those that blamed “bad apples” for diverting prescription opioids to the streets for financial gain, and (3) those that blamed the opioid crisis on international supply of heroin and synthetic drugs.

i. Over-Prescription as a Cause of the Opioid Crisis

Variations of causal stories that attributed the cause of the opioid crisis to physician over-prescribing included: (1) The pills themselves were highly addictive,⁴⁸ even for those that used the prescriptions as directed;⁴⁹ and (2) Opioids were over-prescribed and left-over prescriptions⁵⁰ were diverted to the black market or misused by family members and friends.⁵¹ Some narrators explicitly blamed physicians for over-prescribing,⁵² and others blamed “bad apples”⁵³ in the medical industry, pharmacists, physicians, pharmacies, drug manufacturers, and doctor shoppers, for diverting opioids for financial gain.⁵⁴ Some narrators avoided blaming groups of actors directly and, instead, spoke generally about over-prescription or prescription drug availability as a problem.⁵⁵

48 See, e.g., *Opioid Abuse in America: Facing the Epidemic and Examining Solutions: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions*, 114th Cong. 25–27 (2015) (prepared statement of Eric Spofford, Chief Executive Officer, Granite House, Derry, NH; New Freedom Academy, Canterbury, NH), 2015 WL 8158091.

49 See, e.g., *Opioid Abuse Among Older Americans*, *supra* note 43.

50 The term *left-over prescriptions* refers to instances in which the patient does not use the entire amount prescribed and thus some prescription pills are “left over.” See, e.g., *Opioid Crisis: Field Hearing Before the S. Comm. on Homeland Sec. and Governmental Affairs*, 114th Cong. 61–69 (2016) (prepared statement of Tim Westlake, M.D., Vice Chairman, State of Wisconsin Medical Examining Board and Chairman, Controlled Substances Committee) [hereinafter *Heroin and Prescription Opioids in Wisconsin*], 2016 WL 1572172.

51 See, e.g., DEA 2016, *supra* note 47.

52 See, e.g., *Opioid Abuse Among Older Americans*, *supra* note 43.

53 Blaming the “bad apples” is a common causal narrative strategy. See STONE, *supra* note 5, at 208–11.

54 See, e.g., *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50, at 64.

55 See, e.g., *Examining the Opioid Epidemic: Challenges and Opportunities: Hearing Before the S. Comm. on Fin.*, 114th Cong. 42 (2016) (prepared statement of David Hart, Assistant Attorney-in-Charge, Health Fraud Unit/Consumer Protection

For example, the Acting Deputy Administrator of the DEA argued:

Another factor that contributes to the increase of prescription drug diversion is the availability of these drugs in the household. In many cases, dispensed controlled substances remain in household medicine cabinets well after medication therapy has been completed, thus providing easy access to non-medical users, accidental ingestion, or illegal distribution for profit.⁵⁶

By referring to the availability of prescription pain pills in the household, the DEA could reference the consequences of over-prescription (left-over prescriptions) as the cause of the problem, without discussing the prescribers' acts of over-prescribing. Criminal justice agencies, like the DEA, also blamed the "bad apples" in the medical industry directly, for intentionally diverting and profiting from the diversions.⁵⁷ Blaming the bad apples has its political advantages because it allows the blamed group to claim that it is not the group as a whole that is "bad," but rather, a few bad seeds that can be weeded out.⁵⁸ It signals to prescribers that their competence and character were not at issue and assuaged

Section, Oregon Department of Justice), 2016 WL 706631 ("Oregon, like the rest of the nation, has continued to struggle with overprescribing and misuse of prescription opioids."). In some cases, the speaker spoke of how PDMPs decreased the availability of prescription opioids and overdoses. *See, e.g., Heroin/Prescription Drug Abuse: Hearing Before the S Comm. on the Judiciary*, 114th Cong. (2016) (statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse), 2016 WL 319843. These cases focused on the solution of curbing over-prescription rather than the cause of over-prescription itself. *See, e.g., id.; Opioid Crisis: Field Hearing Before the Comm. on S. Homeland Sec. and Governmental Affairs*, 114th Cong. 151–156 (2016) (prepared statement of Carole S. Rendon, Acting U.S. Attorney, Northern District of Ohio, United States Attorney's Office, U.S. Department of Justice), 2016 WL 1608495.

56 *Controlled Substances Quota Process: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 114th Cong. (2015) (statement of Joseph T. Rannazzisi, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration) [hereinafter DEA 2015], 2015 WL 1643509.

