

The Myth of the Addict-Dealer

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Abstract

Drawing on neuroscientific and behavioral research, this Essay shows that severe opioid addiction erodes the very capacities—planning, impulse control, and rational decision-making—that drug distribution requires. The “addict-dealer” is not a category grounded in reality, but a construct produced by expansive statutory definitions and prosecutorial discretion.

This misclassification has consequences. By treating addiction-driven conduct as homicide, DIH prosecutions inflate culpability, blur the constitutional line between status and conduct, and raise serious proportionality concerns under the Eighth Amendment. They also misdirect enforcement away from the actors who structure drug markets while deepening harm in already vulnerable communities. In effect, the law punishes neurological impairment as if it were a criminal enterprise. If criminal liability is to remain credible, it must reflect human capacity rather than ignore it. DIH prosecutions, as currently applied, fail that basic test.

Key Words: Drug-induced homicide, Opioid Use Disorder, Criminal Culpability, Eighth Amendment, prosecutorial misconduct.

The Myth of the Addict-Dealer: *The Criminalization of Addiction*

Introduction

Overdose deaths rarely occur in isolation. They unfold in apartments, alleyways, and parked cars, within tightly interconnected networks of users who share drugs, information, and risk. In these settings, the line between user and distributor is often blurred, if not nonexistent. Yet the legal system draws that line with precision—and with consequence. The United States is prosecuting addiction as homicide. As opioid overdose deaths—driven largely by fentanyl and other synthetic opioids—continue to rise, federal and state prosecutors have increasingly turned to drug-induced homicide (DIH) statutes to impose severe criminal penalties on individuals who supply drugs that result in another person’s death.¹ These prosecutions carry mandatory minimum sentences of twenty years or more and are frequently framed as a necessary response to an ongoing public health crisis. The underlying logic is straightforward: if drug distribution contributes to overdose deaths, then punishing those who supply drugs will deter future harm.

Yet this logic depends on a critical but largely unexamined assumption—that the individuals being prosecuted are meaningfully functioning as “drug dealers” within organized distribution networks. In practice, however, many defendants in DIH cases bear little resemblance to the archetypal dealer. They are not traffickers, managers, or even reliable intermediaries. Instead,

¹ Centers for Disease Control & Prevention, *Drug Overdose Deaths in the United States, 2000–2023* (2024). Drug Enforcement Administration, *National Drug Threat Assessment* 3–5 (2024). Health in Justice Action Lab, *Drug-Induced Homicide Prosecutions Are Counterproductive* (2023), <https://www.healthinjustice.org>.

they are often individuals suffering from advanced opioid use disorder who share drugs within small, unstable networks of mutual addiction.²

The expansion of DIH prosecutions has occurred alongside a broader shift toward punitive responses to the opioid crisis. Although policymakers increasingly acknowledge addiction as a public health issue, enforcement strategies continue to rely heavily on criminalization. This creates a profound tension between medical understanding and legal practice. Individuals are simultaneously recognized as suffering from a chronic brain disorder and punished as though they were fully rational actors engaged in calculated criminal conduct. The result is a conceptual mismatch that lies at the heart of modern drug enforcement policy.

This mismatch is embodied in the “addict-dealer”—a legal fiction that erases the distinction between organized trafficking and conduct shaped by compulsion, withdrawal, and impaired judgment. A corresponding fiction transforms the deceased into an “addict-victim,” recasting a shared condition as a one-sided crime. In death, one becomes innocent; the other, a trafficker. Under expansive statutory definitions, any transfer qualifies as a distribution, regardless of context, intent, or capacity. The result is a legal regime that treats individuals who cannot function as dealers as though they were engaged in a criminal enterprise.

² Leo Beletsky et al., America’s Favorite Antidote: Drug-Induced Homicide Prosecutions and the Expansion of Criminal Liability for Overdose Deaths, 46 *J.L. Med. & Ethics* 430, 433–36 (2018).
Health in Justice Action Lab, *Drug-Induced Homicide Prosecutions Are Counterproductive* (2023), <https://www.healthinjustice.org>.
Traci C. Green et al., An Assessment of Drug-Induced Homicide Laws and Their Impact on Overdose Prevention and Response, 12 *Journal of Public Health Policy*, 1 (2022).

