SUPERIOR COURT OF WASHINGTON IN AND FOR KING COUNTY

KING COUNTY,

Plaintiff,

v.

PURDUE PHARMA, L.P.; PURDUE PHARMA, INC.; THE PURDUE FREDERICK COMPANY, INC.; ENDO HEALTH SOLUTIONS INC.; ENDO PHARMACEUTICALS, INC.; JANSSEN PHARMACEUTICALS, INC.; JOHNSON & JOHNSON; SEATTLE PAIN CENTER MEDICAL CORPORATION d/b/a SEATTLE PAIN CENTER; FRANK D. LI; SALES REPRESENTATIVES JOHN and JANE DOES 1 THROUGH 10, INCLUSIVE, and JOHN AND JANE DOES 1 THROUGH 100, INCLUSIVE,

Defendants.

No.

COMPLAINT

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I. INTRODUCTION

1. The United States is experiencing the worst man-made epidemic in modern medical history—the misuse, abuse, and over-prescription of opioids.

2. Since 2000, more than 300,000 Americans have lost their lives to an opioid overdose, more than five times as many American lives as were lost in the entire Vietnam War. On any given day, 145 people will die from opioid overdoses in the United States.

3. As many state and local governments along with the federal government have recognized, the opioid crisis has become a public health emergency of unprecedented levels. Plaintiff King County, one of the largest counties in the country with approximately 2.15 million residents, has been deeply affected by the crisis. Opioids have reshaped daily reality for King County in numerous ways, including increased and intensified emergency medical responses to overdoses; increased drug-related offenses affecting law enforcement, jails, and courts; additional resources spent on community and social programs; higher workers' compensation costs for prescription opioids and opioid-related claims; and more prevalent drug use throughout the County including in streets, buses, and parks.

4. King County has been working to confront the emergency caused by Defendants' reckless promotion of prescription opioids. In March 2016, King County Executive Dow Constantine and the mayors of Seattle, Auburn, and Renton convened a multidisciplinary Task Force on Heroin and Prescription Opiate Addiction. As discussed in further detail below, the Task Force delivered its report and recommendations in September 2016, Governor Inslee signed several of its recommendations into law in May 2017, lowering barriers to addiction treatment, broadening the availability of overdose-reversing medication, and enabling cities and counties to establish sites connecting people to medication-assisted treatment.

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5. But even as King County marshals considerable resources and expert knowledge to respond to this crisis with forward-thinking solutions, fully addressing the opioid crisis also necessitates looking back and requiring those responsible to pay for their conduct. The opioid epidemic is no accident. On the contrary, it is the foreseeable consequence of Defendants' reckless promotion of the use of potent opioids for chronic pain while deliberately downplaying the significant risks of addiction and overdose.

6. Defendant Purdue set the stage for the opioid epidemic, through the production and promotion of its blockbuster drug, OxyContin. Purdue introduced a drug with a narcotic payload many times higher than that of previous prescription painkillers, while executing a sophisticated, multi-pronged marketing campaign to change prescribers' perception of the risk of opioid addiction and to portray opioids as effective treatment for chronic pain. Purdue pushed its message of opioids as a low-risk panacea on doctors and the public through every available avenue, including through lobbying efforts, direct marketing, front groups, key opinion leaders, unbranded advertising, and hundreds of sales representatives who visited doctors and clinics on a regular basis.

7. As sales of OxyContin and Purdue's profits surged, Defendants Endo and Janssen added additional prescription opioids, aggressive sales tactics, and dubious marketing claims of their own to the deepening crisis. They paid hundreds of millions of dollars to market and promote the drugs, notwithstanding their dangers, and pushed bought-and-paid-for "science" supporting the safety and efficacy of opioids that lacked any basis in fact or reality. Obscured from the marketing was the fact that prescription opioids are not much different than heroin—indeed on a molecular level, they are virtually indistinguishable.

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8. Defendants' efforts were remarkably successful: since the mid-1990s, opioids have become the most prescribed class of drugs in America. Between 1991 and 2011, opioid prescriptions in the U.S. tripled from 76 million to 219 million per year.[1] In 2016, health care providers wrote more than 289 million prescriptions for opioid pain medication, enough for every adult in the United States to have more than one bottle of pills.[2] In terms of annual sales, the increase has been ten-fold; before the FDA approved OxyContin in 1995, annual opioid sales hovered around $1 billion. By 2015, they increased to almost $10 billion. By 2020, revenues are projected to grow to $18 billion.[3]

9. But Defendants' profits have come at a steep price. Opioids are now the leading cause of accidental death in the U.S., surpassing deaths caused by car accidents. Opioid overdose deaths (which include prescription opioids as well as heroin) have risen steadily every year, from approximately 4,030 in 1999, to 15,597 in 2009, and to over 33,000 in 2015. In 2016, that toll climbed to 53,000.[4] As shown in the graph below, the recent surge in opioid-related deaths involves prescription opioids, heroin, and other synthetic opioids. More than half of all opioid overdose deaths involve a prescription opioid like those manufactured by Defendants,[5] and the increase in overdoses from non-prescription opioids is directly attributable to Defendants' success in expanding the market for opioids of any kind.

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[1] Nora D. Volkow, MD, *America's Addiction to Opioids: Heroin and Prescription Drug Abuse*, Appearing before the Senate Caucus on International Narcotics Control, NIH National Institute on Drug Abuse (May 14, 2014), https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse.

[2] *Prevalence of Opioid Misuse*, BupPractice, https://www.buppractice.com/node/15576 (last visited Jan. 5, 2018).

[3] *Report: Opioid pain sales to hit $18.4B in the U.S. by 2020*, CenterWatch (July 17, 2017), https://www.centerwatch.com/news-online/2017/07/17/report-opioid-pain-sales-hit-18-4b-u-s-2020/#more-31534.

[4] *Overdose Death Rates*, NIH National Institute on Drug Abuse, https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates (revised Jan. 2017).

[5] *Understanding the Epidemic*, Centers for Disease Control and Prevention, https://www.cdc.gov/drugoverdose/epidemic/index.html (last updated Aug. 30, 2017).

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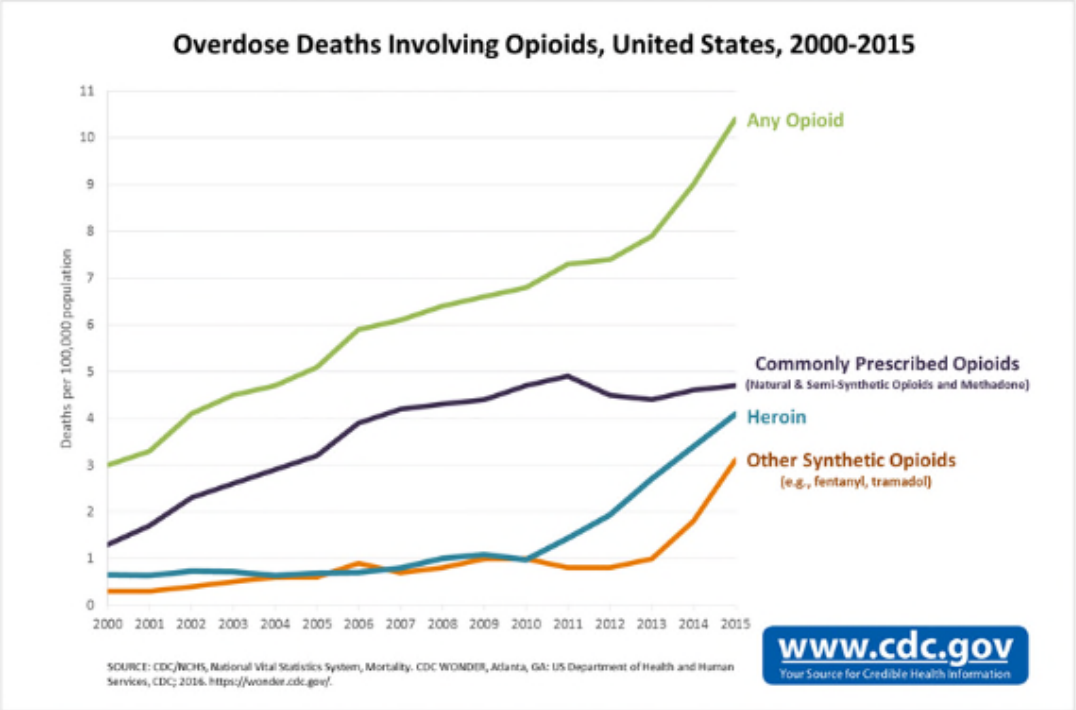

10. To put these numbers in perspective: in 1970, when a heroin epidemic swept the U.S., there were fewer than 3,000 overdose deaths. And in 1988, around the height of the crack epidemic, there were fewer than 5,000 crack overdose deaths recorded. In 2005, at its peak, methamphetamine was involved in approximately 4,500 deaths.

11. Just as it has nationally, the opioid epidemic in King County has exacted a grim toll. Two hundred and nineteen King County residents died from opioid-related overdoses in 2016, making it the second straight year of over 200 opioid-related deaths. These deaths far exceed overdoses from the other three most lethal drugs in King County (methamphetamine, cocaine, and benzodiazepines). In fact, over a ten-year period from 2007 to 2016, fatal overdoses caused by opioids were the leading cause of drug-related deaths in King County by a wide margin, often surpassing the other most lethal drugs by more than 100 deaths on an annual basis.

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12. Beyond the human cost, the CDC recently estimated that the total economic burden of prescription opioid abuse costs the United States $78.5 billion per year, which includes increased costs for health care and addiction treatment, increased strains on human services and criminal justice systems, and substantial losses in workforce productivity.[6] This estimate seems to be conservative. The Council of Economic Advisers—the primary advisor to the Executive Office of the President—recently issued a report stating that it "estimates that in 2015, the economic cost of the opioid crisis was $504.0 billion, or 2.8 percent of GDP that year. This is over six times larger than the most recently estimated economic cost of the epidemic."[7] Whatever the final tally, there is no doubt that this crisis has had a profound economic impact.

13. Defendants orchestrated this crisis. Despite knowing about the true hazards of their products, Defendants misleadingly advertised their opioids as safe and effective for treating chronic pain and pushed hundreds of millions of pills into the marketplace for consumption. Through their sophisticated and well-orchestrated campaign, Defendants touted the purported benefits of opioids to treat pain and downplayed the risks of addiction. Moreover, even as the deadly toll of prescription opioid use became apparent to the Defendants in years following OxyContin's launch, Defendants persisted in aggressively selling prescription opioids and spent hundreds of millions of dollars promoting and marketing opioids.

14. Defendants consistently, deliberately, and recklessly made and continue to make false and misleading statements—including to doctors and patients in King County—regarding, among other things, the low risk of addiction to opioids, opioids' efficacy for chronic pain and

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[6] *CDC Foundation's New Business Pulse Focuses on Opioid Overdose Epidemic*, Centers for Disease Control and Prevention (Mar. 15, 2017), https://www.cdc.gov/media/releases/2017/a0315-business-pulse-opioids.html.

[7] *The Underestimated Cost of the Opioid Crisis*, The Council of Economic Advisers (Nov. 2017), https://static.politico.com/1d/33/4822776641cfbac67f9bc7dbd9c8/the-underestimated-cost-of-the-opioid-crisis-embargoed.pdf.

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ability to improve patients' quality of life with long-term use, the lack of risk associated with higher dosages of opioids, the need to prescribe more opioids to treat withdrawal symptoms, and that risk-mitigation strategies and abuse-deterrent technologies allow doctors to safely prescribe opioids.

15. The Defendant drug manufacturers were also aware of the careless activity of certain doctors and the "pill mills" they operated, including Defendants Frank Li and Seattle Pain Center. These Defendants—just like the drug manufacturers who recklessly marketed and promoted opioids—sought to maximize their own financial gain by putting patients' lives at risk.

16. Sales representatives also aggressively and consistently pushed pills on prescribers, including the Sales Representative Defendants identified herein who promoted opioids to prescribers in King County. The drug manufacturers instructed their sales representatives to assure prescribers that opioids were safe and effective for chronic pain, with virtually no risk of addiction, and the sales representatives continued to make such misrepresentations long after they personally knew that their statements were false and misleading.

17. Because of Defendants' misconduct, King County is experiencing a severe public health crisis and has suffered significant economic damages, including but not limited to increased costs related to public health, opioid-related crimes and emergencies, King County's own self-insured health care, criminal justice, and public safety. As described in more detail below, these increased costs directly impact nearly every department in King County and amount to tens of millions of dollars by even the most conservative estimates.

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18. Accordingly, King County brings this action to hold Defendants liable for their misrepresentations regarding the benefits and risks of opioids, conduct that (i) violates the Washington Consumer Protection Act, RCW 19.86 *et seq.*, (ii) constitutes a public nuisance under Washington law, (iii) constitutes negligence and gross negligence under Washington law, and (iv) has unjustly enriched Defendants.

II. PARTIES

King County

19. Plaintiff King County ("Plaintiff" or "King County" or "County") is a Washington County organized and existing under the laws of the State of Washington, RCW 36.01 *et seq.*

Purdue

20. Defendant Purdue Pharma, L.P. is a limited partnership organized under the laws of Delaware. Defendant Purdue Pharma, Inc. is a New York corporation with its principal place of business in Stamford, Connecticut. Defendant The Purdue Frederick Company is a Delaware corporation with its principal place of business in Stamford, Connecticut. Collectively, these entities are referred to as "Purdue."

21. Each Purdue entity acted in concert with one another and acted as agents and/or principals of one another in connection with the conduct described herein.

22. Purdue manufactures, promotes, sells, markets, and distributes opioids such as OxyContin, MS Contin, Dilaudid/Dilaudid HP, Butrans, Hysingla ER, and Targiniq ER in the United States, including in King County.

23. Purdue generates substantial sales revenue from its opioids. For example, OxyContin is Purdue's best-selling opioid, and since 2009, Purdue has generated between $2

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and $3 billion annually in sales of OxyContin, one of the primary prescription opioids available in the painkiller market.

Endo

24. Defendant Endo Pharmaceuticals, Inc. is a wholly owned subsidiary of Defendant Endo Health Solutions Inc. Both are Delaware corporations with their principal place of business in Malvern, Pennsylvania. Collectively, these entities are referred to as "Endo."

25. Each Endo entity acted in concert with one another and acted as agents and/or principals of one another in connection with the conduct described herein.

26. Endo manufacturers, promotes, sells, markets, and distributes opioids such as Percocet, Opana, and Opana ER in the United States, including in King County.

27. Endo generates substantial sales from its opioids. For example, opioids accounted for more than $400 million of Endo's overall revenues of $3 billion in 2012, and Opana ER generated more than $1 billion in revenue for Endo in 2010 and 2013.

Janssen

28. Defendant Janssen Pharmaceuticals, Inc. is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey, and is a wholly owned subsidiary of Defendant Johnson & Johnson, a New Jersey corporation with its principal place of business in New Brunswick, New Jersey. Collectively, these entities are referred to as "Janssen."

29. Both entities above acted in concert with one another and acted as agents and/or principals of one another in connection with the conduct described herein.

30. Johnson & Johnson is the only company that owns more than 10% of Janssen Pharmaceuticals, Inc., and corresponds with the FDA regarding the drugs manufactured by Janssen Pharmaceuticals, Inc. Johnson & Johnson also paid prescribers to speak about opioids

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manufactured by Janssen Pharmaceuticals, Inc. In short, Johnson & Johnson controls the sale and development of the drugs manufactured by Janssen Pharmaceuticals, Inc.

31. Janssen manufacturers, promotes, sells, markets, and distributes opioids such as Duragesic, Nucynta, and Nucynta ER in the United States, including in King County. Janssen stopped manufacturing Nucynta and Nucynta ER in 2015.

32. Janssen generates substantial sales revenue from its opioids. For example, Duragesic accounted for more than $1 billion in sales in 2009, and Nucynta and Nucynta ER accounted for $172 million in sales in 2014.

33. Together, Purdue, Endo, and Janssen are referred to as the "Manufacturer Defendants."

Seattle Pain Center and Dr. Frank Li

34. Defendant Seattle Pain Center Medical Corporation, d/b/a Seattle Pain Center, is an active for-profit Washington State corporation with its principal place of business in Seattle, Washington. Seattle Pain Center Medical Corporation's corporate mailing address is P.O. Box 58634, Renton, WA 98058-1634. Seattle Pain Center operated eight clinics in the Puget Sound area, including in Seattle and Renton.

35. Defendant Frank D. Li is the medical director, sole shareholder, and registered agent of Seattle Pain Center Medical Corporation, d/b/a Seattle Pain Center. Until July 14, 2016, Dr. Li was licensed to practice medicine in the State of Washington. Dr. Li is a citizen of Washington and, on information and belief, maintains a residence at 1519 E. Denny Way, Seattle, WA 98122-2620.

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Sales Representatives John and Jane Does 1-10, inclusive

36. Sales Representatives John and Jane Does are residents of Washington State who are or were employees of the Manufacturer Defendants who worked in Washington State and in King County promoting the Manufacturer Defendants' prescription opioids directly to physicians, nurses, pharmacists, and others in the medical profession.

37. The true names of these Sale Representatives named John and Jane Does 1 through 10, inclusive, are currently unknown to Plaintiff, and thus, are named as Defendants under fictitious names as permitted by the rules of this Court. Plaintiff will amend this complaint and identify their true identities and their involvement in the wrongdoing at issue, as well as the specific causes of action asserted against them when they become known.

John and Jane Does 1-100, inclusive

38. In addition to the Sales Representative Defendants, the true names, roles, and/or capacities in the wrongdoing alleged herein of Defendants named John and Jane Does 1 through 100, inclusive, are currently unknown to Plaintiff, and thus, are named as Defendants under fictitious names as permitted by the rules of this Court. Plaintiff will amend this complaint and identify their true identities and their involvement in the wrongdoing at issue, as well as the specific causes of action asserted against them when they become known.

III. JURISDICTION AND VENUE

39. Venue is proper in King County pursuant to RCW 4.12.020 and 4.12.025 because Defendants regularly transact business in this county, a significant portion of the acts, omissions, and transactions complained of occurred in this County, and this action seeks to recover a penalty or forfeiture imposed by statute. In addition, venue is proper because some of the Defendants reside in this County.

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40. This Court has personal jurisdiction over Defendants because *inter alia*, they conduct business in Washington and have purposefully availed themselves of the privilege of conducting business in Washington. Defendants have sufficient minimum contacts with Washington to render the exercise of personal jurisdiction over it by Washington courts consistent with traditional notions of fair play and substantial justice.

41. This Court has subject matter jurisdiction pursuant to Washington Constitution Article IV § 6, RCW 2.08.010 and RCW 7.24.010.

IV. FACTUAL ALLEGATIONS

A. Making an Old Drug New Again.

1. A history and background of opioids in medicine.

42. Opioids, including natural, synthetic, and semi-synthetic opioids, are a class of drugs generally used to treat pain. Opioids produce multiple effects on the human body, the most significant of which are analgesia, euphoria, and respiratory depression. In addition, opioids cause sedation and constipation.

43. Most of these effects are medically useful in certain situations, but respiratory depression is the primary limiting factor for the use of opioids. While the body can develop a tolerance to the analgesic and euphoric effects, there is no corresponding tolerance to respiratory depression. Increasing the opioid dose will increasingly depress the respiratory system until, at some point, breathing stops. This is why the risk of opioid overdose is so high, and why many of those who overdose simply go to sleep and never wake up.

44. Natural opioids are derived from the opium poppy and have been used since antiquity, going as far back as 3400 B.C. The opium poppy contains various opium alkaloids, three of which are used in the pharmaceutical industry: morphine, codeine, and thebaine.

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45. In the 1500s, a European alchemist developed a tincture of opium called laudanum, which became popular in Victorian England. Laudanum contains almost all of the opioid alkaloids and is still available by prescription today. English chemists first isolated the morphine and codeine alkaloids in the early 1800s, and Merck began marketing morphine commercially in 1827. Heroin, first synthesized from morphine in 1874, was marketed commercially by the Bayer Pharmaceutical Company beginning in 1898.

46. Opioids provided relief from acute pain and were also useful in treating diarrhea, but there was a problem: they were highly addictive. For a time, morphine was used to treat opium addiction; later, heroin was marketed as a safe alternative to morphine. In 1916, three years after Bayer stopped mass-producing heroin because of its dangers, German chemists synthesized oxycodone from thebaine, with the hope that its different alkaloid source might mean it could provide the benefits of morphine and heroin without the drawbacks.

47. But each opiate was just as addictive as the one before it, and eventually the issue of opioid addiction—affecting, in particular, Civil War veterans treated for pain and "genteel ladies"[8] who were prescribed opiates by their doctors for various ailments—could not be ignored. The nation's first Opium Commissioner, Hamilton Wright, remarked in 1911, "The habit has this nation in its grip to an astonishing extent. Our prisons and our hospitals are full of victims of it, it has robbed ten thousand businessmen of moral sense and made them beasts who prey upon their fellows . . . it has become one of the most fertile causes of unhappiness and sin in the United States."[9]

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[8] Nick Miroff, *From Teddy Roosevelt to Trump: How drug companies triggered an opioid crisis a century ago*, The Washington Post (Oct. 17, 2017), https://www.washingtonpost.com/news/retropolis/wp/2017/09/29/the-greatest-drug-fiends-in-the-world-an-american-opioid-crisis-in-1908/?utm_term=.7832633fd7ca.

[9] *Id.*

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48. Concerns over opioid addiction led to national legislation and international agreements regulating narcotics: the International Opium Convention, signed at the Hague in 1912, and, in the U.S., the Harrison Narcotics Tax Act of 1914. Opioids were no longer marketed as cure-alls, and instead were relegated to the treatment of acute pain.

49. Throughout the twentieth century, pharmaceutical companies continued to develop prescription opioids, but these opioids were generally produced in combination with other drugs, with relatively low opioid content. For example, Percodan, produced by Defendant Endo since 1950, is oxycodone and aspirin, and contains just under 5 mg of oxycodone. Percocet, manufactured by Endo since 1971, is the combination of oxycodone and acetaminophen, with dosage strengths delivering between 2.5 mg and 10 mg of oxycodone. Vicodin, a combination of hydrocodone and acetaminophen, was introduced in the U.S. in 1978 and is sold in strengths of 5 mg, 7.5 mg, and 10 mg of hydrocodone. Defendant Janssen also manufactured a drug with 5 mg of oxycodone and 500 mg of acetaminophen, called Tylox, from 1984 to 2012.

50. In contrast, OxyContin, the product with the dubious honor of the starring role in the opioid epidemic, is pure oxycodone. Purdue initially made it available in the following dosage strengths: 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, and 160 mg. In other words, the weakest OxyContin delivers as much narcotic as the strongest Percocet, and some OxyContin tablets delivered sixteen times as much as that.

51. Prescription opioids are essentially pharmaceutical heroin; they are synthesized from the same plant, have similar molecular structures, and bind to the same receptors in the human brain. It is no wonder then that there is a straight line between prescription opioid abuse

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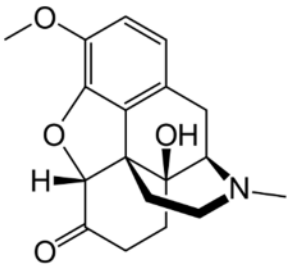
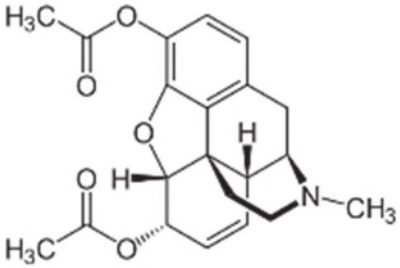
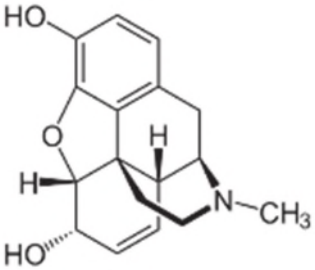
and heroin addiction. Indeed, studies show that over 80% percent of new heroin addicts between 2008 and 2010 started with prescription opioids.[10]

Oxycodone	Heroin	Morphine
		

52. Medical professionals describe the strength of various opioids in terms of "morphine milligram equivalents" ("MME"). According to the CDC, dosages at or above 50 MME/day double the risk of overdose compared to 20 MME/day, and one study found that patients who died of opioid overdose were prescribed an average of 98 MME/day.

53. Different opioids provide varying levels of MMEs. For example, just 33 mg of oxycodone provides 50 MME. Thus, at OxyContin's twice-daily dosing, the 50 MME/day threshold is reached by a prescription of 15 mg twice daily. One 160 mg tablet of OxyContin, which Purdue took off the market in 2001, delivered 240 MME.

[10] Jones CM, *Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers - United States, 2002-2004 and 2008-2010.* Drug Alcohol Depend. 132(1-2):95-100 (Sept. 1, 2013), https://www.ncbi.nlm.nih.gov/pubmed/23410617.

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54. As journalist Barry Meier wrote in his 2003 book *Pain Killer: A "Wonder" Drug's Trail of Addiction and Death*, "In terms of narcotic firepower, OxyContin was a nuclear weapon."[11]

55. Fentanyl, an even more potent and more recent arrival in the opioid tale, is a synthetic opioid that is 100 times stronger than morphine and 50 times stronger than heroin. First developed in 1959, fentanyl is showing up more and more often in the market for opioids created by Defendants' promotion, with particularly lethal consequences.

2. The Sackler family pioneered the integration of advertising and medicine.

56. Given the history of opioid use in the U.S. and the medical profession's resulting wariness, the commercial success of the Manufacturer Defendants' prescription opioids would not have been possible without a fundamental shift in prescribers' perception of the risks and benefits of long-term opioid use.

57. As it turned out, Purdue was uniquely positioned to execute just such a maneuver, thanks to the legacy of a man named Arthur Sackler. The Sackler family is the sole owner of Purdue and one of the wealthiest families in America, surpassing the wealth of storied families like the Rockefellers, the Mellons, and the Busches.[12] Thanks to Purdue and, in particular, OxyContin, the Sacklers' net worth was $13 billion as of 2016. Today, all nine members of the Purdue board are family members, and all of the company's profits go to

[11] Barry Meier, *Pain Killer: A "Wonder" Drug's Trail of Addiction and Death* (Rodale 2003).

[12] Alex Morrell, *The OxyContin Clan: The $14 Billion Newcomer to Forbes 2015 List of Richest U.S. Families*, Forbes (July 1, 2015, 10:17am), https://www.forbes.com/sites/alexmorrell/2015/07/01/the-oxycontin-clan-the-14-billion-newcomer-to-forbes-2015-list-of-richest-u-s-families/#382ab3275e02.

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Sackler family trusts and entities.[13] Yet the Sacklers have avoided publicly associating themselves with Purdue, letting others serve as the spokespeople for the company.

58. The Sackler brothers—Arthur, Mortimer, and Raymond—purchased a small patent-medicine company called the Purdue Frederick Company in 1952. While all three brothers were accomplished psychiatrists, it was Arthur, the oldest, who directed the Sackler story, treating his brothers more as his proteges than colleagues, putting them both through medical school and essentially dictating their paths. It was Arthur who created the Sackler family's wealth, and it was Arthur who created the pharmaceutical advertising industry as we know it—laying the groundwork for the OxyContin promotion that would make the Sacklers billionaires.

59. Arthur Sackler was both a psychiatrist and a marketing executive, and, by many accounts, a brilliant and driven man. He pursued two careers simultaneously, as a psychiatrist at Creedmoor State Hospital in New York and the president of an advertising agency called William Douglas McAdams. Arthur pioneered both print advertising in medical journals and promotion through physician "education" in the form of seminars and continuing medical education courses. He understood intuitively the persuasive power of recommendations from fellow physicians, and did not hesitate to manipulate information when necessary. For example, one promotional brochure produced by his firm for Pfizer showed business cards of physicians from various cities as if they were testimonials for the drug, but when a journalist tried to contact these doctors, he discovered that they did not exist.[14]

[13] David Armstrong, *The man at the center of the secret OxyContin files*, Stat News (May 12, 2016), https://www.statnews.com/2016/05/12/man-center-secret-oxycontin-files/.

[14] Meier, *supra* note 11, at 204.

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60. It was Arthur who, in the 1960s, made Valium into the first $100-million drug, so popular it became known as "Mother's Little Helper." His expertise as a psychiatrist was key to his success; as his biography in the Medical Advertising Hall of Fame notes, it "enabled him to position different indications for Roche's Librium and Valium—to distinguish for the physician the complexities of anxiety and psychic tension."[15] When Arthur's client, Roche, developed Valium, it already had a similar drug, Librium, another benzodiazepine, on the market for treatment of anxiety. So Arthur invented a condition he called "psychic tension"—essentially stress—and pitched Valium as the solution.[16] The campaign, for which Arthur was compensated based on volume of pills sold,[17] was a remarkable success.

61. Arthur's entrepreneurial drive led him to create not only the advertising for his clients but also the vehicle to bring their advertisements to doctors—a biweekly newspaper called the *Medical Tribune*, which he distributed for free to doctors nationwide. Arthur also conceived a company now called IMS Health Holdings Inc., which monitors prescribing practices of every doctor in the U.S. and sells this valuable data to pharmaceutical companies like the Manufacturer Defendants, who utilize it to tailor their sales pitches to individual physicians.

62. Even as he expanded his business dealings, Arthur was adept at hiding his involvement in them. When, during a 1962 Senate hearing about deceptive pharmaceutical advertising, he was asked about a public relations company called Medical and Science Communications Associates, which distributed marketing from drug companies disguised as

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[15] *MAHF Inductees, Arthur M. Sackler*, Medical Advertising Hall of Fame, https://www.mahf.com/mahf-inductees/ (last visited Jan. 5, 2018).

[16] Meier, *supra* note 11, at 202; *One Family Reaped Billions From Opioids*, WBUR On Point (Oct. 23, 2017), http://www.wbur.org/onpoint/2017/10/23/one-family-reaped-billions-from-opioids.

[17] WBUR On Point interview, *supra* note 16.

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news articles, Arthur was able to truthfully testify that he never was an officer for nor had any stock in that company. But the company's sole shareholder was his then-wife. Around the same time, Arthur also successfully evaded an investigative journalist's attempt to link the Sacklers to a company called MD Publications, which had funneled payments from drug companies to an FDA official named Henry Welch, who was forced to resign when the scandal broke.[18] Arthur had set up such an opaque and layered business structure that his connection to MD Publications was only revealed decades later when his heirs were fighting over his estate.

63. Arthur Sackler did not hesitate to manipulate information to his advantage. His legacy is a corporate culture that prioritizes profits over people. In fact, in 2007, federal prosecutors conducting a criminal investigation of Purdue's fraudulent advertising of OxyContin found a "corporate culture that allowed this product to be misbranded with the intent to defraud and mislead."[19] Court documents from the prosecution state that "certain Purdue supervisors and employees, with the intent to defraud or mislead, marketed and promoted OxyContin as less addictive, less subject to abuse and diversion, and less likely to cause tolerance and withdrawal than other pain medications . . ."[20] Half a century after Arthur Sackler wedded advertising and medicine, Purdue employees were following his playbook, putting product sales over patient safety.

3. Purdue and the development of OxyContin

64. After the Sackler brothers acquired the Purdue Frederick Company in 1952, Purdue sold products ranging from earwax remover to antiseptic, and it became a profitable

[18] Meier, *supra* note 11, at 210-14.

[19] Naomi Spencer, *OxyContin manufacturer reaches $600 million plea deal over false marketing practices*, World Socialist Web Site (May 19, 2007), http://www.wsws.org/en/articles/2007/05/oxy-m19.html.

[20] Agreed Statement of Facts, *U.S. v. The Purdue Frederick Company, Inc., et al.*, No. 1:07-cr-00029 (W.D. Va. May 10, 2007).

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business. As an advertising executive, Arthur was not involved, on paper at least, in running Purdue because that would have been a conflict of interest. Raymond became Purdue's head executive while Mortimer ran Purdue's UK affiliate.

65. In the 1980s, Purdue, through its UK affiliate, acquired a Scottish drug producer that had developed a sustained-release technology suitable for morphine. Purdue marketed this extended-release morphine as MS Contin. It quickly became Purdue's best seller. As the patent expiration for MS Contin loomed, Purdue searched for a drug to replace it. Around that time, Raymond's oldest son, Richard Sackler, who was also a trained physician, became more involved in the management of the company. Richard had grand ambitions for the company; according to a long-time Purdue sales representative, "Richard really wanted Purdue to be big—I mean *really* big."[21] Richard believed Purdue should develop another use for its "Contin" timed-release system.

66. In 1990, Purdue's VP of clinical research, Robert Kaiko, sent a memo to Richard and other executives recommending that the company work on a pill containing oxycodone. At the time, oxycodone was perceived as less potent than morphine, largely because it was most commonly prescribed as Percocet, the relatively weak oxycodone-acetaminophen combination pill. MS Contin was not only approaching patent expiration but had always been limited by the stigma associated with morphine. Oxycodone did not have that problem, and what's more, it was sometimes mistakenly called "oxycodeine," which also contributed to the perception of relatively lower potency, because codeine is weaker than morphine. Purdue acknowledged using this to its advantage when it eventually pled guilty to criminal charges of "misbranding" in

[21] Christopher Glazek, *The Secretive Family Making Billions from the Opioid Crisis*, Esquire (Oct. 16, 2017), http://www.esquire.com/news-politics/a12775932/sackler-family-oxycontin/.

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2007, admitting that it was "well aware of the incorrect view held by many physicians that oxycodone was weaker than morphine" and "did not want to do anything 'to make physicians think that oxycodone was stronger or equal to morphine' or to 'take any steps . . . that would affect the unique position that OxyContin'" held among physicians.[22]

67. For Purdue and OxyContin to be "*really* big," Purdue needed to both distance its new product from the traditional view of narcotic addiction risk, and broaden the drug's uses beyond cancer pain and hospice care. A marketing memo sent to Purdue's top sales executives in March 1995 recommended that if Purdue could show that the risk of abuse was lower with OxyContin than with traditional immediate-release narcotics, sales would increase.[23] As discussed below, Purdue did not find or generate any such evidence, but this did not stop Purdue from making that claim regardless.

