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Alexandra Carter
Claremont McKenna College

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Claremont McKenna College

The War on Drugs in Contrast to the War on Big Pharma:
Contextualizing Shifts in Drug Policy During the Opioid
Crisis

Submitted to Professor Jon Shields

By Alexandra Carter

For

Senior Thesis Year-long

29 April 2019

Table of Contents

Abstract.....	4
Acknowledgements.....	5
Introduction	6
Chapter 1: Drug Policies Past and Present.....	13
Chapter 2: Cost-Benefit Analyses and Political Considerations.....	33
Chapter 3: Drug Policies and Socioeconomic Disparities	45
Chapter 4: Context of Today’s Opioid Epidemic.....	55
Conclusion.....	71
Citations.....	73

Abstract

New drug epidemics often unleash punitive campaigns to end them- highlighted by the 1980's drug wars. However, the opioid crisis has been met with public-health driven policies, like clean needle programs and community-based substance abuse therapy. This thesis asks why policy responses to the opioid crisis are so different than those of the War on Drugs.

First, as the cost of the drug war became clearer, policy makers across the political spectrum became less inclined to wage a new punitive war against opioids, especially as public-health responses proved to be more effective while also less costly.

Second, the demographics of those addicted to opioids is different than those who were addicted to crack cocaine. The brunt of War on Drugs policies was felt by those in the lowest socioeconomic brackets and perpetuated poverty in low-income communities. Today's softer approaches have been informed by a greater percentage of middle- to upper-class individuals affected by the opioid crisis.

Third, as opioids have legitimate medical purposes, they are harder to demonize or ban, rendering it more difficult to declare total war against them. Further, the influence opioid manufacturers have has made policy makers less inclined to declare war, taking supply-side action.

Public-health driven policies and policies that minimize supply-side action against pharmaceutical opioid manufacturers are duplicate representations of the United States' departure from War on Drug tactics. As long as the "medical model" of health care, which emphasizes drugs, medical treatment, and surgery is ingrained in society and the economy, these patterns will continue.

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Introduction

Formally declared by President Richard Nixon in 1971, the War on Drugs is commonly referred to as “America’s longest war.” Spanning a number of decades, the tough-on-crime drug policies that characterized the War on Drugs caused irreparable harm that was by no means parallel to the harm that could be ascribed to drug use. The War on Drugs failed to minimize drug use, nor did it address the problems that accompany drug addiction. It also exhausted billions of tax dollars through heightened law enforcement and the expansion of the prison complex without creating any justifiable results.

Policing during the War on Drugs was disproportionately done in low-income urban communities, despite the common knowledge that drug use is significantly higher in middle- to upper-class communities. Drug charges were extremely stringent, as low-level offenders were charged with lengthy sentences and punishment were often equivalent to that designated to violent offenders. Without adequate resources in low-income communities, defendants were left underrepresented by public defenders and susceptible to unfair plea bargains. Prisons became overcrowded by citizens who were unable to afford legal resources and the treatments and medicine necessary address addiction and mental illness- given the tremendously high cost of healthcare. Jails and prisons therefore became the holding grounds for low-income mentally disabled men and women for this reason.

Further, upon being released, offenders faced obstacles impeding them from securing welfare, employment, healthcare, and voting rights. When sentenced for a drug charge, low-level offenders were simultaneously sentenced to a life of poverty and

misfortune. A report by the United Nations concluded: “Getting drug policy right is not a matter of theoretical or intellectual debate- it is one of the key policy challenges of our time.”¹

At the same time that President Clinton was ramping up the War on Drugs in the 1990’s, the media was flooded by pharmaceutical advertisements for any potential ailment. Thus, a strange new tension was born: a righteous movement against illicit drug use increasingly coexists with a more tolerant, even pro-drug pharmaceutical industry.

Today’s opioid crisis is point in case. Even though illicit heroin and fentanyl are responsible for overdose deaths at a greater frequency than prescribed opioids, licit prescription drugs like OxyContin are responsible for one-third of opioid-related overdose deaths. These prescribed narcotics are often the first opioid a victim has used before developing a dependency.²

Today, over 40 Americans die from an opioid overdose a day.³ To address this, action has been necessary by all accounts. A number of policies have been implemented that emphasize public health over incarceration. Examples include diversion programs, community-based substance abuse therapy and vocational training to prepare for reentering their communities. This ideological and bureaucratic shift is welcomed for a myriad of reasons, as it is more cost effective, has reduced rates of recidivism and

¹ Boggs, C. (2016). *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*. London and New York: Routledge.

² Thompson, D. (2019, January 18). Big Pharma's Marketing to Docs Helped Trigger Opioid Crisis: Study. Retrieved from <https://consumer.healthday.com/bone-and-joint-information-4/opioids-990/big-pharma-s-marketing-to-docs-helped-trigger-opioid-crisis-study-741705.html>

³ Derse, A. (2016). *The Opioid Epidemic: New policies, Treatments, Non-opioid Alternatives*. Atlanta, GA: AHC Media.

addiction in former offenders, and reflects moral considerations that were absent for so much of the War on Drugs.

The inherent dissimilarities between the War on Drugs and policy responses to the opioid crisis are marked. This thesis seeks to answer why policy responses to the opioid crisis are so different than those of the War on Drugs.

First, as the cost of the drug war became clearer, policy makers across the political spectrum became less inclined to wage a new punitive war against opioids, especially as public-health responses proved to be more effective while also less costly.

Second, the demographics of those addicted to opioids is different than those who were addicted to crack cocaine. The brunt of War on Drugs policies was felt by those in the lowest socioeconomic brackets and perpetuated poverty in low-income communities. Today's softer approaches have been informed by a greater percentage of middle- to upper-class individuals affected by the opioid crisis.

Not only has the United States moved away from War on Drugs policies used to address drug use, it has also moved away from tactics used for supply-side enforcement. In particular, drug policies today reflect regulatory and disciplinary leniency towards the pharmaceutical companies that manufacture licit opioids, directly defying the bureaucratic aim to minimize drug use and addiction.

As this thesis seeks to answer why policy responses to the opioid crisis are so different than those of the War on Drugs, it must also address why supply-side enforcement during the opioid crisis looks so different than that of the War on Drugs.

While there are striking parallels to the tactics used by the pharmaceutical companies that manufacture licit opioids and illicit drug dealers, these corporations have

sway over the American bureaucracy, affording them the authority to influence regulatory and legislative policies. It is this influence that has made supply-side responses so different during the opioid crisis than those of the War on Drugs.

Supply-side enforcement against drug dealers during the War on Drugs targeted those in low-income urban communities and resulted in incarceration. In contrast, even though pharmaceutical companies like Purdue Pharma have been charged with fines, they are slight in comparison to annual profits and simply considered a price of doing business.

First, I will shed light on drug policies of past and present. What was once regulated, legally manufactured, and used for medicinal purposes eventually became criminalized and morally sensationalized. The lax drug policies of centuries past are often obscured by the history of the aggressive criminal enforcement of the War on Drugs. Representing this aggressive enforcement are the hundred-to-one sentencing ratio and the mandatory minimum sentencing policies, product of the Anti-Drug Abuse Acts of 1986 and 1988.

Since then, policies like the First Step Act have been made with the intention to rectify problems that followed these policies. Beyond addressing penal policy, the First Step Act also implemented a number of therapy-based programs. I will then explore the role different federal agencies have played in facilitating similar programming. The Health Resources and Service Administration, Substance Abuse and Mental Health Service Administration, Department for Health and Human Services, and the Center for Disease Control have all been instrumental in providing medication-assisted treatment and using proactive measures to combat the epidemic.

After reviewing this history, it became clear that tough-on-crime policies created more problems than they addressed, while public health driven policies have proven to be effective.

I argue that as we learned from the mistakes of the War on Drugs, the United States has been able reconcile traditionally liberal ideals of therapy-based programming with more conservative notions about incarceration. Approaches used to determine the costs and benefits of mass incarceration have explicitly demonstrated the enduring costs (both human and economic) of the War on Drugs. For this reason, lawmakers have been more inclined to move towards therapy-based treatment over the more costly route of incarceration.

Many realities of mass incarceration and the War on Drugs have been apparent for decades, like the incompatibility between War on Drugs supply-side enforcement and demand for drug use (as drug prices have proven to be inelastic.) What is different now is a greater inclination to acknowledge these realities, as the political context has shifted. Tough-on-crime policies do not reap the same electoral benefits that they did in decades prior.

While once posed as an issue of survival, crime became less salient of a political issue as crime rates rapidly decreased throughout the 1990s. For this reason, Americans were less worried about crime and punishment and therefore, less concerned with continuing tough-on-crime policies used during the War on Drugs. An additional explanation is that terrorism took precedence as America's greatest concern following

9/11. Congressional hearings regarding crime reached their height in 1996 and nosedived by 2002.⁴

Now, healthcare centric policies reap the electoral benefits that tough-on crime policies did in decades past. The issue voters identified as the most pressing during the 2018 midterm elections was healthcare, more so than similarly emphasized issues like the economy, immigration, or gun policy. 80% of voters described healthcare as “extremely” or “very important” to their vote.⁵

Today’s softer approaches have been informed by a greater percentage of middle-to upper-class individuals affected by the opioid crisis. This is a demographic more active in politics and advocacy, and one that’s voices are more often heard. The brunt of War on Drugs policies was felt by those in the lowest socioeconomic brackets and perpetuated poverty in low-income communities. During the War on Drugs, many voices were unheard from behind bars. Advocacy responses and policy changes today prompted by the opioid epidemic are reflective of the propensity to value certain constituents’ voices over others. This thesis will shed light on the social context that inspires policy-making—namely, how different demographics benefit or are damaged product of these policies.

I will continue the discussion of how economic resources inform enforcement and policy responses. This is a story of political influence, as today’s drug dealers have bureaucratic influence. Instead of discussing this on the individual level, this dialogue will expand to include the corporations who are complicit in the opioid epidemic. With

⁴ Teles, S. M., & Dagan, D. (2016). *Prison Break: Why Conservatives Turned Against Mass Incarceration*. New York, NY: Oxford University Press.

⁵ Newport, F. (2018, November 02). Top Issues for Voters: Healthcare, Economy, Immigration. Retrieved from <https://news.gallup.com/poll/244367/top-issues-voters-healthcare-economy-immigration.aspx>

astronomical profits that afford great influence and clout, the pharmaceutical companies who manufacture highly addictive opioids are able to elude significant punishment. While these companies use eerily similar tactics to black market drug dealers, the licit nature of pharmaceuticals and the role of the healthcare complex adds an additional dimension for consideration.

To close, I will evaluate whether the War on Drugs as we know it has come to an end, whether the policies used to combat the opioid crisis are sustainable, and what is next to come regarding drug policies.

This thesis concludes that while incompatible on the surface level, lenient policies towards drug users and towards pharmaceutical companies both reflect how the medicalization of American society has influenced the departure from the War on Drugs. The “medical model” of health care, which emphasizes drugs, medical treatment, and surgery is ingrained in society and the economy. It is this medical model that can explain the prominence and profits pharmaceutical companies gained. It further points to why the instinctual response now is to remedy issues of addiction through public-health tactics.

Chapter 1: Drug Policies Past and Present

Criminal enforcement of drug use is an invention of the twentieth century. What was once regulated, legally manufactured, and used for medicinal purposes eventually became criminalized and morally sensationalized. The lax drug policies of centuries past are often obscured by the history of the aggressive criminal enforcement of the War on Drugs.

This chapter will trace the drug policies that characterized the last hundred years- from regulatory regimes at the beginning of the twentieth century, to aggressive criminal enforcement during the War on Drugs, to public health centric policies implemented during the opioid crisis. These regimes differ in form and stringency- evidencing the ever-shifting nature of ideologies and the policies that follow. Through examining a number of drug policies, this chapter's main aim is to contextualize what has prompted the shift from War on Drug policies to those of the opioid crisis.

Inconceivable today, heroin, morphine, and other opioids were legally sanctioned medical treatments for many years. As one doctor said during World War II, opiates provided “the most blessed controller of pain and shock produced by God and discovered by man.”⁶ Not only was the medicinal use of these drugs sanctioned, but so was the sale of such. The Harrison Anti-Narcotic Act of 1914 regulated opioids, cocaine, and marijuana. Those who handled these drugs were required to indicate such to the Department of Internal Revenue, acquire a tax “stamp,” and thoroughly note the proceedings that followed as they brought the drugs to market. Licit drug-related business ventures also were required to complete a monthly narcotic report that was shared by the

⁶ Frydl, K. (2013). *The Drug Wars in America*. Cambridge: Cambridge University Press.

