

Opioids, Addiction Treatment, and the Long Tail of Eugenics

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I. INTRODUCTION

Our attitude, treatment, and punishment of opioid addiction partly results from the long, intertwined history of eugenics and incarceration. As I have discussed in other work,¹ there is a thread of eugenics-based philosophy undergirding our widespread imprisonment of the poor, disabled, and dependent. The current approach to opioid addiction in the criminal justice and sentencing worlds reflects this bias, hindering our ability to best treat the opioid crisis. Unsurprisingly, the American public has proven receptive to scare stories about “the dangerous classes.”²

As I discuss below, the 21st century tactics to combat the opioid addiction crisis unwittingly track the methods used to address the widespread use of opioids in the late 19th and early 20th centuries, with equally troubling results. Indeed, addiction to pharmaceutical opiates is no recent problem; historically, iatrogenic drug use has been far more extensive than illicit drug use.³ Old errors are being re-enacted as we attempt to solve the problems of opioid-addicted offenders during sentencing, inside correctional facilities, and on release. Accordingly, before we craft workable policies to combat the opioid crisis, we must fully explore and understand the history of iatrogenic opioid addiction, to avoid making the same mistakes.

II. HISTORY OF REGULATING OPIOIDS

The use of opioids in one form or another dates back centuries, but it wasn't

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¹ See Laura I Appleman, *Deviancy, Dependency, and Disability: The Forgotten History of Eugenics and Mass Incarceration*, 68 DUKE L.J. 417, 419 (2018).

² DIANA R. GORDON, THE RETURN OF THE DANGEROUS CLASSES: DRUG PROHIBITION AND POLICY POLITICS 11 (1994).

³ See David Herzberg, *Entitled to Addiction?: Pharmaceuticals, Race, and America's First Drug War*, 91 BULL. HIST. MED. 586, 586 (2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5679069/> [<https://perma.cc/479R-9CFB>].

until the last third of the 19th century that opiate addiction was identified as a real problem in the United States.⁴ Following the Civil War, a variety of influences combined to bring narcotics addiction out of the shadows to become a matter of local and national concern. This concordance of factors included the increased use of narcotics by doctors, the demographic change regarding who used opiates,⁵ and a strong underpinning of eugenics—specifically, the fear that classes, races, and genders would mix, “degrading” pure American stock.⁶

Throughout the 19th century, the majority of opium addicts were women, with some evidence to suggest that these disproportional numbers persisted until the early 20th century.⁷ Most opium/morphine addicts were between twenty-five and forty-five years old; it was considered a “vice of middle life.”⁸ The users of morphine and opium were largely white and native-born, with a large percentage in the middle or upper classes.⁹ By the 1890s, it is estimated that 4.59 of every thousand people in the United States were addicted to opiates.¹⁰ The emergence of “white markets” for sedatives, stimulants, and narcotics, sold overwhelmingly to white, middle class men and women, cemented this problem.¹¹

Opium and morphine were common additions to over-the-counter pharmaceuticals, found in such concoctions as Dover’s powder, laudanum, and patent medicines.¹² Prior to 1800, opium was available only in its crude forms such as laudanum, “black drop” extracts, or via prescription.¹³ By 1834, opium was the most frequently prescribed drug in the United States.¹⁴

Addiction in the 19th century was principally caused by physician administration of opiates/morphine.¹⁵ Following the introduction and widespread use of the hypodermic needle, which made injection of morphine far easier, morphine use increased dramatically, as injected morphine was one

⁴ See Michael Waldrop, *A Little Less Regulation: Why Federal Pain Management Laws Are Hurting State Efforts to Combat the Opioid Epidemic*, 43 MITCHELL HAMLINE L. REV. 881, 885–86 (2017).

⁵ See TIMOTHY A. HICKMAN, *THE SECRET LEPROSY OF MODERN DAYS: NARCOTIC ADDICTION AND CULTURAL CRISIS IN THE UNITED STATES, 1870–1920*, at 2 (2007).