68. Despite the fact that there has been little or no change in the amount of pain reported in the U.S. over the last twenty years, Purdue recognized an enormous untapped market for its new drug. As Dr. David Haddox, a Senior Medical Director at Purdue, declared on the Early Show, a CBS morning talk program, "There are 50 million patients in this country who have chronic pain that's not being managed appropriately every single day. OxyContin is one of the choices that doctors have available to them to treat that."[24]

69. In pursuit of these 50 million potential customers, Purdue poured resources into OxyContin's sales force and advertising. The graph below shows how promotional spending in

[22] *U.S. v. The Purdue Frederick Company, Inc., et al*., *supra* note 20.
[23] Meier, *supra* note 11, at 269.
[24] *Id.* at 156.

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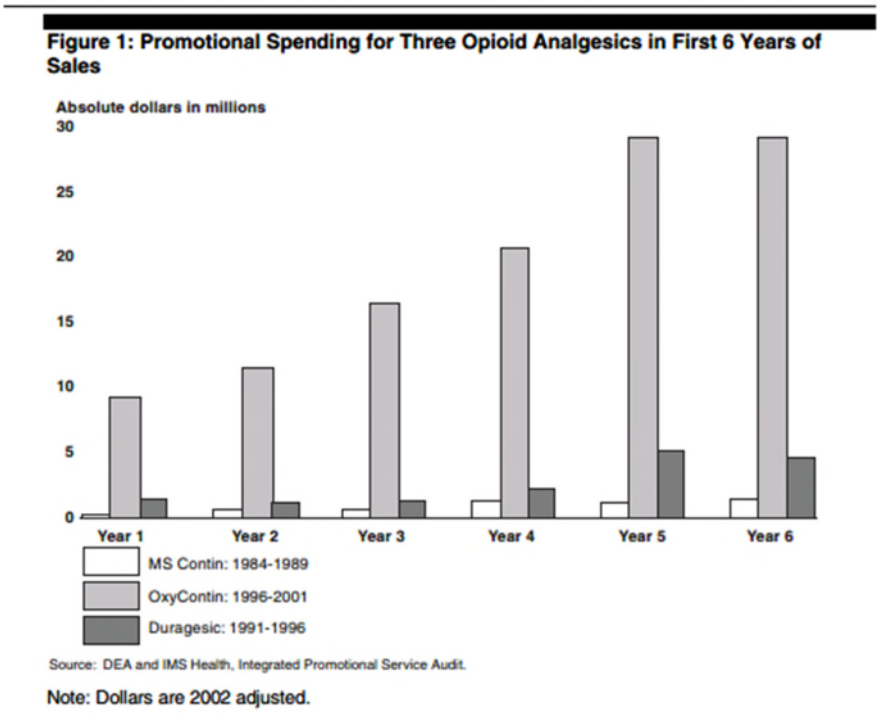
the first six years following OxyContin's launch dwarfed Purdue's spending on MS Contin or Defendant Janssen's spending on Duragesic: [25]



70. Prior to Purdue's launch of OxyContin, no drug company had ever promoted such a pure, high-strength Schedule II narcotic to so wide an audience of general practitioners. Today, one in every five patients who present themselves to physicians' offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receives an opioid prescription.[26]

71. Purdue has generated estimated sales of more than $35 billion from opioids since 1996, while raking in more than $3 billion in 2015 alone. Remarkably, its opioid sales continued

[25] *OxyContin Abuse and Diversion and Efforts to Address the Problem*, U.S. General Accounting Office Report to Congressional Requesters at 22 (Dec. 2003), http://www.gao.gov/new.items/d04110.pdf.

[26] Deborah Dowell, M.D., Tamara M. Haegerich, Ph.D., and Roger Chou, M.D., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*, Centers for Disease Control and Prevention (Mar. 18, 2016), https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

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to climb even after a period of media attention and government inquiries regarding OxyContin abuse in the early 2000s and a criminal investigation culminating in guilty pleas in 2007. Purdue proved itself skilled at evading full responsibility and continuing to sell through the controversy. The company's annual opioid sales of $3 billion in 2015 represent a four-fold increase from its 2006 sales of $800 million.

72. One might imagine that Richard Sackler's ambitions have been realized. But in the best tradition of family patriarch Arthur Sackler, Purdue has its eyes on even greater profits. Under the name of Mundipharma, the Sacklers are looking to new markets for their opioids—employing the exact same playbook in South America, China, and India as they did in the United States.

73. In May 2017, a dozen members of Congress sent a letter to the World Health Organization, warning it of the deceptive practices Purdue is unleashing on the rest of the world through Mundipharma:

> We write to warn the international community of the deceptive and dangerous practices of Mundipharma International—an arm of Purdue Pharmaceuticals. The greed and recklessness of one company and its partners helped spark a public health crisis in the United States that will take generations to fully repair. We urge the World Health Organization (WHO) to do everything in its power to avoid allowing the same people to begin a worldwide opioid epidemic. Please learn from our experience and do not allow Mundipharma to carry on Purdue's deadly legacy on a global stage. . . .
>
> Internal documents revealed in court proceedings now tell us that since the early development of OxyContin, Purdue was aware of the high risk of addiction it carried. Combined with the misleading and aggressive marketing of the drug by its partner, Abbott Laboratories, Purdue began the opioid crisis that has devastated American communities since the end of the 1990s. Today, Mundipharma is using many of the same deceptive and reckless practices to sell OxyContin abroad. . . .
>
> In response to the growing scrutiny and diminished U.S. sales, the Sacklers have simply moved on. On December 18, the Los Angeles Times published an extremely troubling report detailing how in spite of the scores of lawsuits against

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> Purdue for its role in the U.S. opioid crisis, and tens of thousands of overdose deaths, Mundipharma now aggressively markets OxyContin internationally. In fact, Mundipharma uses many of the same tactics that caused the opioid epidemic to flourish in the U.S., though now in countries with far fewer resources to devote to the fallout.[27]

74. Purdue's pivot to untapped markets, after extracting substantial profits from entities like King County and leaving them to address the damage, underscores that its actions have been knowing, intentional, and motivated by profits throughout this entire tragic story.

B. The Booming Business of Addiction.

1. Other Manufacturer Defendants seized the opioid opportunity.

75. Purdue created a market in which the prescription of powerful opioids for a range of common aches and pains was not only acceptable but encouraged—but it was not alone. Defendants Endo and Janssen, each of which already produced and sold prescription opioids, both positioned themselves to take advantage of the opportunity Purdue created, developing both branded and generic opioids to compete with OxyContin while misrepresenting the safety and efficacy of their products.

76. Endo, which for decades had sold Percocet and Percodan, both containing relatively low doses of oxycodone, moved quickly to develop a generic version of extended-release oxycodone to compete with OxyContin, receiving tentative FDA approval for its generic version in 2002. As Endo stated in its 2003 Form 10-K, it was the first to file an application with the FDA for bioequivalent versions of the 10, 20, and 40 mg strengths of OxyContin, which potentially entitled it to 180 days of generic marketing exclusivity—"a significant advantage."[28]

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[27] Letter to Dr. Margaret Chan, World Health Organization (May 3, 2017), http://katherineclark.house.gov/_cache/files/a577bd3c-29ec-4bb9-bdba-1ca71c784113/mundipharma-letter-signatures.pdf.

[28] Endo Pharmaceuticals Holdings, Inc. 2003 Form 10-K at 4, http://media.corporate-ir.net/media_files/irol/12/123046/reports/10K_123103.pdf (last visited Jan. 5, 2018).

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Purdue responded by suing Endo for patent infringement, litigating its claims through a full trial and a Federal Circuit appeal—unsuccessfully. As the trial court found, and the appellate court affirmed, Purdue obtained the oxycodone patents it was fighting to enforce through "inequitable conduct"—namely, suggesting that its patent applications were supported by clinical data when in fact they were based on an employee's "insight and not scientific proof."[29] Endo began selling its generic extended-release oxycodone in 2005.

77. At the same time as Endo was battling Purdue over generic OxyContin—and as the U.S. was battling increasingly widespread opioid abuse—Endo was working on getting another branded prescription opioid on the market. In 2002, Endo submitted applications to the FDA for both immediate-release and extended-release tablets of oxymorphone, branded as Opana and Opana ER.

78. Like oxycodone, oxymorphone is not a new drug; it was first synthesized in Germany in 1914 and sold in the U.S. by Endo beginning in 1959 under the trade name Numorphan, in injectable, suppository, and oral tablet forms. But the oral tablets proved highly susceptible to abuse. Called "blues" after the light blue color of the 10 mg pills, Numorphan provoked, according to some users, a more euphoric high than heroin, and even had its moment in the limelight as the focus of the movie *Drugstore Cowboy*. As the National Institute on Drug Abuse observed in its 1974 report, "Drugs and Addict Lifestyle," Numorphan was extremely popular among addicts for its quick and sustained effect.[30] Endo withdrew oral Numorphan from the market in 1979, reportedly for "commercial reasons."[31]

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[29] *Purdue Pharma L.P. v. Endo Pharm. Inc.*, 438 F.3d 1123, 1131 (Fed. Cir. 2006).

[30] John Fauber and Kristina Fiore, *Abandoned Painkiller Makes a Comeback*, MedPage Today (May 10, 2015), https://www.medpagetoday.com/psychiatry/addictions/51448.

[31] *Id.*

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79. Two decades later, however, as communities around the U.S. were first sounding the alarm about prescription opioids and Purdue executives were being called to testify before Congress about the risks of OxyContin, Endo essentially reached back into its inventory, dusted off a product it had previously shelved after widespread abuse, and pushed it into the marketplace with a new trade name and a potent extended-release formulation.

80. The clinical trials submitted with Endo's first application for approval of Opana were insufficient to demonstrate efficacy, and some subjects in the trials overdosed and had to be revived with naloxone. Endo then submitted new "enriched enrollment" clinical trials, in which trial subjects who do not respond to the drug are excluded from the trial, and obtained approval. Endo began marketing Opana and Opana ER in 2006.

81. Like Numorphan, Opana ER was highly susceptible to abuse. On June 8, 2017, the FDA sought removal of Opana ER. In its press release, the FDA indicated that "the agency is seeking removal based on its concern that the benefits of the drug may no longer outweigh its risks. This is the first time the agency has taken steps to remove a currently marketed opioid pain medication from sale due to the public health consequences of abuse."[32] On July 6, 2017, Endo agreed to withdraw Opana ER from the market.[33]

82. Janssen, which already marketed the Duragesic (fentanyl) patch, developed a new opioid compound called tapentadol in 2009, marketed as Nucynta for the treatment of moderate to severe pain. Janssen launched the extended-release version, Nucynta ER, for treatment of chronic pain in 2011.

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[32] Press Release, U.S. Food & Drug Administration, *FDA requests removal of Opana ER for risks related to abuse* (June 8, 2017), https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm562401.htm.

[33] *Endo pulls opioid as U.S. seeks to tackle abuse epidemic*, Reuters (July 6, 2017, 9:59am), https://www.reuters.com/article/us-endo-intl-opana-idUSKBN19R2II.

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83. The Manufacturer Defendants have reaped enormous profits from the addiction crisis they spawned. For example, Opana ER alone generated more than $1 billion in revenue for Endo in 2010 and again in 2013. Janssen earned more than $1 billion in sales of Duragesic in 2009, and Nucynta and Nucynta ER accounted for $172 million in sales in 2014.

2. Pill Mills and overprescribing doctors also placed their financial interests ahead of their patients' interests.

84. Prescription opioid manufacturers were not the only ones to recognize an economic opportunity. Around the country, including in King County, certain doctors or pain clinics ended up doing brisk business dispensing opioid prescriptions. As explained in further detail below, Defendant Seattle Pain Clinic and Dr. Frank Li operated one of the more egregious pill mills in the country. As Dr. Andrew Kolodny, cofounder of Physicians for Responsible Opioid Prescribing, observed, this business model meant doctors would "have a practice of patients who'll never miss an appointment and who pay in cash."[34]

85. Moreover, the Manufacturer Defendants' sales incentives rewarded sales representatives who happened to have pill mills within their territories, enticing those representatives to look the other way even when their in-person visits to such clinics should have raised numerous red flags. In one example, a pain clinic in South Carolina was diverting massive quantities of OxyContin. People traveled to the clinic from towns as far as 100 miles away to get prescriptions, the DEA's diversion unit raided the clinic, and prosecutors eventually filed criminal charges against the doctors. But Purdue's sales representative for that territory, Eric Wilson, continued to promote OxyContin sales at the clinic. He reportedly told another local physician that this clinic accounted for 40% of the OxyContin sales in his territory. At that

[34] Sam Quinones, *Dreamland: The True Tale of America's Opiate Epidemic* 314 (Bloomsbury Press 2015).

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time, Wilson was Purdue's top-ranked sales representative.[35] In response to news stories about this clinic, Purdue issued a statement, declaring that "if a doctor is intent on prescribing our medication inappropriately, such activity would continue regardless of whether we contacted the doctor or not."[36]

86. Whenever examples of opioid diversion and abuse have drawn media attention, the Manufacturer Defendants have consistently blamed "bad actors." For example, in 2001, during a Congressional hearing, Purdue's attorney Howard Udell answered pointed questions about how it was that Purdue could utilize IMS Health data to assess their marketing efforts but not notice a particularly egregious pill mill in Pennsylvania run by a doctor named Richard Paolino. Udell asserted that Purdue was "fooled" by the "bad actor" doctor: "The picture that is painted in the newspaper [of Dr. Paolino] is of a horrible, bad actor, someone who preyed upon this community, who caused untold suffering. And he fooled us all. He fooled law enforcement. He fooled the DEA. He fooled local law enforcement. He fooled us."[37]

87. But given the closeness with which the Manufacturer Defendants monitored prescribing patterns through IMS Health data, it is highly improbable that they were "fooled." In fact, a local pharmacist had noticed the volume of prescriptions coming from Paolino's clinic and alerted authorities. Purdue had the prescribing data from the clinic and alerted no one. Rather, it appears Purdue and other Manufacturer Defendants used the IMS Health data to target pill mills and sell more pills. Indeed, a Purdue executive referred to Purdue's tracking system

[35] Meier, *supra* note 11, at 298-300.
[36] *Id.*
[37] *Id*. at 179.

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and database as a "gold mine" and acknowledged that Purdue could identify highly suspicious volumes of prescriptions.

88. Sales representatives making in-person visits to such clinics were likewise not fooled. But as pill mills were lucrative for the manufacturers and individual sales representatives alike, the Manufacturer Defendants and their employees turned a collective blind eye, allowing certain clinics to dispense staggering quantities of potent opioids and feigning surprise when the most egregious examples eventually made the nightly news.

3. Widespread prescription opioid use broadened the market for heroin and fentanyl.

89. The Manufacturer Defendants' marketing scheme achieved a dramatic expansion of the U.S. market for opioids, prescription and non-prescription alike. Heroin and fentanyl use has surged—a foreseeable consequence of the Manufacturer Defendants' successful promotion of opioid use coupled with the sheer potency of their products.

90. In his book *Dreamland: The True Tale of America's Opiate Epidemic*, journalist Sam Quinones summarized the easy entrance of black tar heroin in a market primed by prescription opioids:

> His black tar, once it came to an area where OxyContin had already tenderized the terrain, sold not to tapped-out junkies but to younger kids, many from the suburbs, most of whom had money and all of whom were white. Their transition from Oxy to heroin, he saw, was a natural and easy one. Oxy addicts began by sucking on and dissolving the pills' timed-release coating. They were left with 40 or 80 mg of pure oxycodone. At first, addicts crushed the pills and snorted the powder. As their tolerance built, they used more. To get a bigger bang from the pill, they liquefied it and injected it. But their tolerance never stopped climbing. OxyContin sold on the street for a dollar a milligram and addicts very quickly were using well over 100 mg a day. As they reached their financial limits, many switched to heroin, since they were already shooting up Oxy and had lost any fear of the needle.[38]

[38] Quinones, *supra* note 34, at 165-66.

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91. In a study examining the relationship between the abuse of prescription opioids and heroin, researchers found that 75% of those who began their opioid abuse in the 2000s reported that their first opioid was a prescription drug.[39] As the graph below illustrates, prescription opioids replaced heroin as the first opioid of abuse beginning in the 1990s.

The JAMA Network

From: **The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years**

JAMA Psychiatry. 2014;71(7):821-826. doi:10.1001/jamapsychiatry.2014.366

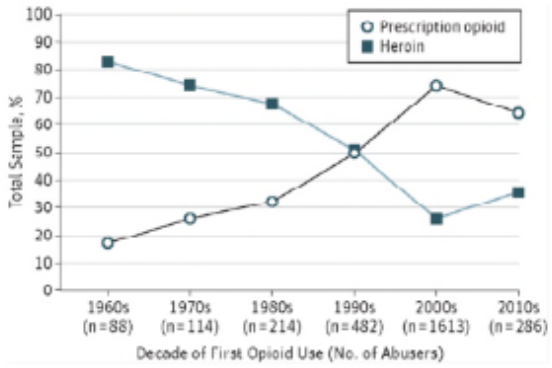

Figure Legend:

Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of AbuseData are plotted as a function of the decade in which respondents initiated their opioid abuse.

92. The researchers also found that nearly half of the respondents who indicated that their primary drug was heroin actually preferred prescription opioids, because the prescription drugs were legal, and perceived as "safer and cleaner." But, heroin's lower price point is a

[39] Theodore J. Cicero, PhD, Matthew S. Ellis, MPE, Hilary L. Surratt, PhD, *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, JAMA Psychiatry 71(7):821-826 (2014), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1874575.

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distinct advantage. While an 80 mg OxyContin might cost $80 on the street, the same high can be had from $20 worth of heroin.

93. As noted above, there is little difference between the chemical structures of heroin and prescription opioids. Between 2005 and 2009, Mexican heroin production increased by over 600%. And between 2010 and 2014, the amount of heroin seized at the U.S.-Mexico border more than doubled.

94. From 2002 to 2016, fatal overdoses related to heroin in the U.S. increased by **533%**—from 2,089 deaths in 2002 to 13,219 deaths in 2016.[40]

95. Along with heroin use, fentanyl use is on the rise, as a result of America's expanded appetite for opiates. But fentanyl, as noted above, is fifty times more potent than heroin, and overdosing is all too easy. Fentanyl is expected to cause over 20,000 overdoses in 2017.[41]

96. As Dr. Caleb Banta-Green, senior research scientist at the University of Washington's Alcohol and Drug Abuse Institute, told The Seattle Times in August 2017, "The bottom line is opioid addiction is the overall driver of deaths. People will use whatever opioid they can get. It's just that which one they're buying is changing a bit."[42]

C. The Manufacturer Defendants Promoted Prescription Opioids Through Several Channels.

97. Despite knowing the devastating consequences of widespread opioid use, the Manufacturer Defendants engaged in a sophisticated and multi-pronged promotional campaign

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[40] Niall McCarthy, *U.S. Heroin Deaths Have Increased 533% Since 2002*, Forbes (Sept. 11, 2017, 8:26am), https://www.forbes.com/sites/niallmccarthy/2017/09/11/u-s-heroin-deaths-have-increased-533-since-2002-infographic/#13ab9a531abc.

[41] *Id.*

[42] *Opioids: The Leading Cause of Drug Deaths in Seattle Area*, University of Washington School of Public Health (Aug. 25, 2017), http://sph.washington.edu/news/article.asp?content_ID=8595.

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designed to achieve just that. By implementing the strategies pioneered by Arthur Sackler, the Manufacturer Defendants were able to achieve the fundamental shift in the perception of opioids that was key to making them blockbuster drugs.

98. The Manufacturer Defendants disseminated their deceptive statements about opioids through several channels.[43] First, the Manufacturer Defendants aggressively and persistently pushed opioids through sales representatives. Second, the Manufacturer Defendants funded third-party organizations that appeared to be neutral but which served as additional marketing departments for drug companies. Third, the Manufacturer Defendants utilized prominent physicians as paid spokespeople—"Key Opinion Leaders"—to take advantage of doctors' respect for and reliance on the recommendations of their peers. Finally, the Manufacturer Defendants also used print and online advertising, including unbranded advertising, which is not reviewed by the FDA.

99. The Manufacturer Defendants spent substantial sums and resources in making these communications. For example, Purdue spent more than $200 million marketing OxyContin in 2001 alone.[44]

1. The Manufacturer Defendants aggressively deployed sales representatives to push their products.

100. The Manufacturer Defendants communicated to prescribers directly in the form of in-person visits and communications from sales representatives.

[43] The specific misrepresentations and omissions are discussed below in Section D.

[44] *Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health, Education, Labor and Pensions*, 107th Cong. 2 (Feb. 12, 2002) (testimony of Paul Goldenheim, Vice President for Research, Purdue Pharma), https://www.gpo.gov/fdsys/pkg/CHRG-107shrg77770/html/CHRG-107shrg77770.htm.

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101. The Manufacturer Defendants' tactics through their sales representatives—also known as "detailers"—were particularly aggressive. In 2014, the Manufacturer Defendants collectively spent well over $100 million on detailing branded opioids to doctors.

102. Each sales representative has a specific sales territory and is responsible for developing a list of about 105 to 140 physicians to call on who already prescribe opioids or who are candidates for prescribing opioids.

103. When Purdue launched OxyContin in 1996, its 300-plus sales force had a total physician call list of approximately 33,400 to 44,500. By 2000, nearly 700 representatives had a total call list of approximately 70,500 to 94,000 physicians. Each sales representative was expected to make about 35 physician visits per week and typically called on each physician every 3 to 4 weeks, while each hospital sales representative was expected to make about 50 physician visits per week and call on each facility every 4 weeks.[45]

104. One of Purdue's early training memos compared doctor visits to "firing at a target," declaring that "[a]s you prepare to fire your 'message,' you need to know where to aim and what you want to hit!"[46] According to the memo, the target is physician resistance based on concern about addiction: "The physician wants pain relief for these patients without addicting them to an opioid."[47]

105. To hit that target, Purdue sales representatives were taught to say, "The delivery system is believed to reduce the abuse liability of the drug."[48] But as one sales representative

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[45] *OxyContin Abuse and Diversion and Efforts to Address the Problem*, *supra* note 25, at 20.

[46] Meier, *supra* note 11, at 102.

[47] *Id.*

[48] Patrick Radden Keefe, *The Family That Built an Empire of Pain*, The New Yorker (Oct. 30, 2017), https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain; see also Meier, *supra* note 11, at 102 ("Delayed absorption, as provided by OxyContin tablets, is believed to reduce the abuse liability of the drug.").

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told a reporter, "I found out pretty fast that it wasn't true."[49] In 2002, former Purdue sales manager William Gergely told a Florida state investigator that sales representatives were instructed to say that OxyContin was "virtually non-addicting" and "non-habit-forming."[50]

106. As Shelby Sherman, a Purdue sales representative from 1974 to 1998, told a reporter regarding OxyContin promotion, "It was sell, sell, sell. We were directed to lie. Why mince words about it?"[51]

107. The Manufacturer Defendants utilized lucrative bonus systems to encourage their sales representatives to stick to the script and increase opioid sales in their territories. Purdue paid $40 million in sales incentive bonuses to its sales representatives in 2001 alone, with annual bonuses ranging from $15,000 to nearly $240,000.[52] The training memo described above, in keeping with a Wizard of Oz theme, reminded sales representatives: "A pot of gold awaits you 'Over the Rainbow'!"[53]

108. As noted above, the Manufacturer Defendants have also spent substantial sums to purchase, manipulate, and analyze prescription data available from IMS Health, which allows them to track initial prescribing and refill practices by individual doctors, and in turn to customize their communications with each doctor. The Manufacturer Defendants' use of this marketing data was a cornerstone of their marketing plan,[54] and continues to this day.

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[49] Keefe, *supra* note 48.

[50] Fred Schulte and Nancy McVicar, O*xycontin Was Touted As Virtually Nonaddictive, Newly Released State Records Show*, Sun Sentinel (Mar. 6, 2003), http://articles.sun-sentinel.com/2003-03-06/news/0303051301_1_purdue-pharma-oxycontin-william-gergely.

[51] Glazek, *supra* note 21.

[52] Art Van Zee, M.D., *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99(2) Am J Public Health 221-27 (Feb. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2622774/.

[53] *Id.* at 103.

[54] *Id.*

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109. The Manufacturer Defendants also aggressively pursued family doctors and primary care physicians perceived to be susceptible to their marketing campaigns. The Manufacturer Defendants knew that these doctors relied on information provided by pharmaceutical companies when prescribing opioids, and that, as general practice doctors seeing a high volume of patients on a daily basis, they would be less likely to scrutinize the companies' claims.

110. Furthermore, the Manufacturer Defendants knew or should have known the doctors they targeted were often poorly equipped to treat or manage pain comprehensively, as they often had limited resources or time to address behavioral or cognitive aspects of pain treatment or to conduct the necessary research themselves to determine whether opioids were as beneficial as the Manufacturer Defendants claimed. In fact, the majority of doctors and dentists who prescribe opioids are not pain specialists. For example, a 2014 study conducted by pharmacy benefit manager Express Scripts reviewing narcotic prescription data from 2011 to 2012 concluded that of the more than 500,000 prescribers of opioids during that time period, *only 385* were identified as pain specialists.[55]

111. When the Manufacturer Defendants presented these doctors with sophisticated marketing material and apparently scientific articles that touted opioids' ability to easily and safely treat pain, many of these doctors began to view opioids as an efficient and effective way to treat their patients.

112. In addition, sales representatives aggressively pushed doctors to prescribe stronger doses of opioids. For example, one Purdue sales representative in Florida wrote about

[55] *A Nation in Pain*, Express Scripts (Dec. 9, 2014), http://lab.express-scripts.com/lab/publications/a-nation-in-pain.

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working for a particularly driven regional manager named Chris Sposato and described how Sposato would drill the sales team on their upselling tactics:

> It went something like this. "Doctor, what is the highest dose of OxyContin you have ever prescribed?" "20mg Q12h." "Doctor, if the patient tells you their pain score is still high you can increase the dose 100% to 40mg Q12h, will you do that?" "Okay." "Doctor, what if that patient them came back and said their pain score was still high, did you know that you could increase the OxyContin dose to 80mg Q12h, would you do that?" "I don't know, maybe." "Doctor, but you do agree that you would at least Rx the 40mg dose, right?" "Yes."
>
> The next week the rep would see that same doctor and go through the same discussion with the goal of selling higher and higher doses of OxyContin. Miami District reps have told me that on work sessions with [Sposato] they would sit in the car and role play for as long as it took until [Sposato] was convinced the rep was delivering the message with perfection.

113. The Manufacturer Defendants used not only incentives but competitive pressure to push sales representatives into increasingly aggressive promotion. One Purdue sales representative recalled the following scene: "I remember sitting at a round table with others from my district in a regional meeting while everyone would stand up and state the highest dose that they had suckered a doctor to prescribe. The entire region!!"

114. The Manufacturer Defendants applied this combination of intense competitive pressure and lucrative financial incentives because they knew that sales representatives, with their frequent in-person visits with prescribers, were incredibly effective. In fact, manufacturers' internal documents reveal that they considered sales representatives their "most valuable resource."

2. The Manufacturer Defendants bankrolled seemingly independent "front groups" to promote opioid use and fight restrictions on opioids.

115. The Manufacturer Defendants funded, controlled, and operated third-party organizations that communicated to doctors, patients, and the public the benefits of opioids to treat chronic pain. These organizations—also known as "front groups"—appeared independent

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and unbiased. But in fact, they were but additional paid mouthpieces for the drug manufacturers. These front groups published prescribing guidelines, unbranded materials, and other programs that promoted opioid treatment as a way to address patients' chronic pain. The front groups targeted doctors, patients, and lawmakers, all in coordinated efforts to promote opioid prescriptions.

116. The Manufacturer Defendants spent significant financial resources contributing to and working with these various front groups to increase the number of opioid prescriptions written.

117. The most prominent front group utilized by the Manufacturer Defendants was the **American Pain Foundation** (APF), which received more than $10 million from opioid drug manufacturers, including the Manufacturer Defendants, from 2007 through 2012. Purdue contributed $1.7 million and Endo also contributed substantial sums to the APF.[56]

118. Throughout its existence, APF's operating budget was almost entirely comprised of contributions from prescription opioid manufacturers. For instance, nearly 90% of APF's $5 million annual budget in 2010 came from "donations" from some of the Manufacturer Defendants, and by 2011, APF was entirely dependent on grants from drug manufacturers, including from Purdue and Endo. Not only did the Manufacturer Defendants control APF's purse strings, APF's board of directors was comprised of doctors who were on the Manufacturer Defendants' payrolls, either as consultants or speakers at medical events.[57]

119. Although holding itself out as an independent advocacy group promoting patient well-being, APF consistently lobbied against federal and state proposals to limit opioid use.

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[56] Charles Ornstein and Tracy Weber, *The Champion of Painkillers*, ProPublica (Dec. 23, 2011, 9:15am), https://www.propublica.org/article/the-champion-of-painkillers.

[57] *Id.*

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120. Another prominent front group was the **American Academy of Pain Medicine** (AAPM), which has received over $2.2 million in funding since 2009 from opioid drug manufacturers, including the Manufacturer Defendants. Like APF, AAPM presented itself as an independent and non-biased advocacy group representing physicians practicing in the field of pain medicine, but in fact was just another mouthpiece the Manufacturer Defendants used to push opioids on doctors and patients.[58]

121. Both the APF and the AAPM published treatment guidelines and sponsored and hosted medical education programs that touted the benefits of opioids to treat chronic pain while minimizing and trivializing their risks. The treatment guidelines the front groups published—many of which are discussed in detail below—were particularly important to the Manufacturer Defendants in ensuring widespread acceptance for opioid therapy to treat chronic pain. The Manufacturer Defendants realized, just as the CDC has, that such treatment guidelines can "change prescribing practices," because they appear to be unbiased sources of evidence-based information, even when they are in reality marketing materials.

122. For instance, the AAPM, in conjunction with the **American Pain Society** (APS), issued comprehensive guidelines in 2009 titled "Guideline for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain – Evidence Review" ("2009 Guidelines"). The 2009 Guidelines promoted opioids as "safe and effective" for treating chronic pain, despite acknowledging limited evidence to support this statement. Unsurprisingly, the Manufacturer Defendants have widely referenced and promoted these guidelines, issued by front groups the

[58] Tracy Weber and Charles Ornstein, *Two Leaders in Pain Treatment Have Long Ties to Drug Industry*, ProPublica (Dec. 23, 2011, 9:14am), https://www.propublica.org/article/two-leaders-in-pain-treatment-have-long-ties-to-drug-industry.

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Manufacturer Defendants funded and controlled. These 2009 Guidelines are still available online today.[59]

123. In addition, the Manufacturer Defendants participated in the **Pain Care Forum**, a coalition of drug makers, trade groups, and nonprofit organizations. From 2006 to 2015, participants in the Pain Care Forum spent over $740 million lobbying in the nation's capital and in all fifty statehouses on an array of issues, including opioid-related measures. The collective spending on lobbying and campaigns amounts to more than two hundred times the $4 million spent during the same period by the handful of groups that work to warn the public about the dangers of opioids and lobby for restrictions on painkillers.[60]

124. The Manufacturer Defendants have also targeted specific groups to encourage opioid prescribing practices. One such group, a University of Wisconsin-based organization known as the **Pain & Policy Studies Group**, received $2.5 million from pharmaceutical companies to promote opioid use and discourage the passing of regulations against opioid use in medical practice. The Pain & Policy Studies Group wields considerable influence over the nation's medical schools as well as within the medical field in general.[61] Purdue was the largest contributor to the Pain & Policy Studies Group, paying approximately $1.6 million between 1999 and 2010.[62]

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[59] *Clinical Guideline for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain*, American Pain Society, http://americanpainsociety.org/uploads/education/guidelines/chronic-opioid-therapy-cncp.pdf (last visited Jan. 5, 2018).

[60] Matthew Perrone and Ben Wieder, *Pro-painkiller echo chamber shaped policy amid drug epidemic*, AP News (Sept. 19, 2016), https://apnews.com/3d257452c24a410f98e8e5a4d9d448a7/pro-painkiller-echo-chamber-shaped-policy-amid-drug.

[61] *The Role of Pharmaceutical Companies in the Opioid Epidemic*, Addictions.com, https://www.addictions.com/opiate/the-role-of-pharmaceutical-companies-in-the-opioid-epidemic/ (last visited Jan. 5, 2018).

[62] John Fauber, *UW group ends drug firm funds*, Journal Sentinel (Apr. 20, 2011), http://archive.jsonline.com/watchdog/watchdogreports/120331689.html.

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125. The **Federation of State Medical Boards** (FSMB) of the United States is a national non-profit organization that represents the 70-state medical and osteopathic boards of the United States and its territories and co-sponsors the United States Medical Licensing Examination. Beginning in 1997, FSMB developed model policy guidelines around the treatment of pain, including opioid use. The original initiative was funded by the Robert Wood Johnson Foundation, but subsequently AAPM, APS, the University of Wisconsin Pain & Policy, and the American Society of Law, Medicine, & Ethics all made financial contributions to the project.

126. FSMB's 2004 Model Policy encourages state medical boards "to evaluate their state pain policies, rules, and regulations to identify *any regulatory restrictions or barriers that may impede the effective use of opioids* to relieve pain."[63]

127. One of the most significant barriers to convincing doctors that opioids were safe to prescribe to their patients for long-term treatment of chronic pain was the fact that many of those patients would, in fact, become addicted to opioids. If patients began showing up at their doctors' offices with obvious signs of addiction, the doctors would, of course, become concerned and likely stop prescribing opioids. And, doctors might stop believing Defendants' claims that addiction risk was low.

128. To overcome this hurdle, the Manufacturer Defendants promoted a concept called "pseudoaddiction." The Manufacturer and Sales Representative Defendants told doctors that when their patients appeared to be addicted to opioids—for example, asking for more and higher doses of opioids, increasing doses themselves, or claiming to have lost prescriptions in

[63] *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, Federation of State Medical Boards of the United States, Inc. (May 2004), http://www.painpolicy.wisc.edu/sites/www.painpolicy.wisc.edu/files/model04.pdf.

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order to get more opioids—this was not actual addiction. Rather, the Manufacturer and Sales Representative Defendants told doctors what appeared to be classic signs of addiction were actually just signs of undertreated pain. The solution to this "pseudoaddiction": more opioids. Instead of warning doctors of the risk of addiction and helping patients to wean themselves off of powerful opioids and deal with their actual addiction, Defendants pushed even more dangerous drugs onto patients.