Department of International Revenue with the Bureau of Narcotics within the Department of Treasury.⁷ The financial accountability that occurred with registration and transparent communication with federal agencies mirrored that of any other business venture.

In the years between the end of World War II and President Nixon's formal proclamation of a "War on Drugs" in 1971, the United States evolved from a regulatory system into a restrictive and penal one. Some presume that the mandatory minimum prison terms were the product of the War on Drugs, as this sentencing protocol was one of the most commonly recognized (and maligned) War on Drugs policy. While it was in this period that mandatory minimums became a staple of tough-on-crime practices, mandatory minimums were introduced and used by the government as early as the 1950s.⁸

Following World War II, lawmakers focused their efforts on illegal drugs, but only towards particular operations. Preliminarily, police sought out corrupt metropolitan vice squads and Federal Bureau of Narcotics agents. As years passed, lawmakers' concern for disciplinary drug enforcement grew. Sociologist James Whitman cites this greater concern as being the "paradoxical result of the absence of aristocracy and a modern penchant for populist crusades." Alternatively, academic Jonathon Simon chalks this to "the broad episteme or body of ideas shaping the modern understanding of punishment, including the critical discursive, political, and disciplinary moments that enabled a punitive paradigm to emerge as a structuring frame of governance."⁹

⁷ Ibid.

⁸ Ibid.

⁹ Ibid.

By the time that Nixon proclaimed his “War on Drugs,” police were able to glance at an illegal drug and quickly identify it, which was untrue only twenty years prior. Now police regularly took into custody individuals for drug violations. Beyond policing for mere drug possession, police began to use this as a means and justification to police, especially in low-income metropolitan areas.¹⁰

The War on Drugs marked the beginning of a new era, characterized by tough-on-crime policies. Two of the most damning and prominent policies of the War on Drugs included the hundred-to-one sentencing ratio and the aforementioned mandatory minimum sentencing.

Implemented through the Anti-Drug Abuse Acts of 1986 and 1988, the hundred-to-one sentencing ratio inflicted considerably harsher penalties for those arrested for crack cocaine offenses than for those arrested for powder cocaine offenses. Per this policy, individuals in possession of five grams of crack cocaine received the same minimum sentence as someone with 500 grams of powder cocaine.¹¹ This policy was in many ways an attack on low-income urban communities, as crack cocaine is significantly cheaper than powder cocaine, thus used with greater frequency in these communities.

Beyond the hundred-to-one sentencing ratio, the Anti-Drug Abuse Acts of 1986 and 1988 allowed sentencing measures to reach even greater extremes, with the intensification of mandatory minimum sentencing. The Anti-Drug Abuse Act of 1986 required a minimum sentence of five years for offenses that included 5 grams of crack,

¹⁰ Ibid.

¹¹ U.S. Supreme Court Weighs 100-to-1 Disparity in Crack/Powder Cocaine Sentencing. (2007, October 2). Retrieved from <https://www.aclu.org/news/us-supreme-court-weighs-100-1-disparity-crackpowder-cocaine-sentencing>

500 grams of cocaine, 1 kilogram of heroin, 40 grams of a substance with fentanyl, 5 grams of methamphetamine, or 100 kilograms or 100 plants of marijuana. Individuals were eligible for forty years for certain levels of drug possession and could even serve a life sentence for greater amounts.¹²

Mandatory minimum sentencing stripped judges from their general authority to consider the circumstances of the crime as they relate to the defendant themselves when determining the sentence.¹³ For this reason, someone delivering drugs would receive the same punishment that one would if they were in control of the whole operation and were found with the same levels of possession.¹⁴

Mandatory minimum sentencing transfers the normally held authority of a judge to the prosecutor. Prosecutors often are able to intimidate defendants with the threat of lengthy mandatory minimum sentences into pleading guilty for a reduced sentence. Sometimes, defendants will plead guilty for a reduced sentence, even when they did not commit the crime, in fear of the possibility of a mandatory sentence.¹⁵

Just as criminal enforcement of drugs is an invention of the twentieth century, so is the prison complex and the mass incarceration that followed. Between 1925 and 1973, state and federal prison populations remained exceptionally consistent. The prison population was 785,000 in 1965, but product of draconian sentencing measures grew to seven million in 2010. Crime rates skyrocketed by 135% from 1964 to 1968, which

¹² Ibid.

¹³ Ibid.

¹⁴ Mandatory Minimums and Sentencing Reform. (n.d.). Retrieved from <https://www.cjpf.org/mandatory-minimums>

¹⁵ Ibid.

explains a greater emphasis on crime and punishment. However, crime rates began to drop within the next decade while intense policing and punishment remained.¹⁶

As bureaucratic attention centered towards drug enforcement and the prison complex, education, healthcare, and the welfare system were largely disregarded. Funding for welfare programs was reallocated towards law enforcement. There were institutional changes to welfare programs, such as President Clinton's move to replace Aid to Families with Dependent Children (ADFC) with Temporary Assistance to Needy Families (TANF)- severely minimizing welfare benefits. Additional policies were implemented that restricted welfare access to drug offenders which perpetuated poverty and socio-economic disparities in these communities. Social programming that could aid those most negatively affected by the War on Drugs was underfunded and minimal, perpetuating drug use and crime in low income metropolitan areas.¹⁷

At a time of great economic collapse in low-income urban communities, poverty became nearly inescapable. A lacking welfare state but massive and enduring prison system made it so that significant social change is reliant first on remedying the prison system and the policies that lead those to enter it.¹⁸ For this reason, softer approaches to drug use and crime that have accompanied the opioid epidemic are especially welcomed and appreciated.

Examples of softer approaches include diversion programs instead of incarceration, community-based substance abuse therapy and vocational training to

¹⁶ Murakawa, N. (2014). *The First Civil Right : How Liberals Built Prison America*. [N.p.]: Oxford University Press.

¹⁷ Ibid.

¹⁸ Ibid.

prepare for reentering their communities. A shift away from policies used during the War on Drugs towards these softer approaches has been noticeable on both the state and federal level. This shift has entailed a greater focus on public and community health and less of a reliance on the prison complex. Unlike War on Drug policies, responses to the opioid epidemic have proven to reduce rates of recidivism and addiction in drug users.

Minimizing punishment and extending treatment to those who suffer from addiction is action on drug markets' consumer-side. This softening can be seen as beneficial to communities and the country at large. In contrast, actions leading to and in response to the opioid epidemic addressing the drug market's supply-side have been highly destructive.

Greater leniency from governmental agencies like the Food and Drug Administration (FDA) and Drug Enforcement Agency (DEA), who are responsible for macro-level enforcement and intimate ties with presidential administrations, the federal legislative branch, and state governments has allowed for less regulation and minimal consequences to the supply-side actors in the opioid crisis. This stands stark contrast to the action taken against supply-side actors in decades past- those selling on street corners instead of in corporate medical complexes.

For the remainder of this chapter, I will call to attention policies relating to the opioid crisis that exemplify a departure from War on Drug policies. The softening of sentencing policies and the public health initiatives that have followed the onset of the opioid crisis represent a more sympathetic response to drug-use and addiction. Drug policies that reflect regulatory and disciplinary leniency for the Big Pharma companies

who have played a role in facilitation the opioid crisis embody the extent of corporate influence over the bureaucracy.

All policies represent how addiction and crime have been reframed during the twenty-first century following the uncompromising War on Drugs that characterized the latter half of the twentieth century. Further, these policies both reflect why the medicalization of American society has influenced the departure from War on Drug policies.

To first consider are how sentencing policies have changed since the War on Drugs. Congress approved the Fair Sentencing Act in 2010, which minimized the sentencing disparity between crack and powder cocaine convictions. What was once hundred-to-one became eighteen-to-one. The effort was largely bipartisan and is part of a trend of federal level initiatives intended to lessen racial and socio-economic disparities. As the disparity between crack and powder cocaine still exists, the system is by no means fully remedied. However, this is a positive step in the right direction.¹⁹

The Fair Sentencing Act per the U.S. Sentencing Commission has also allowed for those convicted of crack cocaine felonies before the act's implementation to appear in front of a federal judge who can reevaluate and potentially lessen the sentence. A positive move in the right direction, but not a complete remedy, as the offenders are still bound by pre-Fair Sentencing Act mandatory minimums.²⁰

Following the Fair Sentencing Act, The First Step Act was implemented to build upon the Fair Sentencing Act's successes. The intention of the First Step Act was to

¹⁹ Fair Sentencing Act. (n.d.). Retrieved from <https://www.aclu.org/issues/criminal-law-reform/drug-law-reform/fair-sentencing-act>

²⁰ Ibid.

rectify overwhelming mass incarceration in the United States. The First Step Act abridges mandatory minimum sentences for nonviolent drug charges. It also lessens the federal “three strikes” mandate, which levies a life sentence after a third drug offense. Over two-thirds of federal prisoners who are serving life sentences are doing so after being arrested for a nonviolent offense. Now, the “three strikes” mandate has been reduced to a 25-year sentence. Most momentously, the First Step Act enlarges the “drug safety-valve,” which allows judges greater authority to diverge from mandatory minimums when ruling on nonviolent drug charges.²¹

The First Step Act made the Fair Sentencing Act void, as the First Step Act now applies to a greater number of former offenders. The First Step Act now includes an additional 3,000 offenders charged with felonies related to crack who were not initially included in the benefits of the Fair Sentencing Act.²²

The First Step Act also represents a pivot towards therapy-based programs and those that prepare offenders to successfully re-enter their communities. The legislation allows prisoners to spend up to ten days in halfway houses or in-home observation after every successful month spent in a rehabilitation program. Vocational and educational instruction are provided to ease transition for offenders and help to reduce rates of recidivism. The federal government has granted \$375 million to these efforts. Lastly, churches and similar programs have better access to prisons to lead programs.²³

²¹ Grawert, A., & Lau, T. (2019, January 04). How the FIRST STEP Act Became Law — and What Happens Next. Retrieved from <https://www.brennancenter.org/blog/how-first-step-act-became-law-and-what-happens-next>.

²² Ibid.

²³ George, J. (2018, November 16). What's Really in the First Step Act? Retrieved from <https://www.themarshallproject.org/2018/11/16/what-s-really-in-the-first-step-act>

After initial resistance from a small group of staunchly conservative Senate Republicans, the bill was approved towards the end of 2018. Following endorsements and compromises led by Republican Senator Ted Cruz, the final bill passed with an 87-12 margin. Notably, all Democrats voted for the bill. Then-House Speaker Paul Ryan sent the bill through the House with great speed, then quickly sent it to President Trump who was in favor of the legislation for a long time. Republican Senator and President pro tempore Chuck Grassley and the Koch Brothers, influential conservative donors and political activists were similarly supportive the legislation.²⁴ Approval from a Republican president, Republican majority senate, and the country's predominant conservative benefactors in itself is evidence that the country has moved away from War on Drug policies and ideologies- as the Republican party was once heavily entrenched in its tough-on-crime attitudes.

The First Step Act is the most sizeable effort on the federal level to abet mass incarceration and demonstrates a bipartisan trend of prison and drug reform. Now regarded as "Trump's criminal justice bill," the First Step Act can now be regarded as a precedent for additional reform for Republicans looking to follow Trump's example. The First Step Act is not perfect, as there are still notable mandatory-minimums and two of the major sentencing stipulations are not retroactive, lessening the act's scope. For this reason, Democrats campaigning for the 2020 presidency now have an interesting opportunity to propose even stronger resolutions to cease max incarceration in contrast to Trump's criminal justice bill.²⁵

²⁴ Grawert & Lau, How the FIRST STEP Act Became Law — and What Happens Next.

²⁵ Ibid.

The executive branch has the authority to set the agenda and key policy issues of the years they are in office. Some presidents have chosen to emphasize tough-on-crime policies, such as President Ronald Reagan and Bill Clinton. In contrast, healthcare reform was one of President Obama's greatest priorities during his presidency. This is important to keep in mind when considering both the focus on public-health centric policies and scope of pharmaceutical influence, as the opioid crisis gained momentum and reached its height during the Obama presidency.