This Essay challenges that classification. Drawing on medical and neuroscientific evidence, it argues that advanced opioid addiction substantially impairs the cognitive and behavioral capacities required to operate as a drug dealer in any meaningful sense. It further demonstrates that the legal framework underlying DIH prosecutions fails to account for these impairments, resulting in a systematic overstatement of culpability. By exposing the “addict-dealer” as a legal myth, this Essay contends that current prosecutorial practices risk imposing severe criminal liability on individuals whose conduct is shaped more by neurological impairment than by deliberate, profit-oriented activity.

The stakes of this misclassification are not abstract. They are measured in decades of incarceration imposed on individuals whose conduct reflects the pathology of addiction rather than the operation of criminal enterprise. If criminal law is to retain its legitimacy, it must distinguish between those who exploit addiction for profit and those who are consumed by it. DIH prosecutions, as currently applied, do not.

I. The Legal Myth of the “Addict-Dealer”

Drug-induced homicide prosecutions depend on a deceptively simple premise: that the defendant is a “drug dealer.” This classification is not merely descriptive—it is dispositive. It is the dealer designation that transforms a drug transaction into a homicide offense carrying severe mandatory minimum penalties. Yet the legal meaning of “dealer” is both underdeveloped and radically overinclusive.

Under federal law, “distribution” encompasses any actual, constructive, or attempted transfer of a controlled substance.³ The *Controlled Substances Act* broadly defines “deliver” to encompass

³ 21 U.S.C. § 802(11); *id.* § 802(8); see also *United States v. Wallace*, 532 F.3d 126, 129–30 (2d Cir. 2008).

any actual, constructive, or attempted transfer, regardless of context or purpose.⁴ Courts have interpreted these provisions expansively, applying them to conduct far removed from traditional notions of drug trafficking.⁵

This definition imposes no requirement of profit, scale, organizational structure, or commercial intent. As a result, the same statutory language applies equally to international traffickers, mid-level distributors, and individuals who share drugs within informal networks of addicts.

This breadth reflects a deliberate legislative choice to cast a wide net over drug-related conduct. But when applied in the context of DIH prosecutions, it produces deeply problematic consequences. By collapsing all forms of transfer into a single category, the law eliminates meaningful distinctions between qualitatively different forms of behavior. The difference between managing a multi-state distribution network and sharing drugs with a friend becomes legally irrelevant.

The consequences of this collapse are magnified by the structure of DIH statutes themselves. These laws attach severe penalties when a death results from the use of distributed drugs, requiring no proof of intent to cause harm. In federal law and many state jurisdictions, liability is *strict*: once causation is established, the defendant may face decades of imprisonment regardless of mental state. The dealer designation thus becomes the gateway through which relatively low-level conduct is transformed into one of the most serious crimes in the criminal code.

⁴ 21 U.S.C. § 802(8) (defining “deliver” as “the actual, constructive, or attempted transfer of a controlled substance”).

⁵ See *United States v. Wallace*, 532 F.3d 126, 129–30 (2d Cir. 2008) (holding that “distribution” under the Controlled Substances Act includes non-commercial transfers and does not require proof of sale or profit).

In practice, this framework sweeps in individuals who lack the characteristics traditionally associated with drug dealers. Many defendants in DIH cases are not engaged in ongoing distribution activities, do not maintain inventory, and do not operate for profit. Instead, they are individuals embedded in networks of shared addiction, where drugs are exchanged, pooled, or redistributed in informal and often chaotic ways. These patterns of behavior bear little resemblance to structured commercial activity, yet they are treated as legally equivalent.

Drug markets, however, are not flat. They are hierarchical and functionally differentiated. At the highest levels are traffickers who import and supply drugs at scale. Below them are high- and mid-level distributors who manage supply chains, coordinate logistics, and oversee networks of lower-level sellers. At the lowest levels are retail sellers who interact directly with users, often in localized and unstable environments. **Figure 1** illustrates this hierarchy.

(Insert Figure 1: Drug Dealer Hierarchy)

This structure reveals that drug distribution involves distinct roles requiring different capacities, resources, and levels of organization. It also highlights the extent to which the legal definition of “dealer” obscures these differences. By treating all transfers equally, the law attributes the characteristics of higher-level actors to individuals who may operate, if at all, at the margins of the distribution system.