129. The FSMB's Model Policy gave a scientific veneer to this fictional and overstated concept. The Policy defines "pseudoaddiction" as "[t]he iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction" and states that these behaviors "resolve upon institution of effective analgesic therapy."[64]

130. In May 2012, Senate Finance Committee Chairman Max Baucus and senior Committee member Chuck Grassley initiated an investigation into the connections of the Manufacturer Defendants with medical groups and physicians who have advocated increased opioid use.[65] In addition to the three manufacturers, the senators sent letters to APF, APS, AAPM, FSMB, the University of Wisconsin Pain & Policy Studies Group, the Joint Commission on Accreditation of Healthcare Organization, and the Center for Practical Bioethics, requesting from each "a detailed account of all payments/transfers received from

[64] *Id.*

[65] *Baucus, Grassley Seek Answers about Opioid Manufacturers' Ties to Medical Groups*, United States Senate Committee on Finance (May 8, 2012), https://www.finance.senate.gov/chairmans-news/baucus-grassley-seek-answers-about-opioid-manufacturers-ties-to-medical-groups.

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corporations and any related corporate entities and individuals that develop, manufacture, produce, market, or promote the use of opioid-based drugs from 1997 to the present."[66]

131. On the same day as the senators' investigation began, APF announced that it would "cease to exist, effective immediately."[67]

3. "It was pseudoscience": the Manufacturer Defendants paid prominent physicians to promote their products.

132. The Manufacturer Defendants retained highly credentialed medical professionals to promote the purported benefits and minimal risks of opioids. Known as "Key Opinions Leaders" or "KOLs," these medical professionals were often integrally involved with the front groups described above. The Manufacturer Defendants paid these KOLs substantial amounts to present at Continuing Medical Education ("CME") seminars and conferences, and to serve on their advisory boards and on the boards of the various front groups.

133. The Manufacturer Defendants also identified doctors to serve as speakers or attend all-expense-paid trips to programs with speakers.[68] The Manufacturer Defendants used these trips and programs—many of them lavish affairs—to incentivize the use of opioids while downplaying their risks, bombarding doctors with messages about the safety and efficacy of opioids for treating long-term pain. Although often couched in scientific certainty, the Manufacturer Defendants' messages were false and misleading, and helped to ensure that millions of Americans would be exposed to the profound risks of these drugs.

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[66] Letter from United States Senate Committee on Finance to American Pain Foundation (May 8, 2012), https://www.finance.senate.gov/imo/media/doc/05092012%20Baucus%20Grassley%20Opioid%20Investigation%20Letter%20to%20American%20Pain%20Foundation2.pdf.

[67] Charles Ornstein and Tracy Weber, *American Pain Foundation Shuts Down as Senators Launch Investigation of Prescription Narcotics*, ProPublica (May 8, 2012, 8:57pm), https://www.propublica.org/article/senate-panel-investigates-drug-company-ties-to-pain-groups.

[68] Van Zee, *The Promotion and Marketing of OxyContin*, *supra* note 52.

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134. It is well documented that this type of pharmaceutical company symposium influences physicians' prescribing, even though physicians who attend such symposia believe that such enticements do not alter their prescribing patterns.[69] For example, doctors who were invited to these all-expenses-paid weekends in resort locations like Boca Raton, Florida, and Scottsdale, Arizona, wrote twice as many prescriptions as those who did not attend.[70]

135. The KOLs gave the impression they were independent sources of unbiased information, while touting the benefits of opioids through their presentations, articles, and books. KOLs also served on committees and helped develop guidelines such as the 2009 Guidelines described above that strongly encouraged the use of opioids to treat chronic pain.

136. One of the most prominent KOLs for the Manufacturer Defendants' opioids was Dr. Russell Portenoy. A respected leader in the field of pain treatment, Dr. Portenoy was highly influential. Dr. Andrew Kolodny, cofounder of Physicians for Responsible Opioid Prescribing, described him "lecturing around the country as a religious-like figure. The megaphone for Portenoy is Purdue, which flies in people to resorts to hear him speak. It was a compelling message: 'Docs have been letting patients suffer; nobody really gets addicted; it's been studied.'"[71]

137. As one organizer of CME seminars, who worked with Portenoy and Purdue, pointed out, "had Portenoy not had Purdue's money behind him, he would have published some papers, made some speeches, and his influence would have been minor. With Purdue's millions behind him, his message, which dovetailed with their marketing plans, was hugely magnified."[72]

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[69] *Id.*

[70] Harriet Ryan, Lisa Girion and Scott Glover, *OxyContin goes global — "We're only just getting started"*, Los Angeles Times (Dec. 18, 2016), http://www.latimes.com/projects/la-me-oxycontin-part3/.

[71] Quinones, *supra* note 34, at 314.

[72] *Id.* at 136.

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138. In recent years, some of the Manufacturer Defendants' KOLs have conceded that many of their past claims in support of opioid use lacked evidence or support in the scientific literature.[73] Dr. Portenoy himself specifically admitted that he overstated the drugs' benefits and glossed over their risks, and that he "gave innumerable lectures in the late 1980s and '90s about addiction that weren't true."[74] He mused, "Did I teach about pain management, specifically about opioid therapy, in a way that reflects misinformation? Well, against the standards of 2012, I guess I did . . . We didn't know then what we know now."[75]

139. Dr. Portenoy did not need "the standards of 2012" to discern evidence-based science from baseless claims, however. When interviewed by journalist Barry Meier for his 2003 book, *Pain Killer*, Dr. Portenoy was more direct: "It was pseudoscience. I guess I'm going to have always to live with that one."[76]

140. Dr. Portenoy was perhaps the most prominent KOL for prescription opioids, but he was far from the only one. In fact, Dr. Portenoy and a doctor named Perry Fine co-wrote *A Clinical Guide to Opioid Analgesia*, which contained statements that conflict with the CDC's 2016 findings, such as the following examples regarding respiratory depression and addiction:

> At clinically appropriate doses, . . . respiratory rate typically does not decline. Tolerance to the respiratory effects usually develops quickly, and doses can be steadily increased without risk.
>
> Overall, the literature provides evidence that the outcomes of drug abuse and addiction are rare among patients who receive opioids for a short period (ie, for

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[73] *See, e.g.*, John Fauber, *Painkiller boom fueled by networking*, Journal Sentinel (Feb. 18, 2012), http://archive.jsonline.com/watchdog/watchdogreports/painkiller-boom-fueled-by-networking-dp3p2rn-139609053.html/ (finding that a key Endo KOL acknowledged that opioid marketing went too far).

[74] Thomas Catan and Evan Perez, *A Pain-Drug Champion Has Second Thoughts*, The Wall Street Journal (Dec. 17, 2012, 11:36am), https://www.wsj.com/articles/SB10001424127887324478304578173342657044604.

[75] *Id.*

[76] Meier, *supra* note 11, at 277.

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acute pain) and among those with no history of abuse who receive long-term therapy for medical indications.[77]

141. Dr. Fine is a Professor of Anesthesiology at the University of Utah School of Medicine's Pain Research Center. He has served on Purdue's advisory board, provided medical legal consulting for Janssen, and participated in CME activities for Endo, along with serving in these capacities for several other drug companies. He co-chaired the APS-AAPM Opioid Guideline Panel, served as treasurer of the AAPM from 2007 to 2010 and as president of that group from 2011 to 2013, and was also on the board of directors of APF.[78]

142. In 2011, he and Dr. Scott Fishman, discussed below, published a letter in *JAMA* called "Reducing Opioid Abuse and Diversion," which emphasized the importance of maintaining patient access to opioids.[79] The editors of *JAMA* found that both doctors had provided incomplete financial disclosures and made them submit corrections listing all of their ties to the prescription painkiller industry.[80]

143. Dr. Fine also failed to provide full disclosures as required by his employer, the University of Utah. For example, Dr. Fine told the university that he had received under $5,000 in 2010 from Johnson & Johnson for providing "educational" services, but Johnson & Johnson's website states that the company paid him $32,017 for consulting, promotional talks, meals and travel that year.[81]

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[77] Perry G. Fine, MD and Russell K. Portenoy, MD, *A Clinical Guide to Opioid Analgesia* 20 and 34, McGraw-Hill Companies (2004), http://www.thblack.com/links/RSD/OpioidHandbook.pdf.

[78] Scott M. Fishman, MD, *Incomplete Financial Disclosures in a Letter on Reducing Opioid Abuse and Diversion*, 306 (13) JAMA 1445 (Sept. 20, 2011), https://jamanetwork.com/journals/jama/article-abstract/1104464?redirect=true.

[79] Perry G. Fine, MD and Scott M. Fishman, MD, *Reducing Opioid Abuse and Diversion*, 306 (4) JAMA 381 (July 27, 2011), https://jamanetwork.com/journals/jama/article-abstract/1104144?redirect=true.

[80] *Incomplete Financial Disclosures in: Reducing Opioid Abuse and Diversion*, 306 (13) JAMA 1446 (Oct. 5, 2011), https://jamanetwork.com/journals/jama/fullarticle/1104453.

[81] Weber and Ornstein, *supra* note 58.

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144. In 2012, along with other KOLs, Dr. Fine was investigated for his ties to drug companies as part of the Senate investigation of front groups described above. When Marianne Skolek, a reporter for the online news outlet Salem-News.com and a critic of opioid overuse, wrote an article about him and another KOL being investigated, Dr. Fine fired back, sending a letter to her editor accusing her of poor journalism and saying that she had lost whatever credibility she may have had. He criticized her for linking him to Purdue, writing, "I have never had anything to do with Oxycontin development, sales, marketing or promotion; I have never been a Purdue Pharma speaker"—neglecting to mention, of course, that he served on Purdue's advisory board, as the JAMA editors had previously forced him to disclose. [82]

145. Another Utah physician, Dr. Lynn Webster, was the director of Lifetree Clinical Research & Pain Clinic in Salt Lake City from 1990 to 2010, and in 2013 was the president of AAPM (one of the front groups discussed above). Dr. Webster developed a five-question survey he called the Opioid Risk Tool, which he asserted would "predict accurately which individuals may develop aberrant behaviors when prescribed opioids for chronic pain."[83] He published books titled *The Painful Truth: What Chronic Pain Is Really Like and Why It Matters to Each of Us* and *Avoiding Opioid Abuse While Managing Pain.*

146. Dr. Webster and the Lifetree Clinic were investigated by the DEA for overprescribing opioids after twenty patients died from overdoses. In keeping with the opioid industry's promotional messages, Dr. Webster apparently believed the solution to patients' tolerance or addictive behaviors was more opioids: he prescribed staggering quantities of pills.

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[82] Marianne Skolek, *Doctor Under Senate Investigation Lashes Out at Journalist*, Salem News (Aug. 12, 2012, 8:45pm), http://www.salem-news.com/articles/august122012/perry-fine-folo-ms.php.

[83] Lynn Webster and RM Webster, *Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool* 6 (6) Pain Med. 432 (Nov.-Dec. 2005), https://www.ncbi.nlm.nih.gov/pubmed/16336480.

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Tina Webb, a Lifetree patient who overdosed in 2007, was taking as many as 32 pain pills a day in the year before she died, all while under doctor supervision.[84] Carol Ann Bosley, who sought treatment for pain at Lifetree after a serious car accident and multiple spine surgeries, quickly became addicted to opioids and was prescribed increasing quantities of pills; at the time of her death, she was on seven different medications totaling approximately 600 pills a month.[85] Another woman, who sought treatment from Lifetree for chronic low back pain and headaches, died at age 42 after Lifetree clinicians increased her prescriptions to 14 different drugs, including multiple opioids, for a total of 1,158 pills a month.[86]

147. By these numbers, Lifetree resembles the pill mills and "bad actors" that the Manufacturer Defendants blame for opioid overuse. But Dr. Webster was an integral part of the Manufacturer Defendants' marketing campaigns, a respected pain specialist who authored numerous CMEs sponsored by Endo and Purdue. And the Manufacturer Defendants promoted his Opioid Risk Tool and similar screening questionnaires as measures that allow powerful opioids to be prescribed for chronic pain.

148. Even in the face of patients' deaths, Dr. Webster continues to promote a pro-opioid agenda, even asserting that alternatives to opioids are risky because "[i]t's not hard to overdose on NSAIDs or acetaminophen."[87] He argued on his website in 2015 that DEA restrictions on the accessibility of hydrocodone harm patients, and in 2017 tweeted in response

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[84] Jesse Hyde and Daphne Chen, *The untold story of how Utah doctors and Big Pharma helped drive the national opioid epidemic*, Deseret News (Oct. 26, 2017, 12:01am), https://www.deseretnews.com/article/900002328/the-untold-story-of-how-utah-doctors-and-big-pharma-helped-drive-the-national-opioid-epidemic.html.

[85] Stephanie Smith, *Prominent pain doctor investigated by DEA after patient deaths*, CNN (Dec. 20, 2013, 7:06am), http://www.cnn.com/2013/12/20/health/pain-pillar/index.html.

[86] *Id.*

[87] *APF releases opioid medication safety module*, Drug Topics (May 10, 2011), http://drugtopics.modernmedicine.com/drug-topics/news/modernmedicine/modern-medicine-news/apf-releases-opioid-medication-safety-module.

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to CVS Caremark's announcement that it will limit opioid prescriptions that "CVS Caremark's new opioid policy is wrong, and it won't stop illegal drugs."[88]

149. Another prominent KOL is Dr. Scott M. Fishman, the Chief of the Department of Pain Medicine at University of California, Davis. He has served as president of APF and AAPM, and a consultant and a speaker for Purdue, in addition to providing the company grant and research support. He also has had financial relationships with Endo and Janssen. He wrote a book for the FSMB called *Responsible Opioid Use: A Physician's Guide*, which was distributed to over 165,000 physicians in the U.S.

150. Dr. Fishman and Dr. Fine, along with Dr. Seddon Savage, published an editorial in the Seattle Times in 2010, arguing that Washington legislation proposed to combat prescription opioid abuse would harm patients, in particular by requiring chronic pain patients to consult with a pain specialist before receiving a prescription for a moderate to high dose of an opioid.[89]

151. These KOLs and others—respected specialists in pain medicine—proved to be highly effective spokespeople for the Manufacturer Defendants.

4. The Manufacturer Defendants used "unbranded" advertising as a platform for their misrepresentations about opioids.

152. The Manufacturer Defendants also aggressively promoted opioids through "unbranded advertising" to generally tout the benefits of opioids without specifically naming a particular brand of opioid. A trick often used by pharmaceutical companies, unbranded

[88] @LynnRWebsterMD, Twitter (Dec. 7, 2017, 1:45pm), https://twitter.com/LynnRWebsterMD/status/938887130545360898.

[89] Perry G. Fine, Scott M. Fishman, and Seddon R. Savage, *Bill to combat prescription abuse really will harm patients in pain*, The Seattle Times (Mar. 16, 2010, 4:39pm), http://old.seattletimes.com/html/opinion/2011361572_guest17fine.html.

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marketing is not typically reviewed by the FDA, giving the pharmaceutical companies considerable leeway to make sweeping claims about types of drugs. Conversely, branded marketing, which identifies and promotes a specific drug, is subject to FDA review for consistency with the drug's label and adequate presentation of risk and benefits.

153. By engaging in unbranded advertising, the Manufacturer Defendants were and are able to avoid FDA review and issue general statements to the public including that opioids improve function, that addiction usually does not occur, and that withdrawal can easily be managed.

154. Through the various marketing channels described above—all of which the Manufacturer Defendants controlled, funded, and facilitated, and for which they are legally responsible—the Manufacturer Defendants made false or misleading statements about opioids despite the lack of scientific evidence to support their claims, while omitting the true risk of addiction and death.

D. Specific Misrepresentations Made by Defendants.

155. All Defendants have made and/or continue to make false or misleading claims in the following areas: (1) the low risk of addiction to opioids, (2) opioids' efficacy for chronic pain and ability to improve patients' quality of life with long-term use, (3) the lack of risk associated with higher dosages of opioids, (4) the need to prescribe more opioids to treat withdrawal symptoms, and (5) that risk-mitigation strategies and abuse-deterrent technologies allow doctors to safely prescribe opioids for chronic use. These illustrative but non-exhaustive categories of Defendants' misrepresentations about opioids are described in detail below.

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1. Defendants falsely claimed that the risk of opioid abuse and addiction was low.

156. Collectively, Defendants have made a series of false and misleading statements about the low risk of addiction to opioids over the past twenty years. Defendants have also failed to take sufficient remedial measures to correct its false and misleading statements.

157. The Manufacturer Defendants knew that many physicians were hesitant to prescribe opioids other than for acute or cancer-related pain because of concerns about addiction. Because of this general perception, sales messaging about the low risk of addiction was a fundamental prerequisite misrepresentation.

158. When Purdue launched OxyContin in 1996, it did so with the statement that OxyContin's patented continuous-release mechanism "is believed to reduce the abuse liability." This statement, which appeared in OxyContin's label and which sales representatives were taught to repeat verbatim, was unsupported by any studies, and was patently false. The continuous-release mechanism was simple to override, and the drug correspondingly easy to abuse. This fact was known, or should have been known, to Purdue prior to its launch of OxyContin, because people had been circumventing the same continuous-release mechanism for years with MS Contin, which in fact commanded a high street price because of the dose of pure narcotic it delivered. In addition, with respect to OxyContin, Purdue researchers notified company executives, including Raymond and Richard Sackler, by email that patients in their clinical trials were abusing the drug despite the timed-release mechanism.[90]

159. But this misrepresentation alone would likely not have been enough to overcome decades of wariness regarding opioid use. Purdue, which had not conducted any studies about

[90] WBUR On Point interview, *supra* note 16.

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abuse potential or addiction risk as part of its application for FDA approval for OxyContin, needed some sort of research to back up its messaging. Purdue (and, later, the other Manufacturer Defendants) found this "research" in the form of a one-paragraph letter to the editor published in the New England Journal of Medicine (NEJM) in 1980.

160. This letter, by Dr. Hershel Jick and Jane Porter, declared the incidence of addiction "rare" for patients treated with opioids.[91] They had analyzed a database of hospitalized patients who were given opioids in a controlled setting to ease suffering from acute pain. These patients were not given long-term opioid prescriptions or provided opioids to administer to themselves at home, nor was it known how frequently or infrequently and in what doses the patients were given their narcotics. Rather, it appears the patients were treated with opioids for short periods of time under in-hospital doctor supervision.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

[91] Jane Porter and Herschel Jick, MD, *Addiction Rare in Patients Treated with Narcotics*, 302(2) N Engl J Med. 123 (Jan. 10, 1980), http://www.nejm.org/doi/pdf/10.1056/NEJM198001103020221.

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161. As Dr. Jick explained to a journalist years later, he submitted the statistics to NEJM as a letter because the data were not robust enough to be published as a study, and that one could not conclude anything about long-term use of opioids from his figures.[92] Dr. Jick also recalled that no one from drug companies or patient advocacy groups contacted him for more information about the data.[93]

162. Nonetheless, Defendants regularly invoked this letter as proof of the low addiction risk in connection with taking opioids despite its obvious shortcomings. Defendants' egregious misrepresentations based on this letter included claims that *less than one percent* of opioid users become addicted.

163. The limited facts of the study did not deter Defendants from using it as definitive proof of opioids' safety. The enormous impact of Defendants' misleading amplification of this letter was well documented in another letter published in the NEJM on June 1, 2017, describing the way the one-paragraph 1980 letter had been irresponsibly cited and in some cases "grossly misrepresented." In particular, the authors of this letter explained:

> [W]e found that a five-sentence letter published in the *Journal* in 1980 was heavily and uncritically cited as evidence that addiction was rare with long-term opioid therapy. We believe that this citation pattern contributed to the North American opioid crisis by helping to shape a narrative that allayed prescribers' concerns about the risk of addiction associated with long-term opioid therapy . . .[94]

164. Unfortunately, by the time of this analysis and the CDC's findings in 2016, the damage had already been done. "It's difficult to overstate the role of this letter," said Dr. David

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[92] Meier, *supra* note 11, at 174.

[93] *Id.*

[94] Pamela T.M. Leung, B.Sc. Pharm., Erin M. Macdonald, M.Sc., Matthew B. Stanbrook, M.D., Ph.D., Irfan Al Dhalla, M.D., David N. Juurlink, M.D., Ph.D., *A 1980 Letter on the Risk of Opioid Addiction*, 376 N Engl J Med 2194-95 (June 1, 2017), http://www.nejm.org/doi/full/10.1056/NEJMc1700150#t=article.

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Juurlink of the University of Toronto, who led the analysis. "It was the key bit of literature that helped the opiate manufacturers convince front-line doctors that addiction is not a concern."[95]

165. Defendants successfully manipulated the 1980 Porter and Jick letter as the "evidence" supporting their fundamental misrepresentation that the risk of opioid addiction was low when opioids were prescribed to treat pain. For example, in its 1996 press release announcing the release of OxyContin, Purdue advertised that the "fear of addiction is exaggerated" and quoted the chairman of the American Pain Society Quality of Care Committee, who claimed that "there is very little risk of addiction from the proper uses of these [opioid] drugs for pain relief."[96]

PR Newswire

May 31, 1996, Friday - 15:47 Eastern Time

NEW HOPE FOR MILLIONS OF AMERICANS SUFFERING FROM PERSISTENT

The fear of addiction is exaggerated.

One cause of patient resistance to appropriate pain treatment -- the fear of addiction -- is largely unfounded. According to Dr. Max, "Experts agree that most pain caused by surgery or cancer can be relieved, primarily by carefully adjusting the dose of opioid (narcotic) pain reliever to each patient's need, and that there is very little risk of addiction from the proper uses of these drugs for pain relief."

Paul D. Goldenheim, M.D., Vice President of Purdue Pharma L.P. in Norwalk, Connecticut, agrees with this assessment. "Proper use of medication is an essential weapon in the battle against persistent pain. But too often fear, misinformation and poor communication stand in the way of their legitimate use."

[95] *Painful words: How a 1980 letter fueled the opioid epidemic*, STAT (May 31, 2017), https://www.statnews.com/2017/05/31/opioid-epidemic-nejm-letter/.

[96] Press Release, OxyContin, *New Hope for Millions of Americans Suffering from Persistent Pain: Long-Acting OxyContin Tablets Now Available to Relieve Pain* (May 31, 1996, 3:47pm), http://documents.latimes.com/oxycontin-press-release-1996/.

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166. Dr. Portenoy, the Purdue KOL mentioned previously, also stated in a promotional video from the 1990s that "the likelihood that the treatment of pain using an opioid drug which is prescribed by a doctor will lead to addiction is extremely low."[97]

167. Purdue also specifically used the Porter and Jick letter in its 1998 promotional video "I got my life back," in which Dr. Alan Spanos says "In fact, the rate of addiction amongst pain patients who are treated by doctors *is much less than 1%*."[98]

[97] Catan and Perez, *supra* note 74.

[98] Our Amazing World, *Purdue Pharma OxyContin Commercial*, https://www.youtube.com/watch?v=Er78Dj5hyeI (last visited Jan. 5, 2018) (emphasis added).

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168. The Porter and Jick letter was also used on Purdue's "Partners Against Pain" website, which was available in the early 2000s, where Purdue claimed that the addiction risk with OxyContin was very low.[99]

169. The Porter and Jick letter was used frequently in literature given to prescribing physicians and to patients who were prescribed OxyContin.[100]

170. In addition to the Porter and Jick letter, Defendants exaggerated the significance of a study published in 1986 regarding cancer patients treated with opioids. Conducted by Dr. Portenoy and another pain specialist, Dr. Kathleen Foley, the study involved only 38 patients, who were treated for non-malignant cancer pain with low doses of opioids (the majority were given less than 20 MME/day, the equivalent of only 13 mg of oxycodone).[101] Of these 38 patients, only two developed problems with opioid abuse, and Dr. Portenoy and Dr. Foley concluded that "opioid maintenance therapy can be a safe, salutary and more humane alternative to the options of surgery or no treatment in those patients with intractable non-malignant pain and no history of drug abuse . . ."[102] Notwithstanding the small sample size, low doses of opioids involved, and the fact that all the patients were cancer patients, Defendants used this study as "evidence" that high doses of opioids were safe for the treatment of chronic non-cancer pain.

171. Defendants' repeated misrepresentations about the low risk of opioid addiction were so effective that this concept became part of the conventional wisdom. Dr. Nathaniel Katz,

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[99] Van Zee, *The Promotion and Marketing of OxyContin*, *supra* note 52.

[100] Art Van Zee, M.D., *The OxyContin Abuse Problem: Spotlight on Purdue Pharma's Marketing* (Aug. 22, 2001), https://web.archive.org/web/20170212210143/https://www.fda.gov/ohrms/dockets/dockets/01n0256/c000297-A.pdf.

[101] Russell K. Portenoy and Kathleen M. Foley, *Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases*, 25 Pain 171-86 (1986), https://www.ncbi.nlm.nih.gov/pubmed/2873550.

[102] *Id.*

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a pain specialist, recalls learning in medical school that previous fears about addiction were misguided, and that doctors should feel free to allow their patients the pain relief that opioids can provide. He did not question this until one of his patients died from an overdose. Then, he searched the medical literature for evidence of the safety and efficacy of opioid treatment for chronic pain. "There's not a shred of research on the issue. All these so-called experts in pain are dedicated and have been training me that opioids aren't as addictive as we thought. But what is that based on? It was based on nothing."[103]

172. At a hearing before the House of Representatives' Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce in August 2001, Purdue continued to emphasize "legitimate" treatment, dismissing cases of overdose and death as something that would not befall "legitimate" patients: "Virtually all of these reports involve people who are abusing the medication, not patients with legitimate medical needs under the treatment of a healthcare professional."[104]

173. Purdue spun this baseless "legitimate use" distinction out even further in a patient brochure about OxyContin, called "A Guide to Your New Pain Medicine and How to Become a Partner Against Pain." In response to the question, "Aren't opioid pain medications like OxyContin Tablets 'addicting'? Even my family is concerned about this," Purdue claimed that there was no need to worry about addiction if taking opioids for legitimate, "medical" purposes:

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[103] Quinones, *supra* note 34, at 188-89.

[104] *Oxycontin: Its Use and Abuse: Hearing Before the H. Subcomm. on Oversight and Investigations of the Comm. on Energy and Commerce*, 107th Cong. 1 (Aug. 28, 2001) (statement of Michael Friedman, Executive Vice President, Chief Operating Officer, Purdue Pharma, L.P.), https://www.gpo.gov/fdsys/pkg/CHRG-107hhrg75754/html/CHRG-107hhrg75754.htm.

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> Drug addiction means using a drug to get "high" rather than to relieve pain. You are taking opioid pain medication for medical purposes. The medical purposes are clear and the effects are beneficial, not harmful.

174. Similarly, Dr. David Haddox, Senior Medical Director for Purdue, cavalierly stated, "[w]hen this medicine is used appropriately to treat pain under a doctor's care, it is not only effective, it is safe."[105] He went so far as to compare OxyContin to celery, because even celery would be harmful if injected: "If I gave you a stalk of celery and you ate that, it would be healthy for you. But if you put it in a blender and tried to shoot it into your veins, it would not be good."[106]

175. Purdue sales representatives also repeated these misstatements regarding the low risk for addiction to doctors across the country.[107] Its sales representatives targeted primary care physicians in particular, downplaying the risk of addiction and, as one doctor observed, "promot[ing] among primary care physicians a more liberal use of opioids."[108]

176. Purdue sales representatives were instructed to "distinguish between iatrogenic addiction (<1% of patients) and substance abusers/diversion (about 10 percent of the population abuse something: weed; cocaine; heroin; alcohol; valium; etc.)."[109]

177. Purdue also marketed OxyContin for a wide variety of conditions and to doctors who were not adequately trained in pain management.[110]

178. As of 2003, Purdue's Patient Information guide for OxyContin contained the following language regarding addiction:

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[105] Roger Alford, *Deadly OxyContin abuse expected to spread in the U.S.*, Charleston Gazette, Feb. 9, 2001.
[106] *Id.*
[107] Barry Meier, *In Guilty Plea, OxyContin Maker to Pay $600 Million*, The New York Times (May 10, 2007), http://www.nytimes.com/2007/05/10/business/11drug-web.html.
[108] Van Zee, *The Promotion and Marketing of OxyContin*, *supra* note 52.
[109] Meier, *supra* note 11, at 269.
[110] *OxyContin Abuse and Diversion and Efforts to Address the Problem*, *supra* note 25.

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> Concerns about abuse, addiction, and diversion should not prevent the proper management of pain. The development of addiction to opioid analgesics in properly managed patients with pain has been reported to be rare. However, data are not available to establish the true incidence of addiction in chronic pain patients.

179. Although Purdue has acknowledged it has made some misrepresentations about the safety of its opioids,[111] it has done nothing to address the ongoing harms of their misrepresentations; in fact, it continues to make those misrepresentations today.

180. Defendant Endo also made dubious claims about the low risk of addiction. For instance, it sponsored a website, PainKnowledge.com, on which in 2009 it claimed that "[p]eople who take opioids as prescribed usually do not become addicted."[112] The website has since been taken down.

181. In another website, PainAction.com—which is still currently available today—Endo also claimed that "most chronic pain patients do not become addicted to the opioid medications that are prescribed for them."[113]

182. In a pamphlet titled "Understanding Your Pain: Taking Oral Opioid Analgesics," Endo assured patients that addiction is something that happens to people who take opioids for reasons other than pain relief, "such as unbearable emotional problems"[114]:

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[111] Following the conviction in 2007 of three of its executives for misbranding OxyContin, Purdue released a statement in which they acknowledged their false statements. "Nearly six years and longer ago, some employees made, or told other employees to make, certain statements about OxyContin to some health care professionals that were inconsistent with the F.D.A.-approved prescribing information for OxyContin and the express warnings it contained about risks associated with the medicine. The statements also violated written company policies requiring adherence to the prescribing information."

[112] German Lopez, *US officials are starting to treat opioid companies like Big Tobacco—and suing them*, Vox (Aug. 9, 2017, 3:53pm), https://www.vox.com/policy-and-politics/2017/6/7/15724054/opioid-companies-epidemic-lawsuits.

[113] *Opioid medication and addiction*, Pain Action (Aug. 17, 2017), https://www.painaction.com/opioid-medication-addiction/.

[114] *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004), http://www.thblack.com/links/RSD/Understand_Pain_Opioid_Analgesics.pdf.

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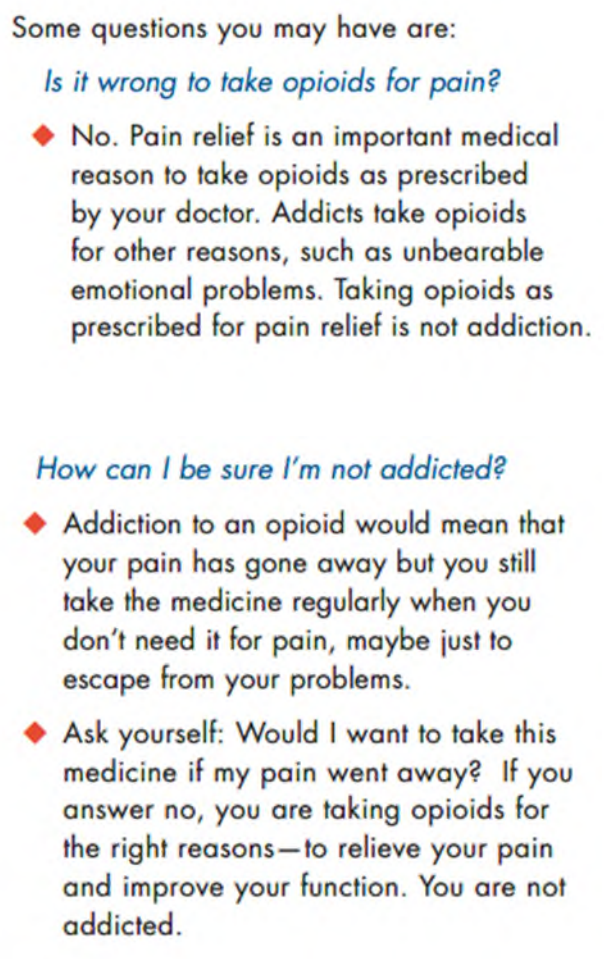

Some questions you may have are:

Is it wrong to take opioids for pain?

- No. Pain relief is an important medical reason to take opioids as prescribed by your doctor. Addicts take opioids for other reasons, such as unbearable emotional problems. Taking opioids as prescribed for pain relief is not addiction.

How can I be sure I'm not addicted?

- Addiction to an opioid would mean that your pain has gone away but you still take the medicine regularly when you don't need it for pain, maybe just to escape from your problems.
- Ask yourself: Would I want to take this medicine if my pain went away? If you answer no, you are taking opioids for the right reasons—to relieve your pain and improve your function. You are not addicted.

183. In addition, Endo made statements in pamphlets and publications that most health care providers who treat people with pain agree that most people do not develop an addiction problem. These statements also appeared on websites sponsored by Endo, such as Opana.com.

184. In its currently active website, PrescribeResponsibly.com, Defendant Janssen states that concerns about opioid addiction are "overestimated" and that "true addiction occurs only in a small percentage of patients."[115]

[115] Keith Candiotti, M.D., *Use of Opioid Analgesics in Pain Management*, Prescribe Responsibly, http://www.prescriberesponsibly.com/articles/opioid-pain-management (last modified July 2, 2015).

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Use of Opioid Analgesics in Pain Management

Other Opioid Analgesic Concerns

Aside from medical issues related to opioid analgesics, there are nonmedical issues that may have an impact on prescribing patterns and patient use of these drugs. Practitioners are often concerned about prescribing opioid analgesics due to potential legal issues and questions of addiction.[15,16] By the same token, patients report similar concerns about developing an addiction to opioid analgesics.[17] While these concerns are not without some merit, it would appear that they are often overestimated. According to clinical opinion polls, true addiction occurs only in a small percentage of patients with chronic pain who receive chronic opioid analgesics analgesic therapy.[18]

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

185. Similarly, in a 2009 patient education video titled "Finding Relief: Pain Management for Older Adults," Janssen sponsored a video by the American Academy of Pain Medicine that indicated that opioids are rarely addictive. The video has since been taken down.[116]

[116] Molly Huff, *Finding Relief: Pain Management for Older Adults*, Centers for Pain Management (Mar. 9, 2011), http://www.managepaintoday.com/news/-Finding-Relief-Pain-Management-for-Older-Adults.