⁶ See DAVID T. COURTWRIGHT, *DARK PARADISE: A HISTORY OF OPIUM ADDICTION IN AMERICA* 36 (2001).

⁷ *Id.*

⁸ *See id.* at 37.

⁹ *Id.* at 37, 41.

¹⁰ *See id.* at 9.

¹¹ Herzberg, *supra* note 3, at 592.

¹² COURTWRIGHT, *supra* note 6, at 35–36.

¹³ ROBERT M. HARDAWAY, *NO PRICE TOO HIGH: VICTIMLESS CRIMES AND THE NINTH AMENDMENT* 87 (2003).

¹⁴ COURTWRIGHT, *supra* note 6, at 45.

¹⁵ *See id.* at 42.

of the few reliable respites from excruciating pain.¹⁶ Therapeutically induced, or iatrogenic, addiction was extremely widespread throughout the 19th and early 20th centuries, particularly for those who had chronic medical issues.¹⁷ Although concerns with morphine's addictive nature were prevalent by the late 1880s, many doctors continued to prescribe it simply due to inadequate medical education.¹⁸ Approximately 15% of all prescriptions in 1888's Boston, for example, were for opiates.¹⁹

The other main delivery service for opiate use was through the widespread use of patent medicines.²⁰ The active ingredients in most of these patent medicines were alcohol, cocaine, and morphine.²¹ Many of the drug companies selling such patent medicines subtly discouraged the use of a physician, claiming these medicines would allow an individual to diagnose and treat herself.²²

Until the 1890s, use of opiates was not a federal offense.²³ Prior to 1906, any laws concerning opiates were local, imposed either by cities or individual states, and only nine states and territories had laws prohibiting nonprescription opium sales.²⁴ In 1874, San Francisco became the first city to criminalize the smoking of opium in opium dens.²⁵ It did not ban opium's sale, import, or use otherwise, however.²⁶ San Francisco's ban on smoking opium resulted directly from openly anti-Chinese sentiment, culminating in fears that opium smoking was yet another way that Chinese immigrants sought to undermine American society.²⁷ Thus, hardening attitudes regarding the increasing Chinese immigrant

¹⁶ See Joseph M. Gabriel, *Opiate Addiction and the History of Pain and Race in the US*, CONVERSATION (June 19, 2018), <https://theconversation.com/opiate-addiction-and-the-history-of-pain-and-race-in-the-us-97430> [<https://perma.cc/6CSU-PASJ>].

¹⁷ See COURTWRIGHT, *supra* note 6, at 48.

¹⁸ *Id.* at 49–50.

¹⁹ Erick Trickey, *Inside the Story of America's 19th-Century Opiate Addiction*, SMITHSONIAN MAG. (Jan. 4, 2018), <https://www.smithsonianmag.com/history/inside-story-americas-19th-century-opiate-addiction-180967673/> [<https://perma.cc/CFU7-CZH3>].

²⁰ Patent medicines were not really patented, instead protected by trademark and considered “proprietary” remedies, sold by drug manufacturers who aimed their products at the general public. Joseph F. Spillane, *The Road to the Harrison Narcotics Act: Drugs and Their Control, 1875–1918*, in FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 4 (Jonathon Erlen & Joseph F. Spillane eds., 2004).

²¹ *Id.*

²² *Id.*

²³ HARDAWAY, *supra* note 13, at 88.

²⁴ Audrey Redford & Benjamin Powell, *Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914*, 20 INDEP. REV. 509, 519 (2016).

²⁵ *Opium Throughout History*, PBS: FRONTLINE (1998), <https://www.pbs.org/wgbh/pages/frontline/shows/heroin/etc/history.html> [<https://perma.cc/4XVN-7ZXQ>].