In response to the opioid crisis, Obama sanctioned the Comprehensive Addiction and Recovery Act (CARA,) a bipartisan initiative passed in 2016. CARA providing \$500 million to states for programming such as alternative therapies, treatments, and drug education. CARA authorized nurse practitioners and physician assistants to write prescriptions for addiction treatment medications. This is meaningful, as many nonprofit treatment centers do not have enough physicians to give care and prescriptions to everyone.²⁶

Not a specific response to the opioid crisis, but instrumental in providing the care necessary to combat opioid addiction and its repercussions is the Affordable Care Act. Colloquially referred to as "Obamacare," the Affordable Care Act (ACA) was the Obama administration's defining piece of legislation. The ACA was created with the aim of lowering the cost of healthcare, making health insurance more obtainable, and increasing the scope of Medicaid, and support innovative medical care designed to lower the cost of health care generally.²⁷ When the ACA's Title I, describes the ten "essential health

²⁶ Derse, *The Opioid Epidemic: New policies, Treatments, Non-opioid Alternatives*.

²⁷ Affordable Care Act (ACA) - HealthCare.gov Glossary. (n.d.). Retrieved from <https://www.healthcare.gov/glossary/affordable-care-act/>

benefits” that all health insurance policies must cover, “mental health and substance use disorder services, including behavioral health treatment” are included. There are significant financial burdens associated with addiction and many rely on Medicaid as a result.²⁸

The ACA is a broad piece of legislation that transformed healthcare services at large. As there was a disregard for the socioeconomic barriers to receiving adequate sufficient healthcare during the War on Drugs, the ACA is especially meaningful in providing healthcare at large and that targeted to treat addiction and its corollaries.

Manifesting this move towards not only addressing drug use, but the additional health problems that follow, text from a Department of Health and Human Services HHS report is as follows:

Opioid misuse and opioid use disorders have devastating effects. As we see all too often in cases of overdose deaths, lives end prematurely and tragically. Other serious consequences include neonatal abstinence syndrome and transmission of infectious diseases such as HIV and viral hepatitis, as well as compromised physical and mental health. Social consequences include loss of productivity, increased crime and violence, neglect of children, and expanded health care costs.²⁹

²⁸ Mcdonough, J. E. (2016). Behind the Bipartisan Kumbaya on Opioids and Drug Abuse. *The Milbank Quarterly*, 94 (2), 242-245. doi:10.1111/1468-0009.12187

²⁹ United States, U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2018, September). *Facing Addiction in America The Surgeon General's Spotlight on Opioids*. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

Public health approaches that take into consideration additional life-threatening diseases that follow drug use is just as important as addressing drug use itself. Injected drugs are highly correlated with the transmission of many blood-borne diseases, such as HIV/AIDS and hepatitis. While HIV diagnoses declined through the mid-1990s, they are now increasing in tandem to the opioid crisis. 10% of new HIV diagnoses are among those who inject drugs.³⁰

Clean needle programs have been implemented to address this. Clean needle programs decrease rates of blood-borne disease transmission like HIV/AIDS and do not increase rates of drug use. They also connect participants with medical and mental health services, housing programs, and case management, all at little to no cost.³¹

Unlike during the War on Drugs, policies today take into consideration the complex nature of addiction and drug-use. Addiction takes much to overcome. Even when progress is made, relapses happen frequently. Clean needle programs are one manifestation of this. Another manifestation is the expansion of naloxone access.

Naloxone is a medication that can reverse an opioid overdose. It can be injected or used as a nasal spray one to three hours following the opioid consumption. Good Samaritan Laws apply to in the majority of states- meaning that if an overdose occurs, there are no legal ramifications for drug possession. States differ on specifics of naloxone regulations, but the majority have allowed naloxone to be obtained without a patient-specific prescription. Just as proven with clean needle programs, studies have indicated that expanding access naloxone does not increased rates of opioid use.³²

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

Unlike policies during the War on Drugs, many policy responses to the opioid epidemic (such as expanding access to naloxone) are proactive in their nature. Beyond naloxone, proactive measures include using data analytics and research to determine an appropriate course of action; implementing prevention measures; and sponsoring educational programs for healthcare providers and communities at large.

The Health Resources and Services Administration (HRSA) has strengthened MAT and increased in scope the mental health and substance use disorder services that concentrate on treatment, prevention, and education on opioid abuse. HRSA has further worked to incorporate these programs into primary care. Since the beginning of 2017, more than 200 health centers have participated in HRSA-funded assistance programs through the Opioid Addiction Treatment Extension for Community Healthcare Outcomes project.³³

Since 2017, HHS has allocated over \$2 billion in grants to support research and action against the opioid crisis. HHS has also joined forces with federal agencies as well as state and local governments. Also collaborating with HHS is the Substance Abuse and Mental Health Service Administration (SAMHSA) In a public statement, SAMHSA described its mission to:

Increase access to evidence-based interventions- especially in communities hardest hit by the opioid crisis. We are (1) working with states and their communities to increase access to prevention, treatment and recovery support services for opioid use disorder; (2) supporting providers' efforts to offer

³³ *The Federal Response to the Opioid Crisis* (2017) (testimony of Dr. Francis Collins, NIH Director and others Senate Committee on Health, Education, Labor & Pensions).

specialized treatment to pregnant and postpartum women with opioid use disorder and their opioid-exposed infants; (3) promoting early intervention and treatment as healthier alternatives to detaining people with opioid addiction in our criminal justice systems; (4) and facilitating the expansion of telemedicine to deliver Medication-Assisted treatment (MAT) to people in need in rural communities and to enhance rural providers' skills.³⁴

SAMHSA created Opioid State Targeted Response (STRA) grants, which are two-year plans sanctioned by the 21st Century Cures Act (P.L. 155-255). SAMHSA bestowed \$485 million to states during the 2017 fiscal year, letting states concentrate on especially pressing issues, such as making treatment more accessible. Similarly, the Substance Abuse Prevention and Treatment Block Grant (SABG), which was first created in 1992, is another source of funding for states. SABG represents 32% of state substance abuse funding. SABG is largely open-ended, allowing states to use funding to support their communities in the method most suited to their needs.³⁵

SAMHSA additionally has a number of measures intended for bettering MAT programs. MAT proves to be successful but is severely underused. SAMHSA's Medication Assisted Treatment for Prescription Drug and Opioid Addiction (MAT-PDOA) program enables greater MAT access by giving grants to states most burdened by the opioid crisis. Twenty-two states use funding from MAT-PDOA. As of September

³⁴ United States, U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2018, September). *Facing Addiction in America The Surgeon General's Spotlight on Opioids*. Retrieved by https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

³⁵ Ibid.

2017, SAMHSA had provided over \$345 million worth of grants in the span of three years towards supplemental MAT-PDOA grants to six states.³⁶

SAMHSA additionally works to educate a greater number of healthcare providers on how to provide opioid addiction treatment. This is of great importance, as studies suggest that 70% of doctors in the United States have failed tests of their understanding of drugs.³⁷ Leading to the opioid epidemic, medical professionals overprescribed opioids in large part because of misconceptions regarding the severity of these drugs.

In the span of four years since SAMHSA initiated its Provider's Clinical Support System (PCSS)-MAT, over 62,000 healthcare providers have benefited from online or in-person educational programs. (PCSS)-MAT is free of charge, initiates mentor programs with specialists, and grants healthcare providers with access to a library of evidence-based practice materials.³⁸

SAMHSA finances MAT for populations most susceptible and at risk, like those within the criminal justice system. 20% of grant money given to SAMHSA's participants within the criminal justice system can be used to acquire FDA-approved medicines to treat addiction. Since 2013, SAMHSA has documented steep growth in the amounts of drug courts including MAT in their programs. Today, 57% include MAT.³⁹

To better understand the extent of the epidemic and what methods of prevention and treatment prove to be the most successful, the Center for Disease Control (CDC)

³⁶ Ibid.

³⁷ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

³⁸ United States, U.S. Department of Health and Human Services (HHS), Office of the Surgeon General. (2018, September). *Facing Addiction in America The Surgeon General's Spotlight on Opioids*. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf

³⁹ Ibid.

facilitates data collection. For example, CDC's Enhanced State Opioid Overdose Surveillance (ESOOS) program sponsors 32 states as well as Washington DC. ESOOS works to advance the speed at which both fatal and non-fatal opioid overdoses are reported, allowing for more acute public health responses. One of the most cutting-edge features of ESOOS is its use of emergency department and emergency medical services (EMS) data to follow and understand morbidity data. With this information, ESOOS implements early warning systems to catch drastic rises (like possible outbreaks) or drops (like effective intervention efforts) in overdoses.⁴⁰

The CDC oversees epidemiological investigations (Epi-Aids) in states, aiding them when they are hit the hardest by the opioid crisis. As the War on Drugs proved in many ways that the federal government is not the most equipped governing body to handle drug-related policy, policy responses to the opioid crisis have allowed state and local governments greater authority. Collaboration between federal agencies like the CDC and states during the opioid crisis has proven to be effectual, as states can regard for specific considerations while having access to federal-level resources

For example, from 2012 and 2015, Massachusetts noted a major escalation in opioid related deaths, from 698 to 1,747. Nearly 75% of these deaths were related to fentanyl. The Massachusetts Department of Public Health (MDPH) collaborated with the CDC to determine the role that illicitly-manufactured fentanyl (IMF) played in the increase of opioid-related deaths. The CDC joined forces with the MDPH, SAMHSA, and DEA to determine if fentanyl was being mixed with or sold as heroin, leading to the

⁴⁰ *The Federal Response to the Opioid Crisis* (2017) (testimony of Dr. Francis Collins, NIH Director and others Senate Committee on Health, Education, Labor & Pensions).

increase in deaths. These organizations determined that 82% of fentanyl-related deaths were related to IMF.⁴¹

In response to this discovery, the CDC suggested that MDPH instruct health care providers and law enforcement on overdose prevention, check up on at-risk communities for heroin or fentanyl use, and make naloxone more available. The CDC additionally created a specific course of action for Massachusetts- encouraging the state to reach out to those with past histories of opioid overdoses, substance abuse, or current users enrolled in programs to connect them with treatment or additional programs to inform them of fentanyl's threats.⁴²

Beyond aiding states, the CDC educates law enforcement agencies, such as the DEA, so that on the federal level there is greater collaboration between public health focused agencies and enforcement agencies. An example of such is when the CDC worked with High Intensity Drug Trafficking Areas (HIDTA) directors to brainstorm tactics, coordinate training, aid public health analysts within the program, and advance performance.⁴³

Rather than arresting offenders, the DEA is cooperating with the CDC and other agencies in the name of public health. This stands in stark contrast to all the raids and arrests facilitated by the DEA during the War on Drugs. While greater sympathy from the DEA towards consumers is welcomed, they have grown notably laxer when enforcing the supply-side actors (Big Pharma) of today's opioid epidemic.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid.

This is highly contradictory- by allowing greater leeway to Big Pharma, more consumers get hooked on prescribed narcotics, often moving onto these licit drugs' cheaper and illicit cousin, heroin. An unfortunate reality, the DEA's leniency towards Big Pharma is the product of corporate influence over governing bodies. With this influence, Big Pharma corporations can protect profits in a blatant disregard for the health of its consumers.

As this thesis seeks to answer why policy responses to the opioid crisis are so different than those of the War on Drugs, it must also address why supply-side enforcement during the opioid crisis looks so different than that of the War on Drugs. This is a story of political influence, as today's drug dealers have bureaucratic influence.

For example, in the same year that the opioid epidemic was labeled the most fatal drug epidemic to hit the United States, Congress implemented the Ensuring Patient Access and Effective Drug Enforcement Act. This significantly hindered the DEA from taking action against pharmaceutical companies complicit in the illicit drug market of prescription opioids.⁴⁴

Before this policy's implementation, drug distributors were penalized when completing questionable transactions for hundreds of millions of pills despite warnings from the DEA. These pills would go on to be sold by corrupt healthcare professionals on the black market. Despite this common recognition of where such questionable orders

⁴⁴ Higham, S., & Bernstein, L. (2017, October 15). How Congress allied with drug company lobbyists to derail the DEA's war on opioids. Retrieved from https://www.washingtonpost.com/graphics/2017/investigations/dea-drug-industry-congress/?utm_term=.98694b26c304

would go, distributors would ignore the DEA’s warnings, given the resulting billions of dollars in sales.⁴⁵

The Ensuring Patient Access and Effective Drug Enforcement Act inhibits the DEA from stopping questionable pharmaceutical shipments from the companies. Without this authority, the DEA does not have the same capability of stopping pharmaceuticals from entering the illicit market.⁴⁶

While the DEA was initially able to halt these efforts, the bill was eventually passed in 2016. Representative Tom Marino, who proposed the bill, accused the DEA of behaving toward pharmaceutical companies like they were “illicit narcotic cartels” when the bill was initially thwarted. Marino went on to describe “this mind-set [as] extremely dangerous to legitimate business.”