57 *See, e.g., id.*

58 *See* STONE, *supra* note 5, at 206–28, for a general discussion about the uses of the "bad apple" narrative in the policy process.

any fears that prescribers, as a group, would be punished for the actions of outliers. Further, supporting such a narrative justified the involvement of criminal justice agencies like Department of Justice and the DEA⁵⁹ and enabled them to request funding to support their role in addressing the opioid crisis.⁶⁰ With the decrease in support for criminal justice solutions to addressing drug problems, agencies like the DEA must continue to justify their expenditures and budget requests. Going along with the health framing, but insisting that there are still “bad guys” within the medical industry causing the problem at issue, allows agencies like the DEA to carve out a role as a “fixer” of the problem and in doing so ensure their continued relevance.⁶¹

Since medical professionals, particularly physicians’ groups and nurses’ associations, are generally positively socially constructed⁶² and relatively politically powerful,⁶³ it is not surprising that some pressure groups did not expressly blame prescribers directly for causing the crisis. These groups focused instead on suggesting solutions, including PDMPs and promulgating physician guidelines, both of which were described as tools that could be used to help practitioners do their jobs better,⁶⁴ as opposed to punishment

59 See DEA 2015, *supra* note 56.

60 Office of the Press Secretary, The White House, *FACT SHEET: President Obama Proposes \$1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic* (Feb. 2, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/02/02/president-obama-proposes-11-billion-new-funding-address-prescription>.

61 For a more detailed accounting of the changing narratives of criminal justice actors in response to the opioid crisis, see Taleed El-Sabawi, *Carrots, Sticks and Problem Drug Use: The Law Enforcement Lobby’s Contribution to the Policy Discourse on Drug Use & the Opioid Crisis*, OHIO ST. L.J. (forthcoming 2019).

62 Individual actors are organized by society into groups. See ANNE LARASON SCHNEIDER & HELEN INGRAM, *POLICY DESIGN FOR DEMOCRACY* 107–09 (1997). These groups are ascribed certain characteristics, often resulting in the group as being either negatively or positively construed. *Id.* These constructions do more than determine the social value of members of the groups, but also have political consequences in the policymaking process. *See id.*

63 *See id.*

64 *See, e.g., VA Opioid Prescription Policy, Practice and Procedures: Hearing Before the S. Comm. on Veterans’ Affairs*, 114th Cong. 6–10 (2015) (prepared statement of Carolyn Clancy, M.D., Interim Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs) [hereinafter Clancy, *VA Opioid Prescription Policy*] (Veterans Administration’s explanation of the benefits of a PDMP), 2015 WL 1348882.

for misdeeds.

Some narratives did directly blame prescribers as a group for over-prescribing.⁶⁵ Oftentimes, those most critical of the medical profession came from within it. For example, two physician testifiers, one representing the Wisconsin Medical Board, and the other representing the Phoenix House, a well-known treatment facility, blamed prescribers for causing the opioid crisis,⁶⁶ but communicated prescribers' good intentions and lack of malice, emphasizing that they had meant to help, not harm.⁶⁷ They argued that although their actions may have been intentional (prescribing opioids), the consequences of their actions (addiction, overdoses, and diversion) were unintended.

Aside from deflecting blame by arguing that the consequences of their acts were unintended, prescribers tried to shift blame by using (1) narratives that argued that "bad apples" were responsible for over-prescribing and diversion, (2) narratives that attempted to shift the focus to another point in the causal chain, and (3) narratives that blamed the system's emphasis on treating pain for all patients seeking care.

For example, some physicians that testified embraced the bad apple strategy in order to deflect blame from the profession as a whole.⁶⁸ Such a causal narrative strategy allowed the profession as a group to shift the blame to the greedy and malicious doctor

65 See *Examining the True Costs of Alcohol and Drug Abuse in Native Communities: Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. (2015), 18–22 (prepared statement of Hon. Melanie Benjamin, Chief Executive, Mille Lacs Band of Ojibwe Indians) [hereinafter *Drug Abuse in Native Communities*], 2015 WL 4572873; *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50; *Opioid Use Among Seniors: Hearing Before the S. Spec. Comm. on Aging*, 114th Cong. (2016) (statement of Jerome Adams, M.D., MPH, Commissioner, Indiana State Department of Health), 2016 WL 739340.