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186. Janssen also approved and distributed a patient education guide in 2009 that attempted to counter the "myth" that opioids are addictive, claiming that "[m]any studies show that opioids are rarely addictive when used properly for the management of chronic pain."[117]

187. In addition, all three of the Manufacturer Defendants used third parties and front groups to further their false and misleading statements about the safety of opioids.

188. For example, in testimony for the Hearing to Examine the Effects of the Painkiller OxyContin, Focusing on Risks and Benefits, in front of the Senate Health, Education, Labor and Pensions Committee in February 2002, Dr. John D. Giglio, Executive Director of the APF, the organization which, as described above, received the majority of its funding from opioid manufacturers, including Purdue, stated that "opioids are safe and effective, and only in rare cases lead to addiction."[118] Along with Dr. Giglio's testimony, the APF submitted a short background sheet on "the scope of the undertreatment of pain in the U.S.," which asserted that "opioids are often the best" treatment for pain that hasn't responded to other techniques, but that patients and many doctors "lack even basic knowledge about these options and fear that powerful pain drugs will [c]ause addiction." According to the APF, "most studies show that less than 1% of patients become addicted, which is medically different from becoming physically dependent."[119]

189. The APF further backed up Purdue in an amicus curiae brief filed in an Ohio appeals court in December 2002, in which it claimed that "medical leaders have come to

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[117] Lopez, *supra* note 112.

[118] *Oxycontin: Balancing Risks and Benefits: Hearing of the S. Comm. on Health, Education, Labor and Pensions*, 107th Cong. 2 (Feb. 12, 2002) (testimony of John D. Giglio, M.A., J.D., Executive Director, American Pain Foundation), https://www.help.senate.gov/imo/media/doc/Giglio.pdf.

[119] *Id.*

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understand that the small risk of abuse does not justify the withholding of these highly effective analgesics from chronic pain patients."[120]

190. In a 2007 publication titled "Treatment Options: A Guide for People Living with Pain," APF downplayed the risk of addiction and argued that concern about this risk should not prevent people from taking opioids: "Restricting access to the most effective medications for treating pain is not the solution to drug abuse or addiction."[121] APF also tried to normalize the dangers of opioids by listing opioids as one of several "[c]ommon drugs that can cause physical dependence," including steroids, certain heart medications, and caffeine.[122]

191. Defendants' repeated statements about the low risk of addiction when taking opioids as prescribed for chronic pain were blatantly false and were made with reckless disregard for the potential consequences.

2. Defendants falsely claimed that opioids were proven effective for chronic pain and would improve quality of life.

192. Not only did Defendants falsely claim that the risk of addiction to prescription opioids was low, Defendants represented that there was a significant upside to long-term opioid use, including that opioids could restore function and improve quality of life.[123]

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[120] Brief Amici Curiae of American Pain Foundation, National Foundation for the Treatment of Pain, and The Ohio Pain Initiative, in Support of Defendants/Appellants, *Howland v. Purdue Pharma, L.P., et al.*, Appeal No. CA 2002 09 0220 (Butler Co., Ohio 12th Court of Appeals, Dec. 23, 2002), https://ia801005.us.archive.org/23/items/279014-howland-apf-amicus/279014-howland-apf-amicus.pdf.

[121] *Treatment Options: A Guide for People Living with Pain*, American Pain Foundation, https://assets.documentcloud.org/documents/277605/apf-treatmentoptions.pdf (last visited Jan. 5, 2018).

[122] *Id.*

[123] This case *does not* request or require the Court to specifically adjudicate whether opioids are appropriate for the treatment of chronic, non-cancer-pain—though the scientific evidence strongly suggests they are not.

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193. Such claims were viewed as a critical part of the Manufacturer Defendants' marketing strategies. An internal Purdue report from 2001 noted the lack of data supporting improvement in quality of life with OxyContin treatment:

> Janssen has been stressing decreased side effects, especially constipation, as well as patient quality of life, as supported by patient rating compared to sustained release morphine…We do not have such data to support OxyContin promotion. . . . In addition, Janssen has been using the "life uninterrupted" message in promotion of Duragesic for non-cancer pain, stressing that Duragesic "helps patients think less about their pain." This is a competitive advantage based on our inability to make any quality of life claims.[124]

194. Despite the lack of data supporting improvement in quality of life, Purdue ran a full-page ad for OxyContin in the Journal of the American Medical Association in 2002, proclaiming, "There Can Be Life With Relief," and showing a man happily fly-fishing alongside his grandson.[125] This ad earned a warning letter from the FDA, which admonished, "It is particularly disturbing that your November ad would tout 'Life With Relief' yet fail to warn that patients can die from taking OxyContin."[126]

195. Purdue also consistently tried to steer any concern away from addiction, and focus on its false claims that opioids were effective and safe for dealing with chronic pain. At a hearing before the House of Representatives' Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce in August 2001, Michael Friedman, Executive Vice President and Chief Operating Officer of Purdue, testified that "even the most vocal critics of opioid therapy concede the value of OxyContin in the legitimate treatment of pain," and that

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[124] Meier, *supra* note 11, at 281.

[125] *Id.* at 280.

[126] Chris Adams, *FDA Orders Purdue Pharma To Pull Its OxyContin Ads*, The Wall Street Journal (Jan. 23, 2003, 12:01am), https://www.wsj.com/articles/SB1043259665976915824.

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"OxyContin has proven itself an effective weapon in the fight against pain, returning many patients to their families, to their work, and to their ability to enjoy life."[127]

196. Purdue sponsored the development and distribution of an APF guide in 2011 which claimed that "multiple clinical studies have shown that opioids are effective in improving daily function, psychological health, and health-related quality of life for chronic pain patients." This guide is still available today.

197. Purdue also ran a series of advertisements of OxyContin in 2012 in medical journals titled "Pain vignettes," which were styled as case studies of patients with persistent pain conditions and for whom OxyContin was recommended to improve their function.

198. Purdue and Endo also sponsored and distributed a book in 2007 to promote the claim that pain relief from opioids, by itself, improved patients' function. The book remains for sale online today.

199. Endo's advertisements for Opana ER claimed that use of the drug for chronic pain allowed patients to perform demanding tasks like construction and portrayed Opana ER users as healthy and unimpaired.

200. Endo's National Initiative on Pain Control (NIPC) website also claimed in 2009 that with opioids, "your level of function should improve; you may find you are now able to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy when your pain was worse."

[127] *Oxycontin: Its Use and Abuse, supra* note 104.

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201. Endo further sponsored a series of CME programs through NIPC which claimed that chronic opioid therapy has been "shown to reduce pain and depressive symptoms and cognitive functioning."

202. Through PainKnowledge.org, Endo also supported and sponsored guidelines that stated, among other things, that "Opioid Medications are a powerful and often highly effective tool in treating pain," and that "they can help restore comfort, function, and quality of life."[128]

203. In addition, Janssen sponsored and edited patient guides which stated that "opioids may make it easier for people to live normally." The guides listed expected functional improvements from opioid use, including sleeping through the night, and returning to work, recreation, sex, walking, and climbing stairs.

204. Janssen also sponsored, funded, and edited a website which featured an interview edited by Janssen that described how opioids allowed a patient to "continue to function." This video is still available today.

205. Furthermore, sales representatives for Purdue, Endo, and Janssen communicated and continue to communicate the message that opioids will improve patients' function, without appropriate disclaimers.

206. Defendants' statements regarding opioids' ability to improve function and quality of life are false and misleading. As the CDC's 2016 Guidelines confirm, not a single study supports these claims.

207. In fact, to date, there have been no long-term studies that demonstrate that opioids are effective for treating long-term or chronic pain. Instead, reliable sources of

[128] *Informed Consent for Using Opioids to Treat Pain,* Painknowledge.org (2007), https://www.mainequalitycounts.org/image_upload/Opioid%20Informed%20Consent%20Formatted_1_23_2008.pdf.

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information, including from the CDC in 2016, indicate that there is "*[n]o evidence*" to show "a long-term benefit of opioids in pain and function versus no opioids for chronic pain."[129] By contrast, significant research has demonstrated the colossal dangers of opioids. The CDC, for example, concluded that "[e]xtensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury)" and that "[o]pioid pain medication use presents serious risks, including overdose and opioid use disorder."[130]

3. Defendants falsely claimed doctors and patients could increase opioid usage indefinitely without added risk.

208. Defendants also made false and misleading statements claiming that there is no dosage ceiling for opioid treatment. These misrepresentations were integral to Defendants' promotion of prescription opioids for two reasons. First, the idea that there was no upward limit was necessary for the overarching deception that opioids are appropriate treatment for chronic pain. As discussed above, people develop a tolerance to opioids' analgesic effects, so that achieving long-term pain relief requires constantly increasing the dose. Second, the dosing misrepresentation was necessary for the claim that OxyContin and competitor drugs allowed 12-hour dosing.

209. Twelve-hour dosing is a significant marketing advantage for any medication, because patient compliance is improved when a medication only needs to be taken twice a day. For prescription painkillers, the 12-hour dosing is even more significant because shorter-acting painkillers did not allow patients to get a full night's sleep before the medication wore off. A Purdue memo to the OxyContin launch team stated that "OxyContin's positioning statement is 'all of the analgesic efficacy of immediate-release oxycodone, with convenient q12h dosing,'"

[129] Dowell, et al., *supra* note 26.
[130] *Id.*

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and further that "[t]he convenience of q12h dosing was emphasized as the most important benefit."[131]

210. Purdue executives therefore maintained the messaging of 12-hour dosing even when many reports surfaced that OxyContin did not last 12 hours. Instead of acknowledging a need for more frequent dosing, Purdue instructed its representatives to push higher-strength pills.

211. For example, in a 1996 sales strategy memo from a Purdue regional manager, the manager emphasized that representatives should "convinc[e] the physician that there is no need" for prescribing OxyContin in shorter intervals than the recommended 12-hour interval, and instead the solution is prescribing higher doses. The manager directed representatives to discuss with physicians that there is "no[] upward limit" for dosing and ask "if there are any reservations in using a dose of 240mg-320mg of OxyContin."[132]

212. As doctors began prescribing OxyContin at shorter intervals in the late 1990s, Purdue directed its sales representatives to "refocus" physicians on 12-hour dosing. One sales manager instructed her team that anything shorter "needs to be nipped in the bud. NOW!!"[133]

213. These misrepresentations were incredibly dangerous. As noted above, opioid dosages at or above 50 MME/day double the risk of overdose compared to 20 MME/day, and 50 MME is equal to just 33 mg of oxycodone. Notwithstanding the risks, the 2003 Conversion Guide for OxyContin contained the following diagram for increasing dosage up to 320 mg:

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[131] *OxyContin launch*, Los Angeles Times (May 5, 2016), http://documents.latimes.com/oxycontin-launch-1995/.

[132] *Sales manager on 12-hour dosing*, Los Angeles Times (May 5, 2016), http://documents.latimes.com/sales-manager-on12-hour-dosing-1996/.

[133] Harriet Ryan, Lisa Girion, and Scott Glover, *'You Want a Description of Hell?' OxyContin's 12-Hour Problem* (May 5, 2016), http://www.latimes.com/projects/oxycontin-part1/.

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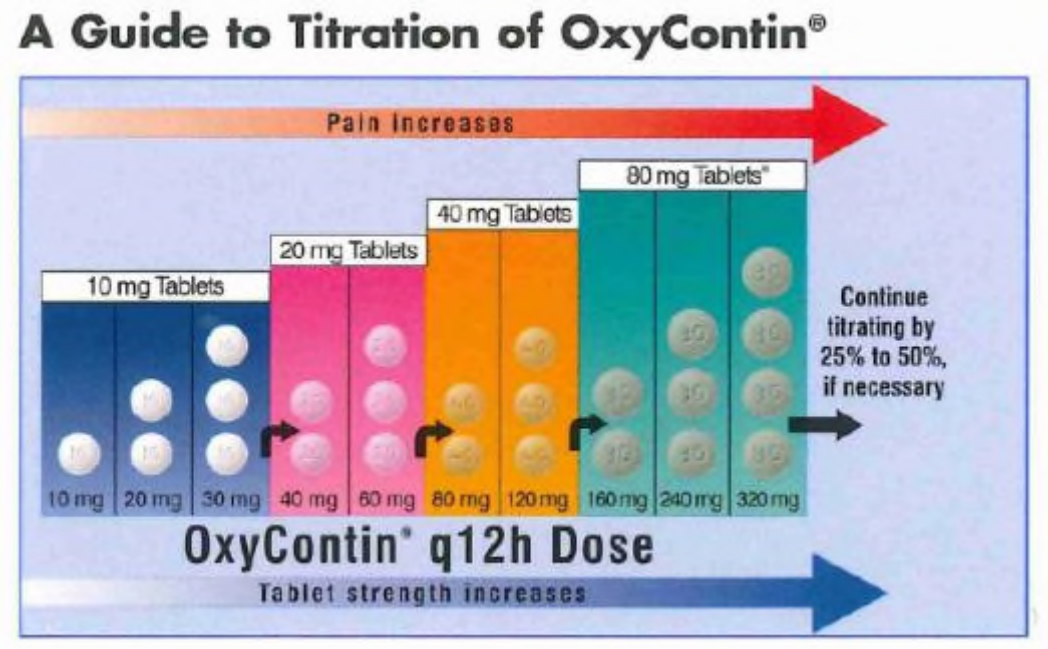

214. In a 2004 response letter to the FDA, Purdue tried to address concerns that patients who took OxyContin more frequently than 12 hours would be at greater risk of side effects or adverse reactions. Purdue contended that the peak plasma concentrations of oxycodone would not increase with more frequent dosing, and therefore no adjustments to the package labeling or 12-hour dosing regimen were needed.[134] But these claims were false, and Purdue's suggestion that there was no upper limit or risk associated with increased dosage was incredibly misleading.

215. Suggesting that it recognized the danger of its misrepresentations of no dose ceiling, Purdue discontinued the OxyContin 160mg tablet in 2007 and stated that this step was taken "to reduce the risk of overdose accompanying the abuse of this dosage strength."[135]

[134] *Purdue Response to FDA, 2004*, Los Angeles Times (May 5, 2016), http://documents.latimes.com/purdue-response-fda-2004/.

[135] *OxyContin Tablets Risk Management Program*, Purdue Pharma L.P., https://web.archive.org/web/20170215064438/https:/www.fda.gov/ohrms/dockets/DOCKETS/07p0232/07p-0232-cp00001-03-Exhibit-02-Part-1-vol1.pdf (revised May 18, 2007).

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216. But still Purdue and the other Manufacturer Defendants worked hard to protect their story. In March 2007, Dr. Gary Franklin, Medical Director for the Washington State Department of Labor & Industries, published the *Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain*. Developed in collaboration with providers in Washington State who had extensive experience in the evaluation and treatment of patients with chronic pain, the guideline recommended a maximum daily dose of opioids to protect patients.

217. In response, Purdue sent correspondence to Dr. Franklin specifically indicating, among other things, that "limiting access to opioids for persons with chronic pain is not the answer" and that the "safety and efficacy of OxyContin doses greater than 40 mg every 12 hours in patients with chronic nonmalignant pain" was well established. Purdue even went so far as to represent to Dr. Franklin that even if opioid treatment produces significant adverse effects in a patient, "this does not preclude a trial of another opioid."

218. In 2010, Purdue published a Risk Evaluation and Mitigation Strategy ("REMS") for OxyContin, but even the REMS does not address concerns with increasing dosage, and instead advises prescribers that "dose adjustments may be made every 1-2 days"; "it is most appropriate to increase the q12h dose"; the "total daily dose can usually be increased by 25% to 50%"; and if "significant adverse reactions occur, treat them aggressively until they are under control, then resume upward titration."[136]

[136] *OxyContin Risk Evaluation and Mitigation Strategy*, Purdue Pharma L.P., https://web.archive.org/web/20170215190303/https://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM220990.pdf (last modified Nov. 2010).

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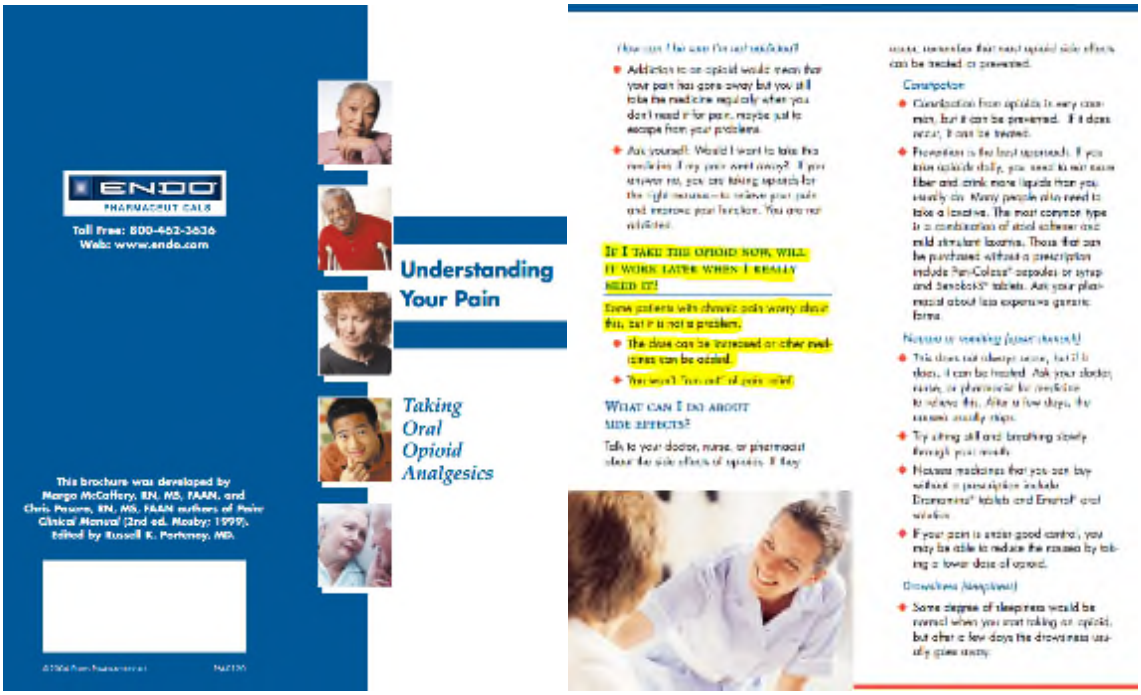
219. In 2012, APF claimed on its website that there was no "ceiling dose" for opioids for chronic pain.[137] APF also made this claim in a guide sponsored by Purdue, which is still available online.

220. Accordingly, Purdue continued to represent both publicly and privately that increased opioid usage was safe and did not present additional risk at higher doses.

221. Endo, on a website it sponsors, PainKnowledge.com, also made the claim in 2009 that opioid dosages could be increased indefinitely.

222. In the "Understanding Your Pain" pamphlet discussed above, Endo assures opioid users that concern about developing tolerance to the drugs' pain-relieving effect is "not a problem," and that "[t]he dose can be increased" and "[y]ou won't 'run out' of pain relief."[138]



[137] Noah Nesin, M.D., FAAFP, *Responsible Opioid Prescribing*, PCHC https://www.mainequalitycounts.org/image_upload/Keynote-%20Managing%20Chronic%20Pain%20and%20Opioids_Nesin.pdf (last visited Jan. 5, 2018).

[138] *Understanding Your Pain: Taking Oral Opioid Analgesics*, Endo Pharmaceuticals (2004), http://www.thblack.com/links/RSD/Understand_Pain_Opioid_Analgesics.pdf.

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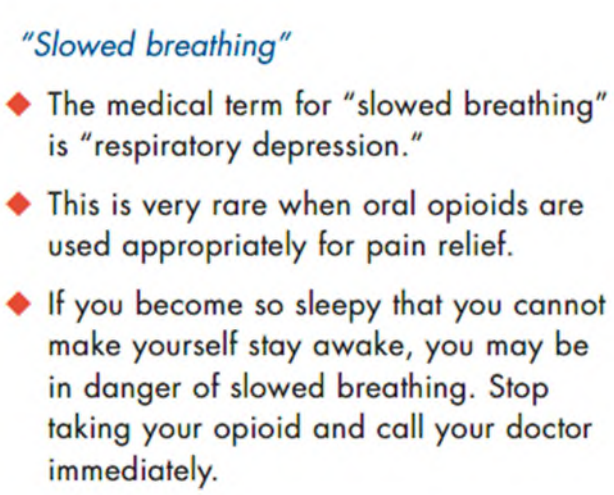
223. Dosage limits with respect to opioids are particularly important not only because of the risk of addiction but also because of the potentially fatal side effect of respiratory depression. Endo's "Understanding Your Pain" pamphlet minimized this serious side effect, calling it "slowed breathing," declaring that it is "very rare" when opioids are used "appropriately," and never stating that it could be fatal:



"Slowed breathing"

- The medical term for "slowed breathing" is "respiratory depression."
- This is very rare when oral opioids are used appropriately for pain relief.
- If you become so sleepy that you cannot make yourself stay awake, you may be in danger of slowed breathing. Stop taking your opioid and call your doctor immediately.

224. Janssen also made the same misrepresentations regarding the disadvantages of dosage limits for other pain medicines in a 2009 patient education guide, while failing to address the risks of dosage increases with opioids.

4. Defendants falsely instructed doctors and patients that more opioids were the solution when patients presented symptoms of addiction.

225. Not only did Defendants hide the serious risks of addiction associated with opioids, they actively worked to prevent doctors from taking steps to prevent or address opioid addiction in their patients.

226. One way that Defendants worked to obstruct appropriate responses to opioid addiction was to push a concept called "pseudoaddiction." Dr. David Haddox—who later became a Senior Medical Director for Purdue—published a study in 1989 coining the term,

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which he characterized as "the iatrogenic syndrome of abnormal behavior developing as a direct consequence of inadequate pain management."[139] ("Iatrogenic" describes a condition induced by medical treatment.) In other words, he claimed that people on prescription opioids who exhibited classic signs of addiction—"abnormal behavior"—were not addicted, but rather simply suffering from under-treatment of their pain. His solution for pseudoaddiction? More opioids.

227. Although this concept was formed based on a single case study, it proved to be a favorite trope in the Manufacturer Defendants' marketing schemes. For example, using this study, Purdue informed doctors and patients that signs of addiction are actually the signs of under-treated pain which should be treated with even more opioids. Purdue reassured doctors and patients, telling them that "chronic pain has been historically undertreated."[140]

228. The Manufacturer Defendants continued to spread the concept of pseudoaddiction through the APF, which even went so far as to compare opioid addicts to coffee drinkers. In a 2002 court filing, APF wrote that "[m]any pain patients (like daily coffee drinkers) claim they are 'addicted' when they experience withdrawal symptoms associated with physical dependence as they decrease their dose. But unlike actual addicts, such individuals, if they resume their opioid use, will only take enough medication to alleviate their pain . . ."[141]

229. In a 2007 publication titled "Treatment Options: A Guide for People Living with Pain," the APF claimed: "*Physical dependence is normal*; any patient who is taking an opioid on a regular basis for a few days should be assumed to be physically dependent. This does **NOT**

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[139] David E. Weissman and J. David Haddox, *Opioid pseudoaddiction--an iatrogenic syndrome*, 36(3) Pain 363-66 (Mar. 1989), https://www.ncbi.nlm.nih.gov/pubmed/2710565.

[140] *Oxycontin: Its Use and Abuse*, *supra* note 104.

[141] APF Brief Amici Curiae, *supra* note 120 at 10-11.

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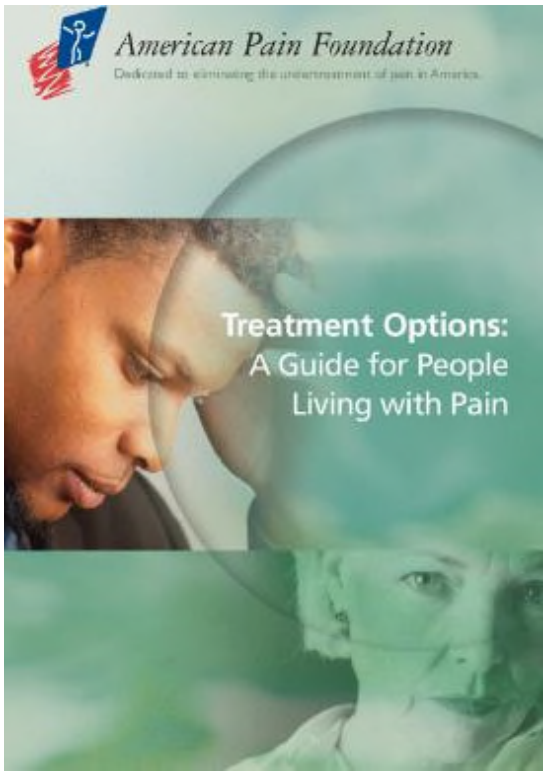
mean you are addicted."[142] In this same publication, when describing behaviors of addiction, the APF again used the idea of pseudoaddiction, claiming that people who are not substance abusers may also engage in behaviors that mirror those of actual addicts.



Side effects

The most common side effects of opioids include constipation, nausea and vomiting, sedation (sleepiness), mental clouding and itching. Some people may also experience dizziness or difficulty urinating. Respiratory depression, a decreased rate and depth of breathing, is a serious side effect associated with overdose.

The good news is that most side effects go away after a few days. However, side effects may continue in some people. Constipation is most likely to persist. Some pain experts believe all patients started on an opioid also should be taking a stool softener or a laxative. Others believe that this treatment is appropriate only if a patient is prone to developing significant constipation because of advanced age, poor diet, other diseases, or the use of other constipating drugs. Your healthcare provider can give advice on what to eat and what medicines to use to treat constipation. Always make certain to drink plenty of fluids and be as active as possible.

If any of the other side effects don't go away, they can also be treated. Be certain to tell your provider if you are having any problems. Serious side effects such as delirium or respiratory depression can occur if the dose is increased too quickly, especially in someone who is just starting to take opioids. Tell your provider if you are unable to concentrate or think clearly after you have been taking an opioid for a few days. Report other medications you may be taking that make you sleepy. Do not drive when you first start taking these drugs or immediately after the dose has been increased. Most persons will adapt to these medicines over time and can drive safely while taking them for pain control. If side effects remain troublesome, your provider may switch you to a different opioid. The amount of pain relief can be maintained after such a switch and often the side effects can be reduced.

Common drugs that can cause physical dependence

- Opioids
- Stimulants
- Sedatives
- Steroids
- Certain Antidepressants
- Certain Heart Medications
- Caffeine

Tolerance, physical dependence and addiction

You and your healthcare provider may worry about tolerance, physical dependence and addiction. It's sometimes easy to confuse the meaning of these words. Tolerance refers to the situation in which a drug becomes less effective over time. However, many persons with persistent pain don't develop tolerance and stay on the same dose of opioid for a long time. Many times when a person needs a larger dose of a drug, it's because their pain is worse or the problem causing their pain has changed.

Physical dependence means that a person will develop symptoms and signs of withdrawal (e.g., sweating, rapid heart rate, nausea, diarrhea, goosebumps, anxiety) if the drug is suddenly stopped or the dose is lowered too quickly. Physical dependence is normal: any patient who is taking an opioid on a regular basis for a few days should be assumed to be physically dependent. This does **NOT** mean you are addicted. In fact, many non-addictive drugs can produce physical dependence. To prevent withdrawal from occurring, the dose of the medication must be decreased slowly.

If you believe that you no longer need to take the opioid medication or want to reduce the dose, it is essential to speak to your provider. They will guide you on how to decrease your dose over time to prevent the experience of withdrawal.

230. Purdue published a REMS for OxyContin in 2010, and in the associated Healthcare Provider Training Guide stated that "[b]ehaviors that suggest drug abuse exist on a continuum, and pain-relief seeking behavior can be mistaken for drug-seeking behavior."[143]

231. Purdue worked, and continues to work, to create confusion about what addiction is. For example, Purdue continues to emphasize that abuse and addiction are separate and distinct from physical dependence. Regardless of whether these statements may be technically correct, they continue to add ambiguity over the risks and benefits of opioids.

[142] *Treatment Options: A Guide for People Living with Pain*, *supra* note 121.
[143] *OxyContin Risk Evaluation and Mitigation Strategy*, *supra* note 136.

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232. Endo sponsored an NIPC CME program in 2009 which promoted the concept of pseudoaddiction by teaching that a patient's aberrant behavior was the result of untreated pain. Endo substantially controlled NIPC by funding its projects, developing content, and reviewing NIPC materials.

233. A 2001 paper which was authored by a doctor affiliated with Janssen stated that "[m]any patients presenting to a doctor's office asking for pain medications are accused of drug seeking. In reality, most of these patients may be undertreated for their pain syndrome."[144]

234. In 2009, on a website it sponsored, Janssen stated that pseudoaddiction is different from true addiction "because such behaviors can be resolved with effective pain management."[145]

235. Indeed, on its currently active website PrescribeResponsibly.com, Janssen defines pseudoaddiction as "a syndrome that causes patients to seek additional medications due to inadequate pharmacotherapy being prescribed. Typically, when the pain is treated appropriately, the inappropriate behavior ceases."[146]

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[144] Howard A. Heit, MD, FACP, FASAM, *The truth about pain management: the difference between a pain patient and an addicted patient*, 5 European Journal of Pain 27-29 (2001), http://www.med.uottawa.ca/courses/totalpain/pdf/doc-34.pdf.

[145] Chris Morran, *Ohio: Makers Of OxyContin, Percocet & Other Opioids Helped Fuel Drug Epidemic By Misleading Doctors, Patients*, Consumerist (May 31, 2017, 2:05pm), https://consumerist.com/2017/05/31/ohio-makers-of-oxycontin-percocet-other-opioids-helped-fuel-drug-epidemic-by-misleading-doctors-patients/.

[146] Howard A. Heit, MD, FACP, FASAM and Douglas L. Gourlay, MD, MSc, FRCPC, FASAM, *What a Prescriber Should Know Before Writing the First Prescription, Prescribe Responsibly*, http://www.prescriberesponsibly.com/articles/before-prescribing-opioids#pseudoaddiction (last modified July 2, 2015).

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236. As set forth in more detail below, these statements were false and misleading as evidenced by, *inter alia*, the findings made by the CDC in 2016. Indeed, there is simply no evidence that pseudoaddiction is a real phenomenon. As research compiled by the CDC and others makes clear, pseudoaddiction is pseudoscience—nothing more than a concept the Manufacturer Defendants seized upon to help sell more of their actually addicting drugs.

5. Defendants falsely claimed that risk-mitigation strategies, including tapering and abuse-deterrent technologies, made it safe to prescribe opioids for chronic use.

237. Even when Defendants acknowledge that opioids pose some risk of addiction, they dismiss these concerns by claiming that addiction can be easily avoided and addressed

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through simple steps. In order to make prescribers feel more comfortable about starting patients on opioids, Defendants falsely communicated to doctors that certain screening tools would allow them to reliably identify patients at higher risk of addiction and safely prescribe opioids, and that tapering the dose would be sufficient to manage cessation of opioid treatment. Both assertions are false.

238. For instance, as noted above, Purdue published a REMS for OxyContin in 2010, in which it described certain steps that needed to be followed for safe opioid use. Purdue stressed that all patients should be screened for their risk of abuse or addiction, and that such screening could curb the incidence of addiction.[147]

239. The APF also proclaimed in a 2007 booklet, sponsored in part by Purdue, that "[p]eople with the disease of addiction may abuse their medications, engaging in unacceptable behaviors like increasing the dose without permission or obtaining the opioid from multiple sources, among other things. Opioids get into the hands of drug dealers and persons with an addictive disease as a result of pharmacy theft, forged prescriptions, Internet sales, and even from other people with pain. It is a problem in our society that needs to be addressed through many different approaches."[148]

240. On its current website for OxyContin,[149] Purdue acknowledges that certain patients have higher risk of opioid addiction based on history of substance abuse or mental illness—a statement which, even if accurate, obscures the significant risk of addiction for all patients, including those without such a history, and comports with statements it has recently

[147] *Oxycontin Risk Evaluation and Mitigation Strategy, supra* note 136.
[148] *Treatment Options: A Guide for People Living with Pain, supra* note 121.
[149] OxyContin, https://www.oxycontin.com/index.html (last visited Jan. 5, 2018).

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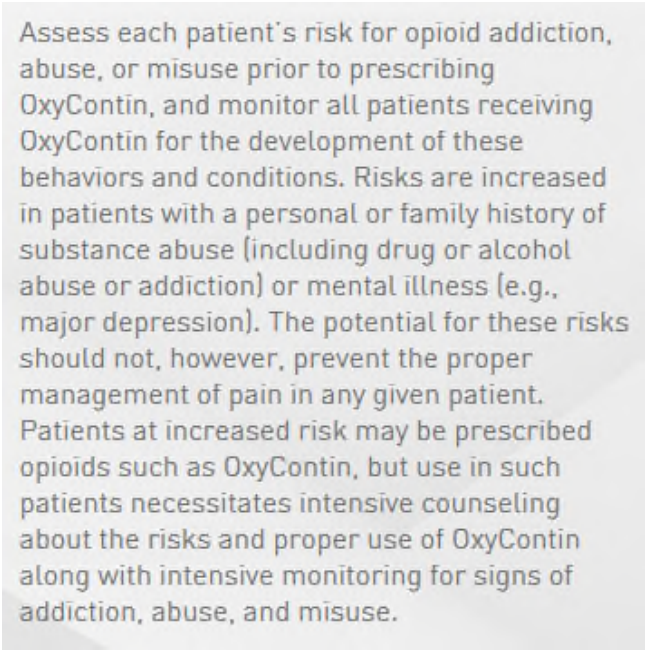
made that it is "bad apple" patients, and not the opioids, that are arguably the source of the opioid crisis:


Assess each patient's risk for opioid addiction, abuse, or misuse prior to prescribing OxyContin, and monitor all patients receiving OxyContin for the development of these behaviors and conditions. Risks are increased in patients with a personal or family history of substance abuse (including drug or alcohol abuse or addiction) or mental illness (e.g., major depression). The potential for these risks should not, however, prevent the proper management of pain in any given patient. Patients at increased risk may be prescribed opioids such as OxyContin, but use in such patients necessitates intensive counseling about the risks and proper use of OxyContin along with intensive monitoring for signs of addiction, abuse, and misuse.