This misalignment gives rise to the “addict-dealer” myth. Individuals with severe opioid addiction—who often lack the stability, mental capacity, and intent associated with distribution—are nonetheless classified as dealers because they engage in conduct that technically falls within statutory definitions. The following sections demonstrate why this

classification is fundamentally incompatible with both the medical realities of addiction and the functional demands of drug distribution.

II. Addiction, Incapacity, and the Brain (Full Expansion)

Drug addiction is not simply a pattern of poor choices or a failure of willpower; it is a chronic, relapsing brain disorder that fundamentally alters cognition, behavior, and the capacity for self-regulation.⁶ Modern neuroscience has established that opioid use disorder involves long-lasting changes in both the structure and function of the brain, particularly in regions responsible for executive functioning, impulse control, and decision-making.⁷ These changes are not merely theoretical—they produce observable impairments that directly undermine the assumptions about rational agency that underlie criminal liability.

Opioids, especially fentanyl, exert their effects by binding to mu-opioid receptors in the brain, particularly within the mesolimbic reward system. This interaction produces a rapid and intense release of dopamine, creating powerful sensations of pleasure, relief, and well-being.⁸ The strength of this reinforcement is central to the development of addiction. Unlike natural rewards, which produce moderate and regulated dopamine responses, opioids generate a flood of neurochemical activity that overwhelms the brain's regulatory systems.

Over time, the brain adapts to these repeated surges. It reduces endogenous dopamine production and decreases receptor sensitivity, a process known as downregulation. As a result, individuals

⁶ National Inst. on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction* (2020), <https://nida.nih.gov>.

⁷ Antoine Bechara, Decision Making, Impulse Control and Loss of Willpower to Resist Drugs: A Neurocognitive Perspective, 8, *National Neuroscience* 1458, 1458–59 (2005).

Nora D. Volkow et al., Neurobiologic Advances from the Brain Disease Model of Addiction, 374 *Lancet Psychiatry* 760 (2016).

⁸ Nora D. Volkow & George F. Koob, Brain Disease Model of Addiction: Why Is It So Controversial? 374 *Lancet Psychiatry* 677, 678–80 (2015).

National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction* (2020), <https://nida.nih.gov>.

become progressively less able to derive pleasure from ordinary activities such as eating, social interaction, or work. What initially begins as drug use to achieve euphoria evolves into drug use to avoid dysphoria. The individual no longer seeks the drug to feel good, but to avoid feeling profoundly unwell.⁹

This transition marks a critical shift in behavior. At early stages, drug use may be voluntary and recreational. At advanced stages, it becomes compulsive and survival-driven. The brain's reward system is effectively recalibrated so that the absence of the drug produces a state of distress that demands immediate relief. This process significantly constrains the individual's capacity for deliberation and self-control.

Withdrawal plays a central role in this cycle. Opioid withdrawal is not a mild discomfort; it is an intensely distressing physiological and psychological state. Symptoms commonly include severe muscle and bone pain, nausea, vomiting, insomnia, anxiety, and overwhelming cravings. These symptoms can begin within hours of the last dose and can persist for days or weeks. During withdrawal, behavior is dominated by a singular objective: obtaining relief from suffering. This urgency is not easily overridden by considerations of legality, long-term consequences, or moral judgment.

From a neurological perspective, withdrawal represents a state in which the brain's stress systems are activated while its reward systems are suppressed. The resulting imbalance produces a powerful motivational force that prioritizes drug-seeking behavior above all else. In this state, the

⁹ Eric J. Nestler, Cellular Basis of Memory for Addiction, 6 *Dialogues in Clinical Neuroscience* 5, 7–10 (2004).

capacity for reflective decision-making is severely compromised. Behavior becomes reactive rather than deliberative.¹⁰

In addition to these functional changes, opioid addiction produces measurable structural damage in the brain. Neuroimaging studies have consistently demonstrated reductions in gray matter volume in the prefrontal cortex, a region critical for executive functioning.¹¹ The prefrontal cortex is responsible for planning, impulse control, judgment, and the ability to evaluate consequences. It is the brain region most closely associated with what the law considers rational decision-making.