66 *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50; *Heroin and Prescription Drug Abuse: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 113th Cong. (2014) (statement of Andrew Kolodny, M.D., Chief Medical Officer, Phoenix House Foundation) [hereinafter *Statement of Kolodny*], 2014 WL 1990484. See, e.g., *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50, at 62 ("To speak frankly, there can be no doubt that the sources of the supply of opioids stem from the ease of availability of prescription opioids due to over-prescription by doctors themselves. We physicians need to own our part in the problem.").

67 See, e.g., *Statement of Kolodny*, *supra* note 66, at *2 ("Doctors didn't start overprescribing opioids out of malicious intent. For most of us it was a desire to treat pain more compassionately that led to overprescribing.").

68 See, e.g., *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50.

dealers, the “bad guys.” Blame was also shifted from physicians to “doctor shoppers,”⁶⁹ persons who went from doctor to doctor drug-seeking. Although doctor shoppers may have been individuals with opioid use disorder that were drug-seeking, the DEA frequently characterized “doctor shoppers” as part of pharmaceutical diversion schemes, grouping them with the likes of “prescription forgery rings, and practitioners and pharmacists who knowingly divert controlled substance pharmaceuticals.”⁷⁰ Persons with opioid use disorders that were seeking opioids were more often referred to as drug seekers, and although drug seekers were also blamed for “doctor shopping,” they were not portrayed as the “bad guys.” They were described more so as persons who needed to be identified and offered help. They were portrayed as persons who were ill and needed treatment as opposed to “bad apples.”⁷¹

Another narrative strategy used to deflect blame away from prescribers was to redirect focus to another point in the causal chain. For example, some prescribers argued that opioid pain pill manufacturers, like Purdue, misrepresented the safety of their products.⁷² Prescribers argued that they relied on the misrepresentations provided to them by companies like Purdue when deciding how to treat patients with chronic pain.⁷³ The Food and Drug Administration was also blamed for allowing companies like Purdue to market their drugs for chronic pain, despite the lack of evidence for its efficacy.⁷⁴

69 See, e.g., *America’s Heroin and Opioid Abuse Epidemic: Hearing Before the H. Comm. on Oversight and Gov’t Reform*, 114th Cong. 24–34 (2016) (written statement of Louis J. Milione, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration), 2016 WL 1106485.

70 *Id.* at 28, 30.

71 See, e.g., DEA 2016, *supra* note 46. Even the DEA refrained from portraying drug users as criminals, opting to refer to them instead as “our family members, friends, neighbors, and colleagues.” *Id.* at *1.

72 See *Examining Heroin and Opiate Abuse in Southwestern Pennsylvania: Hearing Before the Subcomm. on Health Care of the S. Comm. on Fin.*, 114th Cong. 39–41 (2015) (prepared statement of A. Jack Kabazie, M.D., System Director, Division of Pain Medicine, Allegheny Health Network) [hereinafter *Opiate Abuse in Southwestern Pennsylvania*], 2015 WL 5999232; Statement of Kolodny, *supra* note 66.

73 See, e.g., Statement of Kolodny, *supra* note 66.

74 One narrator blamed not only Purdue Pharma but also the FDA’s improper enforcement of “the Federal Food, Drug and Cosmetic Act (FD&C Act) in 1996, when Purdue Pharma released OxyContin. The FD&C Act prohibits drug companies from promoting products for conditions where evidence of safety and efficacy is lacking. Instead of enforcing the FD&C Act, FDA allowed

Finally, prescribers blamed the system as a whole for pressuring them to address pain at every visit by treating pain as the fifth vital sign.⁷⁵ This emphasis was institutionalized with system-wide quality measures that tied physicians' performance ratings with patient reports of whether or not their pain was adequately addressed.⁷⁶ Further, this emphasis persisted despite the lack of tools, aside from prescription opioids, available to prescribers to address pain.⁷⁷

b. Demand-Side Causal Stories

In the 2014–2016 legislative discourse analyzed, demand-side causal stories, or causal stories that attributed the cause of the opioid crisis to users' demand for drugs, focused on the lack of access to treatment and the biological mechanisms of addiction. The idea that socio-economic, psychological, or sociological circumstances caused or even contributed to the opioid crisis was largely lacking from the congressional hearing testimony. Despite recent and past research that acknowledges the roles of depression,⁷⁸ joblessness,⁷⁹

Purdue Pharma to promote OxyContin to family doctors for treatment of common aches and pains and to launch a campaign of misinformation about opioid risks and benefits." *Id.* at *3.