It should be noted that Marino was initially nominated to be Trump’s drug czar but was required to remove himself from consideration given his role in pushing the Ensuring Patients Access and Efficient Drug Enforcement Act. As this position would have made Marino responsible with confronting the opioid epidemic, his financial ties and relationship to Big Pharma made him an inappropriate nominee by all accounts.⁴⁷

Following the Ensuring Patient Access and Effective Drug Enforcement Act, DEA action against physicians, pharmacies, and drug manufacturers declined. While there were 65 instances of suspended orders in 2011, this sum dropped to six by 2017.⁴⁸

⁴⁵ Ibid.

⁴⁶ Ibid.

⁴⁷ McGreal, C. (2017, October 19). How big pharma's money – and its politicians – feed the US opioid crisis. Retrieved from <https://www.theguardian.com/us-news/2017/oct/19/big-pharma-money-lobbying-us-opioid-crisis>

⁴⁸ Higham & Bernstein, How Congress allied with drug company lobbyists to derail the DEA's war on opioids.

The bill was passed by general consent, a legislative mechanism used for bills that appear to be uncontroversial. Beyond the representatives who sponsored Ensuring Patient Access and Effective Drug Enforcement Act and collaborated with pharmaceuticals in doing so, most representatives were unaware of the true nature of the law. Further, former senior administration officials to the Obama administration have remarked that the administration and the president were oblivious of the bill's true meaning when sanctioning it.⁴⁹

Similar to the DEA, while the Food and Drug Administration (FDA) is supposed to operate as a watch-dog agency over the drug industry, it has become a pawn to corporate interests result of institutional changes. When Congress implemented the Prescription Drug User Fee Act, drug companies now began to pay FDA "user fees" for mandated testing, fees to accelerate permission to release drugs to market, which is often a complicated and drawn-out process. Drug companies now spent \$310,000 for each application. These fees eventually accounted for half of the FDA budget, making the department reliant on the companies they were supposed to be monitoring.⁵⁰

Relationships between Big Pharma and federal enforcement and regulatory agencies have progressively mirrored that of two businesses cooperating.⁵¹ While there are merits to the increasing scope of the medical model (public health-driven response), a direct byproduct is the influence Big Pharma has garnered as a result. Greater leniency in drug policies towards both consumers and producers are duplicate representation of

⁴⁹ Ibid.

⁵⁰ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

⁵¹ Ibid.

societal attitudes towards addiction, the role of the prison complex, and corporate influence.

The stringency of drug policy in the United States in the last century has continually fluctuated- from regulatory regimes at the beginning of the twentieth century, to aggressive criminal enforcement during the War on Drugs, to the public health centric policies that have characterized the last decade. Policymaking is multifaceted and while social considerations are of utmost importance, they do not represent the whole picture. The following chapter will detail the cost/benefit analyses and political considerations that further played a part in drug policy liberalization.

Chapter 2: Cost-Benefit Analyses and Political Considerations

In 1986, Congressional representative Newt Gingrich yearned for a “decisive, all-out effort to destroy the underground drug empire,” with hopes of World War II scale efforts. Twenty-five years later, Gingrich conceded that, “There is an urgent need to address the astronomical growth in the prison population, with its huge costs in dollars and lost human potential. The criminal-justice system is broken, and conservatives must lead the way in fixing it.”⁵² Both responses from Gingrich represent Republican ideologies- as he initially spoke to the party’s tough-on-crime stances, then eventually rooted notions on the criminal-justice system in the party’s typical anti-statist and fiscally conservative ideology.

The stark contrast between Gingrich’s initial sentiments on the War on Drugs versus what he has expressed in recent years is evidentiary of the shift in War on Drugs attitudes. As Gingrich now acknowledges, the War on Drugs has had exorbitant costs. In this chapter, I will argue that as approaches used to determine the costs and benefits of mass incarceration have explicitly demonstrated the enduring costs (both human and economic) of the War on Drugs, lawmakers have been more inclined to move towards therapy-based treatment over the more costly route of incarceration.

There is now a greater inclination to acknowledge the realities of mass incarceration and the War on Drug. While apparent for decades, policymakers now reconcile the departure from War on Drug tactics since the political context in the country has shifted, especially for the Republican party. Tough-on-crime policies do not reap the

⁵² Teles & Dagan, *Prison Break: Why Conservatives Turned Against Mass Incarceration*.

same electoral benefits that they did in decades prior.

This chapter will first explore numerous cost-benefit analyses indicating the merits of therapy-based treatment and the failings of the prison complex. This chapter is driven by a quantitative analysis, rooting the merits justifying these shifts in policy in concrete numbers and data.

To follow I will trace the declining salience of crime control as a political and electoral issue. To close, I will explore the economics of War on Drugs policies by considering governmental spending

Discussions of the War on Drugs are intrinsically related to that of the prison complex, given the mass incarceration that followed heightened drug enforcement. The prison complex is the cumulation of thousands of local governments, 50 state systems, and a federal system. 57% of spending on the prison complex is done by state governments and 32% is done by local governments. The Prison Policy Initiative determined that \$182 billion or more was spent on the prison complex annually, an astronomical sum.⁵³ While the Republican party is defined anti-statist and fiscally conservative ideology, expenditures on the prison complex have been largely excluded from those ideological considerations.

Massive spending was initially justified on the grounds of reducing societal ills. It could perhaps be easier to reconcile costly policies if they reaped the benefits intended, but these policies have proven to be ineffective in addressing addiction and recidivism in offenders.

⁵³ Wagner, P., & Rabuy, B. (n.d.). Following the Money of Mass Incarceration. Retrieved from <https://www.prisonpolicy.org/reports/money.html>

In contrast, treatment programs have proven to decrease the social and economic cost of drug abuse with greater success than incarceration, as evidenced by cost-benefit analyses. Therapeutic programs focused on abetting the social costs associated with addiction and incarceration are both less invasive and expensive supplements to incarceration.

Cost-benefit analyses are a quantitative supplement to the qualitative arguments advocating for treatment programs over incarceration on the grounds of moral and ethical considerations. The Washington State Institute for Public Policy (WSIPP) conducts cost-benefit analysis by considering “what is the benefit of each dollar of criminal justice programming spending as measured for taxpayers by program costs, and for crime victims by lower crime rates, and less recidivism.” WSIPP found that drug treatment completed while incarcerated returned between \$1.91 and \$2.69 for every dollar spent. Alternatively, community-based drug treatment completed instead of incarceration returned \$8.87 for every dollar spent. These treatment programs also noted greater rates of program completion and smaller rates of recidivism.⁵⁴

Recidivism, or when one reoffends after being released from incarceration is an important gauge to measure the effectiveness of retributive systems. If incarceration is meant to reduce crime, it should also reduce recidivism. For this reason, lower rates of recidivism related to treatment driven programs substantiates evidence of these programs’ ability to address crime.

⁵⁴ McVay, D., Schiraldi, V., & Ziedenberg, J. (2004, January). *Treatment or Incarceration: National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment* (Rep.). Retrieved http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01_rep_mdtreatmentorincarceration_acdp.pdf

Drug courts are another route that have been proven to reduce recidivism. Drug courts exclusively hear cases related to drug-use and then make recommendations accordingly, like routing drug testing, treatment, and surveillance. Drug courts were first created in 1989 in Florida and since have expanded across the country.⁵⁵

The University of Maryland's Department of Criminology and Criminal Justice discovered that drug court defendants are notably less likely to be arrested in the year following their conviction than those who did not go through the drug courts. Via a grant from the National Institute of Justice, researchers at the Urban Institute found that, "within one year after graduation, 16.4% of drug court graduates had been charged with a serious offense. Within two years, the percentage rises to 27.5%."⁵⁶

In contrast, when the Department of Justice researched general rates of recidivism, they determined that roughly 60% of those formerly incarcerated will be re-arrested within two years and 67.5% will be re-arrested within three years. Specific to those arrested for a drug offense, 41.2% are re-arrested.⁵⁷

Beyond addressing recidivism, programs commissioned by Drug Treatment Courts "reduced the annual cost to house an offender from \$20,000 to \$4,000," as determined by the Maryland State Commission on Criminal Justice Sentencing. In Maryland, when someone is found guilty in a Drug Treatment Court, they are either to complete "regimented offender treatment centers, day reporting, intensive supervision,

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Ibid.

and home detention, and graduated sanctions for program failures” supplemental to time spent incarcerated or they participate in diversion programs.⁵⁸

Through diversion programs, when someone is convicted of a crime, reparations are made through completing treatment programs, paying reparations, or giving back to the community through community service. The results of a study conducted in 2010 revealed that if instead of being sent to prison, 10% of those who qualify for diversion programs were sent to community-based substance abuse therapy programs, the criminal justice system would save \$4.8 billion. Even more, cost-benefit analyses prove that every \$1 spent towards drug treatment returns \$12 in savings on the expenses related to crime and incarceration.⁵⁹

Diversion programs have proven to be well-received across the country, even in predominantly Republican states. Further, diversion programs that address the fundamental issues that drove someone to commit a crime also have proven to be more successful in both decreasing rates of recidivism.⁶⁰

In some cases, the driving factor leading someone to commit a crime is drug use and addiction. Addiction itself leads to incarceration on the grounds of drug charges and possession. For this reason and many others, addiction is of utmost importance to address when working to inspire meaningful change. Incarceration during the War on Drugs neglected to address addiction- thus continuing the cycle of addiction (and often

⁵⁸ Ibid.

⁵⁹ Kubic, M. W., & Pendergrass, T. (2018, July 09). Diversion Programs Are Cheaper and More Effective Than Incarceration. Prosecutors Should Embrace Them. Retrieved from <https://www.aclu.org/blog/smart-justice/diversion-programs-are-cheaper-and-more-effective-incarceration-prosecutors>

⁶⁰ Ibid.

incarceration) once an offender was released. In contrast, therapy programs have proven to be effectual in minimizing drug use and addiction.

The National Treatment Improvement Evaluation Study (NTIES), as conducted by the Center for Substance Abuse Treatment “observed a pattern of substantially reduced alcohol and drug use in every type of treatment modality, with reductions typically between one-third and two-thirds depending on the type of service unit and the specific measure.”⁶¹ RAND Corporation contrasted the benefits of a variety of other law enforcement tactics to treat intense cocaine addiction and determined that treatment is three times more successful than mandatory minimum prison sentences.⁶²

Validating treatment’s merits through a cost-benefit analysis, RAND corporation examined the costs and benefits of drug war enforcement versus those of treatment. RAND concluded that for every \$1 spent on treatment, \$7.50 is saved in lower rates of crime and recovered human capital. RAND further reported:

“An additional cocaine-control dollar generates societal cost savings of 15 cents if used for source-country control, 32 cents if used for interdiction, and 52 cents if used for domestic enforcement. In contrast, the savings from treatment programs are larger than control costs: an additional cocaine-control dollar generates societal cost savings of \$7.48 if used for treatment.”⁶³

⁶¹ McVay, Schiraldi, & Ziedenberg, *Treatment or Incarceration: National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment*.

⁶² Ibid.

⁶³ Ibid.

Cost-benefit analyses continually highlight the effectiveness of therapy programs- while saving tax payers' dollars, therapy programs reduce rates of recidivism and addiction. Following a model of more comprehensive approaches to reducing drug use, there is now a greater consideration for the motives that drive people to use drugs. As Lewis Lapham suggests that "the keepers of the nation's conscience would be better advised to address those conditions- poverty, lack of opportunity and education- from which drugs offer an illusory means of escape."⁶⁴

Upon this point, the National Center on Alcoholism and Substance Abuse based out of Columbia University remarked:

Drug-involved offenders typically develop chronic dependence on the drug economy for subsistence. Reconnecting ex-offenders to the world of legitimate employment is crucial to maintaining recovery and reducing future criminal behavior. Chronic joblessness or underemployment limits their ability to leave the drug-crime lifestyle, to support a family and to successfully transition from the treatment program to the community. Repeat felony offenders are ineligible for federal education grants, membership in some trade unions and government jobs, and in many cases public assistance programs; most lack the social, educational, or vocational skills they need to find employment.⁶⁵

⁶⁴ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

⁶⁵ McVay, Schiraldi, & Ziedenberg, *Treatment or Incarceration: National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment*.dp.pdf

For this reason, there are programs across the country that combine therapy and rehabilitation with classes that teach the skills necessary to find employment. For example, the Drug Treatment Alternative to Prison (DTAP) is based in Brooklyn, New York and rehabilitates drug dependent defendants who plead guilty to a crime through a residential and community-based therapy program for up to two years instead of incarceration.⁶⁶

92% of DTAP participants were employed after finishing the program. This rate of employment after completing the program is over three times greater than rate of employment before being arrested. Increasing rates of employment is beneficial to the individuals themselves, but also to the community. Commerce is generated and former inmates have greater accountability and means to provide for themselves and their families.⁶⁷

The National Center on Addiction and Substance Abuse based out of Columbia University additionally determined that DTAP substantially decreased rates of recidivism and drug use while also empowering more program participants to successfully secure a job. Even though DTAP includes residency, vocational training, support services, and therapy, it collectively costs collectively \$32,974 per patient- half the amount that would be spent if the program participant was sent to prison instead for the same length of time.⁶⁸

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ibid.