Damage to the prefrontal cortex has profound implications. Individuals with reduced gray matter in this region exhibit diminished capacity to inhibit impulses, difficulty evaluating risks, and impaired ability to prioritize long-term goals over immediate rewards. In practical terms, this means that individuals with advanced opioid addiction are less able to pause before acting, to consider alternative courses of action, or to conform their behavior to legal or social norms.

Equally significant is the deterioration of white matter in the brain. White matter consists of the neural pathways that connect different regions of the brain, enabling communication between cognitive, emotional, and motor systems.¹² When white matter integrity is compromised, the

¹⁰ George F. Koob, Neurobiology of Opioid Addiction: Opponent Process, Hyperkatifeia, and Negative Reinforcement, 1 *Biological Psychiatry: Cognitive Neuroscience and Neuroimaging* 23 (2016).

Kent C. Berridge & Terry E. Robinson, Liking, Wanting, and the Incentive-Sensitization Theory of Addiction, 28 *American Psychologist* 670 (2016).

¹¹ Z. Shi et al., A Longitudinal Structural Magnetic Resonance Imaging Study of Opioid Use Disorder, *Molecular Psychiatry* (2024).

V. Pando-Naude et al., Gray and White Matter Morphology in Substance Use Disorders, *Translational Psychiatry* (2021).

¹² N. S. Warner et al., Prescription Opioids and Brain Structure in Community-Dwelling Adults, *Mayo Clinic Proceedings* (2024).

S. Mehta et al., Alterations in Volume and Functional Connectivity in Opioid Use Disorder, *Radiology* (2024).

brain's ability to coordinate complex processes is disrupted. This can result in deficits in attention, memory, learning, and problem-solving.

The distinction between gray matter and white matter damage is critical. Gray matter loss affects the ability to make decisions; white matter deterioration affects the ability to execute those decisions. Together, these impairments create a condition in which individuals may not only make poor choices but also lack the capacity to perform even basic tasks consistently and in an organized manner.

These neurological impairments are reinforced by changes in learning and behavior. Addiction is associated with a shift from goal-directed behavior to habit-based behavior. Early drug use may involve conscious decisions aimed at achieving a desired outcome. Over time, however, repeated use leads to the formation of conditioned responses. Environmental cues—such as specific locations, people, or routines—become strongly associated with drug use and can trigger cravings automatically.

This process, often referred to as conditioning, results in behavior that is increasingly automatic and less subject to conscious control. Even in the absence of deliberate intent, individuals may find themselves engaging in drug-seeking behavior in response to cues embedded in their environment. This further reduces the role of rational deliberation in guiding behavior.

Relapse provides additional insight into the nature of addiction. Studies consistently show that relapse rates for opioid addiction are extraordinarily high, often exceeding those for other chronic conditions.¹³ Even after periods of abstinence, individuals remain vulnerable to relapse due to

¹³ Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 *Science* 45, 46–47 (1997); National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction* (2020), <https://nida.nih.gov>.

persistent changes in brain function and conditioning. The risk of relapse is particularly acute during periods of stress or exposure to drug-related cues.

This pattern underscores the chronic nature of addiction. It is not a condition that can be easily reversed through willpower or short-term intervention. Rather, it is characterized by long-term vulnerability and the need for sustained management. The persistence of relapse risk reflects the depth of the underlying neurological changes.

From a behavioral perspective, these changes manifest in ways that are readily observable. Individuals with advanced opioid addiction often exhibit significant impairments in daily functioning. They may struggle to maintain employment, adhere to schedules, or manage basic responsibilities. Personal hygiene may deteriorate. Financial obligations may be neglected. Social relationships may become strained or limited to other individuals engaged in drug use.

These patterns are not simply the result of poor choices; they are consistent with a condition that impairs executive functioning and self-regulation. The inability to maintain routines, fulfill obligations, or engage in sustained goal-directed activity reflects a diminished capacity for organization and control.

This has direct implications for the classification of such individuals as “drug dealers.” Even low-level drug distribution requires a baseline level of cognitive stability and behavioral consistency. Dealers must be able to maintain inventory, track transactions, coordinate with suppliers and customers, and respond to changing circumstances. They must be reliable, organized, and capable of sustained engagement in complex activities.