75 See, e.g., Daigh, *VA Opioid Prescription Policy*, *supra* note 47, at 12 ("Adequate management of pain has become a tenant of the compassionate delivery of health care. Subjective pain levels are now considered to be the fifth vital sign in medicine in addition to body temperature, pulse rate, respiration rate, and blood pressure.").

76 See, e.g., *Opiate Abuse in Southwestern Pennsylvania*, *supra* note 72, at 39–40 ("Physicians who have compensation or employment tied to patient satisfaction scores may feel pressure to prescribe opioids in response to patient pain complaints.").

77 See, e.g., *Addressing Trauma and Mental Health Challenges in Indian Country: Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. 30–35 (2016) (prepared statement of Kathryn R. Eagle-Williams, M.D., CEO/Quality Care Director, Elbowoods Memorial Health Center, Mandan, Hidatsa and Arikara Nation), 2016 WL 4527182 (discussing the lack of tools to address mental health issues in Native American communities, including the use of opiates "to mask mental illness.").

78 See Katherine McLean, "There's Nothing Here": *Deindustrialization as Risk Environment for Overdose*, 29 INT'L J. DRUG POL'Y 19, 24–25 (2016).

79 *Id.* at 24.

lack of social connectedness,⁸⁰ neighborhood sociocultural factors,⁸¹ and lack of hope (for the betterment of life's circumstances)⁸² in influencing addiction and overdose, reference to such causes was largely ignored in the 2014–2016 hearing testimony.

The narratives that cited the lack of access to treatment as a cause of the opioid crisis were often ambiguous. Most implied that access to treatment was a problem without referring to the lack of treatment as a cause of the opioid crisis, but rather proposing solutions that include expanding funding provided to treatment systems.⁸³ These narratives generally called for an increase in funding.⁸⁴

Another subset of narratives cited the lack of “evidence-based” or “quality” treatment as a problem contributing to the opioid crisis. These narratives were frequently coupled with solutions proposing increased access to medication assisted treatment (MAT).⁸⁵ In other words, there seemed to be a common association of MAT with evidence-based or quality treatment. Not all MAT was treated equally, with some narrators supporting certain types of MAT over others.⁸⁶ Many of these narrators were careful to acknowledge

80 See generally Amary Mey et al., *What's the Attraction? Social Connectedness as a Driver of Recreational Drug Use*, 23 J. SUBSTANCE USE 327 (2018); Theophile Niyonsenga et al., *Social Support, Attachment, and Chronic Stress as Correlates of Latina Mother and Daughter Drug Use Behaviors*, 21 AM. J. ADDICTIONS 157 (2012); John Oetzel et al., *Social Support and Social Undermining as Correlates for Alcohol, Drug, and Mental Disorders in American Indian Women Presenting for Primary Care at an Indian Health Service Hospital*, 12 J. HEALTH COMM. 187 (2007).

81 COMM. ON OPPORTUNITIES IN DRUG ABUSE RESEARCH, INST. OF MED., *PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH* 126–27 (1996) (discussing sociocultural and environmental factors in certain communities that affect drug use and abuse).

82 See generally HART, *supra* note 30.

83 See, e.g., *Opioid Abuse Among Older Americans*, *supra* note 43; *Heroin/Prescription Drug Abuse: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Linda E. Hurley, Chief Operating Officer and Director, Clinical Services, CODAC Behavioral Healthcare, Inc.), 2016 WL 319842.

84 See, e.g., *America's Growing Heroin Epidemic: Hearing Before the Subcomm. on Crime, Terrorism, Homeland Sec., and Investigations of the S. Comm. on the Judiciary*, 114th Cong. 60–68, 64 (2015) (prepared statement of Nancy G. Parr, Commonwealth's Attorney, City of Chesapeake, Va.) 2015 WL 4538567 (“There are too few treatment programs. There are too few affordable treatment programs. There is insufficient funding for valid treatment programs. There is a stigma related to seeking treatment. Money addresses the first three problems and education can address the fourth.”).

85 See, e.g., NIDA 2014, *supra* note 41.

86 Some groups voiced concern over the addictiveness of methadone, the

that MAT could and should be combined with psychotherapeutic treatment and that MAT was not for everyone.⁸⁷ However, the need to expand the number of treatment providers that were legally able to provide MAT was frequently mentioned.⁸⁸

Although overdose reversal medications (ORMs) do not technically reduce the demand for drugs, I considered any narrative referencing the lack of access to ORM as demand causal narratives, because ORM are harm-reduction methods that are meant to be followed up with treatment for the underlying substance abuse.⁸⁹ Lack of access to ORM was not necessarily cited as a major cause of the opioid crisis; however, lack of access to ORM was cited as a factor that contributed to the scope of the problem.⁹⁰ Further, even if the causal narratives used did not cite to a lack of access to ORM as the dominant cause, many referred to increasing access to ORM

potential for its abuse, and the possibility of diversion. *See, e.g., Drug Abuse in Native Communities, supra* note 65.

