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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.

* Assistant Professor of Law, Pennsylvania State University, Dickinson Law. The author wishes to thank the hosts of and participants in Northeastern University School of Law’s 2018 annual conference, “Diseases of Despair: The Role of Law & Policy,” and to acknowledge the terrific research assistance of Emily Paul and Penn State Dickinson Law’s Addiction Legal Resources Team—Bryan Caffrey, Andrea Jenkins, Evan Marmie, Tori Remington, Alexander Short, and Wyatt Weisenberg. This Article is dedicated to the individuals affected by addiction whose stories informed and inspired our research. The author wishes to disclose a financial relationship with the U.S. Department of Justice and Office of Management & Budget.

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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. DEP'T 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.