These requirements are fundamentally incompatible with the impairments associated with advanced opioid addiction. An individual who cannot consistently manage basic daily tasks is unlikely to function effectively within a distribution network that requires coordination, planning, and reliability. The very capacities that enable a person to operate as a dealer—foresight, discipline, and control—are among the first to deteriorate under prolonged opioid use.

Moreover, addiction introduces a direct conflict between the role of dealer and the condition of dependence. A dealer must preserve inventory and prioritize distribution over consumption. An individual with opioid addiction, by contrast, experiences powerful compulsions to consume the drug, particularly during withdrawal. This creates an inherent instability that undermines the possibility of sustained participation in distribution.

In this sense, addiction is not merely a mitigating factor—it is structurally incompatible with the role that the law attributes to individuals classified as dealers. The legal assumption that such individuals can operate as rational actors within a distribution system is inconsistent with the medical evidence.

The law's failure to account for these realities results in a profound mismatch between legal classification and human capability. By treating individuals with severe addiction as though they possess the cognitive and behavioral capacities of organized distributors, DIH prosecutions attribute a level of agency and competence that the evidence does not support.

This mismatch is not a minor error. It goes to the heart of criminal liability. If the law is to assign blame and impose punishment, it must do so based on an accurate understanding of the actor's

capacities. When it fails to do so, it risks imposing punishment that is not only excessive but fundamentally unjust.

In addition to structural and functional impairments, advanced opioid addiction is associated with significant disruptions in what neuroscientists describe as executive control networks. These networks are responsible for coordinating goal-directed behavior across time, allowing individuals to plan, prioritize, and adapt to changing circumstances.¹⁴ When functioning properly, executive control enables a person to maintain focus on long-term objectives, resist distractions, and regulate impulses. In individuals with severe opioid dependence, however, these networks are compromised, resulting in fragmented and inconsistent behavior.

This fragmentation is evident in the inability to sustain organized activity over extended periods. Tasks that require sequencing—such as managing resources, coordinating interactions, or maintaining schedules—become difficult to execute reliably. Individuals may begin tasks but fail to complete them, lose track of obligations, or act reactively rather than strategically. These impairments are not merely inconveniences; they reflect a diminished capacity for sustained goal-oriented functioning.

Another critical component of addiction is the disruption of decision-making under conditions of uncertainty. Research has shown that individuals with opioid dependence exhibit altered risk processing, often placing disproportionate weight on immediate rewards while discounting future

¹⁴ Antoine Bechara, Decision Making, Impulse Control and Loss of Willpower to Resist Drugs: A Neurocognitive Perspective, 8 *Nature Neuroscience* 1458 (2005); Barry J. Everitt & Trevor W. Robbins, Drug Addiction: Updating Actions to Habits to Compulsions Ten Years On, 17 *Annual Review of Psychology* 23 (2016).

consequences.¹⁵ This phenomenon, sometimes described as “temporal discounting,” results in a preference for immediate relief over long-term benefit. In practical terms, this means individuals are more likely to engage in behaviors that provide short-term relief from withdrawal or craving, even when those behaviors carry significant risks.

This altered decision-making process has direct implications for criminal law. The assumption that individuals can evaluate risks and conform their behavior accordingly is central to the assignment of culpability. When that capacity is impaired, the relationship between action and blame becomes more complex. The law may continue to assign responsibility, but it cannot do so accurately without accounting for the diminished capacity that shapes the behavior in question.¹⁶

Importantly, the impairments associated with addiction are not uniform; they exist along a spectrum. Some individuals retain greater degrees of functioning, while others experience profound deficits. However, DIH prosecutions do not meaningfully account for this variation. Instead, they apply a binary classification—dealer or non-dealer—that ignores the continuum of capacity. This lack of nuance results in the over-inclusion of individuals whose conduct is more accurately understood as symptomatic of addiction rather than indicative of organized criminal activity.

¹⁵ Daniel A. R. Cabral et al., Associations Between Delay Discounting and Unhealthy Behaviors in Substance Use Recovery, 262 *Drug & Alcohol Dependence* 111395 (2024).

Xiwen Chen, Huanxin Wang & Cong Fan, Episodic Future Thinking Modulates Delay Discounting in Individuals with Problematic Substance Use: A Narrative Review, 17 *Frontiers in Psychiatry* 1760734 (2026).