87 *See, e.g.,* NIDA 2014, *supra* note 41.

88 *See, e.g., Opioid Abuse Among Older Americans, supra* note 43; *Opioid Abuse in America: Facing the Epidemic and Examining Solutions: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions, 114th Cong. 8–15 (2015)* (prepared statement of Leana Wen, M.D., Health Department Commissioner, Baltimore, MD), 2015 WL 8489722; Statement of Kolodny, *supra* note 66.

89 *Naloxone for Opioid Overdose: Life-Saving Science, NAT'L INST. FOR DRUG ABUSE*, <https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science/naloxone-opioid-overdose-life-saving-science> (last updated Mar. 2017).

90 *See, e.g., Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2016, Part 6: Hearing Before the Subcomm. on the Dep'ts of Labor, Health and Human Servs., Educ., and Related Agencies of the H. Comm. on Appropriations, 114th Cong. 568–72 (2016)* (prepared statement of Whitney O'Neill Englander, Government Relations Manager, Harm Reduction Coalition), 2015 WL 1967922; *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 114th Cong. 15–24 (2015)* (prepared statement of Fred Wells Brason, II, President and Chief Executive Officer, Project Lazarus), 2015 WL 1384265; *Examining the True Costs of Alcohol and Drug Abuse in Native Communities: Hearing Before the S. Comm. on Indian Affairs, 114th Cong. 11–16 (2015)* (prepared statement of Mirtha Beadle, Director, Office of Tribal Affairs and Policy Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), 2015 WL 4572876; *What Is the Federal Government Doing to Combat the Opioid Abuse Epidemic?: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce, 114th Cong. 58–70 (2015)* (prepared statement of Douglas C. Throckmorton, M.D., Deputy Director, Center for Drug Evaluation and Research, Food and Drug Administration), 2015 WL 1967893.

when proposing solutions to the problem.⁹¹

Finally, some causal stories did mention the lack of patient education as a contributing factor to the opioid crisis or referenced the need to educate patients on the risks of opioid prescriptions in an effort to decrease their demand for the drugs.⁹²

B. Summary of Findings

While CARA evidenced a rare instance in U.S. drug policy in which health solutions dominated legislation, the causal narratives used and the solutions adopted appeared more of a departure from the U.S.'s past approaches to drug policy than they actually were. The types of causal stories used by pressure groups in hearing testimony equally favored supply-side causal theories and ambiguous calls for increasing the access to treatment; the solutions offered focused on decreasing the supply of opioids, most often through reducing the prescription of opioids overall via prescriber education and PDMPs. Although health actors may have been called to implement the proposals and health-related terminology may have been used, at their core, these solutions are supply-side solutions. The actors in the causal stories were different but the storylines remained similar. The drug dealers of the 1980s and 1990s were changed to physicians

91 See, e.g., Clancy, *VA Opioid Prescription Policy*, *supra* note 64; *Drug Enforcement Administration: Hearing Before the Subcomm. on Crime, Terrorism, Homeland Sec., and Investigations of the H. Comm. on the Judiciary*, 113th Cong. 12–18 (2014) (prepared statement of Hon. Michele M. Leonhart, Administrator, Drug Enforcement Administration), 2014 WL 4643550; *Examining the Policies and Priorities of the U.S. Department of Health and Human Services: Hearing Before the H. Comm. on Educ. and the Workforce*, 114th Cong. 12–28 (2016) (prepared statement of Hon. Sylvia Matthews Burwell, Secretary, U.S. Department of Health and Human Services), 2016 WL 1023258. Increasing access to ORMs included training or calling for the training of first responders to administer ORMs. See, e.g., *Border Security—2015, Volume 2 of 2: Hearing Before the S. Comm. on Homeland Sec. and Gov't Affairs*, 114th Cong. 1568–1578 (2015) (prepared statement of Hon. R. Gil Kerlikowske, Comm'r, U.S. Customs and Border Protection, U.S. Department of Homeland Security), 2015 WL 5317597; *Deadly Synthetic Drugs and Poison Peddlers: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Sullivan K. Smith, MD, FACEP, Medical Director, Emergency Department Cookeville Regional Medical Center, Cookeville, Tenn.), 2016 WL 3165409.