241. Additionally, on its current website, Purdue refers to publicly available tools that can assist with prescribing compliance, such as patient-prescriber agreements and risk assessments.[150]

242. Purdue continues to downplay the severity of addiction and withdrawal and claims that dependence can easily be overcome by strategies such as adhering to a tapering schedule to successfully stop opioid treatment. On the current website for OxyContin, it instructs that "[w]hen discontinuing OxyContin, gradually taper the dosage. Do not abruptly discontinue OxyContin."[151] And on the current OxyContin Medication Guide, Purdue also states

[150] *ER/LA Opioid Analgesics REMS*, Purdue, http://www.purduepharma.com/healthcare-professionals/responsible-use-of-opioids/rems/ (last visited Jan. 5, 2018).

[151] Oxycontin.com, *supra* note 149.

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that one should "taper the dosage gradually."[152] As a general matter, tapering is a sensible strategy for cessation of treatment with a variety of medications, such as steroids or antidepressants. But the suggestion that tapering is sufficient in the context of chronic use of potent opioids is misleading and dangerous, and sets patients up for withdrawal and addiction.

243. In its "Dear Healthcare Professional" letter in 2010, Purdue instructed doctors to gradually taper someone off of OxyContin to prevent signs and symptoms of withdrawal in patients who were physically dependent.[153] Nowhere does Purdue warn doctors or patients that tapering may be inadequate to safely end opioid treatment and avoid addiction.

244. Endo also suggests that risk-mitigation strategies enable the safe prescription of opioids. In its currently active website, Opana.com, Endo states that assessment tools should be used to assess addiction risk, but that "[t]he potential for these risks should not, however, prevent proper management of pain in any given patient."[154]

245. On the same website, Endo makes similar statements about tapering, stating "[w]hen discontinuing OPANA ER, gradually taper the dosage."[155]

246. Janssen states on its currently active website, PrescribeResponsibly.com, that the risk of opioid addiction "can usually be managed" through tools such as "opioid agreements" between patients and doctors.[156]

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[152] *OxyContin Full Prescribing Information*, Purdue Pharma LP, http://app.purduepharma.com/xmlpublishing/pi.aspx?id=o (last visited Jan. 5, 2018).
[153] *OxyContin Risk Evaluation and Mitigation Strategy*, *supra* note 136.
[154] Opana ER, http://www.opana.com (last visited Jan. 5, 2018).
[155] *Id.*
[156] Heit & Gourlay, *supra* note 146.

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247. Each Defendant's statements about tapering misleadingly implied that gradual tapering would be sufficient to alleviate any risk of withdrawal or addiction while taking opioids.

248. Defendants have also made and continue to make false and misleading statements about the purported abuse-deterrent properties of their opioid pills to suggest these reformulated pills are not susceptible to abuse. In so doing, Defendants have increased their profits by selling more pills for substantially higher prices.

249. For instance, since at least 2001, Purdue has contended that "abuse resistant products can reduce the incidence of abuse."[157] Its current website touts abuse-deterrent properties by saying they "can make a difference."[158]

250. On August 17, 2015, Purdue announced the launch of a new website, "Team Against Opioid Abuse," which it said was "designed to help healthcare professionals and laypeople alike learn about different abuse-deterrent technologies and how they can help in the reduction of misuse and abuse of opioids."[159] This website appears to no longer be active.

251. A 2013 study which was authored by at least two doctors who at one time worked for Purdue stated that "[a]buse-deterrent formulations of opioid analgesics can reduce abuse."[160] In another study from 2016 with at least one Purdue doctor as an author, the authors

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[157] *Oxycontin: Its Use and Abuse*, *supra* note 104.

[158] *Opioids with Abuse-Deterrent Properties*, Purdue, http://www.purduepharma.com/healthcare-professionals/responsible-use-of-opioids/opioids-with-abuse-deterrent-properties/ (last visited Jan. 5, 2018).

[159] *Purdue Pharma L.P. Launches TeamAgainstOpioidAbuse.com*, Purdue (Aug. 17, 2015), http://www.purduepharma.com/news-media/2015/08/purdue-pharma-l-p-launches-teamagainstopioidabuse-com/.

[160] Paul M. Coplan, Hrishikesh Kale, Lauren Sandstrom, Craig Landau, and Howard D. Chilcoat, *Changes in oxycodone and heroin exposures in the National Poison Data System after introduction of extended-release oxycodone with abuse-deterrent characteristics*, 22 (12) Parmacoepidemiol Drug Saf. 1274-82 (Sept. 30, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4283730/.

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claimed that abuse decreased by as much as 99% in some situations after abuse-deterrent formulations were introduced.[161]

252. Interestingly, one report found that the original safety label for OxyContin, which instructed patients not to crush the tablets because it would have a rapid release effect, may have inadvertently given opioid users ideas for techniques to get high from these drugs.[162]

253. In 2012, Defendant Endo replaced the formula for Opana ER with a new formula with abuse-deterrent properties that it claimed would make Opana ER resistant to manipulation from users to snort or inject it. But the following year, the FDA concluded:

> While there is an increased ability of the reformulated version of Opana ER to resist crushing relative to the original formulation, study data show that the reformulated version's extended-release features can be compromised when subjected to other forms of manipulation, such as cutting, grinding, or chewing, followed by swallowing.
>
> Reformulated Opana ER can be readily prepared for injection, despite Endo's claim that these tablets have "resistance to aqueous extraction (i.e., poor syringeability)." It also appears that reformulated Opana ER can be prepared for snorting using commonly available tools and methods.
>
> The postmarketing investigations are inconclusive, and even if one were to treat available data as a reliable indicator of abuse rates, one of these investigations also suggests the troubling possibility that a higher percentage of reformulated Opana ER abuse is via injection than was the case with the original formulation.[163]

254. Despite the FDA's determination that the evidence did not support Endo's claims of abuse-deterrence, Endo advertised its reformulated pills as "crush resistant" and directed its sales representatives to represent the same to doctors. Endo improperly marketed Opana ER as

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[161] Paul M. Coplan, Howard D. Chilcoat, Stephen Butler, Edward M. Sellers, Aditi Kadakia, Venkatesh Harikrishnan, J. David Haddox, and Richard C. Dart, *The effect of an abuse-deterrent opioid formulation (OxyContin) on opioid abuse-related outcomes in the postmarketing setting*, 100 Clin. Pharmacol. Ther., 275-86 (June 22, 2016), http://onlinelibrary.wiley.com/doi/10.1002/cpt.390/full.

[162] *OxyContin Abuse and Diversion and Efforts to Address the Problem*, *supra* note 25.

[163] *FDA Statement: Original Opana ER Relisting Determination*, U.S. Food & Drug Administration (May 10, 2013), https://wayback.archive-it.org/7993/20171102214123/https://www.fda.gov/Drugs/DrugSafety/ucm351357.htm.

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crush-resistant, when Endo's own studies showed that the pill could be crushed and ground. In 2016, Endo reached an agreement with the Attorney General of the State of New York that required Endo to discontinue making such statements.[164]

255. Defendants' assertions that their reformulated pills could curb abuse were false and misleading, as the CDC's 2016 Guideline, discussed below, confirm.

256. Ultimately, even if a physician prescribes opioids after screening for abuse risk, advising a patient to taper, and selecting brand-name, abuse-deterrent formulations, chronic opioid use still comes with significant risks of addiction and abuse. Defendants' statements to the contrary were designed to create a false sense of security and assure physicians that they could safely prescribe potent narcotics to their patients.

E. The Falseness of Defendants' Claims Is Brought into Stark Relief by the Work of the Washington Department of Labor and Industries.

257. Contrary to Defendants' misrepresentations about the benefits and risks of opioids, growing evidence suggests that using opioids to treat chronic pain leads to overall negative outcomes, delaying or preventing recovery and providing little actual relief, all while presenting serious risks of overdose.

258. One place where this evidence surfaced is the Washington State Department of Labor and Industries ("L&I"). The Department of L&I runs the State's workers' compensation program, which covers all employees in the state, other than those who work for large companies and government entities. In 2000, L&I's new chief pharmacist, Jaymie Mai, noticed an increase in prescription of opioids for chronic pain, approximately 50 to 100 cases a

[164] Press Release, Attorney General Eric T. Schneiderman, *A.G. Schneiderman Announces Settlement with Endo Health Solutions Inc. & Endo Pharmaceuticals Inc. Over Marketing of Prescription Opioid Drugs* (Mar. 3, 2016), https://ag.ny.gov/press-release/ag-schneiderman-announces-settlement-endo-health-solutions-inc-endo-pharmaceuticals.

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month.[165] It was then that she discovered some of these same workers were dying from opioid overdoses. That workers suffered back pain or sprained knees on the job was nothing new, but workers dying from their pain medication was assuredly not. Mai reported what she was seeing to L&I's Medical Director, Dr. Gary Franklin.[166]

259. In addition to being L&I's Medical Director, Dr. Franklin is a research professor at the University of Washington in the departments of Environmental Health, Neurology, and Health Services. Alarmed by Mai's finding, Dr. Franklin and Mai undertook a thorough analysis of all recorded deaths in the state's workers' comp system. In 2005, they published their findings in the American Journal of Industrial Medicine.[167]

260. Their research showed that the total number of opioid prescriptions paid for by the Workers' Compensation Program tripled between 1996 and 2006.[168] Not only did the number of prescriptions balloon, so too did the doses; from 1996 to 2002 the mean daily morphine equivalent dose ("MED") nearly doubled, and remained that way through 2006.[169] As injured Washington workers were given more prescriptions of more higher doses of opioids the rates of opioid overdoses among that population jumped, from zero in 1996 to more than twenty in 2005. And in 2009, over thirty people receiving opioid prescriptions through the Workers' Compensation Program died of an opioid overdose.[170]

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[165] Quinones, *supra* note 34, at 203.

[166] *Id*.

[167] Gary M. Franklin, M.D., MPH, Jaymie Mai, Pharm.D., Thomas Wickizer, Ph.D., Judith A. Turner, Ph.D., Deborah Fulton-Kehoe, Ph.D., MPH, and Linda Grant, BSN, MBA, *Opioid dosing trends and mortality in Washington State Workers' Compensation, 1996-2002*, 48 Am J Ind Med 91-99 (2005).

[168] Gary M. Franklin, M.D., MPH, Jaymie Mai, Pharm.D., Thomas Wickizer, Ph.D., Judith Turner, Ph.D., Mark Sullivan, M.D., Ph.D., Thomas Wickizer, Ph.D., and Deborah Fulton-Kehoe, Ph.D., *Bending the Prescription Opioid Dosing and Mortality Curves: Impact of the Washington State Opioid Dosing Guideline*, 55 Am J Ind Med 325, 327 (2012).

[169] *Id*. at 327-28.

[170] *Id*. at 328.

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261. Armed with these alarming statistics, Dr. Franklin, in conjunction with other doctors in Washington, set out to limit the doses of opioids prescribed through the workers' compensation program. As part of that effort, in 2007 the Agency Medical Directors Group launched an Interagency Guideline on Opioid Dosing, aimed at reducing the numbers of opioid overdoses. Through this, and other related efforts, both the rates of opioid prescriptions and the sizes of doses have declined in Washington, beginning in 2009. As opioid prescriptions rates for injured workers have declined, so too has the death rate among this population.[171]

262. Dr. Franklin's research not only demonstrated the dangers of prescription opioids, but also showed that the use of opioids to treat pain after an injury actually prevents or slows a patient's recovery.

263. In a study he published in 2008, Dr. Franklin looked at Washington State employees who had suffered a low back injury on the job, and compared the impact of opioid prescriptions on the outcomes for these workers.

264. The results of his study were striking: after controlling for numerous variables, Dr. Franklin's research showed that if an injured worker was prescribed opioids soon after the injury, high doses of opioids, or opioids for more than week, the employee was far more likely to experience negative health outcomes than the same employee who was not prescribed opioids in these manners.

265. For example, the study showed that, after adjusting for the baseline covariates, injured workers who received a prescription opioid for more than seven days during the first six weeks after the injury were 2.2 times more likely to remained disabled a year later than workers

[171] *Id.*

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with similar injuries who received no opioids at all. Similarly, those who received two prescriptions of opioids for the injury were 1.8 times more likely to remain disabled a year after their injury than workers who received no opioids at all. Those receiving daily doses higher than 150 MED more than doubled the likelihood of disability a year later, relative to workers who received no opioids.[172]

266. The results of this study are troubling: not only do prescription opioids present significant risks of addiction and overdose, but they also appear to hinder patient recovery after an injury.

267. This dynamic presents problems for employers, too, who bear significant costs when their employees do not recover quickly from workplace injuries. Employers are left without their labor force, and may be responsible for paying for the injured employee's disability for long periods of time.

F. The 2016 CDC Guidelines and Other Recent Studies Confirm That Defendants' Statements About the Risks and Benefits of Opioids are Patently False.

268. Contrary to the statements made by Defendants in their well-orchestrated campaign to tout the benefits of opioids and downplay their risks, recent studies confirm Defendants' statements were false and misleading.

269. The CDC issued its *Guideline for Prescribing Opioids for Chronic Pain* on March 15, 2016 (the "2016 CDC Guideline" or "Guideline").[173] The 2016 CDC Guideline, approved by the FDA, "provides recommendations for primary care clinicians who are

[172] Franklin, GM, Stover, BD, Turner, JA, Fulton-Kehoe, D, Wickizer, TM, *Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort,* 33 Spine 199, 201-202.

[173] Dowell, et al., *supra* note 26.

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prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care." The Guideline also assesses the risks and harms associated with opioid use.

270. The 2016 CDC Guideline is the result of a thorough and extensive process by the CDC. The CDC issued the Guideline after it "obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee." The recommendations in the 2016 CDC Guideline were further made "on the basis of a systematic review of the best available evidence . . ."

271. The CDC went through an extensive and detailed process to solicit expert opinions for the Guideline:

> CDC sought the input of experts to assist in reviewing the evidence and providing perspective on how CDC used the evidence to develop the draft recommendations. These experts, referred to as the "Core Expert Group" (CEG) included subject matter experts, representatives of primary care professional societies and state agencies, and an expert in guideline development methodology. CDC identified subject matter experts with high scientific standing; appropriate academic and clinical training and relevant clinical experience; and proven scientific excellence in opioid prescribing, substance use disorder treatment, and pain management. CDC identified representatives from leading primary care professional organizations to represent the audience for this guideline. Finally, CDC identified state agency officials and representatives based on their experience with state guidelines for opioid prescribing that were developed with multiple agency stakeholders and informed by scientific literature and existing evidence-based guidelines.

272. The 2016 Guideline was also peer-reviewed pursuant to "the final information quality bulletin for peer review." Specifically, the Guideline describes the following independent peer-review process:

> [P]eer review requirements applied to this guideline because it provides influential scientific information that could have a clear and substantial impact on public- and private-sector decisions. Three experts independently reviewed the guideline to determine the reasonableness and strength of recommendations; the clarity with which scientific uncertainties were clearly identified; and the rationale, importance, clarity, and ease of implementation of the recommendations. CDC selected peer reviewers based on expertise, diversity of scientific viewpoints, and independence from the guideline

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> development process. CDC assessed and managed potential conflicts of interest using a process similar to the one as described for solicitation of expert opinion. No financial interests were identified in the disclosure and review process, and nonfinancial activities were determined to be of minimal risk; thus, no significant conflict of interest concerns were identified.

273. The findings in the 2016 CDC Guideline both confirmed the existing body of scientific evidence regarding the questionable efficacy of opioid use and contradicted Defendants' statements about opioids.

274. For instance, the Guideline states "[e]xtensive evidence shows the possible harms of opioids (including opioid use disorder, overdose, and motor vehicle injury)" and that "[o]pioid pain medication use presents serious risks, including overdose and opioid use disorder." The Guideline further confirms there are significant symptoms related to opioid withdrawal, including drug cravings, anxiety, insomnia, abdominal pain, vomiting, diarrhea, sweating, tremor, tachycardia (rapid heartbeat), spontaneous abortion and premature labor in pregnant women, and the unmasking of anxiety, depression, and addiction. These findings contradict statements made by Defendants regarding the minimal risks associated with opioid use, including that the risk of addiction from chronic opioid use is low.

275. The Guideline also concludes that there is "[n]o evidence" to show "a long-term benefit of opioids in pain and function versus no opioids for chronic pain . . ." Furthermore, the Guideline indicates that "continuing opioid therapy for 3 months substantially increases the risk of opioid use disorder." Indeed, the Guideline indicates that "[p]atients who do not experience clinically meaningful pain relief early in treatment . . . are unlikely to experience pain relief with longer-term use," and that physicians should "reassess[] pain and function within 1 month" in order to decide whether to "minimize risks of long-term opioid use by discontinuing opioids" because the patient is "not receiving a clear benefit." These findings flatly contradict claims

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made by the Defendants that there are minimal or no adverse impacts of long-term opioid use, or that long-term opioid use could actually improve or restore a patient's function.

276. In support of these statements about the lack of long-term benefits of opioid use, the CDC concluded that "[a]lthough opioids can reduce pain during short-term use, the clinical evidence review found insufficient evidence to determine whether pain relief is sustained and whether function or quality of life improves with long-term opioid therapy." The CDC further found that "evidence is limited or insufficient for improved pain or function with long-term use of opioids for several chronic pain conditions for which opioids are commonly prescribed, such as low back pain, headache, and fibromyalgia."

277. With respect to opioid dosing, the Guideline reports that "[b]enefits of high-dose opioids for chronic pain are not established" while the "risks for serious harms related to opioid therapy increase at higher opioid dosage." The CDC specifically explains that "there is now an established body of scientific evidence showing that overdose risk is increased at higher opioid dosages." The CDC also states that there is an "increased risk[] for opioid use disorder, respiratory depression, and death at higher dosages." As a result, the CDC advises doctors to "avoid increasing dosage" above 90 morphine milligram equivalents per day. These findings contradict statements made by Defendants that increasing dosage is safe and that under-treatment is the cause for certain patients' aberrant behavior.

278. The 2016 CDC Guideline also contradicts statements made by Defendants that there are reliable risk-mitigation tactics to reduce the risk of addiction. For instance, the Guideline indicates that available risk screening tools "show insufficient accuracy for classification of patients as at low or high risk for [opioid] abuse or misuse" and counsels that

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doctors "should not overestimate the ability of these tools to rule out risks from long-term opioid therapy."

279. Finally, the 2016 CDC Guideline states that "[n]o studies" support the notion that "abuse-deterrent technologies [are] a risk mitigation strategy for deterring or preventing abuse," noting that the technologies—even when they work—"do not prevent opioid abuse through oral intake, the most common route of opioid abuse, and can still be abused by nonoral routes." In particular, the CDC found as follows:

> The "abuse-deterrent" label does not indicate that there is no risk for abuse. No studies were found in the clinical evidence review assessing the effectiveness of abuse-deterrent technologies as a risk mitigation strategy for deterring or preventing abuse. In addition, abuse-deterrent technologies do not prevent unintentional overdose through oral intake. Experts agreed that recommendations could not be offered at this time related to use of abuse-deterrent formulations.

Accordingly, the CDC's findings regarding "abuse-deterrent technologies" directly contradict Purdue and Endo's claims that their new pills deter or prevent abuse.

280. Notably, in addition to the findings made by the CDC in 2016, the Washington State Agency Medical Directors' Group (AMDG)—a collaboration among several Washington State Agencies—published its *Interagency Guideline on Prescribing Opioids for Pain* in 2015. The AMDG came to many of the same conclusions as the CDC did. For example, the AMDG found that "there is little evidence to support long term efficacy of [chronic opioid analgesic therapy, or "COAT"] in improving function and pain, [but] there is ample evidence of its risk for harm . . ."[174]

281. In addition, as discussed above, in contrast to Defendants' statements that the 1980 Porter and Jick letter provided evidence of the low risk of opioid addiction in pain patients,

[174] *Interagency Guideline on Prescribing Opioids for Pain*, Agency Medical Directors' Group (June 2015), http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

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the NEJM recently published a letter largely debunking the use of the Porter and Jick letter as evidence for such a claim.[175] The researchers demonstrated how the Porter and Jick letter was irresponsibly cited and, in some cases, "grossly misrepresented," when in fact it did not provide evidence supporting the broad claim of low addiction risk for all patients prescribed opioids for pain. As noted above, Dr. Jick reviewed only files of patients administered opioids in a hospital setting, rather than patients sent home with a prescription for opioids to treat chronic pain.

282. The authors of the 2017 letter described their methodology as follows:

> We performed a bibliometric analysis of this [1980] correspondence from its publication until March 30, 2017. For each citation, two reviewers independently evaluated the portrayal of the article's conclusions, using an adaptation of an established taxonomy of citation behavior along with other aspects of generalizability . . . For context, we also ascertained the number of citations of other stand-alone letters that were published in nine contemporaneous issues of the *Journal* (in the index issue and in the four issues that preceded and followed it).
>
> We identified 608 citations of the index publication and noted a sizable increase after the introduction of OxyContin (a long-acting formulation of oxycodone) in 1995 . . . **Of the articles that included a reference to the 1980 letter, the authors of 439 (72.2%) cited it as evidence that addiction was rare in patients treated with opioids. Of the 608 articles, the authors of 491 articles (80.8%) did not note that the patients who were described in the letter were hospitalized at the time they received the prescription, whereas some authors grossly misrepresented the conclusions of the letter** . . . Of note, affirmational citations have become much less common in recent years. In contrast to the 1980 correspondence, 11 stand-alone letters that were published contemporaneously by the Journal were cited a median of 11 times.[176]

283. The researchers provided examples of quotes from articles citing the 1980 letter, and noted several shortcomings and inaccuracies with the quotations. For instance, the researchers concluded that these quotations (i) "overstate[] conclusions of the index

[175] Leung, et al., *supra* note 94.
[176] *Id.* (emphasis added).

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publication," (ii) do[] not accurately specify its study population," and (iii) did not adequately address "[l]imitizations to generalizability."[177]

Quote	Reference	Comment
"This pain population with no abuse history is literally at no risk for addiction."	Kowal N. What is the issue?: pseudoaddiction or undertreatment of pain. Nurs Econ 1998;17(6):348–9	
"In truth, however, the medical evidence overwhelmingly indicates that properly administered opioid therapy rarely if ever results in "accidental addiction" or "opioid abuse"."	Libby RT. Treating Doctors as Drug Dealers: The Drug Enforcement Administration's War on Prescription Painkillers. The Independent Review 2006;10(4):511-545.	
"Fear of addiction may lead to reluctance by the physician to prescribe. [...] However, there is no evidence that this occurs when prescribing opioids for pain."	Iles S, Catterall JR, Hanks G. Use of opioid analgesics in a patient with chronic abdominal pain. Int J Clin Pract 2002;56(3):227–8.	
"In reality, medical opioid addiction is very rare. In Porter and Jick's study on patients treated with narcotics, only four of the 11,882 cases showed psychological dependency."	Liu W, Xie S, Yue L, et al. Investigation and analysis of oncologists' knowledge of morphine usage in cancer pain treatment. Onco Targets Ther 2014;7:729–37.	Overstates conclusions of the index publication does not accurately specify its study population. Limitations to generalizability are not otherwise explicitly mentioned.
"Physicians are frequently concerned about the potential for addiction when prescribing opiates; however, there have been studies suggesting that addiction rarely evolves in the setting of painful conditions."	Curtis LA, Morrell TD, Todd KH. Pain Management in the Emergency Department 2006;8(7).	
"Although medicine generally regards anecdotal information with disdain (rigorously controlled double-blind clinical trials are the "gold standard"), solid data on the low risk of addiction to opioid analgesics and the manageability of adverse side effects have been ignored or discounted in favor of the anecdotal, the scientifically unsupported, and the clearly fallacious."	Rich BA. Prioritizing pain management in patient care. Has the time come for a new approach. Postgrad Med 2001;110(3):15–7.	
"The Boston Drug Surveillance Program reviewed the charts of nearly 12,000 cancer pain patients treated over a decade and found only four of them could be labeled as addicts."	Levy MH. Pharmacologic management of cancer pain. Semin Oncol 1994;21(6):718–39.	Incorrectly identifies the index study population as cancer patients; does not otherwise address limitations to generalizability.

284. Based on this review, the researchers concluded as follows:

> [W]e found that a five-sentence letter published in the Journal in 1980 was heavily and uncritically cited as evidence that addiction was rare with long-term opioid therapy. We believe that this citation pattern contributed to the North American opioid crisis by helping to shape a narrative that allayed prescribers' concerns about the risk of addiction associated with long-term opioid therapy. In 2007, the manufacturer of OxyContin and three senior executives pleaded guilty to federal criminal charges that they misled

[177] Supplementary Appendix to Pamela T.M. Leung, B.Sc. Pharm., Erin M. Macdonald, M.Sc., Matthew B. Stanbrook, M.D., Ph.D., Irfan Al Dhalla, M.D., David N. Juurlink, M.D., Ph.D., *A 1980 Letter on the Risk of Opioid Addiction*, 376 N Engl J Med 2194-95 (June 1, 2017), http://www.nejm.org/doi/suppl/10.1056/NEJMc1700150/suppl_file/nejmc1700150_appendix.pdf.

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> regulators, doctors, and patients about the risk of addiction associated with the drug. Our findings highlight the potential consequences of inaccurate citation and underscore the need for diligence when citing previously published studies.[178]

285. These researchers' careful analysis demonstrates the falsity of Defendants' claim that this 1980 letter was evidence of a low risk of addiction in opioid-treated patients. By casting this letter as evidence of low risk of addiction, Defendants played fast and loose with the truth, with blatant disregard for the consequences of their misrepresentations.

G. Defendants Seattle Pain Clinic and Dr. Frank Li Operated a Pill Mill That Distributed a Dangerously High Volume of Opioids in King County.

286. In addition to the egregious misrepresentations made by Defendants, other entities and individuals played a significant role in creating the opioid crisis, including entities and individuals in King County.

287. On or around January 31, 2008, Frank D. Li established the Seattle Pain Clinic (SPC). Dr. Li is an anesthesiologist and board-certified pain specialist, and is licensed to practice in Washington and California. SPC represents itself as a pain management treatment center focused on "finding treatment alternatives to narcotic pain medications" by incorporating "emerging best practices."[179]

288. SPC opened its first clinic in King County and expanded rapidly thereafter. By 2016, SPC was operating one laboratory and seven additional pain clinics throughout Washington State, including two in the County—one in Seattle and another in Renton.[180]

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[178] Leung, et al., *supra* note 94.

[179] Statement of Charges, *In the Matter of the License to Practice as a Physician and Surgeon of: Frank D. Li, MD* ("*In the Matter of Dr. Li*") ¶ 1.2, No. M2016-705, State of Washington Medical Quality Assurance Commission (July 13, 2016), https://www.seattle.gov/documents/departments/cityAttorney/opioidLitigation/FN5-IntheMatterofLicensetoPractice-FrankDLiMD-07-13-16.pdf.

[180] *Id.*

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289. Dr. Li was SPC's sole medical doctor, and one of its only pain management specialists. In addition, as the owner of SPC and employer for all the clinic providers, Dr. Li established the business model, treatment protocols, and training for treating chronic pain patients.[181] Rather than acting in the best interests of his patients, however, Dr. Li—like the Manufacturer Defendants—sought to advance his own financial interests and the interests of SPC at the expense of SPC patients. Indeed, like doctors at other pill mills in the country, Dr. Li sought to maximize the amount of prescriptions available to his patients.

290. In order to carry out his plan and maximize revenue, Dr. Li encouraged general practitioners throughout Washington State to refer their "most difficult pain patients" to SPC. But he failed to ensure that SPC had the requisite policies and procedures, infrastructure, and qualified pain management specialists necessary to serve the large number of patients referred to his practice who needed more than a prescription of opioids with little or no efficacy to meet their needs.[182]

291. In fact, Dr. Li had a practice of hiring providers with little or no experience or training in treating chronic noncancer pain. These providers generally joined SPC on Dr. Li's representation to provide training in chronic pain treatment. SPC and Dr. Li allowed many providers who recently graduated from clinical school and allowed them to treat patients and bill for services before obtaining an established National Provider Identified (NPI) number or insurance credential.[183]

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[181] *Id.* at ¶ 1.4.

[182] Attorney General of Washington, Medicaid Fraud Control Unit, Memorandum re Unprofessional conduct complaint against Dr. Frank D. Li, at 1-2 (May 12, 2015), https://www.documentcloud.org/documents/2996985-MFCU-Complaint.html.

[183] Statement of Charges, *supra* note 179, at ¶ 1.39.

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292. In interviews and statements provided to the Washington Attorney General Medicaid Fraud Control Unit (MCFU), former SPC providers indicated that Dr. Li recruited them with promises of new facilities and expensive machinery that were ultimately false.[184] The hiring process was exceedingly simple and straightforward, consisting of a single-page application and a brief on-line interview with Dr. Li.

293. Training was also virtually non-existent. As set forth above, new SPC hires awaiting insurance accreditation often treated patients without supervision (thus bypassing insurance companies' quality control mechanisms). In order to conceal this breach of protocol, Dr. Li and SPC instructed unaccredited providers to access SPC's electronic systems using the credentials of an accredited provider.

294. On its website, SPC advertises that it offers at least seventeen different services designed to treat non-cancer pain. But in reality, almost all SPC patients received opioids. For instance, Medicaid records reviewed by MCFU showed that approximately 85% of SPC patients received opioid treatment and that Dr. Li and several of his subordinates were among the top providers of opioids in the state.[185]

295. The majority of SPC patient encounters are characterized as "medication management" or "prescription refill" visits. Every SPC Medicaid patient on opioid therapy visits an SPC provider at least every 90 days to obtain a 90-day supply of drugs.[186] Former employees told MCFU that, in a typical refill appointment, patients would provide a urine sample to a

[184] Medicaid Fraud Control Unit Memorandum, *supra* note 182, at 5.
[185] *Id.* at 6.
[186] *Id.*

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medical assistant and then see an "SPC provider for five minutes or less, just enough time to prescribe 90 days' worth of opioids."[187]

296. SPC pressured its practitioners to work fast and write prescriptions routinely. Every provider was required to see eighteen to twenty patients per eight hours, and bonuses were provided for additional patients. As such, SPC providers could not conduct meaningful medical examinations to determine an appropriate course of treatment, and in fact were discouraged from doing so.

297. Pressured to fill opioid prescriptions at an alarmingly fast rate, SPC practitioners routinely disregarded signs of abuse. SPC's practice of collecting urine samples on every visit only served to increase medical billings.[188] The test results themselves were consistently disregarded and patients who tested positive for illicit drug abuse—or negative for opioids, suggesting that those patients were seeking opioids to then resell on the street—were nonetheless permitted to continue opioid therapy.

298. Witnesses interviewed by MCFU with knowledge of Dr. Li and SPC's practices indicated that SPC became "well known amongst opioid addicts and other drug seekers as an easy place to get drugs."[189] And addicts flocked to SPC clinics, sometimes travelling large distances from all over the state and region. Ultimately, SPC served over 25,000 patients, many of whom obtained opioids from SPC after being rejected by practitioners at other facilities.

299. Former SPC employees have openly described SPC as a "pill mill" and acknowledged the low quality of patient "care" the center provided. Concern over SPC's

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[187] *Id.*
[188] *Id.*
[189] *Id.*

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practices resulted in massive employee turnover. Most SPC providers interviewed by MFCU acknowledged that they left the center out of fear for their professional licenses. But when they left, other unsupervised and unaccredited practitioners took their places.

300. Tragically, at least 60 SPC patients died between 2010 and 2015.[190] SPC conducted no investigation into these deaths. But Washington State's Medical Quality Assurance Commission (MQAC) did examine and investigate them. In particular, MQAC reviewed medical records for eighteen of the sixty patients and concluded that sixteen patients died from an opioid overdose within mere days or weeks of filling an opioid prescription provided by SPC. MQAC determined further that with each of these patients SPC "defaulted to opiatecentric treatment plans" without adequate review of medical histories, imaging studies, and specialty consultations. Each patient was routinely given "increasing and continuing opioid doses" with subsequent visits.

301. The Washington State Department of L&I also took note of Dr. Li and SPC's practices of overprescribing opioids. In 2013, L&I denied Dr. Li's application to prescribe drugs for the workers' compensation program. That decision, officials said, was based on "noncompliant" prescribing practices and substandard care of a patient who died of an overdose. Dr. Li withdrew his application before L&I officials could report the denial, the charging statement said.[191]

302. Interviews conducted by MFCU of those with knowledge regarding Dr. Li and SPC confirm these practices. For example, a 55-year old patient overdosed on opioids just two

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[190] *Id.*

[191] JoNel Aleccia, *DEA, state crack down on pain doctor over opiate prescriptions, citing 18 deaths*, The Seattle Times (July 15, 2016, 4:33am), https://www.seattletimes.com/seattle-news/health/dea-state-crack-down-on-pain-doctor-over-opiate-prescriptions-citing-18-deaths/.

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days after receiving prescriptions from SPC for Purdue's MS Contin and generic oxycodone. This patient had an extensive history of hospitalizations for respiratory failure and suffered from multiple conditions, including opioid dependence. SPC nevertheless increased her opioid dosages. In fact, on her last visit to SPC, this patient tested positive for benzodiazepines not prescribed by SPC. As medical professionals at SPC should have known, mixing benzodiazepines with opioids increases the potential for fatal overdose. Yet SPC prescribed this patient aggressively higher doses of opioids, and she died days later.[192]

303. Another 28-year-old SPC patient overdosed on opioids just five days after she filled an opioid prescription written by SPC. She had visited SPC eleven times over the prior year complaining of knee pain. She repeatedly tested positive for THC and cocaine, had a history of depression and childhood abuse, and tested negative for opioids, indicating she was diverting her prescriptions and potentially selling them to others on the street.[193] Nonetheless, she received escalating dosages of opioids.