The cost-benefit analyses included in the chapter thus far clearly evidence the merits of therapy-based programming over incarceration. For this reason, one may call into question why it took decades for these programs to be implemented.

Reduced rates of addiction, increased workforce participation, and reduced government spending are central to current policy implementation today; politicians during the War on Drugs prioritized policies intended to reduce crime rates.

Policies were initially created in response increases in rates of violent crimes, thus placing a greater emphasis on incarceration. In 1960, the American murder rate was 5.1 per 100,000 and was 10.2 by 1980.⁶⁹ The illicit drug market played a role in greater crime rates. Fear swept the nation, as an Urban League poll reported that over two thirds of respondents in low-income communities revealed that they were “afraid to walk in their own neighborhoods.”⁷⁰ While a slippery slope of increasingly stringent and draconian policies followed, they were product of a time when dialogue about crime dominated public discourse.

However, crime control has since become less salient of a political issue due to rapid decrease in crime rates throughout the 1990s and a changing political and electoral context. For this reason, policymakers (especially Republicans) have become more inclined to consider therapy-based alternatives and depart from tough-on-crime polices.

While paramount to Republican electoral success during the 1980s and 1990s, being tough-on-crime was not so by the 2000s. *Campaigns and Elections Magazine* wrote that Republicans had relied on “the bitter irony for conservatives is that their

⁶⁹ Teles & Dagan, *Prison Break: Why Conservatives Turned Against Mass Incarceration*.

⁷⁰ Forman, James (2017). *Locking Up Our Own: Crime and Punishment in Black America*. New York: Farrar, Straus and Giroux.

success in moving the nation toward their side on many of these issues has taken them away as prime campaign fodder.”⁷¹ By making crime the wedge issue it became, Democrats needed to tap into (thus similarly benefitting from) this issue for political and electoral success.

President Bill Clinton and Congressional Democrats matched conservative efforts to gain control over the issue. Staffers alerted Clinton early in his presidency of “the prospect of a bidding war in both houses, in which Republicans and even liberal Democrats would compete to prove that they care more about crime than the administration,” continuing that, “ Senator Biden and others are urging us to pre-empt this debate by pledging more resources for cops, drug treatment, and prisons.”⁷²

Biden played an integral part in facilitating the debate, as he aimed to “maintain crime as a Democratic initiative” and to “control the agenda.”⁷³ Biden pressed for the “rapid enactment of the Biden/Clinton bill,” named so to drive home the role the Democratic party played in its implementation.

However, by emphasizing his role, Biden became engrained in the tough-on-crime narrative. This is still relevant today, as Biden has entered the 2020 presidential race. Biden has since apologized for this role and has advocated for the softening of sentencing laws while he was vice president during the Obama administration.

Regardless of these apologies, Biden was instrumental in passing the 1994 Violent Crime Control Act and even sponsored the 1988 Anti-Drug Abuse Act.⁷⁴

⁷¹ Teles & Dagan, *Prison Break: Why Conservatives Turned Against Mass Incarceration*.

⁷² Murakawa, *The First Civil Right : How Liberals Built Prison America*.

⁷³ Ibid.

⁷⁴ Akin, S. (2019, April 25). In 2020, Biden experience could turn out to be baggage. Retrieved from <https://www.rollcall.com/news/campaigns/2020-biden-experience-turn-baggage>

Biden took pride in both his role and the Democratic party's role instituting tough-on-crime policies. In response to Senator Hatch charging Democrats with "bowing to the liberal wing of the Democratic Party," insinuating that they were still not tough enough on crime, Biden responded asserting,

Let me define the liberal wing of the Democratic Party. The liberal wing of the Democratic Party has 70 enhanced penalties, and my friend from California, Senator Feinstein, outlined every one of them. I gave a list to her today. She asked what is in there to every one of them. The liberal wing of the Democratic Party is for 125,000 new State prison cells. The liberal wing of the Democratic Party is not the old wing I knew. So if that is what he [Hatch] defines as the liberal wing of the Democratic party, then I suspect I would like to see the conservative wing of the Democratic Party.⁷⁵

Just as tough-on-crime policies represented an ideological departure in the Democratic party, they also represented one in the Republican party. The Republican party is generally concerned with limiting government spending, yet largely disregarded this ideological tenant during the War on Drugs. While exorbitant spending could be reconciled during the War on Drugs, tactics to minimize government expenditures became a greater political and electoral priority again for the Republican party.

⁷⁵ Murakawa, *The First Civil Right : How Liberals Built Prison America*.

The repercussions of the 2001 and 2008 economic recessions influenced reform efforts, as many states were looking for techniques to reduce spending. Additionally, the momentum of a growing Tea Party movement within the Republican party inspired stauncher anti-statist attitudes regarding government oversight and spending.⁷⁶

To quote former Nobel Laureate James Buchanan, “Economics put limits on people’s utopias.”⁷⁷ War on Drug policies were economically irrational- with exorbitant costs despite few successes. Cost-benefit analyses have consistently demonstrated that unlike tough-on-crime policies, therapeutic programs are cost-effective and have a significantly more positive impact. Coupled with the declining salience of crime control as political and electoral issues, “stiff sentencing and more prisons,” moved instead towards “smart sentencing and less incarceration.”⁷⁸

This chapter has paid greater attention to the data and logic that informs policy-making. However, numbers and political strategy are part of the picture. While statistics can be used to discuss rates of recidivism and addiction, they do not reflect the implications of such on those most affected by these policies. The following chapter will shed greater light on the social context that inspires policy-making, how different demographics benefit or are damaged product of such, and how this has played in the move away from drug war tactics.

⁷⁶ Teles & Dagan, *Prison Break: Why Conservatives Turned Against Mass Incarceration*.

⁷⁷ The Economics Behind the U.S. Government's Unwinnable War on Drugs. (2013, July 1). Retrieved from <https://www.econlib.org/library/Columns/y2013/Powelldrugs.html>

⁷⁸ Teles & Dagan, *Prison Break: Why Conservatives Turned Against Mass Incarceration*.

Chapter 3: Drug Policies and Socioeconomic Disparities

While the United States is one of the most financially prosperous countries in history, there is inherent socioeconomic inequality and in many ways a disregard for this imbalance.⁷⁹ This imbalance is manifested in a number of ways- most pertinent to this context, the quality and quantity of resources available and the extent to which one's voice is heard and valued by policymakers.

In this chapter, I will argue that the shift away from War on Drug policies towards those of the War on Drugs to the opioid epidemic has been undoubtedly influenced by socioeconomic imbalances.

This chapter will contextualize the relationship between poverty and the drug wars by considering the decline of the welfare state, economic collapse in low-income communities, targeted and disproportionate punishment aimed towards these communities, and lacking resources to contest or abet these punishments.

It would be remiss to disregard the role of race in these epidemics, as those affected by the crack epidemic were predominantly African American while those affected by the opioid epidemic of the most recent decade are predominantly white Americans. Race is undeniably intertwined in the narrative of the War on Drugs, but the shift from drug war policies to those of today can be better substantiated by a discussion of socioeconomics.

Identifying race as the predominant factor in drug policymaking presupposes that racial animus that drove the War on Drugs. But that assumption is far from clear.

⁷⁹ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

Although it remains a hotly contested question, much evidence suggests that the War on Drugs was driven by supplemental factors, such as class tensions, decline of the welfare state, and a desire to protect African Americans from the scourge of drugs.

While there are undeniably racial elements to the war on drugs, it is important to keep in mind the role the African American community played in shaping the war on drugs and criminal policy as “citizens, voters, mayors, legislators, prosecutors, police officers, police chiefs, corrections officials, and community activists.”⁸⁰

Readdressing socioeconomic and more specifically today’s context, this chapter will address why today’s softer approaches to address drug use have been informed by a greater percentage of middle- to upper-class individuals affected by the opioid crisis. This demographic has been proven to use illicit drugs with greater frequency than those in low-income communities, yet very rarely spend time incarcerated for drug use or possession. In spite of this, it is licit drugs that this demographic has become hooked on more than illicit drugs. Greater advocacy responses and policy changes that have followed the opioid epidemic reflect the bureaucratic tendency to value certain constituents’ voices over other’s.

While the new therapy-driven and sympathetic policies benefit those across all demographics, one cannot help but wonder how the crack epidemic would have been different if this sympathy existed then.

At the same time that the War on Drugs gained steam, low-income urban communities were hit with extraordinary economic hardship. Factory jobs had been a common occupation for the decades prior, as they did not require as much formal

⁸⁰ Forman, *Locking Up Our Own: Crime and Punishment in Black America*.

education and were consistent but began to vanish as companies began to outsource labor to other countries.⁸¹ In tandem, institutional changes were made to welfare programs which hindered many from accessing the resources necessary for survival- food, shelter, and healthcare. For these reasons, poverty became nearly inescapable in low-income communities. As poverty continued, so did drug use, as intoxication can allow for disassociation from the reality of poverty, lack of opportunity and education.⁸²

During the Clinton Administration, the Personal Responsibility and Work Opportunity Reconciliation Act was implemented, replacing Aid to Families with Dependent Children (ADFC) with Temporary Assistance to Needy Families (TANF). Not only did TANF limit assistance to five-years maximum over one's life, but also barred anyone who had been convicted of a felony drug offense from welfare and food stamps.⁸³ To finance the War on Drugs, funding for welfare programs was reallocated towards law enforcement. The budget for prisons soon became twice what had been allotted to Aid to Families with Dependent Children (ADFC) or food stamps.⁸⁴

Resources that had previously been used to support public housing were now used to finance prison construction. When President Bill Clinton was in office, Washington DC decreased resources for public housing by \$17 billion, a cutback of 61%. Federally assisted public housing programs also had the authority to deny applicants with a criminal record. At this same time, funding for corrections was increased by \$19 billion,

⁸¹ Alexander, M. (2012). *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. The New Press.

⁸² Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

⁸³ Alexander, *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*.

⁸⁴ Ibid.

an amplification of 171%. Some commented that these policies made “the construction of prisons the nation’s main housing program for the urban poor.”⁸⁵

Drug war policies themselves further perpetuated hardship and poverty in low-income urban communities by taking advantage of those with minimal resources to contest charges. For example, asset forfeiture allows for the confiscation of cash, cars, or other property presumed to be related to criminal activity, even if the owner is not arrested for a crime. 80% of civil asset forfeitures are from those who never receive criminal charges.⁸⁶

There were many innocent men and women affected by asset confiscation. An ACLU report from Philadelphia revealed that 71% of those affected by cash forfeiture annually were never convicted of a crime. Those in low-income communities are more inclined to carry cash, thus making them more susceptible. Those affected by civil asset forfeiture did not generally have the capability to challenge civil forfeiture proceedings, meaning that they very rarely took action to seek reparations for their wrongfully confiscated assets.⁸⁷

In 2008, the U.S. Department of Justice’s Asset Forfeiture Fund (AFF) had over \$1 billion in forfeited assets that could be used to finance federal law enforcement. For context, in 1986, one year after the AFF began, it acquired \$93.7 million in forfeited assets. In 2008, the U.S. Treasury Department had over \$400 million in forfeited assets. Asset forfeiture was not just on the federal level. Between 2001 and 2002, currency

⁸⁵ Ibid.