92 See, e.g., *VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 113th Cong. 33–39 (2014) (prepared statement of Robert Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans' Affairs), 2014 WL 768554.

or prescribers. Prescription drug companies and pill mills were substituted in for the international drug cartels.⁹³ There appeared to be a general consensus that it was the availability of opioids that caused the nation's drug problems—the underlying assumption that the mere availability of psychoactive substances would create a new class of drug users.

Although the focus of the narratives and the aligning solutions were supply-oriented, and not evidence of a demand-side focus found in more progressive drug policy, these supply-side solutions were not the same criminal justice-oriented solutions of the past.⁹⁴ And such a shift is at least a symbolic victory, as it evidences an understanding that the U.S.'s historic approach is not effective. However, the types of causal stories used to describe the opioid crisis and aligned solutions are piecemeal at best, superficial at worst, and only bring the U.S. marginally closer to embracing the most evidence-based drug policy regimes.

Moreover, the discourse focused more so on which policy solutions to enact, as opposed to fully engaging in a discussion of what caused the opioid crisis in the first place. In much of the testimony, it was accepted as a given that over-prescription caused the opioid crisis and, as such, over-prescription needed to be curtailed. While the need to cut down on opioid prescriptions and to simultaneously better fund substance abuse treatment centers are worthwhile endeavors, unless the U.S. fully engages in a discussion of what causes a person to misuse prescription pain medication or illicit drugs, the billions of dollars of funding allocated to addressing the opioid crisis will not produce the desired results, nor will they have any lasting effect on stymieing future drug crises.

Had their motivation been collectively to redefine problem drug use in a manner most aligned with best practices in drug policy, pressure groups might have focused on demand-side approaches that emphasize a public health orientation, or even better yet, an emphasis on improving the well-being of the drug user so that he is less likely to use.

IV. Concluding Thoughts

In this article, I have reviewed the ways in which pressure

93 See, e.g., DEA 2016, *supra* note 46, at *3. Mexican cartels were also referenced as contributors to the opioid crisis, but the cartels were blamed far less frequently than health actors. See, e.g., *id.*

94 El-Sabawi, *supra* note 1, at 3–4.

groups can use causal stories to influence the types of policy solutions available to legislators seeking to address the policy problem, specifically the current opioid crisis. To lend credence to the theoretical literature cited, I analyzed congressional hearing testimony given by pressure groups testifying on problem drug use prior to the passage of CARA, health-oriented federal legislation aimed at addressing the drug crisis. Since the types of causal theories used to describe a policy problem are posited to align with the types of solutions adopted, I expected to see health-oriented causal stories dominating the criminal justice-oriented causal stories commonly used to justify past U.S. drug policy.⁹⁵

Pressure groups did indeed utilize a health-oriented approach to characterize the opioid crisis. The causal stories used painted the issue as one that was caused by health actors and one that should be solved using the health system. The transition from a criminal justice orientation to a health orientation shifted the blame from the drug user's character to forces outside of the user's control, like outside actors and biological predispositions. In doing so, the hearing testimony often portrayed drug users as persons in need of medical help as opposed to criminal punishment. This shift away from what European scholars have termed the "moral paradigm" approach and toward an assistentialism approach is laudable, as it makes treatment more likely than incarceration.⁹⁶

Such a framing, however, remains decades behind our European counterparts who have surpassed the assistentialism approach to embrace a public health approach and have progressed beyond the public health approach to advocate for a well-being approach.⁹⁷ Preceding CARA's enactment, the bipartisan support for addressing problem drug use and the more positive social construction of the target population of drug users⁹⁸ offered

95 See generally *id.* (providing overview of some of these criminal justice oriented causal stories and policies).

96 The "moral paradigm" approach was influenced by puritan ideology; the dominant causal narrative attributed addiction to the individual's lack of self-control and overall character weakness, and drug users were characterized as "sinful" and "vicious." See YSA ET AL., *supra* note 9, at 3–4. The assistentialism approach is characterized by a belief that drug users are in need of saving and that the healthcare professional is the individual best suited for doing the saving; the dominant causal narrative attributed addiction to disease. See *id.* at 4.