304. Yet another 35-year-old SPC patient died less than a year after beginning treatment there. He had an extensive history of illicit drug use, bipolar disorder, depression, suicidal ideation, obesity, hypertension, psychiatric hospitalizations, post-traumatic stress disorder resulting from childhood sexual abuse, and dependencies on methamphetamine and alcohol. This patient admitted to over-use of prescribed medications, but was nonetheless prescribed escalating doses of Endo's Percocet and Janssen's Nucynta. He died of mechanical asphyxia brought on by the combined effects of various opioids.[194]

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[192] Statement of Charges, *supra* note 179, at ¶ 1.24.
[193] Medicaid Fraud Control Unit Memorandum, *supra* note 182.
[194] *Id.*

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305. The MFCU ultimately concluded that SPC and Li utilized "[p]rolonged oral opioid therapy at dosages greatly exceeding 120 MED without evidence of functional improvement"; used "unaccredited, inexperienced, and inadequately trained and supervised ARNPs to care for complex, high risk patients"; issued "[h]igh opioid dosage rates"; and inflicted "[w]ide-spread and significant patient harm including the unintentional overdose opioid deaths of many Medicaid patients."[195]

306. As tragic and preventable as these deaths were, focusing solely on overdoses in SPC's patient population would grossly understate the harm SPC has caused. CDC has calculated that, on average, for every 1 overdose death there are 10 abuse treatment admissions, 26 emergency department visits for misuse, 108 people dependent on opioids, and 733 non-medical users. Under these ratios, SPC's prescribing conduct has led to at least 260 abuse treatment admissions, 416 emergency department visits, 1,728 opioid-dependent people, and 11,728 non-medical users.

307. As a result of these egregious practices, on July 14, 2016, MQAC summarily suspended Dr. Li's license to practice medicine in Washington State. MQAC concluded the suspension was justified because SPC established a business model and clinical practice that focused on maximizing billable amounts by increasing the number of patients treated, the frequency of patient office visits, and the volume of billable services. MQAC further concluded that Dr. Li and SPC sought out vulnerable chronic pain patients enrolled in Medicaid insurance and maintained these patients on opioid therapy by providing continuing prescriptions despite knowledge of medication abuse, diversion and overdose.

[195] *Id.* at 12.

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308. On August 5, 2016, California suspended Dr. Li's California medical license. On February 13, 2017, the DEA revoked Dr. Li's registrations to dispense controlled substances.

309. Patients of SPC and Dr. Li were ultimately given opiates inappropriately, with little supervision, and in significant amounts that may also have sent the powerful medications onto the street to be sold. As set forth by the MFCU, Li "failed to ensure that SPC (Seattle Pain Centers) had the infrastructure and qualified pain management specialists necessary to serve the large numbers of complex patients referred to his practice . . . Instead, Dr. Li's rapid expansion of SPC's clinical practice placed the care of those 'most difficult pain patients' in the hands or providers who were not qualified or able to care for such patients." SPC and Dr. Li contributed significantly to the opioid epidemic that continues to harm the County.

310. In addition, the Manufacturer Defendants knew that SPC and Dr. Li were operating a pill mill. As explained herein, the Manufacturer Defendants maintain highly sophisticated databases that track where their drugs are being prescribed, in what quantities, and by whom. Indeed, this IMS data was utilized by the Manufacturer Defendants to track which doctors they needed to direct more resources to in order to increase their prescription habits.

311. Based on this data, they knew or should have known that SPC and Dr. Li were doling out prescriptions for the vast majority of their patients and in high and unreasonable quantities. Nevertheless, the Manufacturer Defendants did nothing to stop SPC and Dr. Li's behavior, and in fact, encouraged it by purchasing multiple meals for Dr. Li. Thus, any suggestion that the problems caused by SPC and Dr. Li relieve the Manufacturer Defendants of liability is dubious at best.

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H. Sales Representatives Defendants John and Jane Does Knew or Should Have Known their Representations Regarding the Safety and Efficacy of Prescription Opioids in King County Were False and Misleading.

312. As discussed above, sales representatives also played a key role in promoting the Manufacturer Defendants' opioids. Also known as "detailers," these sales representatives routinely visited physicians, nurses, pharmacists, and others in the medical community to deliver the Manufacturer Defendants' messages about the safety and efficacy of opioids. In face-to-face meetings, detailers would urge doctors to prescribe opioids to their patients for a wide range of ailments, making the same types of misrepresentations the Manufacturer Defendants made, as detailed above.

313. But these sales representatives were not simple conduits of information, merely passing on what they believed to be good scientific information to doctors. Instead, the sales representatives knew, or should have known, that they were making false and misleading statements and providing untrue information to doctors and others about opioids.

314. Former sales representative Steven May, who worked for Purdue from 1999 to 2005, explained to a journalist how he and his coworkers were trained to overcome doctors' objections to prescribing opioids. The most common objection he heard about prescribing OxyContin was that "it's just too addictive."[196] May memorized this line from the drug's label: "The delivery system is believed to reduce the abuse liability of the drug." He repeated that line to doctors even though he "found out pretty fast that it wasn't true."[197] He and his coworkers learned quickly that people were figuring out how to remove the time-releasing coating, but they

[196] David Remnick, *How OxyContin Was Sold to the Masses* (Steven May interview with Patrick Radden Keefe), The New Yorker (Oct. 27, 2017), https://www.newyorker.com/podcast/the-new-yorker-radio-hour/how-oxycontin-was-sold-to-the-masses.

[197] Keefe, *supra* note 48.

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continued making this misrepresentation until Purdue was forced to remove it from the drug's label. In addition, May explained, he and his coworkers were trained to "refocus" doctors on "legitimate" pain patients, and to represent that "legitimate" patients would not become addicted. In addition, they were trained to say that the 12-hour dosing made the extended-release opioids less "habit-forming" than painkillers that need to be taken every four hours. Sales Representative Defendants knew or should have known that such statements were false and misleading, yet they continued to make them.

315. Sales representatives also quickly learned that the prescription opioids they were promoting were dangerous. For example, May had only been at Purdue for two months when he found out that a doctor he was calling on had just lost a family member to an OxyContin overdose.[198] And as another sales representative wrote on a public forum:

> Actions have consequences - so some patient gets Rx'd the 80mg OxyContin when they probably could have done okay on the 20mg (but their doctor got "sold" on the 80mg) and their teen son/daughter/child's teen friend finds the pill bottle and takes out a few 80's... next they're at a pill party with other teens and some kid picks out a green pill from the bowl... they go to sleep and don't wake up (because they don't understand respiratory depression) Stupid decision for a teen to make...yes... but do they really deserve to die?

316. Sales representatives, including the Sales Representative Defendants, knew or should have known the potential consequences of pushing potent doses of opioids for chronic pain and other common indications.

317. Sales Representative Defendants are current Washington State residents who made false and misleading statements to doctors and others in King County about the safety and efficacy of opioids. These detailers also provided doctors and health care providers in the County with pamphlets, visual aids, and other marketing materials designed to increase the rate

[198] Remnick, *supra* note 196.

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of opioids prescribed to patients. Sales Representative Defendants knew the doctors they visited relied on the information they provided, and that the doctors had minimal time or resources to investigate their veracity independently.

318. Sales Representative Defendants were also given bonuses when doctors whom they had detailed wrote prescriptions for their company's drug. Because of this incentive system, detailers stood to gain significant bonuses if they had a pill mill in their sales region.[199] Sales representatives could be sure that doctors and nurses at pill mills would be particularly receptive to their messages and incentives, and receive "credit" for the many prescriptions these pill mills wrote.

319. In King County, some Sales Representative Defendants targeted their efforts at Dr. Li and other doctors, nurses, and staff at SPC. On information and belief, those Sales Representative Defendants knew or should have known that some of the statements they made and information they provided about opioids to providers at SPC were false and misleading.

320. For example, some Sales Representative Defendants told providers at SPC that the Washington State opioid prescription guidelines were wrong and overly conservative, including those related to calculating the relative strength of different brands of opioids. Sales Representative Defendants urged SPC staff to give patients more opioids, and particular brands of opioids, even when this was incorrect or conflicted with Washington State guidelines or other medical information. Sales Representative Defendants knew or should have known these, and other statements, were false and misleading. Nevertheless, these detailers made the

[199] Indeed, Manufacturer Defendants often helped their sales representatives find and target such pill mills. As recently as 2016, Purdue commissioned a marketing study to help target Washington prescribers and spread its deceptive message regarding opioids, and on information and belief, utilized its sale representatives to carry out these strategies.

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misrepresentations described herein because they stood to make thousands of dollars from the improper over prescription of opioids.

321. Other doctors in King County have confirmed they were the target of these tactics too. For example, one family doctor in King County who has been practicing in the Seattle area for more than three decades was repeatedly visited by Purdue detailers. These detailers consistently and aggressively offered free meals—including at some of the most expensive restaurants in Seattle—and other perks to this doctor and other employees of his office. These detailers further knew that this family doctor was more likely to follow company-created guidelines and supposed peer-reviewed studies and articles and would not necessarily have the time to conduct research or investigate the veracity of their representations on his own.

322. Although Plaintiff does not presently know the names of the Sales Representative Defendants, through discovery this information will become available. For example, when Sales Representative Defendants visited doctors, they would make notes on their visit, what questions the doctors had, how they worked to overcome physicians' hesitation to prescribe opioids, and how they sold doctors on the idea of using opioids broadly. These notes will identify the names of the Sales Representative Defendants and some of the misrepresentations they made.

323. Additionally, discovery from the Manufacturer Defendants will reveal the names and employment history of Sales Representatives Defendants.

I. The Opioid Epidemic Caused By Defendants Has Directly Affected King County.

324. Data from King County, described in Section I.1 below, demonstrates a marked increase in opioid use—and opioid overdoses—following Defendants' aggressive promotion of prescription opioids in the County. The data also shows that, as in many other places in the U.S., opioid use in King County is now dominated by heroin, and that first-time opioid users are

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increasingly younger. In addition, as discussed in Section I.2 below, the opioid epidemic has compounded the homelessness crisis in King County. In Section I.3, three personal stories from graduates of the King County Drug Diversion Court illustrate the way in which prescription opioids can lead to addiction.[200]

1. Data from King County shows a sharp increase in opioid use, particularly among young people.

325. King County is one of the largest counties in the country, with approximately 2.15 million residents.[201] It is also one of the fastest growing counties in the nation, as it experienced the fourth-highest population increase in the country from 2015 to 2016.[202] In fact, since 2000, King County's population has grown by more than 360,000 people.[203]

326. King County contains 39 cities, the largest number of any county in Washington State, including Seattle, Bellevue, Kirkland, Kent, Snoqualmie, and Burien—six of the fastest growing cities in the state.

327. In King County, as in many other communities in the United States, opioid use is at crisis levels. The rate of drug-involved deaths in King County climbed by 46% from 1997 to 2015, and most of that increase is attributable to opioids. Opioid overdose deaths exceeded overdose deaths from other substances by a wide margin each year between 2007 and 2016,

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[200] As illustrated in detail in Section J below, various departments in the County have also incurred substantial costs and have had to allocate significant resources in responding to and addressing the crisis caused by Defendants.

[201] *Quick Facts: King County, Washington*, United States Census Bureau, https://www.census.gov/quickfacts/fact/map/kingcountywashington/PST045216 (last visited Nov. 20, 2017).

[202] *Census Bureau: Seattle-King County scores nation's 4th-highest population gain*, KOMO News (Mar. 23, 2017), http://komonews.com/news/local/census-bureau-seattle-king-county-scores-nations-4th-highest-population-gain.

[203] *See* Demographics Presentation at http://www.kingcounty.gov/depts/executive/performance-strategy-budget/regional-planning/Demographics.aspx (last updated 2016).

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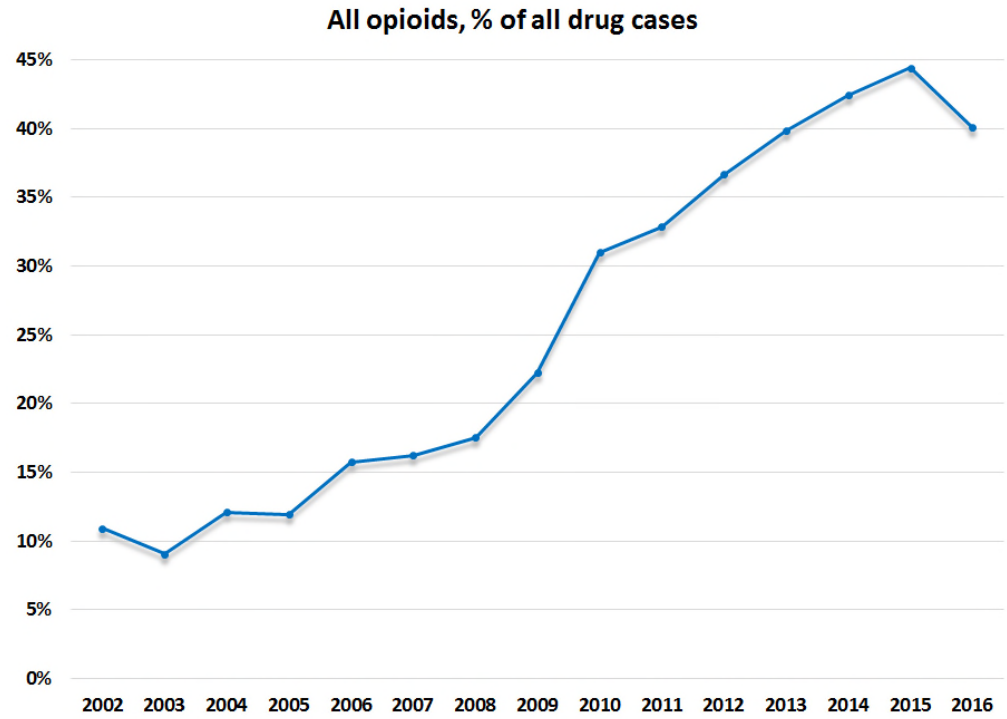
often by more than 100 deaths annually. Opioids claimed 448 lives in King County in 2015 and 2016.

328. Higher overdose rates flowed directly from a sharp rise in opioid prescription rates in King County in the early 2000s. By 2011, the prescribing rate for opioids in King County was 66%; in other words, 66 opioid prescriptions were written for every 100 King County residents. And, despite aggressive efforts by local and state officials to curb the crisis, the prescribing rate remained above 47% through 2016.

329. Additionally, as the number of prescriptions for opioids has grown, so too have crimes related to opioids. In King County, opioids are now implicated in 40% of all criminal cases involving drugs. Only twelve years ago, opioids accounted for only a little over 10% of all drug-related criminal cases.



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330. The rate of people entering treatment programs in King County for opioid addiction and disorder has also risen sharply. From 2010 to 2014, the number of people who entered the publicly funded treatment system each year for heroin-use disorders grew from 1,439 to 2,886—even while the number of people receiving treatment for all other primary drugs of choice declined (except for methamphetamine). In 2015, for the first time, heroin treatment admissions surpassed alcohol treatment admissions. Heroin also surpassed alcohol to become the primary drug used by people seeking withdrawal management (detox) in the King County publicly funded treatment system. And heroin is also the most commonly mentioned drug among King County callers to the Washington Recovery Help Line, totaling 2,100 in 2015, almost double the number in 2012.[204]

331. As these numbers illustrate, heroin use is the latest evolution in the opioid crisis in King County. Heroin overtook prescription opioids as the primary cause of opioid overdose deaths in King County in 2013. This is the same pattern that has occurred around the country: aggressive promotion of prescription opioids broadened the market for all opioids, including heroin. As explained in further detail below, the majority of heroin users in King County report first being introduced to opioids via a prescription opioid. Many then replaced prescription opioids with heroin when they could no longer obtain the prescriptions.

332. Opioid treatment programs (OTP) that dispense methadone and buprenorphine in King County have been working to expand capacity, and the number of admissions to these programs increased from 696 in 2011 to 1,486 in 2014. As of October 1, 2015, there were 3,615 people currently maintained on methadone at an OTP in King County. Statutory capacity

[204] *Final Report and Recommendations*, Heroin and Prescription Opiate Addiction Task Force (Sept. 15, 2016), http://kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/herointf/Final-Heroin-Opiate-Addiction-Task-_Force-Report.ashx?la=en.

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limitations have historically resulted in up to 150 people on a waitlist. Like methadone, buprenorphine is a proven opioid use disorder medication that cuts the odds of dying in half compared to no treatment or counseling only and can be provided at an OTP. Unlike methadone, however, buprenorphine can be prescribed by a physician in an office-based setting and obtained at a pharmacy. Requests for buprenorphine treatment by King County callers to the Recovery Help Line have increased from 147 in 2013 to 363 in 2015. Although buprenorphine has fewer barriers to access than methadone, the County's capacity to provide treatment is limited and far exceeded by demand.

333. Also, people seeking opioid withdrawal management are younger than in previous years. According to the King County Substance Abuse Prevention and Treatment Annual Report, "From the first half of 2008 through the second half of 2011, there was a steady increase in the number and percentage of young adults under 30 years old entering detoxification services. The numbers and percentages of young adults leveled off during 2012, and have remained at higher levels. Among all individuals admitted in 2014, *85 percent of those younger than 30 years old indicated opioids are their primary drug used* compared to 41 percent of those 30 years or older."[205]

334. As illustrated in the chart below, people between 18 and 29 made up nearly 45% of those admitted to opioid treatment programs for the first time, and just those between 22 and 23 made up nearly 9% of first-time admits to opioid treatment.[206]

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[205] *Substance Abuse Prevention and Treatment Annual Report*, King County Mental Health, Chemical Abuse and Dependency Services Division (2014), http://www.kingcounty.gov/~/media/depts/community-human-services/behavioral-health/documents/sud/2014_Substance-Abuse-Report-Card.ashx?la=en.

[206] *Publicly funded treatment admissions in King County*, Alcohol & Drug Abuse Institute http://adai.washington.edu/WAdata/KingCountyDrugTreatment.htm (last visited Jan. 5, 2018).

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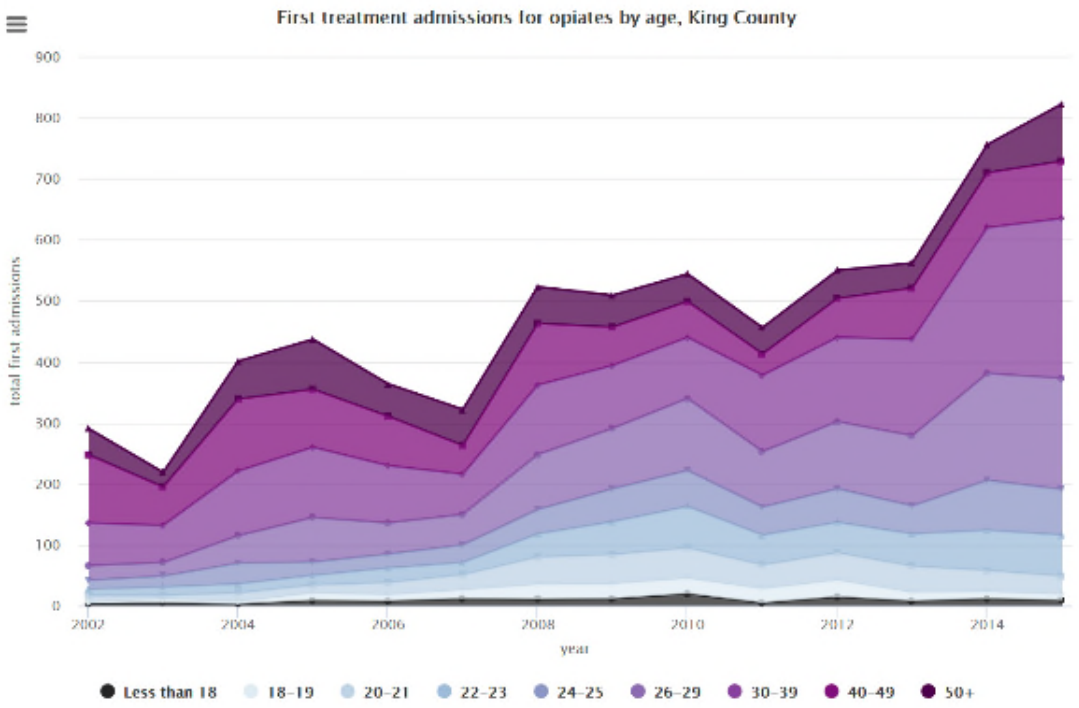
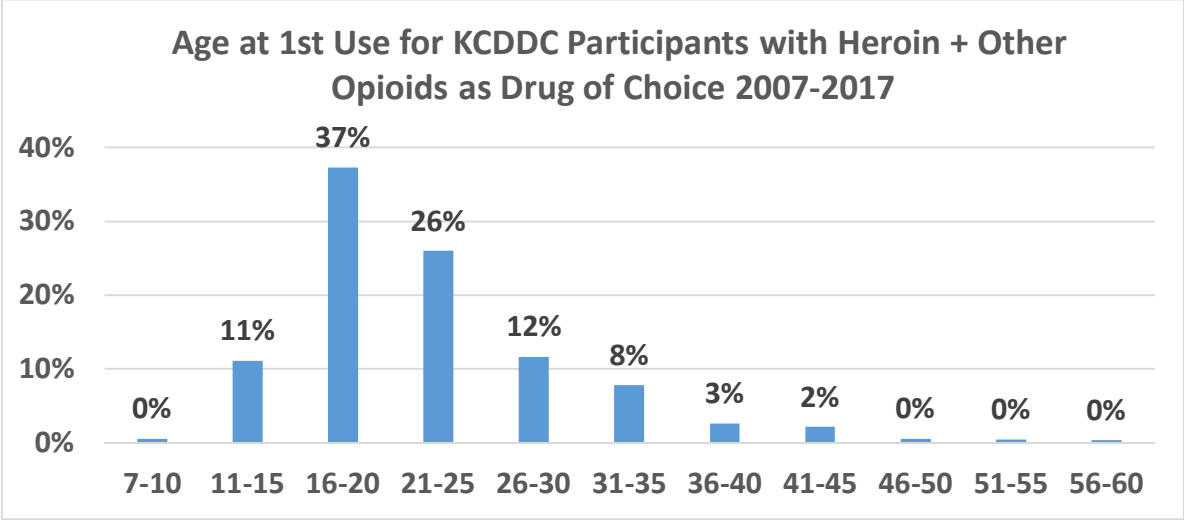


335. The same trend is evident from the participants in King County Drug Diversion Court.[207] Over the past decade, 37% of Drug Court participants for whom opioids were their drug of choice began using opioids between the ages of 16 and 20. And 11% of these participants began using opioids when they were just 11 to 15 years old.



[207] King County Drug Court is discussed more fully below.

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336. Because the individuals using opioids are increasingly younger, the effects of the opioid epidemic will reverberate throughout the County for decades to come. As the University of Washington Alcohol & Drug Abuse Institute observes, "[a] 20-year-old entering treatment in 2010 may well become a 40-year-old still in treatment in 2030."[208]

337. The opioid epidemic has also had an impact on even younger children. For example, 31% of all defendants participating in Drug Court who were arrested for opioid-related crimes are the parent of at least one minor child.

338. This data describes a public health crisis of epidemic proportions in King County. As a practical and financial matter, King County has been saddled with an enormous economic burden. As explained in further detail below, nearly every department in the County is affected by the opioid crisis caused by Defendants, and several departments have direct and specific response costs that total tens of millions of dollars.

339. In addition to direct crisis-response costs, King County has been putting resources into efforts that, it hopes, will bring an end to the opioid epidemic here. As noted above, King County Executive Dow Constantine and the mayors of Seattle, Auburn, and Renton convened a Task Force on Heroin and Prescription Opiate Addiction ("Task Force") in March 2016, bringing together over 30 experts representing multiple disciplines, such as public health, human service agencies, criminal justice, cities, University of Washington, hospitals, treatment providers, and others working together to expand the region's capacity for treatment and prevention capacity. The Task Force delivered a detailed report and recommendations in

[208] *Publicly funded treatment admissions in King County*, *supra* note 206.

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September 2016, and Washington Governor Jay Inslee enacted several of its recommendations into law in May 2017.

340. The Task Force recommended actions in three areas: (1) primary prevention, (2) treatment expansion and enhancement, and (3) health and harm reduction. These include, for example, increasing public awareness of effects of opioid use, including overdose and opioid use disorder; making buprenorphine more accessible; increasing treatment capacity; distributing more naloxone kits; and creating a three-year pilot project that will include at least two safe-use locations providing on-site services and staffed by trained healthcare providers.[209]

341. The Task Force focused on three primary areas in which to develop or enhance strategies to save lives and end the addiction cycle.

342. The first area of focus is primary prevention. Here, the Task Force concluded it was critical to raise awareness and knowledge of the possible adverse effects of opioid use, including overdose and opioid use disorder. Additionally, it emphasized the importance of promoting safe storage and disposal of medications. And finally, the Task Force recommended leveraging and augmenting existing screening practices in schools and health care settings to prevent and identify opioid use disorder.

343. The Task Force's second area of focus was expanding treatment. Here, the Task Force found three actions that were needed: First, create access to buprenorphine for all people in need of services, in low-barrier modalities close to where individuals live. Second, develop treatment on demand for all modalities of substance use disorder treatment services. And, third,

[209] Press Release, King County, *Heroin and opioid task force recommends strategy that focuses on prevention and increasing access to treatment* (Sept. 15, 2016), http://www.kingcounty.gov/elected/executive/constantine/news/release/2016/September/15-heroin-opioid-task-force-report.aspx.

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alleviate barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.

344. Finally, the Task Force focused on health services and overdose prevention. There, the Task Force recommended two strategies: Expand distribution of naloxone throughout the County, and establish at least two Community Health Engagement Locations (CHEL sites) where supervised consumption occurs for adults with substance use disorders in the Seattle and King County region. The Task Force noted that the CHEL pilot program should have a provisional time limit of three years. Continuation of the program beyond that time should be based on evidence of positive outcomes.

345. The Task Force's recommended actions, if fully implemented, are likely to meaningfully combat the opioid epidemic by saving lives now, treating those who suffer from opioid use disorder, and preventing future addictions. The recommended actions, however, are not cheap. Providing sufficient opioid treatment programs to serve the entire County, for example, will cost tens of millions of dollars for years to come.

2. The opioid epidemic has contributed significantly to the homelessness crisis in King County.

346. One particularly visible effect of the opioid epidemic in King County is the growing homeless population.

347. Homelessness has become a persistent problem in the County. The 2016 King County One Night Count found that 4,505 of our neighbors in King County were without shelter that year, a 19% increase over 2015. Including people who were living in shelters, safe havens, and transitional housing, the 2016 Count found 10,730 people were homeless.

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348. The most recent studies show the County's homeless population is nearly 12,000, and only Los Angeles County and New York City have a higher concentration of homeless people than King County.[210]

349. Although the causes of homelessness are multi-faceted and complex, substance abuse is both a contributing cause and result of homelessness. The dramatic rise in homelessness in King County is due in part to the opioid epidemic. Some estimates suggest that the majority of the homeless population is addicted to or uses opioids.

350. Prescription opioids have not only helped to fuel the homeless crisis, but have also made it immeasurably more difficult for the County to address. Mental health services, for example, are critical for many in the homeless population. Unfortunately, opioid use and addiction can make it more difficult to provide effective mental health treatment. Those who need help most often turn to opioids—legal or not—to self-medicate and avoid getting treatment and care that might lead to long-term success and more positive outcomes. Whether opioid addiction caused these people to lose their homes or not, opioid addictions now prevent countless numbers of people from finding a way out of homelessness.

351. Additionally, while the leading cause of death among homeless Americans used to be HIV, it is now drug overdose. A study in JAMA Internal Medicine found that overdoses, most of which involved opioids, are now responsible for the majority of deaths among individuals experiencing homelessness in the Boston area. The same trend is occurring locally, as documented in the death reports of individuals experiencing homelessness in King County.

[210] Vernal Coleman, *King County homeless population third-largest in U.S.*, The Seattle Times (Dec. 7, 2017, 9:59am), https://www.seattletimes.com/seattle-news/homeless/king-county-homeless-population-third-largest-in-u-s/.

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3. Stories from King County Drug Diversion Court graduates demonstrate the easy transition from prescription painkiller to addiction.

352. The scope of the opioid crisis is enormous, and the statistics used to describe it are staggering. But behind each number, of course, is an individual, and the individual stories illustrate the ease with which legal prescription narcotics can pull individuals into addiction. Below are stories of opioid addiction and recovery from three successful King County Drug Diversion Court graduates.

a. Jennifer Gilbert, age 42

353. Ms. Gilbert's opioid addiction began with a work injury. At that time, Ms. Gilbert, a mother of three, had what she described as "a successful job and career." But following her injury, her family doctor gave her as many opioids as she wanted, and then her orthopedist also prescribed opioids, primarily oxycodone. When she finally addressed the issue of addiction with her doctors, knowing that she "come[s] from a long line of addicts," she was told it was not a concern and that if she did end up addicted, they had ways to help with it.

354. She continued taking opioids, developing higher and higher tolerance. Eventually, she found herself "out of control" and running out of pills faster than she could fill her prescriptions, and she again brought up the issue to her doctor. Her doctor responded by dropping her as a patient.

355. For the next four years, Ms. Gilbert gained access to opioids by doctor shopping—racking up tens of thousands of dollars in medical bills to keep feeding her addiction and stave off withdrawal. Ultimately "red-flagged" at every pharmacy, she turned to the street for her pills. She spent over $20,000 in three months. At one point, she checked herself into Recovery Centers of King County, but she wasn't able to stop using. At her peak use, she was taking over 1,000 mg of oxycodone a day.

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356. When Ms. Gilbert was finally caught calling in her own prescriptions, she was referred to Drug Court. She credits the resources she was offered through Drug Court and the Harborview Addiction Program for enabling her to manage her recovery. Today she is on Suboxone maintenance and works as a residential treatment specialist in a detox center. In September of 2017, she completed six years clean.

b. Harvey Nicholson, age 29

357. Mr. Nicholson found his way to OxyContin abuse when his mother was prescribed the drug in high doses, more than she could take. She was prescribed OxyContin for a full 15 years, and during that time put the excess pills in a shoebox in her dresser. In middle school, while struggling with obesity, relating physical problems, and the accidental death of a close friend, Mr. Nicholson found that shoebox. He began taking pills from it and went through the entire box, eventually needing to steal his mother's pills only days after she would fill her prescription.

358. If he could not feed his addiction with his mother's prescription, he turned to the street. Stolen pills from a shoebox had become an addiction that took priority over everything else. When his father passed away in October 2010, Mr. Nicholson was late to the funeral because he was waiting for his dealer. Once he made it to the service, he spent the rest of it nodding out.

359. His mother passed away the following year, leaving Mr. Nicholson with no access to OxyContin. He moved around the country, driven by his habit—from the Tenderloin in San Francisco, to the Haymarket in Boston, to Kensington in north Philadelphia, to Skid Row, and from Nashville to New York City. After three years in New York, he and his wife

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moved to Seattle, where he was arrested in a sting while trying to sell drugs. He was referred to Drug Court.

360. With the help of Drug Court and its programs, Mr. Nicholson completed two years and six months clean on November 11, 2017. He was able to utilize an outpatient treatment center that partners with the Drug Court called Therapeutic Health Services (THS). Through THS, he received methadone treatment, met with a psychologist twice a month to work on mental health issues, and saw a counselor once a month for assistance with sorting out practical needs such as school, healthcare, and generally staying in compliance with the program. Mr. Nicholson also had monthly drug screens at THS, and monthly Drug Court appearances. In addition, he received a monthly bus pass through the program so that he could access treatment.

361. Mr. Nicholson has been doing a slow taper off of methadone over the last twelve months and will be completely done with methadone treatment by the end of January 2018. He believes he is able to tell his story today solely due to the people and the program at Drug Court.

c. Judy Stoeck, age 55

362. Ms. Stoeck was addicted to prescription opioids for roughly eight years. Her drug use started because of a shoulder injury from skiing and turned into an addiction. A mother of two, Ms. Stoeck became, in her words, "the suburban drug addict who only got my drugs from doctors." She found it all too easy in the beginning. As time passed, Ms. Stoeck had to drive farther and farther afield to find doctors who did not know her, but she was still able to obtain prescriptions for opioids.

363. Over the course of her addiction, Ms. Stoeck was prescribed opioids by forty-two healthcare providers—orthopedists, dentists, and general practitioners. Of all these doctors, only

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two of these doctors tried to help her wean off. In fact, even when Ms. Stoeck was participating in Drug Court and working on recovering from addiction, one doctor, a self-described "big proponent of opioids," told Ms. Stoeck that she didn't see a problem with her restarting an opioid prescription once she was done with Drug Court.

364. In the last three years of her addiction, Ms. Stoeck was getting opioids from four doctors at once and filling prescriptions every five days.

365. Eventually, she began forging prescriptions. Only then was she finally caught—something she was silently praying for because she thought the only way out of her habit was jail.

366. Instead, her case was referred to Drug Court, and the resources provided by Drug Court enabled her to make a successful recovery. In addition to monthly appearances at Drug Court and random drug screens twice a week, the Drug Court resources included outpatient treatment through Recovery Centers of King County. Ms. Stoeck availed herself of the Intensive Outpatient Program, which involved counseling sessions three times a week for six months—which she in fact did twice, driven by her motivation to recover and wanting to take advantage of the resources the County offered. After the intensive period, she continued with outpatient treatment at Recovery Centers of King County with twice weekly appointments for a year, and she participated in a mental health assessment through Antioch, a King County grant recipient, on her caseworker's recommendation. Ms. Stoeck took Suboxone as part of her recovery, which she received first through a program at Harborview and then through her physician.

367. Ms. Stoeck has now been clean for approximately six years and works as a Peer Coach with Seattle Area Support Groups & Community Center.

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J. King County Has Borne the Financial Burden of Defendants' Conduct.

368. As a direct result of Defendants' conduct described herein, King County has suffered significant and ongoing harms—harms that will continue well into the future. Each day that Defendants continue to evade responsibility for the epidemic they caused, the County must continue allocating substantial resources to address it.

369. The harms caused by Defendants impact the County in various ways. The statistics and stories shared above provide a glimpse of the devastating toll the opioid crisis has taken on individuals and families in King County. Responding to the consequences of the epidemic, and taking steps to slowly and eventually end it, are high priorities for King County. But in order to respond to the opioid epidemic, King County has had to shoulder the massive economic burden of allocating significant resources to its various departments.

370. King County is served by an array of different departments, agencies, and offices, which provide essential services to the County's residents.[211] While each of these departments, agencies, and offices feel the impact of the opioid crisis in some form, there are certain departments in the County that have especially borne the economic and financial brunt of the epidemic.

371. As explained in further detail below, costs for these departments and the various divisions and agencies within the departments have dramatically increased due to the opioid crisis. Defendants' conduct has forced the County to incur substantial costs it otherwise would not have incurred, and will require the County to spend resources in the future to deal with lasting and ongoing harms.

[211] *Departments, agencies, & offices*, King County, http://www.kingcounty.gov/depts.aspx (last updated Oct. 27, 2017).