²⁶ See *id.*

²⁷ See HARDAWAY, *supra* note 13, at 88. As Hardaway notes, “[t]he first anti-opium crusade in U.S. history was directed against working class Chinese people brought over for cheap labor and no longer needed by 1870.” *Id.* at 89.

population intertwined with a growing worry about dangerous drugs, ultimately creating a generalized panic about smoking opium in specialized parlors.²⁸

By 1896, twenty-two states and territories, including California, Georgia, New York, Washington, and Massachusetts, outlawed the keeping of an opium den for the purpose of smoking opium, although opiate use was not regulated in other ways.²⁹ These laws were passed in reaction to both Chinese immigrants and non-Chinese Americans who had taken up opium smoking, rapidly labeled as “undesirables,” “unholy persons,” and “persons of the underworlds of prostitution, crime, and filthiness.”³⁰ There was a growing fear, stoked heavily by the media,³¹ that opium smoking would spread across the races and up the social ladder as the means for doing so became more respectable.³² Most disturbing to the San Francisco police department was the sight of “white women and Chinamen side by side” in opium dens; as the department noted in a plea to the California state legislature, this was “a humiliating sight to anyone with anything left of manhood.”³³ Indeed, part of the danger of the opium parlor was its lack of regard for class, racial, or gendered status³⁴—all was blurred in the haze of opium smoke.

Morphine and different forms of opiates, on the other hand, were viewed as far less degenerate and destructive. While smoking opium alone was considered dangerous and morally suspect, other opiate uses were seen as standard medical treatment.³⁵ Medicinal use of opium continued to be seen as an acceptable form of behavior, but smoking opium was judged intolerable, and needing to be suppressed with the use of regulation and criminalization.³⁶

In this way, a distinguishing line was drawn between blameless patients lacking volition, forced into opiate addiction through either pain or physician prescription, and the opium smoker, mired in addiction through their own volition (and thus responsible for their narcotic abuse).³⁷ We see a similar classification of opiate users today, with our understanding of users as either patients or criminals,³⁸ licit drug users or illicit pleasure seekers.³⁹

²⁸ Joseph M. Gabriel, *Restricting the Sale of “Deadly Poisons”: Pharmacists, Drug Regulation, and Narratives of Suffering in the Gilded Age*, 9 J. GILDED AGE & PROGRESSIVE ERA 313, 331 (2010).

²⁹ Redford & Powell, *supra* note 24, at 513.

³⁰ *Id.*

³¹ HARDAWAY, *supra* note 13, at 89.

³² See Redford & Powell, *supra* note 24, at 517.

³³ HARDAWAY, *supra* note 13, at 89.

³⁴ HICKMAN, *supra* note 5, at 70.

³⁵ See HARDAWAY, *supra* note 13, at 90.

³⁶ See Gabriel, *supra* note 28, at 332.

³⁷ HICKMAN, *supra* note 5, at 67.

³⁸ See Gabriel, *supra* note 28, at 316.

³⁹ See Herzberg, *supra* note 3, at 588.

Morphine, the active ingredient in opium, was isolated in 1806,⁴⁰ and quickly became the most popular narcotic to treat chronic pain, gaining widespread acceptance as the 19th century progressed.⁴¹ Pure morphine was easily made in large amounts.⁴² From the 1850s on, morphine was primarily used to relieve pain and treat various ailments, although its addictive nature was not unknown.⁴³ As morphine's addictive aspects became clearer, alternatives were synthesized in hopes of finding a less addictive narcotic.⁴⁴ For example, in 1874, Bayer Pharmaceuticals isolated diacetylmorphine in hopes of better treating asthma and bronchitis, creating a new narcotic called heroin.⁴⁵

Bayer began commercially producing heroin in 1898, and the use of heroin by both doctors and addicts increased exponentially.⁴⁶ Heroin was originally believed to be less addictive than morphine, since addiction to heroin took longer than morphine addiction, because smaller amounts were needed per use.⁴⁷ Like laudanum, another opiate derivative, heroin was present in a variety of medicines treating numerous ailments.⁴⁸ In 1906, the American Medical Association approved heroin for general use, urging heroin prescription over morphine, because they believed it was less addictive.⁴⁹ In fact, pharmaceutical grade heroin was twice as powerful as morphine.⁵⁰

Despite widespread use, however, there were no laws regulating the use of morphine, heroin, cocaine,⁵¹ or other drugs, because the use of such opiates was not considered particularly harmful or dangerous.⁵² It took until the late 19th century for even physicians and pharmacists, who had gradually become aware of opiates' addictive nature, to agitate for some sort of regulation and restriction

⁴⁰ Michael J. Brownstein, *A Brief History of Opiates, Opioid Peptides, and Opioid Receptors*, 90 PROC. NAT'L ACAD. SCI. 5391, 5391 (1993), <http://www.pnas.org/content/pnas/90/12/5391.full.pdf> [<https://perma.cc/K8QB-P2PM>].