97 See ALICE RAP FINDINGS, *supra* note 13, at #4, 8, 42, 45, 48, 49.

98 See Taleed El-Sabawi, *What Motivates Legislators to Act: Problem Definition & the*

advocates a policy window of opportunity⁹⁹ for which drug policy advocates could redefine problem drug use. Such an opportunity to re-characterize a policy problem is rare and the manner in which pressure groups choose to do so affects not only the current opioid crisis, but also has long-lasting effects on the path of drug policy in the future.¹⁰⁰

Rather than take full advantage of this opportunity to re-characterize problem drug use in a way that aligned with best practices in drug policy, actors testifying before Congress were focused on the immediate need to decrease the availability of opioids, attributing the cause of the problem to the supply of opioids and proposing solutions to help decrease the supply. Given the over-use of prescription opioids in the last decade, it is not surprising that over-prescription was often cited as the main cause of the opioid crisis and that it was regularly accompanied by solutions aimed at decreasing the number of prescriptions. Despite the short-term benefits of supply control, as a long-term focus of drug policy, supply control-oriented drug policy, as opposed to demand control, is not a feature of the leading European drug policy model¹⁰¹ and has not been successful in controlling drug use in the U.S. historically.¹⁰²

Admittedly, some pressure groups involved in the causal narrative discourse may have been most interested in supporting narratives that protected its members from blame and punishment, as opposed to strategically utilizing this window of opportunity to decrease problem drug use in the long term. However, even drug policy and health advocates that were concerned primarily with improving the rates of addiction and overdose did not take advantage of the opportunity to redefine drug use in a manner that made most likely the adoption of a *drug policy system* that would deliver the best

Opioid Epidemic, a Case Study, 15 IND. HEALTH L. REV. 188, 211–12 (2018) (discussing the social construction of target populations in general and as applied to populations of drug users throughout history).

99 See *supra* text accompanying note 16.

100 See generally FRANK R. BAUMGARTNER ET AL., LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY (2009) (providing an analysis of group efforts to define policy issues and noting the rarity of successful problem re-definition).

101 YSA ET AL., *supra* note 9, at 47–48. None of the trendsetting countries in drug policy prioritize supply reduction, whether it be through efforts to arrest and penalize high traffic offenders, prevent the importation of drugs, or to monitor drug diversion from pharmacies and physicians. See *id.* at 47–68.

102 COURTWRIGHT, *supra* note 23, at 132, 159–60.

long-term results.

Although cloaked in medical and health terminology, many of the causal stories used by pressure groups emphasized the supply, or availability, of prescription opioids as the cause of the crisis and substituted actors in the medical industry for the street drug dealers of past narratives. Despite references to biological or genetic factors or lack of access to health services, the psychological, sociological, economic, and health factors that greatly impact drug use¹⁰³ were essentially ignored. Of course, greater funding for drug treatment is greatly needed, as is the expansion of access to MAT, two solutions that were identified by pressure groups. However, without building the structure that is found in model drug policy systems and without establishing coordination between agencies that address not only treatment but also the triggers and social determinants of drug use, the money allocated to address the opioid crisis will not address the root causes of problem drug use.

Undeniably, the U.S. does not have the social safety net that is the hallmark of many European countries with model drug policies. For example, many of the countries with the best drug policies also have universal healthcare systems, as well as more generous welfare systems.¹⁰⁴ Therefore, some may argue that European countries had the infrastructure and the policy experience to approach drug use as a public health problem or a well-being problem. Even conceding these claims, however, the U.S. does have a shadow or privatized welfare state¹⁰⁵ that it can draw on and private actors within it that it can coordinate with in order to mimic European drug policy without overhauling its social welfare system. Aside from coordinating with the private sector, U.S. policymakers could work with state and local

103 See Laura Stoll & Peter Anderson, *Well-being as a Framework for Understanding Addictive Substances*, in *THE IMPACT OF ADDICTIVE SUBSTANCES AND BEHAVIOURS ON INDIVIDUAL AND SOCIETAL WELL-BEING* 53, 58–64 (Peter Anderson et al. eds., 2015) (discussing the link between factors that comprise a person’s well-being and various addictions). See generally Robert C. Pope et al., *The Social Determinants of Substance Abuse in African American Baby Boomers: Effects of Family, Media Images, and Environment*, 21 *J. TRANSCULTURAL NURSING* 246 (2010). See also Petra Meier et al., *Project Area 3: Determinants of Addiction*, ALICE RAP, <http://www.alicerap.eu/about-alice-rap/areas-a-workpackages/area-3-determinants-of-addiction.html> (last visited Mar. 23, 2018).