⁸⁶ Asset Forfeiture Reform. (n.d.). Retrieved from <http://www.drugpolicy.org/issues/asset-forfeiture-reform>

⁸⁷ Ibid.

forfeitures in nine states amounted to over \$70 million. This does not even take into account cars and other forfeited possessions.⁸⁸

Another drug war policy with intense repercussions in low-income communities for consideration is plea bargaining- when a defendant is coerced into agreeing to a prison sentence due to the threat of a lengthier one. Many stories are told of defendants innocent defendants accepting plea bargains to avoid decades-long sentences. The United States is the only liberal democracy that offers plea bargaining.⁸⁹

In his book *Locked In: The True Causes of Mass Incarceration-and How to Achieve Real Reform*, John Pfaff articulates the authority prosecutors yield product of plea bargaining, saying, “There is basically no limit to how prosecutors can use the charges available to them to threaten defendants... Nearly everyone in prison ended up there by signing a piece of paper in a dingy conference room in a county office building.”⁹⁰

95% of criminal cases in the United States are resolved in plea bargaining. As a result, prosecutors make these important decisions regarding crime and punishment without even having to enter a courtroom. This gave great authority to prosecutors to indict large numbers of defenders, especially those who did not have the financial resources to contest charges.⁹¹

⁸⁸ Williams, Marian R.; Holcomb, Jefferson H.; Kovandzic, Tomislav V; and Bullock, Scott, "Policing for Profit: The Abuse of Civil Asset Forfeiture," The Institute for Justice (Arlington, VA: March 2010), p. 7.

⁸⁹ Gopnik, A. (2019, April 08). Who Belongs in Prison? Retrieved from <https://www.newyorker.com/magazine/2019/04/15/who-belongs-in-prison>

⁹⁰ Pfaff, J. F. (2017). *Locked in: The true causes of mass incarceration - and how to achieve real reform*. New York: Basic Books.

⁹¹ Gopnik, Who Belongs in Prison?

Public defenders are a valuable resource to those who cannot afford an attorney. The majority of defendants rely on public defenders. However, public defenders also lack the resources necessary to aid all that need it. The journalist Amy Bach recounts a day she observed a public defender “plead out” 48 defendants consecutively.⁹²

Inadequate resources are a common theme in the circumstances leading to drug-related incarceration. Beyond barriers to legal resources, low-income individuals also had insufficient means to treat mental illness. Given the extortionate price of healthcare, low-income individuals may not have the ability to procure psychiatric medicines or treatments to treat their conditions. This leaves this demographic vulnerable to drug use and incarceration.

The Bureau of Justice Statistics reported in 2017 that roughly 50% of those in jail today are diagnosed with a mental illness and more than 25% have serious conditions, like bipolar disorder. 75% of those in prison who are mentally ill had formerly spent time in prison or jail, meaning that they reoffended.⁹³ Those in charge of correctional facilities and private health-care companies alike acknowledge that psychiatric facilities would be a more appropriate place to treat mentally ill people, especially if the inmate is considered nonviolent.⁹⁴ Thankfully today, there is a greater recognition of the role mental illness plays in drug use and crime. For this reason, policy initiatives like the Affordable Care Act have tried to break down the barriers to resources.

⁹² Gopnik, We Misunderstand Mass Incarceration.

⁹³ Bailey, D. S. (2003, August). Alternatives to Incarceration. *American Psychological Association*. Retrieved from <https://www.apa.org/monitor/julaug03/alternatives>

⁹⁴ Coll, S. (2019, February 26). The Jail Health-Care Crisis. Retrieved from <https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis>

Thus far, the chapter has contextualized the relationship between poverty and the drug wars by considering the decline of the welfare state, economic collapse in low-income communities, targeted and disproportionate punishment aimed towards these communities, and lacking resources to contest or abet these punishments. These actions continued for many years, as this demographic did not have the same means of advocacy or for many years the attention of policymakers.

From this point forward, the rest of the chapter will be devoted to addressing how middle- to upper-class individuals were able to circumnavigate significant punishment for illicit drug use during the drug wars. It will further address how this demographic has been able to inspire policy changes in response to the opioid epidemic and licit drug addiction.

Due to disproportionate policing, there is a misconception that rates of drug use are more prevalent in low-income communities⁹⁵ However, as journalist William Raspberry describes, the typical drug user is really a “college student, a young professional, a wage earner or a suburban sophisticate” in his article entitled “Go After the Drug Buyers Too.”⁹⁶

The National Institute of Health (NIH) reports that, “Those with the highest incomes were most likely to have engaged in extra-medical use of all drug types but for cocaine.” Cocaine deviated not because those with lower-incomes use it at a greater rate,

⁹⁵ Poverty Myths Busted: Drugs and Poverty Go Together. (2018, July 19). Retrieved from <https://4thworldmovement.org/poverty-myths-busted-drugs-and-poverty-go-together/>

⁹⁶ Forman, *Locking Up Our Own: Crime and Punishment in Black America*.

but because the number of respondents who had used cocaine in the NIH survey cocaine was not large enough.⁹⁷

When investigating dissimilar rates of arrests between crack and cocaine, researchers at New York University learned that crack users (those most probably from low-income communities) were 18 times more likely to be arrested for drug possession than cocaine users (those most probably from higher-income communities.)⁹⁸

On the demand side of drug markets, buyers can come from any neighborhood and social class. However, on the supply side, drug dealers can easily be found selling on street corners and in public spaces and come primarily from the most poverty-stricken and non-white areas of the city. Police with arrest quotas know they can meet said quotas. Researchers infer that spatially discriminatory policing was what inspired larger and growing rates of imprisonment and recidivism in specific neighborhoods, despite crime rates decreasing.⁹⁹ Those with monetary resources in higher socioeconomic strata had other means to acquire drugs at a lower risk where they know police will not be nearby.

Considering the demand side of drug markets during the opioid crisis, these middle- to upper-class individuals are often the ones hooked on prescribed licit medications. For this reason, their supplier is a sanctioned healthcare provider. More broadly, today's "drug dealers" are pharmaceutical companies. For this reason, enforcement and policies look different. As academic and author, Natalie Murakawa writes-

⁹⁷ Poverty Myths Busted: Drugs and Poverty Go Together. (2018, July 19). Retrieved from <https://4thworldmovement.org/poverty-myths-busted-drugs-and-poverty-go-together/>

⁹⁸ Ibid.

⁹⁹ Loury, G. C. (2008). *Race, Incarceration, and American Values*. Cambridge, MA: MIT Press.

Accumulated advantage imparts a presumption of innocence; inherited wealth enables home owners in class-segregated areas (i.e., ‘a safe neighborhood’) and medical insurance for diagnosis of conditions and coverage of various prescriptions such as Ritalin (i.e., more effective form of meth). In contrast, accumulated disadvantage imparts a presumption of guilt.¹⁰⁰

If this is so, the accumulated advantage of someone in a higher socio-economic stratum both allows one to afford both healthcare (i.e., opioid prescriptions) and the presumption of innocence, rather than the low-income individuals presumed guilty and stigmatized for the use of illicit drugs. The accumulated advantage results in treatment, while the accumulated disadvantage results in incarceration.¹⁰¹ Murkawa’s line of thought encapsulates the role socioeconomics have played in today’s opioid crisis.

This is further reflected in the ability middle- to upper-class individuals have played in facilitating a new dialogue and policies. Michael Botticelli, former director of the White House Office of National Drug Control Policy said, “Because the demographic of people affected are more-white, more middle class, these are parents who are empowered. They know how to call a legislator, they know how to get angry with their insurance company, they know how to advocate. They have been so instrumental in changing the conversation.”¹⁰²

¹⁰⁰ Murakawa, *The First Civil Right : How Liberals Built Prison America*.

¹⁰¹ *Ibid.*

¹⁰² Seelye, K. Q. (2015, October 30). In *Heroin Crisis, White Families Seek Gentler War on Drugs*. Retrieved from <https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html>

Families affected by the heroin crisis lobby the state and federal government, hold rallies and start nonprofit organizations with hopes of challenging the draconian methods of traditional drug enforcement. For example, Jim Hood lost his son to heroin and was inspired to organize the “Unite to Face Addiction” rally in Washington DC. This rally included musicians like Sheryl Crow. Following the event, over 750 groups cooperated to create Facing Addiction, a national organization that works to combat addiction. Today, Facing Addiction has a scale comparable to the American Cancer Society and American Heart Society.¹⁰³

In contrast, during the War on Drugs, many voices were unheard from behind bars. Ingrained in our “concept of criminal ‘guilt,’ we miss the larger social context in which crime takes place, and how we need to broaden our blame in order to adjust our justice.”¹⁰⁴ While policy changes have been made to provide treatment to those plagued by addiction and decrease drug-driven incarceration, one must consider that this sympathy did not exist for those who arguably needed it the most. In tandem to institutional reform of the welfare system and economic collapse, heightened disciplinary action resulted in generations essentially confined to a life of poverty.

Greater advocacy responses and policy changes that have followed the opioid epidemic reflect the bureaucratic tendency to value certain constituents’ voices over other’s, as today’s softer approaches to address drug use have been informed by a greater percentage of middle- to upper-class individuals affected by the opioid crisis.

¹⁰³ Ibid.

¹⁰⁴ Gopnik, Who Belongs in Prison?

The following chapter will continue a discussion of how economic resources inform enforcement and policy responses. Instead of discussing this on the individual level, this dialogue will expand to include the corporations who are complicit in the opioid epidemic. With astronomical profits that afford great influence and clout, the pharmaceutical companies who manufacture highly addictive opioids are able to elude significant punishment. While these companies use eerily similar tactics to black market drug dealers, the licit nature of pharmaceuticals and the role of the medical model complex adds an additional dimension for consideration into why the United States has departed from drug war tactics.

Chapter 4: Context of Today's Opioid Epidemic

Regarding today's crisis, political commentator Stephen Colbert said, "There are certain subjects that are genuinely hard to talk about like the opioid crisis. It's an epidemic that affects both political parties, Republican, Democrat, rich people, poor people, it does not discriminate. A lot of people blame Big Pharma, but only because it's their fault."¹⁰⁵

The United States has been confronted by an epidemic of opioid use and addiction, inherently linked to the overprescribing of opioids, like OxyContin. The Center for Disease Control (CDC) reports that rates of opioid prescriptions have quadrupled in the years since 1999. Over 40 Americans die from a prescription opioid overdose daily.¹⁰⁶ This follows decades of overprescribing opioids, to the point where OxyContin was being prescribed for pain management when Tylenol would have sufficed.¹⁰⁷

The opioid epidemic is dissimilar to the heroin and crack epidemics of the past as it is characterized by both illicit and licit drugs. While the addictive nature of the licit drugs has been thoroughly documented, it is unrealistic to wage a "war" on these drugs when there is also a documented health benefit. In this chapter, I will argue that policies are different today than during the War on Drugs as the medical model that emphasizes drugs, medical treatment, and surgery has become engrained in culture, the economy, and politics.

¹⁰⁵ Kreps, D. (2018, September 15). See Stephen Colbert Tackle Opioid Crisis, Criticize Big Pharma on 'Late Show'. Retrieved from <https://www.rollingstone.com/tv/tv-news/stephen-colbert-opioid-crisis-big-pharma-724763/>

¹⁰⁶ Derse, *The Opioid Epidemic: New policies, Treatments, Non-opioid Alternatives*.

¹⁰⁷ Marco, T. (2019, January 29). One of America's richest families is accused of profiting from the nation's opioid crisis. Retrieved from <https://www.cnn.com/2019/01/28/health/purdue-pharma-sackler-family-opioid-crisis/index.html>

I will further argue that the opioid epidemic has not fallen under the umbrella of tough-on-crime War on Drugs policies in large part because of the influence pharmaceutical companies have over presidential administrations, governmental agencies like the FDA, and the legislative branch, thus allowing for less industry regulation. Paradoxically, greater leniency in licit drug policy and regulation stands in direct defiance of the bureaucratic aim to minimize drug use and addiction cited to justify the War on (illicit) Drugs. While incompatible on the surface level, this thesis concludes that lenient policies towards drug users and towards pharmaceutical companies both reflect how the medicalization of American society has influenced the departure from the War on Drugs.

To first consider, today's epidemic is characterized by both licit and illicit drugs, unlike the crack epidemic. As licit drugs serve a medicinal purpose, they must be regulated and not banned, unlike the instinctual response to prohibit illicit drugs.

For many, responding to illicit drug violations with harsh sentencing involves less moral consciousness, as these drugs are sold in markets characterized by violence and those charged with possession made the active decision to seek out drugs like crack cocaine despite its prohibition. The response to criminalize illicit opioid use has additional dimensions, as some develop addiction after being prescribed opioids for pain management rather than after explicitly seeking opioids out for intoxication.