⁴¹ See Waldrop, *supra* note 4, at 887–88.

⁴² Brownstein, *supra* note 40, at 5391.

⁴³ Redford & Powell, *supra* note 24, at 518.

⁴⁴ Waldrop, *supra* note 4, at 888.

⁴⁵ Alan Gordon & Alexandra A. Gordon, *Does It Fit? A Look at Addiction, Buprenorphine, and the Legislation Trying to Make It Work*, 12 J. HEALTH & BIOMEDICAL L. 1, 3 (2016).

⁴⁶ See Sonia Moghe, *Opioid History: From "Wonder Drug" to Abuse Epidemic*, CNN HEALTH (Oct. 14, 2016), <https://www.cnn.com/2016/05/12/health/opioid-addiction-history/index.html> [<https://perma.cc/FFU8-GF33>].

⁴⁷ See Redford & Powell, *supra* note 24, at 518–19.

⁴⁸ See Gordon & Gordon, *supra* note 45, at 3.

⁴⁹ See Caroline J. Acker, *The Habit: Heroin and the Creation of Junkies*, BACK STORY RADIO (Apr. 6, 2018), <https://www.backstoryradio.org/shows/the-habit/#transcript> [<https://perma.cc/82F8-GRKS>] (scroll down to find episode).

⁵⁰ See *id.*

⁵¹ Indeed, cocaine was heavily marketed by pharmaceutical companies in the late 19th century, with physicians endorsing such products as "cocaine snuffs" for their stimulant and tonic effects. See Spillane, *supra* note 20, at 4.

⁵² See Redford & Powell, *supra* note 24, at 518.

on the widely available drugs.⁵³ The line between legitimate and illegitimate forms of drug consumption was just beginning to be drawn, compounding the problem.⁵⁴

The federal government only began to truly regulate opioids in the beginning of the 20th century. In 1906, as part of the Pure Food and Drug Act (motivated itself in part by the widespread use of morphine in 19th century patent medicines), the government began requiring the disclosure of morphine levels in over-the-counter drugs.⁵⁵ This disclosure was primarily to provide the upper-middle class, white opiate user with information about the purity and potency of the narcotics present in the medicine, reacting to contemporary fears about “counterfeit, contaminated, diluted, or decomposed drug materials.”⁵⁶

In 1909, the Smoking Opium Exclusion Act banned the importation, possession and use of “smoking opium,”⁵⁷ but didn’t regulate opium-based medications.⁵⁸ The Opium Exclusion Act was partially motivated by American territorial interests in the Philippines, which had a thriving opium trade, alarming the American missionaries stationed there.⁵⁹ Ironically, the ban on smoking opium led to a much higher domestic use of morphine, heroin, and other far more addictive drugs.⁶⁰

Further regulation of opium quickly followed. The 1914 Harrison Narcotics Tax Act made any company making, importing, or selling any opiate or coca derivative pay a tax.⁶¹ It was strongly championed by various temperance movements, who wanted to address “the obvious damage that this ‘sinful, depraved and immoral behavior’ caused among the ‘inferior races.’”⁶²

These xenophobic and blatantly eugenic beliefs were articulated by the combined forces of U.S. missionaries working in Asian countries, other

⁵³ See COURTWRIGHT, *supra* note 6, at 52.

⁵⁴ See Gabriel, *supra* note 28, at 316.