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372. King County's costs from rendering public services are recoverable pursuant to the causes of actions raised by the County. Defendants' actions alleged herein are not isolated incidents, but instead part of a sophisticated and complex marketing scheme carried out over the course of more than twenty years. Their actions have caused a substantial and long-term burden on the public services provided by the County. In addition, the public nuisance created by Defendants, and the County's requested relief in seeking abatement of that nuisance, further compels Defendants to reimburse and compensate King County for the tens of millions of dollars it has spent in addressing the crisis Defendants caused.

1. The Department of Public Health has incurred enormous costs as a result of Defendants' conduct.

373. The Department of Public Health (DPH) is one of the largest departments in King County, and is comprised of several different divisions that have each felt the economic impacts of the crisis created by Defendants in a unique way.

a. Emergency Medical Services

374. Emergency Medical Services (EMS) provides essential emergency medical and life-saving services to the County and in an area spanning 2,134 square miles. Any time residents of King County call 9-1-1 for an emergency, they use the EMS system which partners with fire departments, paramedic agencies, EMS dispatch centers, and hospitals.

375. EMS is at the front line of the opioid crisis, as they are the first on scene responders to overdoses, deaths, and injuries related to opioid abuse. Accordingly, EMS incurs costs in dealing with the opioid crisis, both in terms of responding to these emergencies and in training and preparing for them.

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376. For example, each time a paramedic or emergency medical technician (EMT) administers naloxone—a medication used to block and reverse the effects of an opioid overdose—through an emergency 9-1-1 call, the County spends significant financial resources.

377. EMS uses a tiered regional Medic One/EMS system to respond to medical emergencies. The first-tier response includes Basic Life Support (BLS) services provided by firefighter/EMTs or community medical technicians, whereas Advanced Life Support (ALS) resources (paramedics) respond to about 25% of all calls and usually arrive second on scene to provide emergency care for critical or life-threatening injuries and illness. ALS resources respond to medical emergencies that are immediately life-threatening, such as cardiac arrest, stroke, overdose, and car accidents. In contrast, BLS calls are for non-acute and non-life-threatening medical issues.

378. EMS must spend County resources in responding to either ALS or BLS calls related to prescription opioid or heroin abuse. For instance, in 2016 alone, the County spent approximately $1.1 million on ALS calls involving the administration of naloxone by EMS paramedics, and spent an additional $765,000 on ALS calls involving the administration of naloxone by Seattle Medic One ALS paramedic providers.

379. In addition, EMS provides training to its providers and to law enforcement through courses related to the treatment of patients with suspected opioid use. Courses are made available to EMS providers and law enforcement through an online training tool maintained by EMS. This training obviously comes at a cost, and from 2016 to present, the County has spent approximately $64,000 on creating and developing these courses.

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380. EMS also incurred costs purchasing and distributing naloxone to its EMTs and fire departments. For instance, from 2012 to present, the County spent nearly $90,000 on naloxone.

381. In addition, EMS conducts BLS Training focused on training EMTs to administer naloxone. From 2016 to present, the County has spent more than $13,000 on this training.

382. EMS also spends resources on staffing, education, and outreach in direct response to the crises created by Defendants, including regional and medical program staffing costs. EMS must spend staff time to review cases involving naloxone administration and development of Quality Improvement reports to providers and to participate in meetings related to the Task Force described above. From 2016 to present, the County spent more than $50,000 on such staffing, education, and outreach.

383. Overdoses are not the only opioid-related health emergencies to which EMS must respond. For example, opioids have helped to drive a wave of new health problems that EMS must deal with. Many of these health problems, including infections and infectious diseases, fall outside the typical emergencies for which EMS was designed to respond or address. As a result, opioids have had more subtle effects on EMS and its budget.

384. Accordingly, EMS has and continues to shoulder a burden on its resources in responding to the opioid crisis caused by Defendants.

b. Prevention Division

385. The Prevention Division works to prevent and control disease in the County, and promotes the adoption and maintenance of healthy behaviors.

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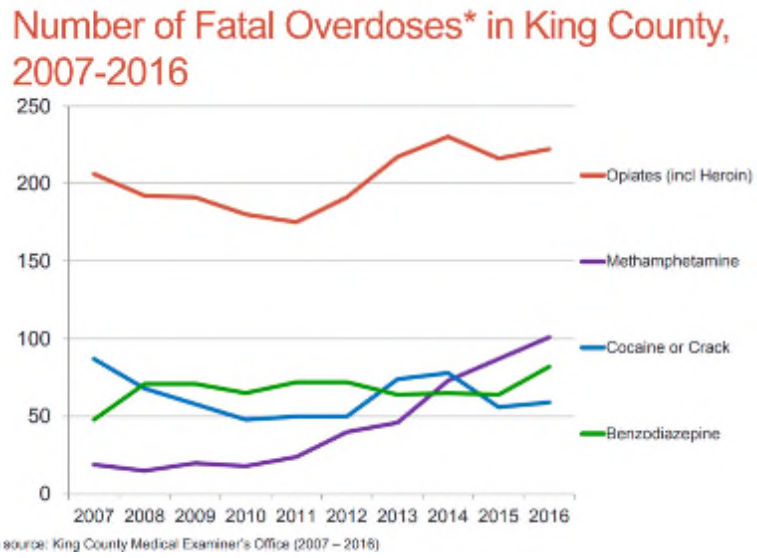
386. The Prevention Division operates the King County Medical Examiner's Office (MEO). The MEO serves the County by investigating sudden, unexpected, violent, suspicious, and unnatural deaths.

387. The public health role of the Medical Examiner is to isolate and identify the causes of sudden, unexpected death that might affect more than one person. When an infectious agent or toxin is implicated in a death, the MEO notifies the family and contacts of the deceased so they may receive any needed medical treatment. Trends in injury and violence are monitored.

388. Ultimately, the King County MEO provides expert medical evaluation and extensive services related to the investigation of deaths that are of concern to the health, safety, and welfare of the community.

389. The opioid epidemic caused by Defendants have obviously caused a substantial burden on the MEO, as deaths related to opioid and heroin overdose have risen dramatically in recent years.

390. In fact, there are substantially more fatal overdoses related to opioids than any other categories of drugs in King County over the last 10 years:



F Data source: King County Medical Examiner's Office (2007 – 2016)

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391. Each one of these deaths is investigated by the County, and the number of deaths due to drugs is a substantial percentage of all deaths in the County. For instance, in 2015, 345 of the 2,103 deaths that were investigated were due to drugs and poisons, or approximately 16% of all deaths in the County.[212] Of the 345 total deaths due to drugs and poisons, 151 were related to opioids. Thus, 151 of the 2,103 deaths in the County were related to opioids, or approximately 9% of all deaths.

392. The financial burden of investigating each of these deaths is obviously substantial. In the last five years, expenses related to opioid deaths have totaled well over $2 million, including nearly $510,000 in 2015 alone.

393. In addition, the Prevention Division has operated the County's Needle Exchange Program since 1989, and currently runs programs in downtown Seattle, Capitol Hill, and South Seattle/South King County. The Needle Exchange Program provides new, sterile syringes and clean injection equipment for people who use drugs by injection. While the Needle Exchange Program serves individuals who use a variety of drugs, a substantial percentage of participants use opioids. In fact, based on 2017 survey data, 82% of participants reported using heroin in the last three months from the date of the survey.

394. The program spends considerable resources each year in staffing, rent, and supplies. For example, from 2012 to present, the Needle Exchange Program has spent nearly $9 million in expenditures in maintaining this program, including nearly $2.5 million in supplies alone. A significant percentage of these costs are directly attributable to the injection of heroin.

[212] 2015 Annual Report, King County Medical Examiner's Office, http://www.kingcounty.gov/depts/health/examiner/~/media/depts/health/medical-examiner/documents/King-County-Medical-Examiner-2015-Annual-Report.ashx (last visited Jan. 5, 2018).

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395. The Prevention Division has also conducted surveys of individuals in its Needle Exchange Program regarding the number of people who began using prescription opioids before turning to heroin. For the 350 individuals surveyed in 2017, nearly 60% reported they started with prescription opioids before becoming addicted to heroin, underscoring the direct link between Defendants' promotion of prescription opioids and the rampant use of heroin throughout the County.

396. As a result, the Prevention Division has spent and will continue to spend substantial sums in responding to the crisis created by Defendants.

c. Community Health Services Division

397. The Community Health Services Division (CHSD) provides public health services at various centers located in King County. CHSD has also felt the economic and financial costs as a direct result of Defendants' conduct.

398. For instance, CHSD runs the Buprenorphine Pathways Program at the Downton Seattle Public Health Center—a program created in direct response to the crisis created by Defendants. The "Bupe Pathway" program uses a harm reduction approach to help address the opioid epidemic and provides low barrier access for individuals into Medical Assisted Treatment (MAT); specifically buprenorphine, an opioid used to treat opioid addiction. From 2016 to 2017, the County has spent approximately $335,000 to initiate this program. Expansion is planned for 2018 and ongoing costs to run and maintain the program will increase in the future.

399. CHSD also manages fourteen different Public Health Centers in the County. CHSD incurs substantial costs in dealing with any primary care visits associated with Opiate Use Disorders (OUDs) as well as indirectly related to OUDs such as chronic pain management,

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wound care, and behavioral health. In addition, CHSD incurs costs in filling prescriptions for drugs directly and indirectly related to opioid abuse treatment, overdose prevention, and chronic pain management, including buprenorphine, naloxone, and other drugs for pain management.

400. In addition, CHSD operates the Healthcare for Homeless Network (HCHN). Across all HCHN program areas—including Mobile Medical Van, Public Health Clinics, and through contractors—CHSD incurs program costs in paying for medications related to OUDs, utilizing data related to OUDs, and maintaining patient health information. For instance, in a ten-month period from January 1, 2017 to September 30, 2017 alone, CHSD was able to diagnose 992 patients with an OUD.

d. Jail Health Services

401. Jail Health Services (JHS) is another division of DPH that feels the economic burdens of the crises created by Defendants. Like EMS, JHS provides naloxone kits through the King County jail system. From 2014 to September 2017, JHS spent approximately $24,000 on these naloxone kits.

402. One of the ways JHS distributes these kits is through its naloxone training program at the Maleng Regional Justice Center (MRJC) in Kent. Through the distribution of these kits, JHS is able to show the crucial role that the criminal justice system can play in preventing overdose deaths. In fact, JHS has documented (based on verbal reports from people who have come back through the jail) thirteen saved lives as a direct result of its kits being distributed.

403. In addition to the hard costs associated with these kits, JHS incurs substantial costs and expends resources on withdrawal management, including nurse triage and provider visits, as well as prescribed medications to manage withdrawal symptoms.

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404. Further, JHS also expends resources and significant staff time in planning for the release of its inmates, including triage/screening, intake assessments, American Society of Addiction Medicine (ASAM) assessments for inpatient treatment placement, coordination of inpatient treatment, coordination of outpatient treatment and/or methadone, and educating soon-to-be released inmates on risk reduction.

e. Environmental Health Services

405. Environmental Health Services (EHS) is generally responsible for promoting safe and healthy environmental conditions through King County. In particular, EHS focuses on disease prevention through sanitation, safe food and water, and proper disposal of wastes and toxics.

406. There are several areas within EHS that have been impacted as a direct result of the epidemic created by Defendants. For instance, EHS is responsible for the safe disposal of solid waste in the County through their Community Environmental Health section—a responsibility that is particularly burdensome when disposing of waste at the various homeless encampments throughout the County. As set forth above, King County has the third highest population of homeless in the country, resulting in a significant burden to EHS in cleaning these encampments.

407. The tens of thousands of needles and syringes that need to be safely disposed of at these encampments—which are prevalent throughout the County—comes at a cost to EHS, which partners with contractors to conduct these cleanings. The proper disposal of used needles and syringes is particularly important because in the absence of proper disposal, the potential theft and re-use of needles is high, as well as the potential for disease transmission from puncture wounds or re-use of the needles.

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408. In addition, EHS is responsible for limiting the exposure of blood-borne pathogens that pose health and environmental risks at these homeless encampments. If these issues go unaddressed and the homeless population at these encampments are not educated about the potential danger associated with this exposure, the individuals at these homeless encampments are at severe risks of contracting diseases.

409. As set forth above, the epidemic caused by Defendants has contributed significantly to the homeless population in King County. With the substantial number of encampments present in King County, EHS must address these clean-up issues at several different large homeless encampment sites throughout the County. In 2017 alone, EHS spent more than $55,000 for these services, and has spent significantly more over at least the past six years in dealing with these issues.

410. Furthermore, as a direct result of the epidemic caused by Defendants, there has been an increased need for homeless encampment assessments focused on disease prevention, including access to sanitation, proper waste disposal, rodent prevention, appropriate food safety/storage, and restroom access. These services have also come at a cost to EHS, which must pay for the staff in their Food Program to address these issues. These encampments, as discussed in further detail below, also place substantial burdens on the County's Department of Natural Resources and Parks.

411. Because EHS must ensure that homeless encampments must also be safe, they must also provide both first-aid kits and naloxone kits to address any overdoses in their camps. Providing these kits and educating the individuals at these encampments also come at a cost to EHS.

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412. As a result, EHS has faced and will continue to face significant costs at its homeless encampments throughout the County due to the opioid epidemic caused by Defendants.

2. The Department of Community and Human Services has expended extraordinary resources attacking the opioid epidemic in King County.

413. The Department of Community and Human Services (DCHS) and the people and communities it serves, are also at the center of the opioid crisis. DCHS provides the County some of the most critical services to address, mitigate, and potentially reverse the opioid epidemic.

414. DCHS manages a wide range of programs and services to assist the County's most vulnerable residents and strengthen its communities. These include services for older adults, developmental disabilities, housing and community development, homeless shelter and services, behavioral health (mental health and substance use disorder) prevention and treatment, veterans' services, women's program services (survivors of domestic violence and sexual assault), education and employment programs, and youth and family services.

415. DCHS is also responsible for providing leadership and coordination to the regional efforts to address homelessness through All Home, as well as oversight and management of the revenues from the Veterans and Human Services Levy, the Best Starts for Kids Levy and the Mental Illness and Drug Dependency sales tax.

416. While there are many ways to articulate the costs the opioid crisis has imposed on DCHS, the Mental Illness and Drug Dependency (MIDD) tax illustrates one portion of the impact the epidemic has on the County.

417. In 2005, the Washington State Legislature granted authority to counties to impose a new 0.1% sales tax to fund new and augmented mental health and substance use

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disorder services. In 2007, recognizing the need for new resources to address the burgeoning population of people exercising homelessness and rising rates of substance use disorder in the County, the King County Executive and Council authorized the levy to begin in 2008. In 2016, the Executive and Council reauthorized the levy. Through the MIDD levy, King County raises approximately $134 million every two years.

418. DCHS manages the funds generated from MIDD, using them to address the intertwined issues of homelessness, substance use disorder, addiction, mental health disorders, and related service needs.

419. Addressing issues of opioid use disorder is at the center of DCHS's MIDD implementation plan. For example, the 2017 MIDD Implementation Plan includes "MIDD 2 Initiative CD-07: Multipronged Opioid Strategies."[213]

420. The goal of this Initiative is to support and implement the recommendations of the Heroin and Prescription Opiate Addiction Task Force, described more fully above. In line with the Task Force's recommendations, this Initiative targets resources in the following areas: Primary Prevention, Treatment and Service Expansion and Enhancement, and User Health and Overdose Prevention. This effort includes, among many others, programs to leverage and augment existing screening practices in schools and health care settings to prevent and identify opioid use disorder. It also aims at reducing barriers placed upon opioid treatment programs, including the number of clients served and siting of clinics.

421. This Initiative will promote equity in access to limited treatment resources, while also ensuring that residents whose heroin use is chaotically and expensively impacting other

[213] *Mental Illness and Drug Dependency 2 Implementation Plan*, King County 94 (June 2017), http://kingcounty.gov/~/media/depts/community-human-services/MIDD/documents/170804_MIDD_Implementation_Plan.ashx?la=en.

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publicly-funded resources (such as emergency medical care, psychiatric hospitalizations, criminal courts and incarceration facilities) have access to less expensive and responsive treatment services. The biennial cost for this Initiative alone is $2,289,000.

422. DCHS is using MIDD funds not just to target the direct impacts of opioid abuse, but also some of the secondary impacts of the opioid epidemic, including homelessness. "MIDD 2 Initiative RR-01: Housing Supportive Services" is an example of this kind of work DCHS is undertaking with MIDD funds.

423. The goal of this Initiative is to increase the number of housed individuals with mental illness and chemical dependency who are receiving supportive housing services, leading to increased housing tenure and housing stability. Housing stability is a key determinant in increasing treatment participation and in reducing use of criminal justice and emergency medical systems. This vital program has a budgeted biennial expenditure of $4,146,712.

424. These Initiatives are just some examples of the $134 million/biennium MIDD money that DCHS is spending to address the impacts of the opioid epidemic in King County. Indeed, King County will have spent at least $625 million of MIDD funds from its inception in 2008 through its 2018 budget. While not every MIDD dollar goes to addressing the opioid epidemic and its many impacts, the vast bulk of MIDD expenditures are aimed at dealing with the consequences of the opioid crisis.

425. DCHS's role in responding to the opioid epidemic is also not limited to its management of MIDD funds.

426. For example, DCHS runs the Homeless Housing Program (HHP), which facilitates human services to support housing stability and individual safety. HHP administers and oversees funding for housing stability and services programs in four broad categories:

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emergency and short-term housing, homeless prevention, permanent housing, and special projects.

427. As part of this work, DCHS operates Coordinated Entry for All (CEA). CEA ensures that people experiencing homelessness in King County can get help finding stable housing by quickly identifying, evaluating, and connecting them to housing support services and housing resources. CEA uses a standardized Housing Triage Tool that matches the right level of services and housing resources to the persons facing a housing crisis.

428. These housing efforts are directly tied to the opioid epidemic, as a significant percentage of King County's homeless population suffers from opioid use disorder. Helping households experiencing homelessness off the streets is not only important for the people without housing, it is important for public health and the health of people in states of homelessness. Once in stable housing, it is often easier to deliver critical human services to this population.

429. Special housing projects, too, allow DCHS to provide critical health care options to King County residents. For example, DCHS is working with its partners to prevent injury and death from opioid overdose by making naloxone kits available to homeless housing and service providers to promote better health and safety in our community.

430. These are just some examples of the broad work that DCHS does to identify, address, and combat the opioid crisis in King County. While this work is critical to treating those affected by this epidemic and bringing it under control, it comes at the cost of hundreds of millions of dollars of County money.

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3. The King County Sherriff's Office has incurred substantial costs in responding to the epidemic caused by Defendants.

431. The King County Sherriff's Office (KCSO) ensures the safety of the entire County through its approximately 1,000 employees. KCSO is the primary law enforcement agency for all unincorporated areas of King County, as well as twelve cities and several additional entities in the County that contract their police services to KCSO, including Sound Transit and King County Metro Transit.[214]

432. KCSO provides a variety of services to the County's residents through its primary divisions, including the Office of the Sherriff, the Field Operations Division, the Special Operations Division, the Criminal Investigation Division, and the Technical Services Division. KCSO has a massive annual budget in providing these services. For instance, KCSO's budget in 2011 was approximately $138.5 million.

433. A significant portion of these amounts are devoted to addressing and responding to the crisis caused by Defendants. The astounding and devastating rise of opioids—both "legal" and illegal—has profoundly affected public safety issues in the County, and the KCSO's work and resources.

434. For example, the opioid epidemic has forced KSCO to expend significant resources fighting drug trafficking in the County. Of course, before Defendants created the opioid epidemic, illegal drugs were bought and sold in the County. But as prescription opioids and heroin have become more prevalent in the drug trade, illegal drug trafficking in the County has risen significantly.

[214] Approximately 500,000 residents of King County live in either the unincorporated areas or twelve cities that KCSO provides primary law enforcement services to.

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435. Not only has drug use increased in the County, drug trafficking is now more complex. Pills and heroin arrive in the County through large, difficult-to-untangle networks that stretch across state lines. Combatting this rise in drug trafficking has forced the County to put more officers on the street and assign more detectives to investigate these drug cases.

436. The percent of King County drug seizures testing positive for heroin has risen dramatically over a recent eight-year period. In 2008, just 7% of all drug seizures in the County tested positive for heroin. By 2015, that percentage increased nearly six-fold to 40%, placing a significant strain on the approximately 700 deputies working for the KSCO. This increase has forced KCSO deputies to spend time policing opioid-related crimes and offenses and preparing for prosecutions.

437. In addition, because many of the sources of illegal opioids in King County come from large criminal networks, KCSO has spent considerable time and effort coordinating law enforcement efforts with other jurisdictions, including with the City of Seattle.

438. KSCO deputies also are equipped with naloxone—which as described herein is a costly device utilized to reverse an opioid overdoes—and the County has incurred significant costs to ensure this life-saving drug is available to its deputies. KCSO began issuing naloxone to certain deputies in May 2016.

4. The King County Prosecuting Attorney's Office has incurred substantial costs in responding to the epidemic caused by Defendants.

439. The King County Prosecuting Attorney's Office (PAO) represents the County in both criminal and civil matters. It employs over 400 hundred people, more than 200 of whom are attorneys.

440. The Criminal Division represents the state and the county in criminal matters in the King County District and Superior Courts, the state and federal courts of appeal, and the

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Washington and U.S. Supreme Courts. The Criminal Division, the largest division at the PAO, is responsible for prosecuting all felonies in King County and all misdemeanors in unincorporated areas of King County, including crimes related to opioids.

441. The Civil Division of the PAO serves as legal counsel to the Metropolitan King County Council, the County Executive and all Executive agencies, the Superior and District Courts, the County Assessor, independent boards and commissions, and some school districts.

442. Finally, the Family Support Division is an integral part of the federal and state child support system. The deputies establish paternity for children born out of wedlock, ensure support obligations are enforced, and modify support amounts when necessary.

443. The opioid epidemic has had deep impacts on all three divisions of the PAO. In particular, the Criminal Division has seen a dramatic rise in criminal cases related to opioids over the past decade. In some of these cases, opioids are directly involved in the illegal activity; for example, the PAO routinely prosecutes people who sell heroin or prescription opioids on the illegal market. Opioids play a role in other cases, too, even when the charges are not related to controlled substances violations. Many of these cases are time intensive and cost the PAO significant resources to prosecute.

444. The Civil and Family Support Divisions, too, have not been immune to the impacts of the opioid epidemic. The Civil Division may be involved in employment disputes when an employee tests positive for opioid abuse. And the Family Support Division's work becomes more complex when parents are addicted to opioids.

5. The opioid epidemic has had deep impacts on King County's court system.

445. The opioid epidemic has also put significant demands on King County Superior Court resources, and the staff and judges who work there.

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446. With fifty-five judges on the bench, King County Superior Court is the largest trial court in Washington State. It handles both civil and criminal matters.

447. The unfolding tragedy of the opioid crisis is chronicled on the Superior Court's docket. There, one can find defendants charged with selling heroin, forging prescriptions for OxyContin, or stealing power tools to fund an opioid addiction. In Family Court, the toll of the crisis is catalogued in divorces, dependency cases, and other matters that arise when a parent or child becomes addicted to opioids.

448. The cases that come before the Court not only demonstrate some of the effects of the crisis on King County residents, but have direct and significant costs to the County. It takes significant resources to try criminal cases. And, although critical to the efforts to produce favorable outcomes for opioid users and their families, the many programs the Superior Court has developed and run are not cheap. Family Court Operations cost the County over $11 million in 2016.[215] And while all of these costs, of course, are not related to opioids, significant Court resources are used to address the increasing impacts of the epidemic.

449. The increase in both criminal and civil cases related to opioid use and abuse has put a substantial strain on the Court's resources. It has had to shift resources away from some areas in order to meet the challenges of opioid-related litigation.

6. King County Adult Drug Diversion Court has keenly felt the impacts of the opioid epidemic.

450. The impact of Defendants' opioid crisis to the County's court system is nowhere more apparent than in King County Drug Diversion Court (KCDDC).

[215] 2016 King County Superior Court Annual Report 17, http://www.kingcounty.gov/~/media/courts/superior-court/docs/get-help/general-information/annual-report-2016.ashx?la=en (last visited Jan. 5, 2018).

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451. KCDDC, a division of the King County Department of Judicial Administration, is an innovative and vital program designed to address the unique demands and challenges of drug-related crimes. Created in August 1994, KCDDC, also known as "Drug Court," provides eligible defendants charged with felony drug and property crimes, the opportunity for substance use disorder and mental health treatment and access to other ancillary services such as housing, transportation and job skills training. Eligible defendants can elect to participate in the program or proceed with traditional court processing. After choosing to participate in the program, defendants come under the court's supervision and are required to attend treatment sessions, undergo random urinalysis, and appear before the Drug Court judge on a regular basis. If defendants meet the requirements of each of the four phases of Drug Court, they graduate from the program and their charges are dismissed. If defendants fail to make progress they are terminated from the program and sentenced on their original charge. Successful participants take an average of twenty months to complete the program. KCDDC provides treatment to an estimated 320 individuals at any one time.

452. The King County Prosecuting Attorney's Office screens police referrals for Drug Court eligibility. When the Prosecutor determines a defendant to be KCDDC eligible, the case is filed directly into KCDDC for arraignment. Defendants, whose cases have been filed mainstream, may ask to have the case reviewed again by the Prosecutor. If found to be eligible the case is transferred into KCDDC.

453. From KCDDC's inception in 1994 through December 2017, 2,402 people have successfully completed the requirements and graduated from the program.

454. The Drug Court has been a success by all measures. For example, jail bookings have been reduced by as much as 61% for KCDDC participants and the average number of jail

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days used decreased by 45%.[216] And approximately 68% of cases that opt in to KCDDC have a result of successful graduation and dismissal of the felony charge(s).

455. KCDDC has been on the front lines of the opioid epidemic. The number of defendants in Drug Court because of their addiction to opioids has been on the rise. Not only has this increase strained the Drug Court's resources, many of these defendants are the most difficult to treat because of the scope of their addiction. In fact, between 2007 and 2017, 61% of the people entering Drug Court because of opioid abuse had already overdosed on opioids at least once prior to starting the program.

456. Since 2011, when KCDDC began specifically tracking this data, defendants whose criminal charges involved prescription opioids and heroin have made up a significant portion of the participants in the KCDDC program. In 2011, there were seventy-five defendants who entered into KCDDC for charges related to prescription opioids or heroin. And between January and November 2017, already seventy-nine defendants charged with opioid-related crimes have entered into the KCDDC program.

457. As illustrated in the chart below, the number of KCDDC participants whose criminal charges involved opioids has grown since 2011, reaching 43% of the cases in KCDDC, in 2015.

[216] King County Mental Illness Drug Dependency Advisory Committee, *Mental Illness and Drug Dependency Ninth Annual Report* 42 (Feb. 2017), http://www.kingcounty.gov/~/media/depts/community-human-services/MIDD/Reports/170814_MIDD_Ninth_Annual_Report.ashx?la=en.

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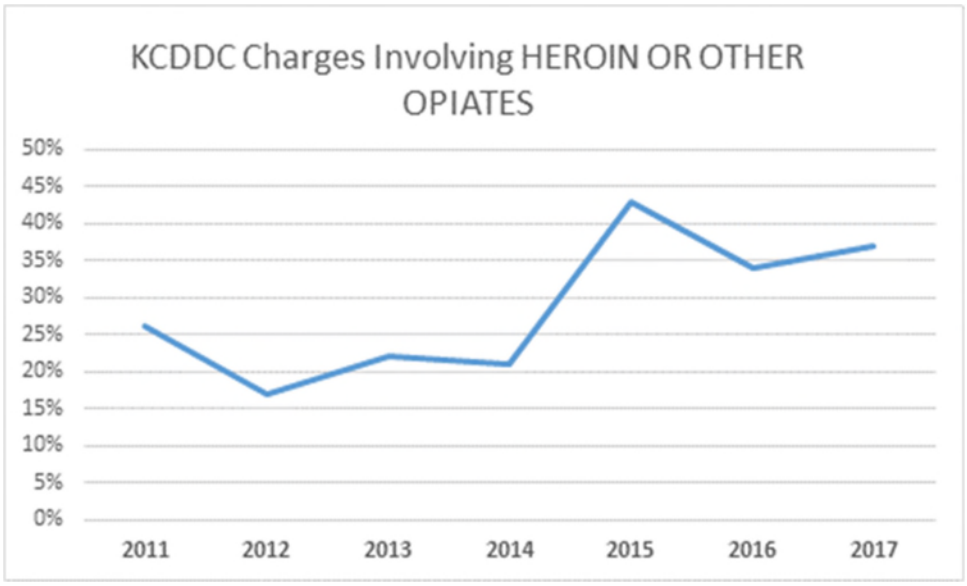
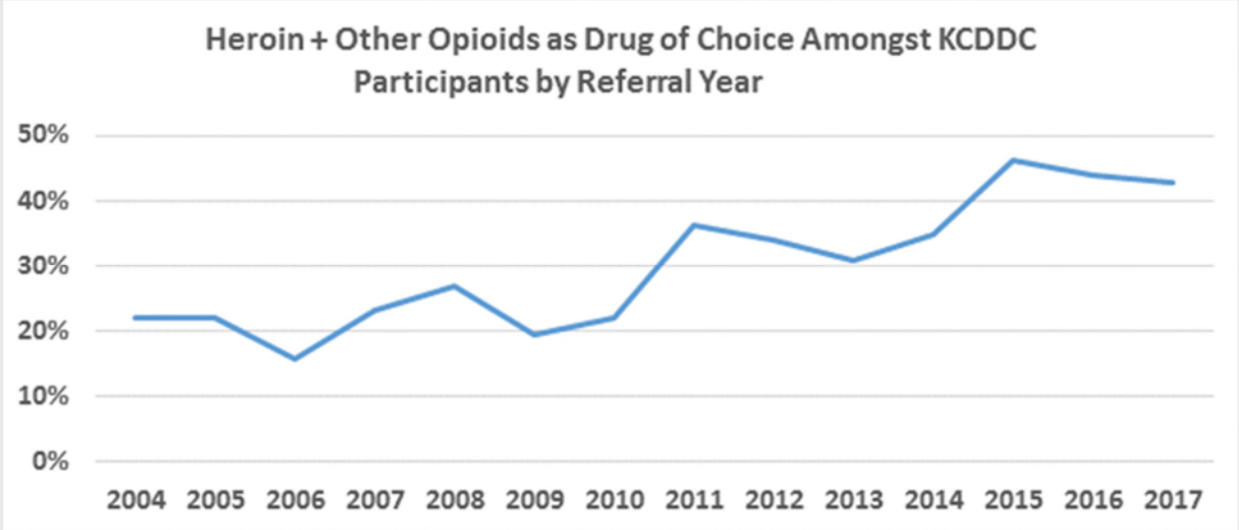


458. The increasing prevalence of defendants who are in the KCDDC program because of opioids continues a trend that began in the early 2000s. When defendants enter KCDDC, they are asked to identify their primary "drug of choice." Over the past 13 years, the prevalence of heroin and other opioids as the primary drug of choice of defendants has more than doubled. The graph below shows that since 2004, rates of opioid users in KCDDC have gone from around 20% to well over 40% by 2015.



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459. Of note, the prevalence of defendants using prescription opioids was relatively low in 2004 through 2007, making up between one and four percent of the program's enrollees each year. But, by 2008, those numbers began to rise until 2011, where they peaked at twelve percent of the program's enrollees that year. Since then, prescription opioid users enrolling in Drug Court have declined to between 2% and 4% in the last two years. By contrast, however, heroin users have continued to increase with no decline. Between 2004 and 2010, between 14% and 20% of defendants enrolled in KCDDC were heroin users. By 2014, that number had risen to 32%, and in 2017 already 41% of defendants entering KCDDC are heroin users.

460. The Drug Court provides vital services to King County. KCDDC diverts defendants from Superior Court mainstream case processing and the full criminal trial proceedings. KCDDC's program is informed by decades of research about best practices and key components of an effective drug court. KCDDC interrupts the cycle of addiction and incarceration, leading to significant avoided costs in terms of jail and prison days as well as future criminal case processing. And, by focusing on rehabilitation, and providing drug addiction treatment, mental health counselling, and other services, Drug Court is more effective than the traditional criminal justice routes at producing successful outcomes for defendants. A July 2013 analysis of Drug Court participation in Washington State found crime reductions translated into a net benefit to taxpayers of $22,000 per participant or a $4 return for every $1 invested.[217]

[217] Jim Mayfield, MA, Sharon Estee, Ph.D., Callie Black, MPH, Barbara E.M. Felver, MES, MPA, *Drug Court Outcomes: Outcomes of Adult Defendants Admitted to Drug Courts Funded by the Washington State Criminal Justice Treatment Account*, Washington State Department of Social and Health Services: Research and Data Analysis Division (July 2013), https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-89.pdf.

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461. Although it provides key services to King County and its residents, KCDDC is expensive to operate. Each defendant who is referred to KCDDC spends an average of eleven months in the program. Those who choose to formally opt in take longer, spending an average of twenty months in the program. While there, many defendants will spend sixty days in the in-custody treatment program at the Maleng Regional Justice Center. Drug Court also provides outpatient treatment and, as appropriate, residential treatment, for the duration of the defendant's participation in the program. For KCDDC, opioid-using defendants can be particularly costly, as defendants will receive opioid maintenance therapy, including methadone and buprenorphine, to help address withdrawal symptoms and help to address problems of relapsing. And KCDDC provides short-term and long-term housing, job training, and other critical services.

462. Heroin and prescription opioid users have put particular strains on KCDDC's resources. Not including staff salaries, other program costs, the cost of defendant transportation to treatment or transitional recovery-oriented housing provided to some participants, the cost of treating defendants whose drug of choice is heroin or other opioid in 2016 was at least $765,000. This includes costs for methadone, the transitional recovery program, outpatient treatment, inpatient treatment,[218] and urinalysis drug tests. Over the last decade, to treat heroin and opioid users, this program has spent well over $7 million, and that does not include staff time or salaries.

463. While it is imperative to provide defendants in Drug Court the resources and care they need to address their addiction, providing appropriate care to participants with opioid

[218] This estimate assumes all defendants are able to use the least expensive in-patient treatment option—which costs approximately $4,300 per patient. By contrast, the most expensive impatient treatment option costs as much as $27,198 per patient.