Even though illicit heroin and fentanyl are responsible for overdose deaths at a greater frequency than prescribed opioids, there is an intrinsic and perhaps causal

relationship between opioid and heroin use.¹⁰⁸ The American Society of Addiction Medicine reports that 80% of those who use heroin began with prescription narcotics, eventually moving onto heroin as it is less expensive.¹⁰⁹ As the relationship between licit and illicit opioid use has proven to be causal relationship, policies today reflect greater sympathy to drug users- whether or not they use licit or illicit drugs.

The initial and especially potent OxyContin design prompted addiction in so many; but once its potency was reduced following its reformulated, users instead resorted to heroin. Heroin dealers from Mexico spread throughout the United States at greater rates to sell to the growing market of those initially hooked on OxyContin and the likes.¹¹⁰

Those hooked on prescription narcotics may also turn to heroin in instances where governmental action is taken against prescription narcotics. For example, in 2011, Florida Attorney General Pam Bondi collaborated with the state legislature to increase enforcement and implementation of the Prescription Drug Monitoring Programs. At this time, there were more pain clinics (“pill mills”) than McDonalds in the state. While Florida noted a significant decrease in fatalities related to opioids like OxyContin and Oxycodone, there was a rapid increase in overdoses from fentanyl-laced heroin. Today, 14 people die from an opioid-related overdose in Florida daily.¹¹¹

The marked expansion of general drug use in America has prompted drug markets

¹⁰⁸ Thompson, “Big Pharma’s Marketing to Docs Helped Trigger Opioid Crisis.”

¹⁰⁹ Galvin, G. (2019, January 28). He Brought Big Tobacco to Heel. Now He’s Targeting Big Pharma. Retrieved from <https://www.usnews.com/news/health-news/articles/2019-01-28/mike-moore-big-pharma-should-pay-for-opioid-crisis>

¹¹⁰ Keefe, P. R. (2019, February 28). The Family That Built an Empire of Pain. Retrieved from <https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>

¹¹¹ Aronberg, D. (2018, June 11). Big Pharma’s avoidable role in the man-made opioid epidemic. Retrieved from <https://thehill.com/opinion/criminal-justice/391451-big-pharmas-complicit-and-avoidable-role-in-the-man-made-opioid>

(both licit and illicit) to reach a broader range of ages, geographical regions, and demographics.¹¹² The War on Drugs was posed as a means “to save middle-class kids from the threat of a drug epidemic,” yet it did not protect against dangers of licit drugs.¹¹³ Adolescents use licit psychoactive drugs more often to get intoxicated, like narcotics and amphetamines. These drugs are easily accessed from family members prescriptions, are low in cost, and pose little legal threat. As comprehensive drug sales increased by 40% between 1990 and 2010, misuse of prescription drugs in adolescents between the ages of twelve and sixteen has also increased. Data suggests that 15% of students in high school “pharm” prescribed medicines.¹¹⁴

Illicit drugs are often represented as being distinctively addictive and injurious, but we often disregard these same characteristics in over-the-counter pharmaceuticals. The opioid crisis has proven that heroin and prescribed opioids alike can result in addiction; intense health, financial, and social costs; and fatalities.¹¹⁵ This reality has become more apparent at a time when marijuana, a once deeply criminalized drug, is now being used for medicinal and recreational purposes with great success.

As the medical marijuana movement gained momentum across the country, the nation has observed the drug’s ability remedy issues rather than creating them, as suggested by governmental rhetoric and media portrayal for decades.

Today, twenty-five states and Washington DC implemented medical marijuana systems. By the beginning of 2016, an additional sixteen states approved the medical use

¹¹² Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

¹¹³ Loury, G. C. (2008). *Race, Incarceration, and American Values*. Cambridge, MA: MIT Press.

¹¹⁴ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

¹¹⁵ Ibid.

of cannabidiol oils, which remain illicit under the Controlled Substances Act. States that have not sanctioned the use of medicinal marijuana are objectively the country's most conservative. However, polling data still indicates significant support for medical marijuana. Recent polling demonstrated "75% in Alabama, 80% in Georgia, and 71% in Oklahoma" were in favor of implementing a medical marijuana system.¹¹⁶

While state and local governments across the country advocate for more liberal drug policies that include the legalization of marijuana, the federal level anti-drug establishment remain inflexible. Marijuana, which is less expensive, easily attainable, and does not produce the same harmful side-effects could challenge Big Pharma's profits if consumers chose marijuana over vexed pharmaceuticals like Vicodin and OxyContin.

For this reason, the War on Drugs has been propelled by a coalition between Big Pharma and governmental powers- with mutual support for prohibition. Exemplifying such is the Partnership for a Drug-Free America (PDFA). Created in the 1990s, PDFA was predominantly funded by pharmaceutical companies like Merck, Pfizer, Johnson & Johnson, Bristol-Myers, Squibb, and Procter and Gamble. Insurance companies like Aetna, Metropolitan Life, and Allstate also were liberal with donations. Non-drug companies like Comcast, JPMorgan Chase, and Disney corporation also became involved with PDFA in the last decade PDFA educated adolescents about the dangers of "killer weed" and the "plague of street drugs," asserting that addiction was society's greatest malady.¹¹⁷

¹¹⁶ Hudak, J. (2016). *Marijuana: A Short History*. Washington, D.C.: Brookings Institution Press.

¹¹⁷ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

This sort of hyperbolic rhetoric stands in contrast to the rhetoric used by pharmaceutical advertisements that minimize the ramifications of opioid drug use. A dichotomy exists between Big Pharma's corporate interest regarding drug prevention and its corporate interest in maximizing pharmaceutical sales represents a chasm between moral and economic imperative. Big Pharma companies were driven by profit and a disregard for the addictive nature of its product- ultimately leading to what has become the most fatal drug epidemic in the United States.

The role Big Pharma has played in informing drug policies over the last twenty years cannot be overstated. PDFA represent how Big Pharma has advocated for greater stringency and continued drug war tactics. Alternative to this, Big Pharma has advocated (with great success) for pro-business regulatory and enforcement policies. Mechanisms that afford Big Pharma the ability to influence drug policies are cyclical: profits heightened from less regulation affords the corporations the financial means to lobby the government for additional freedom.

Via its relationship with the government, Big Pharma companies have been able to obtain significant subsidies, obstruct imports, sponsor research, contest regulations, slacken FDA's testing protocols, hinder DEA enforcement, and directly advertise to consumers.¹¹⁸ All of these privileges indicate greater leniency in drug policy creation and enforcement.

Purdue Pharma best represents how Big Pharma corporations have been able to achieve great economic and political success via lenient drug policies. Purdue Pharma

¹¹⁸ Ibid.

first released OxyContin in 1996- a prescribed opioid that is chemically similar to heroin and two times more potent than morphine.¹¹⁹ OxyContin quickly became the most commonly prescribed name brand narcotic in the United States. Five years following OxyContin's introduction, sales surpassed more than \$1 billion annually.¹²⁰ Since then, OxyContin has made \$35 billion in revenue for the company. *Forbes* labeled the Sackler's (the company's founders) as one of the most affluent families in the country, with a collective net worth surmounting \$13 billion.¹²¹

While "the goal should have been to sell the least dose of the drug to the smallest number of patients," this goal was out of line with the company's revenue driven approach.¹²² Purdue Pharma's sales department was motivated to promote OxyContin with memos from sales managers like, "\$\$\$\$\$\$\$\$\$\$\$\$ It's Bonus Time in the Neighborhood!"¹²³

Before Purdue Pharma introduced OxyContin, opioids had been exclusively for terminally ill patients or to treat pain prompted by cancer. Purdue Pharma identified an opening in the market and started to zero in on general practitioners with little history of treating intense chronic pain. Purdue Pharma began the practice of prescribing opioids for common-place chronic pain, additionally inspiring other pharmaceuticals to do the same.¹²⁴ This pivot from selective prescribing for especially ill patients towards prescribing to address a myriad of pains exponentially increased the amount of opioid

¹¹⁹ Keefe, *The Family That Built an Empire of Pain*.

¹²⁰ Aronberg, *Big Pharma's avoidable role in the man-made opioid epidemic*.

¹²¹ *Ibid.*

¹²² *Ibid.*

¹²³ *Ibid.*

¹²⁴ Morrissey, C. (n.d.). *Big Pharma Held Accountable for the Opioid Epidemic?* Retrieved from <https://www.searidgedrugrehab.com/article-big-pharma-opioid.php>

being prescribed while driving many to addiction.¹²⁵ Purdue Pharma advertised OxyContin as a harmless prescription, saying that only 1% of those prescribed would become addicted. This misinformation made health care practitioners and consumers alike unwary of prescribing substantial doses for a lengthy period of time.¹²⁶

Business tactics demonstrate the company's awareness of the product's addictiveness. Even worse than a disregard of the drug's addictive nature, Purdue Pharma actively capitalized on OxyContin's addictive nature. This recognition is important, as it signals Purdue Pharma's malintent and culpability. For this reason, one would assume that legal punishment would match those taken against illicit drug dealers who act with similar intent and methods.

Parallels between Purdue Pharma and the illicit drug markets are plentiful. As Sam Quinones, author of *Dreamland: The True Tale of America's Opiate Epidemic* points out, both the Xalisco boys and Purdue Pharma single out their market by finding the local methadone clinic. Purdue Pharma uses Information Medical Statistics (IMS) data to determine which locations and demographics will be persuadable and vulnerable to OxyContin marketing.¹²⁷

Lawyer Mitchel Denham says that Purdue Pharma identified "communities where there is a lot of poverty and a lack of education and opportunity... looking at numbers that showed these people have work-related injuries, they go to the doctor more often, they get treatment for pain." The implications of such advertising efforts are directly correlated to opioid abuse, as a county-by-county analysis demonstrated greater rates of

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Thompson, "Big Pharma's Marketing to Docs Helped Trigger Opioid Crisis."

opioid use in counties drug companies concentrated their advertising.¹²⁸

Another parallel between Purdue Pharma and the illicit drug markets, just as the Xalisco boys provide prospective customers with samples of their product free of charge, so did Purdue Pharma. When Purdue Pharma first launched OxyContin, they implemented a program where medical professionals could give patients coupons for a free first prescription. This program was terminated four years after its inception. In that span of time, 34,000 of these coupons had been used.¹²⁹

This coupon program targeted consumers and healthcare practitioners alike. A similar tactic, Purdue Pharma implemented a “speaker bureau” that compensated healthcare professionals for educating patients and colleagues about OxyContin. When payments by drug companies are made to medical professionals per 100,000 people to market the pharmaceutical opioids, fatalities prompted by opioid overdoses increased by 18% with every three supplemental payments to medical professionals.¹³⁰

There were certainly physicians who actively partook in black market sales by creating pill mills- pain management clinics that prescribe for profit over anything else.¹³¹ However, this does not represent the vast majority of healthcare providers, as many were simply swept up and seduced by Purdue Pharma’s aggressive tactics.¹³²

Keith Humphreys, former drug-policy advisor to the Obama Administration and current professor at Stanford University laments, “The real Greek tragedy of this [is] that

¹²⁸ Ibid.

¹²⁹ Keefe, *The Family That Built an Empire of Pain*.

¹³⁰ Thompson, “Big Pharma's Marketing to Docs Helped Trigger Opioid Crisis.”

¹³¹ Keefe, *The Family That Built an Empire of Pain*.

¹³² Ibid.

so many well-meaning doctors got co-opted.¹³³ Those within Purdue Pharma understood that most doctors incorrectly believed that Oxycodone was not as potent as morphine. Rather than addressing this misconception, Purdue Pharma exploited it- further evidence of malintent and culpability.¹³⁴

Despite considerable evidence indicating the contrary, Purdue Pharma consistently charges physicians with being the actors to create and amplify the opioid crisis are. Addressing this inaccuracy, Healthcare Distribution Alliance Senior Vice President John Parker said, “the idea that distributors are responsible for the number of opioid prescriptions written defies common sense and lacks understanding of how the pharmaceutical supply chain actually works and is regulated.”¹³⁵

Upon this point, Jim Geldohf, former DEA program manager in Detroit remarked, “When you’re selling half a million pills to some pharmacy and you’re telling me that you don’t know what the rules are for a suspicious order? Greed always trumped compliance. It did every time. It was about money, and it’s as simple as that.”¹³⁶

Under normal protocol, the DEA should halt such astronomical pharmaceutical deliveries. However, Big Pharma had the power to influence legislation that would hinder the DEA’s enforcement abilities. Spearhead by Representative Tom Marino, the policy bars the DEA from blocking suspicious pharmaceutical shipments from the companies. When initially blocked, Marino charged the DEA with treating pharmaceutical

¹³³ Ibid.