⁵⁵ NAT’L ACAD. SCIS., PAIN MANAGEMENT AND THE OPIOID EPIDEMIC: BALANCING SOCIETAL AND INDIVIDUAL BENEFITS AND RISKS OF PRESCRIPTION OPIOID ABUSE 359 (2017), <https://www.ncbi.nlm.nih.gov/books/NBK458654/> [<https://perma.cc/Z5CL-U9NJ>].

⁵⁶ See Wallace F. Janssen, *The Story of the Laws Behind the Labels*, FDA CONSUMER MAG. 2, 4 (1981), <https://www.fda.gov/downloads/AboutFDA/History/FOrgsHistory/EvolvingPowers/UCM593437.pdf> [<https://perma.cc/NN9S-VECF>].

⁵⁷ The ban was due largely to nativist fears and prejudice about Chinese immigrants smoking opium and spreading the habit to Americans. See Trickey, *supra* note 19, at 3.

⁵⁸ See Redford & Powell, *supra* note 24, at 521 (noting that *smoking* opium was banned).

⁵⁹ See Trickey, *supra* note 19, at 3.

⁶⁰ See Redford & Powell, *supra* note 24, at 523.

⁶¹ See Moghe, *supra* note 46, at 2. The Harrison Drug Act was passed for a number of reasons, including the desire to “confine narcotics traffic to legitimate medical channels;” to “bring drug transactions into the light of day;” to “eliminate drug peddling;” to “provide more information about the narcotics supply chain;” and to create a workable mechanism “through which antinarcotic states could better enforce the importation of drugs into their state” from pro-narcotic states. Redford & Powell, *supra* note 24, at 524.

⁶² Joseph D. McNamara, *The Hidden Costs of America’s War on Drugs*, 26 J. PRIV. ENTERPRISE 97, 98 (2011).

American religious groups, and temperance organizations, and persuaded Congress that not only were narcotics sinful, but that their users were also dangerous and depraved.⁶³ In their view, narcotics needed to be outlawed because “[c]ocaine raised the specter of the wild Negro, opium the devious Chinese, morphine the tramps in the slums.”⁶⁴ The opium den posed a particular danger because its existence was just barely out of sight, hidden but easily accessible within the cellars and back alleyways of American cities.⁶⁵ Although Chinese immigration was banned in 1882, both Chinese individuals and opium parlors remained as signifiers of foreign menace.⁶⁶

One result of the Harrison Act was its restriction of prescribing narcotics to addicts, thereby eliminating a safe, legal way for them to obtain the drugs (what we now call maintenance).⁶⁷ Although pharmacists and physicians could still prescribe opiates, the practice was sharply curtailed, since the law contained enough ambiguities about whether an addict could be prescribed opiates, even for maintenance reasons.⁶⁸ Moreover, any physician or pharmacist suspected of prescribing to addicts was either prosecuted or harassed.⁶⁹

Meanwhile, the quest for a nonaddictive pain reliever continued.⁷⁰ In 1916, German scientists first synthesized oxycodone, in hopes that it would provide the pain relief of heroin and morphine without their addictive qualities.⁷¹ Oxycodone, of course, is the primary active ingredient inside the highly addictive narcotic OxyContin, promoted by Purdue Pharma as a nonaddictive opioid suitable for long-term use of chronic pain relief.⁷²

Further crackdown on the use of narcotics was enabled by the passage of the Narcotic Drugs Import and Export Act of 1922, which prohibited the possession, use, or import of narcotics—largely cocaine and opium—except for medical use.⁷³ The 1922 Act also established the Federal Narcotics Control Board for enforcement purposes.⁷⁴ Heroin was ultimately made illegal in 1924

⁶³ *See id.*

⁶⁴ DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* 65 (3d ed. 1987).

⁶⁵ HICKMAN, *supra* note 5, at 62.

⁶⁶ *Id.* at 64.

⁶⁷ *See* Redford & Powell, *supra* note 24, at 526.

⁶⁸ *See* COURTWRIGHT, *supra* note 6, at 2.

⁶⁹ *Id.*

⁷⁰ *See* Waldrop, *supra* note 4, at 889.