104 See generally YSA ET AL., *supra* note 9.

105 See, e.g., MARIE GOTTSCHALK, *THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES* 1–2 (2000).

governments, as well as with existing federal programs, to offer coordinated services and rehabilitation programs for drug users or persons at risk for drug use. Federal funding to address the opioid crisis can be allocated not only to fund treatment, but also to assist with housing, job training, and trauma treatment, thereby increasing drug users' quality of life and decreasing their demand for drugs.

However, without framing drug use as a problem caused by demand—as a problem which is rooted in psychological, social, economic, and behavioral factors—the wrap-around solutions needed to treat and prevent drug use are not even on the table for discussion. Such a holistic causal definition is necessary to make policy alternatives available that embrace multimodal policies, involving the medical, public health, social services, criminal justice, housing sector, rehabilitation services, and job training and reintegration programs that are key features of trendsetting drug policy models adopted in other developed countries. These policy frameworks not only address current drug crises but also prevent future crises by ensuring a continuum of care that extends beyond the walls of traditional treatment and confinement—progressing to the adoption of what European scholars have called the “well-being paradigm,” whose end outcome is to improve drug users' well-being.¹⁰⁶

Pressure groups that have the time and attention of legislators looking to adopt a problem definition for the opioid crisis are in prime positions to popularize such demand causal stories. And, although it is common for scholars and concerned citizens to consider organized interests as corrupt players in politics, they offer both groups access to the problem definition process. After all, organized interests include professional organizations and citizens' groups, groups that are open to legal scholars and concerned citizens alike to join, to participate in, and to influence.

In conclusion, pressure groups' adoption of a health approach to defining the opioid crisis was notable, but far from the redefinition needed to effectuate true drug policy reform. If policy actors are interested in both addressing current drug misuse and preventing future increases in misuse and overdose deaths, the causal stories that they use to describe the cause of drug use must be more than

106 ALICE RAP, DESCRIPTION AND ANALYSIS OF ADDICTION GOVERNANCE PRACTICES UNDERSTANDING CHANGES IN GOVERNANCE PRACTICE 129 (2014), https://www.alicerap.eu/resources/documents/cat_view/1-alice-rap-project-documents/7-technical-reports.html?start=10.

superficially health-oriented. Concerned actors must dig deeper and ask not only why is there an increase in the drug supply, but ask instead, why is there an increase in demand for drugs? Dr. Andrew Weil provides a thought-provoking answer to this question that can challenge the dominant causal theories used to explain the opioid crisis. He writes,

To come up with a valid explanation, we simply must suspend our value judgments about kinds of drugs and admit (however painful it might be) that the glass of beer on a hot afternoon and the bottle of wine with a fine meal are no different in kind from the joint of marijuana or the snort of cocaine; nor is the evening devoted to cocktails essentially different from the day devoted to mescaline. All are examples of the same phenomenon: the use of chemical agents to induce alterations in consciousness.¹⁰⁷

He goes on to theorize that people use drugs because they wish to change their consciousness, and their inner need to change consciousness is mostly unaffected by whether or not the drugs are legal.¹⁰⁸ If Dr. Weil is correct and people do demand and use drugs to alter their consciousness—if the need and desire to alter one's consciousness is so deep that legality of the drug is inconsequential—then maybe rather than focusing on decreasing the supply of drugs, drug policy advocates are best advised to ask why chronic and long-term drug users feel such an overwhelming desire to alter their consciousness, or put another way, to escape their reality. Do they have an underlying and untreated mental health issue for which drug use provides relief? Are their living circumstances so abysmal that a drug-induced state is their best escape? Or, are they genetically predisposed to addiction or have underlying altered brain structure from use? These questions are by no means exhaustive and do not address all of the potential causes for a user's demand for a drug. However, asking such questions leads us to identifying causes that align with policy proposals that can change the path of drug policy from a supply orientation to a demand orientation. Pressure groups'

107 Andrew Weil, *Why People Take Drugs*, in *THE AMERICAN DRUG SCENE: READINGS IN A GLOBAL CONTEXT* 72–80, 73 (James A. Inciardi & Karen McElrath eds., Oxford Univ. Press, 7th ed. 2015) (1972).

108 *Id.* at 73–74, 80.

use of a health-oriented frame is a step in the right direction, as long as we acknowledge that it is a small step, and move forward with the intent of taking advantage of future windows of political opportunity to advance not only a health frame but a public health frame, or even a well-being frame, that places the demand of the user at the heart of its narrative.



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