Warren K. Bickel et al., Behavioral Economics of Substance Use Disorders, 41 *Annual Review of Clinical Psychology* 641 (2015)

¹⁶ M. A. N. van Oorsouw et al., Criminal Responsibility and Substance Use Disorders: A Forensic Perspective, *Frontiers in Psychiatry* (2024).

Stephen J. Morse, Brain Overclaim Syndrome and Criminal Responsibility: A Diagnostic Note, 3 *Ohio State Journal of Criminal Law*, 397 (2016).

The mismatch between legal classification and neurological reality becomes especially stark when considering the demands of sustained coordination. Even minimal participation in distribution networks requires consistency over time—responding to messages, maintaining availability, managing supply, and navigating interpersonal dynamics. These tasks require cognitive stability and behavioral regulation. For individuals with advanced opioid addiction, such stability is absent.

This instability is not merely episodic; it is structural. The cycles of intoxication and withdrawal, combined with impaired executive functioning, create a pattern of behavior that is inherently unpredictable. Plans are made and abandoned, commitments are formed and broken, and actions are driven by immediate physiological states rather than deliberate intention. This pattern is fundamentally incompatible with the sustained organization required for drug distribution.

The legal system's failure to recognize these limitations results in a form of misattribution. It treats individuals as though they possess capacities that, in many cases, have been significantly eroded by addiction. This misattribution is not simply inaccurate—it is consequential. It forms the basis for assigning the most severe forms of criminal liability, including homicide, to individuals whose conduct is shaped by impairment rather than enterprise.

The “addict-dealer” is thus not simply an imprecise label—it is a legal myth that obscures the reality of addiction and distorts the application of criminal law. The following sections demonstrate how this myth is reinforced by misunderstandings about drug distribution and ultimately results in prosecutorial practices that are both legally and morally questionable.

III. The Reality of Drug Distribution

Drug distribution is not a simple or low-skill activity. Even at the lowest levels, it requires organization, reliability, and strategic thinking. Dealers must maintain a steady supply of product, coordinate transactions across unpredictable schedules, and remain continuously available to customers. As one account describes, “your phone is ringing all day... you’re in your car for hours... the moment you sit down, you’re right back on the road.”¹⁷ These demands require sustained attention, memory, and the ability to manage time and logistics under pressure.

At its core, drug distribution is governed by a principle that is both widely recognized and functionally indispensable: “*don’t get high on your own supply*.”¹⁸ This rule is not merely cultural—it reflects the basic economic structure of drug markets. A dealer who consumes their own inventory undermines their ability to operate, repay suppliers, and maintain credibility within the distribution network. Sustained participation in distribution, therefore, requires the capacity to delay gratification, preserve resources, and prioritize long-term stability over immediate consumption.

This requirement highlights a fundamental tension between the role of dealer and the condition of addiction. Advanced opioid dependence is characterized by compulsive use, particularly in the context of withdrawal. Individuals with severe addiction experience powerful physiological and psychological drives to consume drugs, often in ways that override long-term considerations.

¹⁷ Steven D. Levitt & Sudhir A. Venkatesh, An Economic Analysis of a Drug-Selling Gang’s Finances, 115 *Quarterly Journal of Economics*, 755, 760–66 (2000).

¹⁸ Steven D. Levitt & Sudhir A. Venkatesh, An Economic Analysis of a Drug-Selling Gang’s Finances, 115 *Quarterly Journal of Economics* 755, 764–66 (2000).

The very behavior that defines addiction—repeated use despite harmful consequences—is directly incompatible with the discipline required to function as a dealer.

Beyond this core principle, distribution requires managing risk and relationships. Dealers must assess the reliability of suppliers and customers, avoid detection by law enforcement, and respond to financial losses or disputes—often without legal recourse.¹⁹ These tasks require vigilance, adaptability, and the ability to make rapid decisions in high-stakes environments. Even minor failures—missed calls, inconsistent supply, or poor coordination—can result in exclusion from networks or exposure to violence.

The instability associated with addiction further undermines the possibility of sustained participation in distribution. Individuals with opioid dependence often experience cycles of intoxication and withdrawal that disrupt any consistent pattern of activity. Periods of withdrawal can render an individual physically incapable of functioning, while periods of intoxication impair judgment and coordination. This volatility is fundamentally incompatible with the consistency required to maintain supply relationships, manage customers, or operate within a distribution network.