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addictions is often more costly and time intensive than providing services to participants who are addicted to other substances. In short, the opioid epidemic has had profound impacts on the Drug Court and its mission.

7. Defendants' conduct has significantly increased costs to the Department of Adult and Juvenile Detention

464. The Department of Adult and Juvenile Detention (DAJD) operates two adult detention facilities in the County, and a Juvenile Detention Center in Seattle. DAJD provides jail services for all felons in King County and contracts with twenty-seven of the thirty-nine cities in King County to provide misdemeanor jail service.

465. In an effort to reduce criminal justice costs and provide for alternatives to detention, DAJD also operates a Community Correction Division, which was created in 2002. This program provides the court system with pre-trial and sentence alternatives to detention.

466. DAJD is clearly impacted by the crises created by Defendants' conduct, as it receives individuals and inmates who are or who have been opioid and heroin users. Partnering with JHS, DAJD manages this population's medical and behavioral issues related to their use.

467. DAJD also receives individuals and inmates for Felony Drug charges and Felony Property Crime charges. With respect to the latter, DAJD houses inmates charged with or convicted of crimes directly related to the illegal manufacturing, distribution, or possession of opioids or heroin. With respect to the latter, because the price of prescription opioids on the black market is significant, many opioid and heroin abuses have been forced to turn to burglary or other property crimes in order to pay for their addiction. DAJD must obviously detain these individuals pre-trial or after being convicted of burglary or property crimes as well.

468. In 2017, the average daily population (ADP) for all custodial facilities operated by DAJD is about 2,200. For individuals charged or convicted of a Felony Drug charge, the

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ADP is 209, and for individuals charged or convicted of a Felony Property Crime charge, the ADP is 293. Together, these portions of the jail population in the County represent 22.8% of the total jail population.

469. Between 1998 to present, this percentage has ranged between 20.3% on the low end in 2011 to 31.3% on the high end in 2007. During that same time period, the ADP for individuals charged or convicted of a Felony Drug charge has ranged from between 208 on the low end in 2011 to 521 on the high end in 2007, while the ADP for individuals convicted of a Felony Property Crime charge has ranged from between 241 on the low end in 2011 to 337 on the high end in 2007.

470. Furthermore, DAJD provides several different programs and treatments related to the opioid and heroin crises, including Narcotic Anonymous programs in its work release facilities and its adult facilities, and a Substance Use Disorder treatment housing unit at the Maleng Regional Justice Center. Through its Community Center for Alternative Program (CCAP), DAJD also provides treatment services to participants court ordered to CCAP who are assessed with an addiction to opioid and heroin abuse, and prevent further addiction.

471. Taken together, these numbers show the significant costs DAJD has incurred as a result of the crisis caused by Defendants.

8. Defendants' conduct has increased the County's health care costs.

472. Defendants' misrepresentations regarding the purported safety and efficacy of opioids have also substantially increased the County's health care costs. King County provides health insurance to its employees and their dependents. The County is self-insured, which means that when anyone covered by the County's health insurance program visits a doctor or fills a prescription or otherwise incurs covered health-related costs—including, for example, opioid-

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related medical claims—the County pays for those costs directly. In fact, King County employees do not pay a premium, so the County pays the full cost of care.

473. King County provides health insurance to over 14,000 employees, as well as insurance to these employees' dependents. In connection with this coverage, the County has spent significant amounts of money on prescription opioids. For example, between 2012 to 2017 alone, the County spent more than $5.6 million on prescription opioids alone, including those manufactured by Defendants. In fact, from 2014-2016, the County has spent over a million dollars each year on these drugs.

474. In addition, the County also pays for medical claims related to opioids. In other words, any time an individual covered by the County's health insurance program submits a claim for treatment and the primary diagnosis is opioid-related—including for instance, treatment for opioid addiction—the County incurs costs in providing coverage. Between 2012 to 2017, the County spent more than $3.5 million in opioid-related medical claims. On a per individual basis, these costs can be substantial. For example, the County spent more than $600,000 on one insured alone for opioid dependence issues in 2014, and it was not uncommon for the County to spend over $100,000 on a single insured who submits a medical claim related to opioids. Had Defendants told the truth about the risks and benefits of opioids, King County would not have had to pay for these drugs or the costs related to these prescriptions.

475. Even for those people covered by the County who do not get addicted, improperly prescribed opioids carry other costs for the County. For example, when patients receive opioid prescriptions, they often fail to take other steps to address the root causes of their chronic pain. Thus, even if patients are able to wean themselves off of opioids, the underlying conditions often remain, and may have become worse or more difficult and expensive to treat.

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476. Across the United States, people who are prescribed opioid painkillers cost health insurers approximately $16,000 more than those who do not have such prescriptions.[219] Those costs, including those borne by the County, clearly would have been avoided had Defendants not hidden the truth about the risks and benefits of opioids.

477. The County has also shouldered significant health-related costs outside of its health insurance program as a result of Defendants' actions. For instance, when County employees are prescribed opioid painkillers for chronic pain they often are forced to miss work, because the drugs' effects interfere with the ability to work. Since opioid prescriptions fail to treat the cause of the pain, the employees often continue to miss work due to the ongoing problems.

478. In fact, recent studies suggest that opioids actually slow recovery times, keeping employees out of work longer than they would have been had they not taken these unnecessary pharmaceuticals. If those employees become addicted to the opioids, they are likely to miss even more work. Because of Defendants' misstatements, the County's employees have had losses in work time, which result in substantial losses to King County.

479. The County also administers its own workers' compensation program. When someone working for the County is injured on the job, the County pays, among other things, that person's health care costs.

480. The vast majority of these prescriptions related to these workers' compensation claims were unnecessary, as the injuries are typically back strains, joint pain, and other injuries that should be treated with physical therapy, lidocaine patches, and other non-opioid therapies.

[219] *The Impact of the Opioid Crisis on the Healthcare System: A Study of Privately Billed Services*, FAIR Health (2016), http://www.khi.org/assets/uploads/news/14560/the_impact_of_the_opioid_crisis.pdf.

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Yet because of Defendants' marketing efforts, the County purchased prescription opioids in connection with its workers' compensation programs it should have never paid for.

481. And as set forth above, the direct costs of filling the opioid prescriptions is just a small part of the total cost to the County for prescriptions of opioids. Under its workers' compensation plan, the County pays for doctors' visits, lab work, and other costs related to the prescription of opioid painkillers. Had Defendants told the truth about the risks and benefits of opioids, King County would not have had to pay for these drugs or the costs related to their prescription.

482. Not only are opioids inappropriate for treating the vast bulk of the people making workers' compensation claims, the use of opioids often actually slows the recovery process. This means that the injured worker is off the job longer, and the County shoulders larger workers' compensation costs.

483. Under the County's workers' compensation program, it has spent enormous sums filling opioid prescriptions and paying for claims filed by its employees. For example, from 2009 to 2017, the County has paid nearly $160 million to pay for direct claims filed by its workers. While many of these costs were for legitimate causes, a significant percentage of these costs were for prescription opioids and opioid-related treatment that the County should not have paid for but for Defendants' systematic misrepresentations of the benefits and risks of opioids.

9. King County Department of Natural Resources and Parks has also been significantly impacted by the opioid crisis.

484. King County Department of Natural Resources and Parks (DNRP) is organized in four divisions: Parks and Recreation, Water and Land Resources, Wastewater Treatment, and Solid Waste.

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485. DNRP manages a significant amount of land in urban, rural, and wild areas. For example, DNRP manages 200 parks, 175 miles of trails, 28,000 acres of open space throughout the County. And Water and Land Resources Division is tasked with protecting the health of the County's water and land.

486. DNRP is also a capital-intensive department. For example, the Wastewater Treatment Division manages and operates the infrastructure for transporting and treating wastewater for over 1.4 million people in the County, including three wastewater treatment facilities.

487. As the manager of large facilities and significant areas of land, DNRP has been on the front line of the opioid epidemic and the homeless crisis it has driven and shaped. The Department, its employees, and the people who use the DNRP lands, are all affected by the opioid crisis in a variety of ways.

488. First, King County parks and other DNRP land have seen a dramatic and stark increase in heroin and other opioid use. Today, throughout King County's parks, used syringes are found in abundance, people are routinely found shooting up, and others have overdosed.

489. Criminal activity related to heroin and other opioids has increased, too. Today, King County Sheriff deputies are frequently called to address drug deals, prostitution, and violence in King County parks.

490. Criminal activities related to opioids are not limited to parks. DNRP oversees the Wastewater Division, one of the largest capital programs in the County, undertaking a variety of large building projects. This Division has seen significant theft occur, and for one project, the Division estimated that theft, vandalism, and related crimes added $20,000 to $50,000 to the project.

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491. Of more concern is the significant threat these criminal activities present to the safety of DNRP employees and the people who use these parks. For example, several park employees have been assaulted by people who appeared to have been engaged in illegal activities in the park. In some parks, employees are not allowed to work alone or are asked to confine their work to certain times of day. Park employees use particular caution in and around bathrooms, where illegal activities frequently transpire.

492. Additionally, syringes can be found nearly anywhere in parks—in bathrooms, on trails, and even on playgrounds. For example, the stash of used syringes in the photograph below were found in White Center Natural Area, and the syringes filling the bucket were collected in a single day at the same park.

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493. In one particularly concerning event in March 2017, a DNRP employee found a needle buried in the dirt with the point facing up. In other cases, DNRP employees have found syringes affixed to bathroom doors. Used syringes present serious risks of blood-borne disease.

494. The opioid epidemic has also expanded the homeless population that uses parks and DNRP land for unauthorized encampments. That homeless people use King County parks is nothing new. But over the past decade, the number of people living in King County parks has exploded. DNRP employees have noted that ten or fifteen years ago, it was typical to find an encampment once a year. Now, encampments are found weekly in numerous parks and natural areas.

495. Not only are there more encampments, they have become much larger. As the photograph below illustrates, the homeless encampments in County parks can be enormous.

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496. The increased frequency and intensity of homelessness in County parks presents a myriad of issues. First, nearly every encampment in King County parks has used syringes, which present dangers to all who use the park.

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497. Often the encampments are also contaminated with human and other wastes. In fact, now when DNRP clears out an encampment, it often has to treat much of the waste it removes as a biohazard. Below is a picture of part just one tent that was part of a camp at Auburn Narrows Natural Area.

498. This new wave of encampments is not limited to urban parks. DNRP staff have noted that now, encampments are routinely found in natural areas adjacent to regional trails or in other open spaces or green belts. For example, the picture below depicts an encampment in 2011 located in Island Center Forest, a 363-acre forested park on Vashon Island.

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499. Removing and cleaning these encampments is labor and resource intensive. The typical removal takes one or two days, five people, and may require the use of a dump truck and a tractor. The picture below shows the clean-up of a camp at Auburn Narrows Natural Area.

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500. Cleaning encampments presents new risks to employees, because of their close contact with material left behind. This may include needles, and might also expose employees to fentanyl. Even if a minute amount of fentanyl gets on an employee's skin, she or he faces grave danger of an opioid overdose. As a result, DNRP employees are being trained on how to avoid fentanyl contact, and how to respond if they suspect they or their coworkers have been exposed.

501. Not only have the encampments forced DNRP to spend time and resources cleaning camps and ensuring park safety, many of the encampments have undone significant land restoration projects. In the winter of 2015, for example, DNRP cleaned an encampment at Auburn Narrows Park that was located in a large restoration area. Auburn Narrows Park is a 107-acre park located on the Green River, with open meadows, wetlands and side channels adjacent to the Green River, and stands of mature cottonwood floodplain forest. Auburn Narrows has had several large and small habitat restoration projects installed over the last decade, resulting in 65 acres of the site being replanted with native species. Significant portions of restoration projects were seriously damaged, as trees had been cut down, native planting ripped up, and wetland habitat was filled with trash. A small portion of the encampment is depicted in the photograph below.

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502. Unfortunately, as King County's data shows and the near ubiquitous presence of heroin syringes at homeless encampments illustrate, many of the homeless people in these encampments are using opioids.

503. Overdoses have become all too frequent in King County parks. It is not uncommon for park employees to find people who have shot up heroin and passed out in the park. In these situations, park employees call emergency services for help. As discussed above, each of these calls come at a substantial cost to EMS.

504. Many DNRP employees have noticed within the past few years a rise in the aggressive behavior towards parks staff and park users. The majority of such incidents involve people who are under the influence or appear to have lasting effects from substance abuse. In such situations, DNRP has often contacted King County Sheriffs' Department to have such people removed from park property.

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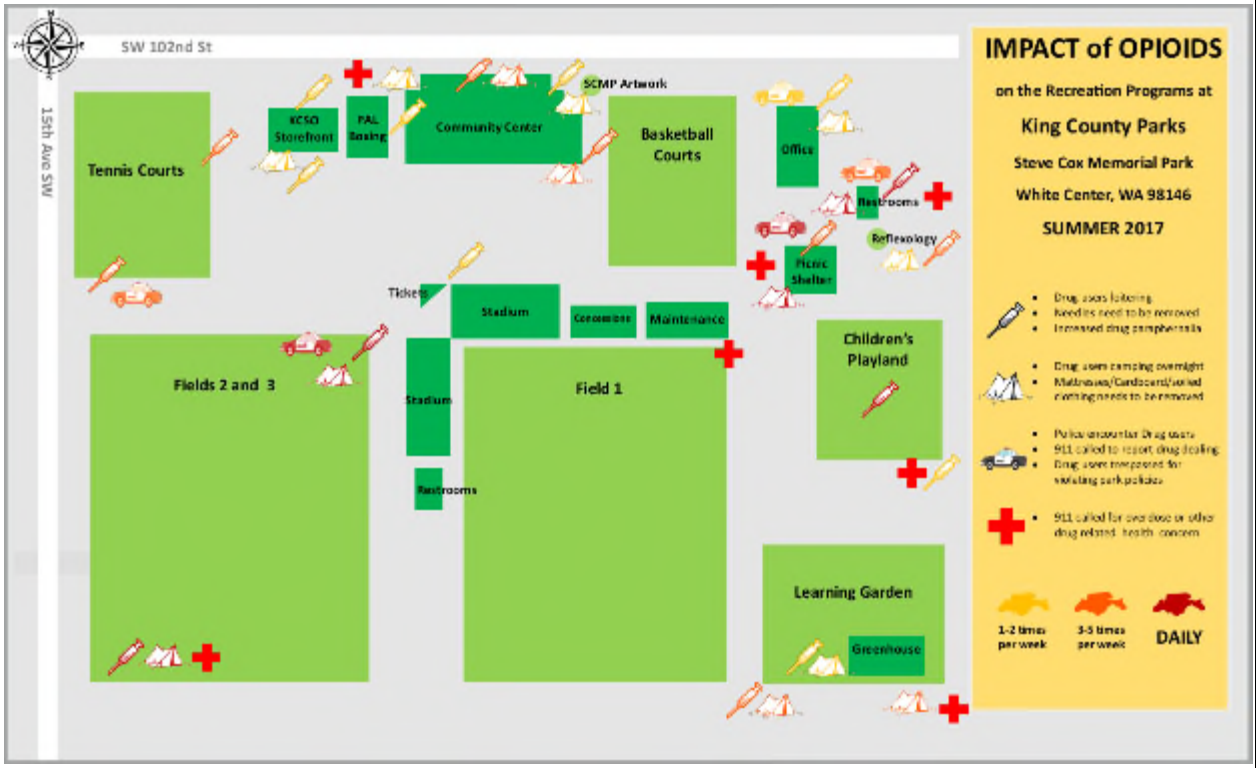
505. Finally, all of these opioid-related issues deter people from using the parks and natural areas.

506. The map of the Impacts of Opioids at Steve Cox Memorial Park, below, shows the extraordinary impact of the opioid epidemic on King County parks. The map shows that every day syringes were found in the Children's Playland area. Every day syringes were found at two locations on the ballfields. Daily the police encountered or were called to respond to drug-related activities at several sites across the park. More than a dozen homeless encampments existed throughout the summer. And 9-1-1 was called at least seven times to report an overdose or drug-related health emergency. All this occurred in the Summer of 2017 in an urban park that measures just 11.5 acres.



507. Parents are less likely to take their children to a park suffering from conditions like these. People are less likely to spend time at a community center or greenhouse when they

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know they will be confronted by used syringes, drug dealing, and other potentially dangerous activities. And, because too many people were using the facility to take drugs and engage in other illegal activity, the park now closes and locks the stadium at night, depriving access to those who would otherwise like to use it. Tragically, the opioid crisis is taking over the County's parks.

10. King County Department of Transportation has also felt significant impacts as a result of the opioid crisis.

A. King County Department of Transportation (DOT) operates 214 bus routes, 7,000 bus stops and 132 park-and-ride facilities as well as Sound Transit's Express bus service

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and the Link light rail. It is also responsible for approximately 1,500 miles of roads, 181 bridges, and the land supporting this infrastructure. DOT also operates the King County International Airport (KCIA) at Boeing Field.

508. As the manager of a significant amount of land, DOT has felt the opioids crisis in ways similar to DNRP. Syringes and homeless encampments can be found across DOT properties.

509. For example, Metro Transit maintains several operations bases around the region where it services buses and other vehicles, bus stops, and other properties. Over the past decade, the areas at and surrounding some of the operations bases have seen a proliferation of homeless encampments. Metro employees now routinely must monitor these homeless encampments to ensure they do not interfere with Metro operations, and to protect employees from potential hazards related to the encampments. In the servicing of bus stops and other Metro facilities, Metro routinely collects significant numbers of syringes, among other hazards.

510. Similarly, people often use bus stops as temporary shelters or places in which to inject heroin or other opioids. Metro routinely sweeps bus stops to ensure they are clean and safe.

511. In November 2013, Metro began tracking the syringes (categorized as "sharps") it collected from property it manages. Since it began tracking in November of 2013, Metro has disposed of *over 650 pounds* of syringes. Gathering and properly disposing of nearly a third of a ton of syringes in four years came at the expense of significant employee time, during which those employees were exposed to risks of needle sticks and related dangers.

512. The opioid epidemic has also interfered with DOT operations and services. It is not an uncommon occurrence for people who appear to be on opioids to create disturbances on

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buses or at transit centers. Metro bus drivers have had to stop their routes and call for Transit Security Officers to respond to these dangerous situations.

513. Even bus and vehicle maintenance has been made more complicated by the opioid epidemic. People who clean the buses at the end of the day are trained to address needles and other bio-hazards that might be left behind on vehicles through a comprehensive program teaching how to handle potential infection risks.

514. Metro is even exploring the possibility of placing blood-borne pathogens and sharps-handling and containment kits on each of the coaches, but it has not identified a possible funding source to do so.

515. And the opioid epidemic affects DOT's work force. Approximately 4400 King County employees have "safety-sensitive" positions, and many of those employees work for DOT. Safety-sensitive employees are those who are responsible for providing a safe work environment for their co-workers and the traveling public. Bus drivers, for example, have safety-sensitive positions.

516. Rules promulgated by the Federal Department of Transportation (49 CFR Part 40), Federal Transit Administration (49 CFR Part 655), Federal Motor Carrier Safety Administrations (49 CFR Part 382), and the US Coast Guard (46 CFR Part 4, 5 & 16) require that employees in safety-sensitive positions are tested for drug and alcohol use.

517. Currently King County is required to test employees in safety-sensitive positions for codeine, morphine, and heroin under these regulations. In an effort to keep the public safe, beginning January 1, 2018, the laws requiring this random testing have been revised to add semi-synthetic opioids, such as hydrocodone, hydromorphone, oxycodone, and oxymorphone to the drug test panel.

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518. When an employee tests positive for one of these drugs, Metro must remove that person from the safety-sensitive position. Then the employee must go through a specific set of steps before potentially returning to work.

519. When employees test positive for opioids it can seriously disrupt Metro's operations and transit service delivery to the region. If a bus driver tests positive for an opioid, they must be removed from their scheduled route and a new driver must be found. If a mechanic refuses to take a test for opioids, they must be removed from their position and a new mechanic has to take over repairing buses.

520. Not only do positive tests result in significant disruptions, they can be very costly to DOT. To fill in schedule gaps some workers may be asked to work overtime. Additional costs associated with King County employees testing positive for an opioid includes, time loss, increased benefit usage, Substance Abuse Professional (SAP) and Employee Assistance Program (EAP) referrals, additional testing for employees retaining their employment under employment agreements.

521. And, simply administering the tests comes with not-insignificant costs. Currently, King County conducts approximately 1,300 tests annually, and will be increasing to 2,600 next year. Each test costs $49, and is expected to increase as new drugs are added to the testing panel.

522. In sum, the opioid epidemic created by Defendants has unequivocally caused King County serious and ongoing harm. As set forth above, the County's costs for human and public services, health care, public health and safety, and law enforcement have all risen dramatically, and the County has suffered serious and tragic consequences as a result.

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523. As the sections above describe in detail, Defendants have caused King County profound injury by misrepresenting the efficacy and safety of their prescription opioids. Defendants must be held responsible for compensating the County for the resulting nuisance. But, the County will continue to suffer these same harms for the foreseeable future unless the opioid epidemic is ended. Defendants must bear the financial burden of stopping the damage they have caused, abating the nuisance, and bringing an end to this crisis.

524. It should be Defendants' responsibility to fund these programs until their opioid epidemic is a thing of the past.

K. No Federal Agency Action, Including by the FDA, Can Provide the Relief King County Seeks Here.

525. The injuries King County has suffered and will continue to suffer cannot be addressed by agency or regulatory action. There are no rules the FDA could make or actions the agency could take that would provide King County the relief it seeks in this litigation.

526. Even if prescription opioids were entirely banned today, thousands of King County residents, and millions of Americans, would remain addicted to opioids. Overdoses will continue. The County will respond to related medical emergencies and administer naloxone. The Sheriff's Department will spend extraordinary resources combatting illegal opioid sales, and the Prosecuting Attorney's Office and King County Courts will remain burdened with opioid-related crimes. And the social services and public health efforts will be stretched thin.

527. Regulatory action would do nothing to compensate the County for the money and resources it has already expended addressing the impacts of the opioid epidemic. Only this litigation has the ability to provide the County with the relief it seeks.

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V. CLAIMS FOR RELIEF

COUNT ONE — VIOLATIONS OF THE WASHINGTON CONSUMER PROTECTION ACT, RCW 19.86, *ET SEQ.*

528. Plaintiff repeats, reasserts, and incorporates the allegations contained above as if fully set forth herein.

529. The Washington Consumer Protection Act is codified at RCW 19.86 *et seq.* (CPA). The CPA establishes a comprehensive framework for redressing the violations of applicable law, and municipalities of Washington State like King County can enforce the CPA and recover damages. RCW 19.86.090. The conduct at issue in this case falls within the scope of the CPA.

530. The CPA prohibits unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce. The Manufacturer Defendants and Sales Representative Defendants engaged and continue to engage in the same pattern of unfair methods of competition, and unfair and/or deceptive conduct pursuant to a common practice of misleading the public regarding the purported benefits and risks of opioids.

531. The Manufacturer Defendants and Sales Representative Defendants, at all times relevant to this Complaint, directly and/or through their control of third parties, violated the CPA by making unfair and/or deceptive representations about the use of opioids to treat chronic and non-cancer pain, including to physicians and consumers in King County. Each Manufacturer Defendant and Sales Representative Defendant also omitted or concealed material facts and failed to correct prior misrepresentations and omissions about the purported benefits and risks of opioids. In addition, each Manufacturer Defendant's and Sales Representative Defendant's silence regarding the full risks of opioid use constitutes deceptive conduct prohibited by the CPA.

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532. These unfair methods of competition and unfair and/or deceptive acts or practices in the conduct of trade or commerce were reasonably calculated to deceive King County and its consumers, and did in fact deceive the County and its consumers. Each Manufacturer Defendant's and Sales Representative Defendant's misrepresentations, concealments, and omissions continue to this day.

533. King County has paid money for prescription opioids for chronic pain. The County has also paid significant sums of money treating those covered by its health insurance for other opioid-related health costs. The Manufacturer Defendants' and Sales Representative Defendants' misrepresentations have further caused the County to spend substantial sums of money on increased law enforcement, emergency services, social services, public safety, and other human services in King County, as described above.

534. But for these unfair methods of competition and unfair and/or deceptive acts or practices in the conduct of trade or commerce, King County would not have incurred the millions of dollars in payments to the Manufacturer Defendants for harmful drugs with limited, if any, benefit, or the substantial costs to the County related to the epidemic caused by Defendants, as fully described above.

535. Logic, common sense, justice, policy, and precedent indicate the Manufacturer Defendants' and Sales Representative Defendants' unfair and deceptive conduct has caused the damage and harm complained of herein. The Manufacturer Defendants and Sales Representative Defendants knew or reasonably should have known that their statements regarding the risks and benefits of opioids were false and misleading, and that their statements were causing harm from their continued production and marketing of opioids. Thus, the harm caused by the Manufacturer Defendants' and Sales Representative Defendants' unfair and deceptive conduct

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to King County was reasonably foreseeable, including the financial and economic losses incurred by the County.

536. Furthermore, the County brings this cause of action in its sovereign capacity for the benefit of the State of Washington. The CPA expressly authorizes local governments to enforce its provisions and to recover damages for violations of the CPA, and this action is brought to promote the public welfare of the state and for the common good of the State.

537. As a direct and proximate cause of each the Manufacturer Defendant's and Sales Representative Defendant's unfair and deceptive conduct, (i) Plaintiff has sustained and will continue to sustain injuries, and (ii) pursuant to RCW 19.86.090, Plaintiff is entitled to actual and treble damages in amounts to be determined at trial, attorneys' fees and costs, and all other relief available under the CPA.

538. The Court should also grant injunctive relief enjoining the Manufacturer Defendants and Sales Representative Defendants from future violations of the CPA. The Manufacturer Defendants' and Sales Representative Defendants' actions, as complained of herein, constitute unfair competition or unfair, deceptive, or fraudulent acts or practices in violation of the CPA.

COUNT TWO — PUBLIC NUISANCE

539. Plaintiff repeats, reasserts, and incorporates the allegations contained above as if fully set forth herein.

540. Pursuant to RCW 7.48.010, an actionable nuisance is defined as, *inter alia*, "whatever is injurious to health or indecent or offensive to the senses . . ."

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541. Pursuant to RCW 7.48.130, "A public nuisance is one which affects equally the rights of an entire community or neighborhood, although the extent of the damage may be unequal."

542. King County and its residents have a right to be free from conduct that endangers their health and safety. Yet Defendants have engaged in conduct which endangers or injures the health and safety of the residents of the County by their production, promotion, distribution, and marketing of opioids for use by residents of King County.

543. Each Defendant has created or assisted in the creation of a condition that is injurious to the health and safety of King County and its residents, and interferes with the comfortable enjoyment of life and property of entire communities and/or neighborhoods in the County.

544. Defendants' conduct has directly caused deaths, serious injuries, and a severe disruption of the public peace, order and safety, including fueling the homeless and heroin crises facing the County described herein. Defendants' conduct is ongoing and continues to produce permanent and long-lasting damage.

545. The health and safety of the residents of King County, including those who use, have used, or will use opioids, as well as those affected by users of opioids, are matters of substantial public interest and of legitimate concern to the County's citizens and its residents.

546. Defendants' conduct has impacted and continues to impact a substantial number of people within King County and is likely to continue causing significant harm to patients with chronic pain who are being prescribed and take opioids, their families, and their communities.

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547. But for Defendants' actions, opioid use and ultimately its misuse and abuse would not be as widespread as it is today, and the massive epidemic of opioid abuse that currently exists would have been averted.

548. Logic, common sense, justice, policy, and precedent indicate Defendants' unfair and deceptive conduct has caused the damage and harm complained of herein. Defendants knew or reasonably should have known that their statements regarding the risks and benefits of opioids were false and misleading, and that their false and misleading statements were causing harm from their continued production and marketing of opioids. Thus, the public nuisance caused by Defendants to King County was reasonably foreseeable, including the financial and economic losses incurred by the County.

549. Furthermore, the County brings this cause of action in its sovereign capacity for the benefit of the State of Washington. The applicable RCW with respect to a public nuisance expressly prohibits the conduct complained of herein, and this action is brought to promote the public welfare of the state and for the common good of the state.

550. In addition, engaging in any business in defiance of a law regulating or prohibiting the same is a nuisance per se under Washington law. Each Defendant's conduct described herein of deceptively marketing opioids violates RCW 7.48.010 and therefore constitutes a nuisance per se.

551. As a direct and proximate cause of Defendants' conduct creating or assisting in the creation of a public nuisance, the County and its residents have sustained and will continue to sustain substantial injuries.

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552. Pursuant to RCW 7.48.020, King County requests an order providing for abatement of the public nuisance that each Defendant has created or assisted in the creation of, and enjoining Defendants from future violations of RCW 7.48.010.

COUNT THREE — NEGLIGENCE

553. Plaintiff repeats, reasserts, and incorporates the allegations contained above as if fully set forth herein.

554. Under Washington law, a cause of action arises for negligence when a defendant owes a duty to a plaintiff and breaches that duty, and proximately causes the resulting injury. *Iwai v. State*, 129 Wn. 2d 84, 96, 915 P.2d 1089 (1996).

555. Each Defendant owed a duty of care to King County, including but not limited to taking reasonable steps to prevent the misuse, abuse, and over-prescription of opioids.

556. In violation of this duty, Defendants failed to take reasonable steps to prevent the misuse, abuse, and over-prescription of opioids in King County by misrepresenting the risks and benefits associated with opioids.

557. As set forth above, Defendants' misrepresentations include falsely claiming that the risk of opioid addiction was low, falsely instructing doctors and patients that prescribing more opioids was appropriate when patients presented symptoms of addiction, falsely claiming that risk-mitigation strategies could safely address concerns about addiction, falsely claiming that doctors and patients could increase opioid usage indefinitely without added risk, deceptively marketing that purported abuse-deterrent technology could curb misuse and addiction, and falsely claiming that long-term opioid use could actually restore function and improve a patient's quality of life. Each of these misrepresentations made by Defendants violated the duty of care to King County.

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558. As a direct and proximate cause of Defendants' unreasonable and negligent conduct, Plaintiff has suffered and will continue to suffer harm, and is entitled to damages in an amount determined at trial.

COUNT FOUR — GROSS NEGLIGENCE

559. Plaintiff repeats, reasserts, and incorporates the allegations contained above as if fully set forth herein.

560. As set forth above, each Defendant owed a duty of care to King County, including but not limited to taking reasonable steps to prevent the misuse, abuse, and over-prescription of opioids.

561. In violation of this duty, each Defendant failed to take reasonable steps to prevent the misuse, abuse, and over-prescription of opioids in King County by misrepresenting the risks and benefits associated with opioids.

562. In addition, each Defendant knew or should have known, and/or recklessly disregarded, that the opioids they manufactured, promoted, and distributed were being used for unintended uses.

563. For instance, Defendants failed to exercise slight care to King County by, *inter alia*, failing to take appropriate action to stop opioids from being used for unintended purposes, including by patients of Defendants Seattle Pain Clinic and Dr. Frank Li. Furthermore, despite each Defendant's actual or constructive knowledge of the wide proliferation and dissemination of opioids in King County, Defendants took no action to prevent the abuse and diversion of their pharmaceutical drugs. In fact, Defendants promoted and actively targeted doctors and their patients in King County through training their sales representatives to encourage doctors to prescribe more prescription opioids.

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564. Defendants' misrepresentations further include falsely claiming that the risk of opioid addiction was low, falsely instructing doctors and patients that prescribing more opioids was appropriate when patients presented symptoms of addiction, falsely claiming that risk-mitigation strategies could safely address concerns about addiction, falsely claiming that doctors and patients could increase opioid usage indefinitely without added risk, deceptively marketing that purported abuse-deterrent technology could curb misuse and addiction, and falsely claiming that long-term opioid use could actually restore function and improve a patient's quality of life. Each of these misrepresentations made by Defendants violated the duty of care to King County, and in a manner that is substantially and appreciably greater than ordinary negligence.

565. As a direct and proximate cause of each Defendant's gross negligence, Plaintiff has suffered and will continue to suffer harm, and is entitled to damages in an amount determined at trial.

COUNT FIVE — UNJUST ENRICHMENT

566. Plaintiff repeats, reasserts, and incorporates the allegations contained above as if fully set forth herein.

567. Each Manufacturer Defendant and Sales Representative Defendant was required to take reasonable steps to prevent the misuse, abuse, and over-prescription of opioids.

568. Rather than prevent or mitigate the wide proliferation of opioids into King County, each Manufacturer Defendant and Sales Representative Defendant instead chose to place its monetary interests first and each Manufacturer Defendant and Sales Representative Defendant profited immensely from supplying prescription opioids to King County.

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569. Each Manufacturer Defendant also failed to maintain effective controls against the unintended and illegal use of their prescription opioids, again choosing instead to place its monetary interests first.

570. Each Manufacturer Defendant and Sales Representative Defendant therefore received a benefit from the sale of prescription opioids to and in King County, and these Defendants have been unjustly enriched at the expense of King County.

571. As a result, King County is entitled to damages on its unjust enrichment claim in an amount to be proven at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff King County respectfully requests the Court order the following relief:

A. An Order that the conduct alleged herein violates the Washington CPA;

B. An Order that Plaintiff is entitled to treble damages pursuant to the Washington CPA;

C. An Order that the conduct alleged herein constitutes a public nuisance, including under RCW 7.48 *et seq.*, and under Washington law;

D. An Order that Defendants abate the public nuisance that they caused;

E. An Order that Defendants are negligent under Washington law;

F. An Order that Defendants are grossly negligent under Washington law;

G. An Order that the Manufacturer Defendants and Sales Representative Defendants have been unjustly enriched at Plaintiff's expense under Washington law;

H. An Order that Plaintiff is entitled to recover all measure of damages permissible under the statutes identified herein and under common law;

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I. An Order that Defendants are enjoined from the practices described herein;

J. An Order that judgment be entered against Defendants in favor of Plaintiff;

K. An Order that Plaintiff is entitled to attorneys' fees and costs pursuant to any applicable provision of law, including but not limited to under the Washington CPA; and

L. An Order awarding any other and further relief deemed just and proper, including pre-judgment and post-judgment interest on the above amounts.

JURY TRIAL DEMAND

Plaintiff demands a trial by jury on all claims and of all issues so triable.

DATED this 5th day of January, 2018.

KING COUNTY

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