¹³⁴ Ibid.

¹³⁵ S.F. Files Lawsuit Against Big Pharma Over Opioid Crisis - December 20, 2018. (2018, December 20). Retrieved from <http://www.sfweekly.com/news/s-f-files-lawsuit-against-big-pharma-over-opioid-crisis/>

¹³⁶ Higham & Bernstein, How Congress allied with drug company lobbyists to derail the DEA's war on opioids.

companies as they were “illicit narcotic cartels,” further claiming that “this mind-set was extremely dangerous to legitimate business.” After the Ensuring Patient Access and Effective Drug Enforcement Act was implemented, there was a drastic decrease in measures taken against questionable pharmaceutical orders. In 2011, 65 pharmaceutical orders were suspended in contrast to six orders in 2017.¹³⁷

While the chapter has largely focused on Purdue Pharma, they are not lone actors, as other pharmaceutical companies have garnered a similarly extensive scope, influence, and assets of oligarchic proportions.

This instance with the DEA is by no means an anomaly, as Big Pharma has extensive ties to the medical system, federal government, state governments, federal agencies, and the media. This is a story of political influence, as today’s drug dealers have bureaucratic influence over regulation and policymaking, thus ensuring their own economic success. It is for this reason that supply-side action is so different today than it was during the War on Drugs.

While the FDA was intended to serve a watch-dog agency over the drug industry, it has for decades been a pawn to corporate interests. When Congress implemented the Prescription Drug User Fee Act, drug companies now began to pay FDA “user fees” for mandated testing, fees to accelerate permission to release drugs to market, which is often a complicated and drawn-out process. Drug companies now spent \$310,000 for each application. These fees eventually accounted for half of the FDA budget, making the department reliant on the companies they were supposed to be monitoring.¹³⁸ As the

¹³⁷ Ibid.

¹³⁸ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

agency became so dependent on user fees from Big Pharma, the the relationship between the FDA and Big Pharma progressively mirrored that of two businesses cooperating.

OxyContin was introduced without any formal clinical studies on how addictive the drug was. Additionally, there have never been any documented clinical trials that explicitly display the success of opioids in treating chronic pain.¹³⁹ However, the FDA sanctioned the narcotic and further described the pill's patented delayed-absorption as a way to "reduce the abuse liability." Dr. Curits Wright was the F.D.A. official who approved OxyContin and promoted it with intense zeal, only to begin working at Purdue Pharma shortly after.¹⁴⁰

For over ten years, Big Pharma would spend tens of thousands of dollars for each opportunity to have its representative directly collaborate with FDA officials regarding opioid policies. Beyond lobbying the FDA, Big Pharma annually spends billions on donations to politicians, especially Republicans.¹⁴¹ Big Pharma was very generous to the Bush presidential campaigns, the McCain campaign, and the Romney campaign. Big Pharma used \$152 million in lobbying efforts during 2016, reports the Center for Responsive Politics. Big Pharma donated over \$20 million specifically to campaigns. 60% of this sum went to Republicans. Former Speaker of the House Paul Ryan received the greatest amount with contributions coming to \$228,670.¹⁴² 90% of members in the House of Representatives and 97 of the 100 US senators have received campaign funding from Big Pharma.¹⁴³

¹³⁹ Morrissey, Big Pharma Held Accountable for the Opioid Epidemic?

¹⁴⁰ Keefe, The Family That Built an Empire of Pain.

¹⁴¹ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

¹⁴² McGreal, How big pharma's money – and its politicians – feed the US opioid crisis.

¹⁴³ Ibid.

Since Big Pharma gained prominence in the 1990s, all White House administrations and many congressional representatives have forged close ties. Even while during his campaign, Obama condemned Big Pharma for their role in making healthcare so expensive, he nonetheless formed close relationships with Big Pharma. Billy Tauzin, then President and CEO of PhRMA (the pharmaceutical lobbying group) became a close ally with Obama in 2009. Obama collaborated with Tauzin and CEOs of pharmaceutical companies like Merck and Pfizer to restrict less expensive imports, challenge price limits, and guarantee government subsidies with the contingency that Big Pharma would champion the administration's reforms. On behalf of nonprofit health care, James Lowe said, "Since Obama came into office, the drug industry has received everything it wants."¹⁴⁴

PhRMA, the trade association, is the biggest at large interest-group, employing over 150 lobbying firms and 675 lobbyists. Lobbyists for PhRMA include twenty-five former representatives.¹⁴⁵ Beyond PhRMA, other lobbying groups exist on behalf of Big Pharma. Citizens for Better Medicare presents itself as a grassroots organization led by senior citizen groups but was created with the exclusive intent of advocating for Big Pharma-specific issues.¹⁴⁶ The Pain Care Forum (PCF) was created by a Purdue Pharma lobbyist. The American Cancer Society has a lobbying subdivision sponsored mostly by pharmaceutical companies and advocates that cancer patients should continue to be

¹⁴⁴ Boggs, *Drugs, Power, and Politics: Narco Wars, Big Pharma, and the Subversion of Democracy*.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid.

prescribed opioids with regularity.¹⁴⁷

On the state level, the Center for Public Integrity reports, “The makers of prescription painkillers have adopted a 50-state strategy that includes hundreds of lobbyists and millions in campaign contributions to help kill or weaken measures aimed at stemming the tide of prescription opioids.”¹⁴⁸ An example of this, New Mexico has the second greatest rates of opioid deaths behind West Virginia. In 2012, a bill was proposed that would have restricted prescriptions to a seven-day maximum for pain management. This bill was shot down after Big Pharma lobbyists fought against it and spent \$32,000 lobbying the state legislature.¹⁴⁹ Additionally, a meeting in San Francisco of West Coast attorneys general was sponsored by opioid producers and distributors who expended over \$100,000 on the event. There are federal restrictions for Congressional lobbyists, but none for lobbying state attorneys general.¹⁵⁰

Despite Big Pharma’s influence and resources, legal action has been sought against these corporations (namely Purdue Pharma). Legal action against these companies request compensation for those affected by the epidemic, rulings to stop all misleading marketing, and require greater liability from the companies. Today, over forty state attorneys general have collaborated to conduct an investigation into the industry. Hundreds of local governments are additionally seeking legal action against the opioid

¹⁴⁷ Lurie, J. (2017, June 23). Opioids are ravaging the country. These lobbyists want to keep the drugs flowing. Retrieved from <https://www.motherjones.com/politics/2016/09/opioid-lobbying-pharmaceutical-companies/>

¹⁴⁸ Ibid.

¹⁴⁹ Ibid.

¹⁵⁰ Julianna Goldman, L. S. (2018, January 25). Drug companies flex lobbying muscle in fight against state opioid lawsuits. Retrieved from <https://www.cbsnews.com/news/drug-companies-flex-lobbying-muscle-in-fight-against-state-opioid-lawsuits/>

industry.¹⁵¹

Lewis S. Nelson, chairman of the Department of Emergency Medicine at Rutgers University describes the state's motivation, saying "It became a state issue because there wasn't a lot of movement on the federal level. to this date, the federal government hasn't been very effective at regulating the practices of these pharmaceutical companies." Beyond the harm done to those affected firsthand by the opioid crisis, New Jersey has noted how expensive the epidemic is. The cost of hospital bills, drug courts, and emergency responses are born by states.¹⁵²

For this reason, New Jersey has sought legal action against a subdivision of Johnson & Johnson that produces opioids, charging the company with misinforming consumers about the addictive nature of the drugs. This is the first time that New Jersey has taken legal action against any company based in the state. The opioid crisis has been especially harmful in the state.¹⁵³

Leading the largest legal battle against Big Pharma is Mike Moore. He and the suit maintain that Purdue Pharma was disingenuous about the addictive character of the opioids to both consumers and medical professionals He acted as the attorney general of Mississippi from 1988 to 2004 but is most recognized for his role in negotiating the \$246 billion, 46-state settlement with Big Tobacco companies at the end of the 1990s. This settlement prompted major advertising restrictions for tobacco and endowed anti-

¹⁵¹ Higham & Bernstein, How Congress allied with drug company lobbyists to derail the DEA's war on opioids.

¹⁵² Corasaniti, N. (2018, November 13). New Jersey Sues Pharmaceutical Company Amid Spiraling Opioid Crisis. Retrieved from <https://www.nytimes.com/2018/11/13/nyregion/nj-opioid-lawsuit.html>

¹⁵³ Ibid.

smoking initiatives.¹⁵⁴

Following Moore's Big Tobacco settlement, television became saturated with infomercials campaigning against cigarettes, labels were slapped across cigarette packages warning of the danger, and curriculums in educational systems increased discussions of tobacco. If Moore is as successful in today's opioid case as he was in the tobacco one, there could be great room for new methods of prevention.

In the meantime, regardless of legal action and fees, Big Pharma continues similar practices without serious ramification. When Purdue Pharma settled for \$60 million in 2007, political commentator Stephen Colbert remarked, "You know you've been bad when the government fines you one aircraft carrier. Of course, this same time they made \$35 billion."¹⁵⁵ Fines paid by these corporations- while exorbitant- are comparatively small in context to overall profits.

Big Pharma executives, while behaving in eerily similar ways to illicit drug dealers, evade prison time. This stands in stark contrast to those who were punished during the War on Drugs. While Purdue Pharma and its counterparts may receive penalties consequent of their actions, by no means is their punishment parallel to those criminalized during the War on Drugs.

A slippery slope of corporate influence transformed supposed watchdog organizations like the FDA and DEA into largely pro-business entities. A balance must exist between more lenient policies of enforcement for common-place drug offenders

¹⁵⁴ Galvin, He Brought Big Tobacco to Heel. Now He's Targeting Big Pharma.

¹⁵⁵ Kreps,. See Stephen Colbert Tackle Opioid Crisis, Criticize Big Pharma on 'Late Show'.

versus lenient regulatory policies resulting in limited governmental oversight of potent and addictive painkillers.

As licit drugs sold by Big Pharma serve a medicinal purpose, they must be regulated and not banned, unlike the instinctual response to prohibit illicit drugs. For this reason, change can only happen once our hyper-medicalized society addresses notions on pain management and the conflicting role Big Pharma has played in facilitating policy. While incompatible on the surface level, this thesis concludes that lenient policies towards drug users and towards pharmaceutical companies both reflect how the medicalization of American society has influenced the departure from the War on Drugs.

Conclusion:

This thesis sought to answer why policy responses to the opioid crisis are so different than those of the War on Drugs- given the inherent dissimilarities between the War on Drugs and policy responses to the opioid crisis.

To do so, I considered public health-driven responses aimed towards addressing addiction. This follows decades of tough-on-crime drug policies and sentencing. I further considered why supply-side enforcement looks so different during the opioid crisis compared to during the War on Drugs. Matthew Murphy, former Chief of Pharmaceutical Investigations for the DEA in Boston makes the acute distinction, “the heroin and cocaine traffickers didn’t have a class ring on their finger from a prestigious university.”¹⁵⁶

With “politically Machiavellian” efforts, pharmaceutical companies have gained the authority to influence greater leniency in regulatory and legislative policies.¹⁵⁷ It is this influence that has made supply-side responses so different during the opioid crisis than those of the War on Drugs.

This thesis concludes that while incompatible on the surface level, lenient policies towards drug users and towards pharmaceutical companies both reflect how the medicalization of American society has influenced the departure from the War on Drugs. The “medical model” of health care, which emphasizes drugs, medical treatment, and surgery is ingrained in society and the economy. It is this medical model that can explain the prominence and profits pharmaceutical companies has gained. It can further explain

¹⁵⁶ Higham & Bernstein, How Congress allied with drug company lobbyists to derail the DEA's war on opioids.

¹⁵⁷ Keefe, The Family That Built an Empire of Pain.

why the instinctual response now is to remedy issues of addiction through public-health tactics.

This thesis concludes that for at least the immediate future, the medical model will continue to have greater influence over the creation of drug policies. This is especially so given the move away from mass incarceration. For this reason, change can only happen once our hyper-medicalized society addresses notions on pain management and the conflicting role Big Pharma has played in facilitating policy.

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