In this sense, drug distribution is not merely the act of transferring drugs from one person to another; it is a sustained pattern of coordinated activity requiring cognitive stability and behavioral discipline. The law’s treatment of all transfers as equivalent obscures reality. By classifying individuals with severe opioid dependence as “dealers,” DIH prosecutions conflate

¹⁹ Bruce D. Johnson et al., *The Rise and Fall of Hard Drugs, Drug Markets, and Violence in Inner-City New York*, 31 *Crime & Justice* 163, 170–75 (2004).
Peter Reuter, *Systemic Violence in Drug Markets*, 9 *Crime, Law & Social Change*, 289, 292–96 (1985).

fundamentally different actors: those who manage and profit from distribution networks, and those whose conduct is driven by compulsion, compassion, and impairment.

This conflation lies at the heart of the “addict-dealer” myth. It attributes to individuals the capacities required to operate within a distribution system while ignoring the medical realities that undermine those very capacities. The result is a legal framework that misidentifies who is truly functioning as a dealer—and, in doing so, misallocates criminal liability.

IV. Constitutional and Policy Implications

If DIH prosecutions routinely rely on the addict-dealer myth, constitutional and policy problems follow. The *Eighth Amendment* requires proportionality in punishment; Supreme Court doctrine instructs that proportionality assessment should consider not merely the harm but the character of the offender.²⁰ When the offender’s character reflects severe neurocognitive impairment related to addiction, imposing decades-long mandatory sentences raises serious proportionality concerns. Essentially, we are imposing a 20-year mandatory sentence for what used to be considered an accident or death by misadventure.

This overextension of criminal liability also reflects a broader institutional tendency to substitute legal formalism for empirical reality. By relying on expansive statutory definitions, prosecutors can construct cases that satisfy the elements of an offense while obscuring the underlying nature of the conduct. The question becomes not whether the defendant functioned as a dealer in any meaningful sense, but whether the statutory definition of “distribution” can be satisfied. This shift from functional analysis to formal classification enables the prosecution of individuals

²⁰ *Graham v. Florida*, 560 U.S. 48, 59–60 (2010).

Miller v. Alabama, 567 U.S. 460, 471–72 (2012).

Youngjae Lee, The Constitutional Right Against Excessive Punishment, 91 *Virginia Law Review* 677, 684–90 (2005).

whose conduct bears little resemblance to the activity that DIH statutes were ostensibly designed to address.

The result is a form of overreach that operates within the boundaries of the law while undermining its underlying principles. Criminal law is not merely a system of rules; it is a system of judgment that depends on accurate assessments of human behavior. When legal categories fail to reflect reality, the judgments they produce become distorted. In the context of DIH prosecutions, this distortion manifests as an inflation of culpability—treating low-level, impairment-driven conduct as though it were equivalent to organized distribution.

This dynamic is particularly troubling given the severity of the penalties involved. Mandatory minimum sentences eliminate judicial discretion, preventing courts from tailoring punishment to the offender's circumstances. Once the elements of the offense are satisfied, the outcome is largely predetermined. This rigidity amplifies the consequences of misclassification, ensuring that errors in labeling translate directly into disproportionate punishment.

Moreover, the use of DIH statutes in this manner risks eroding public confidence in the fairness of the criminal justice system. When individuals who are visibly struggling with addiction are prosecuted as though they were sophisticated criminal actors, the law appears disconnected from lived reality.²¹ This perception is not merely symbolic; it has practical consequences for legitimacy, compliance, and communities' willingness to cooperate with law enforcement.

²¹ Tom R. Tyler & Jeffrey Fagan, Legitimacy and Cooperation: Why Do People Help the Police Fight Crime in Their Communities? 6, *Ohio State Journal of Criminal Law* 231 (2008).
Monica C. Bell, Police Reform and the Dismantling of Legal Estrangement, 126 *Yale Law Journal*. 2054, 2060–65 (2017).

The Court’s decision in *Solem v. Helm* underscored that gross disproportionality could render punishment unconstitutional, and subsequent decisions have reiterated that an offender’s culpability and prospects for rehabilitation bear on the proportionality analysis.²² Comparatively severe punishment aimed at persons whose decision-making capacities are significantly impaired risks violating those principles. *Robinson v. California* also resonates: the Court held that punishing the status of addiction (rather than specific conduct) is constitutionally suspect.²³ DIH prosecutions that recharacterize addiction-driven conduct as homicide blur the constitutional distinction between status and conduct, raising concerns about de facto punishment of status.

Beyond pure constitutional doctrine, public-policy considerations counsel caution. DIH prosecutions produce perverse effects: they may incentivize witnesses at overdose scenes to flee or to withhold aid for fear of being prosecuted if the victim dies; they may increase stigma and deter treatment seeking; and they may consume prosecutorial resources with limited impact on supply chains dominated by organized actors at higher levels. Empirical evidence on deterrence is thin, but the distribution mechanisms for fentanyl and other synthetics are controlled by international and domestic networks that are largely unaffected by prosecutions of low-level users.²⁴ Removing a user from the street seldom reduces supply; instead, it may increase harm to the defendant’s community and family.

²² *Solem v. Helm*, 463 U.S. 277, 290–92 (1983).

Graham v. Florida, 560 U.S. 48, 59–60 (2010).

Miller v. Alabama, 567 U.S. 460, 471–72 (2012).

Jones v. Mississippi, 593 U.S. 98 (2021).

²³ *Robinson v. California*, 370 U.S. 660, 666–67 (1962).

²⁴ Peter Reuter & Mark A. R. Kleiman, Risks and Prices: An Economic Analysis of Drug Enforcement, 7 *Crime & Justice* 289, 296–302 (1986).

Jonathan P. Caulkins & Mark A. R. Kleiman, Drug Enforcement’s Effects on Prices and Availability, in *Crime and Public Policy* 213, 223–26.

Pew Charitable Trusts., *More Imprisonment Does Not Reduce State Drug Problems* (2018).

Prosecutorial discretion complicates the picture. Some prosecutors exercise restraint, using DIH statutes only against clear cases of commercial facilitation or gross recklessness. Others pursue DIH as a default in overdose deaths involving drugs they can tie to an individual. The discretionary landscape matters enormously: prosecutorial norms can either temper the statute's reach or unleash its broad potential. Where prosecutorial policy fails to differentiate, constitutional and moral problems multiply.²⁵

There are also doctrinally sensible reforms that would better align the law with the realities of addiction. Legislatures can refine statutory language to require proof of commercial intent, a profit motive, or repeated distribution rather than a single transfer. Courts can insist on culpability thresholds—mens rea standards requiring proof of recklessness or knowledge of a significant risk, rather than mere causation—before elevating a distribution offense to homicide. Prosecutors can adopt policies that exclude persons whose conduct appears to be primarily a symptom of addiction from DIH charging, absent aggravating features.

Conclusion

The addict-dealer is not a neutral descriptive category; it is a legal myth born of expansive statutory language and prosecutorial discretion. Treating every transfer as if it evidences commercial agency ignores the medical, neurological, and behavioral realities of advanced opioid dependence. It ignores essential differences between organized distributors and dependent

²⁵ Angela J. Davis, *Arbitrary Justice: The Power of the American Prosecutor* 5–11 (2007).
Health in Justice Action Lab, *Drug-Induced Homicide Prosecutions Are Counterproductive* (2023),
<https://www.healthinjustice.org>.

users who transfer drugs within contexts shaped by compulsion, withdrawal, and mutual dependence.

This misclassification has costs: it overstates culpability, invites constitutional challenges on proportionality and status grounds, undermines public health objectives, and diverts enforcement away from actors whose conduct is more centrally responsible for supply and risk. If criminal law is to be legitimate and respected, it must account for the conditions that shape human action; culpability should track the actor's capacities, not an inflated statutory myth.

The evidence is clear enough to demand reform. Lawmakers, courts, and prosecutors should recalibrate DIH liability to account for intent, organization, and the clinical realities of addiction. Where a defendant's conduct stems from advanced dependence rather than commercial intent, the criminal law should reflect that difference—not by retreating from accountability, but by ensuring that punishment is proportional, evidence-based, and consistent with both constitutional guardrails and public health goals.