⁷¹ *Id.*

⁷² *See* Jonathan Stempel, *New York Sues OxyContin Maker Purdue Pharma over Opioids*, REUTERS (Aug. 14, 2018), <https://www.reuters.com/article/us-usa-opioids-purduepharma/new-york-sues-oxycotin-maker-purdue-pharma-over-opioids-idUSKBN1KZ1WZ> [<https://perma.cc/49AD-WNDK>].

⁷³ *See* Ronna J. Dillinger & Jennifer Cameron, *Narcotic Drug Import and Export Act*, in *ENCYCLOPEDIA OF DRUG POLICY* 546, 546 (Mark A. R. Kleiman & James E. Hawdon eds., 2011).

⁷⁴ *See id.*

with the Heroin Act, which prohibited manufacture and importation of the drug, and made possession of heroin illegal, even for medicinal use.⁷⁵

The 1938 Food, Drug, and Cosmetic Act subsequently required drug manufacturers to safety test their products prior to approval.⁷⁶ However, the opioids already being sold, such as codeine, morphine, and oxycodone, were still legal to prescribe to patients.⁷⁷ This was in sharp contrast to the federal and state laws prohibiting the use and sale of such “street” narcotics like heroin, cocaine, and marijuana, which were used by the poor and nonwhite.⁷⁸ Despite copious evidence to the contrary, opium use was largely ascribed to (and blamed on) Chinese laborers, cocaine to Southern African-Americans, and marijuana to Mexican immigrants and citizens.⁷⁹

III. THE CHANGING FACE OF OPIOID ADDICTION

Motivating these changes in drug criminalization and much stricter regulation was a change in opiate addict type. Beginning in the early 20th century, the public, recognized face of the typical opiate addict—middle class, middle-aged Anglo-Saxon white female—began to transform into the far more threatening poor urban residents, who were often categorized as street criminals.⁸⁰ These new opiate users were “white,” but of Southern and Eastern European extraction, whose status as members of the white race was deeply questioned during this era of eugenics and fears of immigration.⁸¹

Starting in the 1870s, opium dens spread across the nation, operated by Chinese immigrants.⁸² These opium dens, found in most major cities, tended to attract both indentured Chinese immigrant workers and white Americans, especially those who were poor, young and male.⁸³ This seeming change in opiate addict, from unthreatening white woman to fear-inducing delinquent, criminal, or recent immigrant, meant that American views and understanding of addiction transformed. The discourse of addiction used racialized and gendered language that helped inscribe stereotypes of Asians, African-Americans, and

⁷⁵ See Redford & Powell, *supra* note 24, at 527.

⁷⁶ See NAT'L ACAD. SCIS., *supra* note 55, at 359.

⁷⁷ See Waldrop, *supra* note 4, at 890.

⁷⁸ See Carl L. Hart, *How the Myth of the “Negro Cocaine Fiend” Helped Shape American Drug Policy*, NATION (Jan. 29, 2014), <https://www.thenation.com/article/how-myth-negro-cocaine-fiend-helped-shape-american-drug-policy/> [https://perma.cc/RF4K-V7RZ]. As Hart observes, “Although the Harrison Act did not explicitly prohibit the use of opiates or cocaine, enforcement of the new law quickly became increasingly punitive. . . .” *Id.*

⁷⁹ See *A Brief History of the Drug War*, DRUG POL'Y ALL., <http://www.drugpolicy.org/issues/brief-history-drug-war> [https://perma.cc/7AJD-RG6E].

⁸⁰ COURTWRIGHT, *supra* note 6, at 1.

⁸¹ Herzberg, *supra* note 3, at 593.

⁸² See Trickey, *supra* note 19, at 2.

⁸³ *Id.*

women of all races.⁸⁴

The reaction to the growing opioid addiction by progressive reformers entirely depended on who the addict was. If the addict was middle class and Anglo-Saxon, their drug dependence was likened to accidental poisoning: “a horrifying tragedy caused by an unregulated market.”⁸⁵ For these unfortunate souls, the solution was stronger consumer protections, such as correct labeling of medicines, as well as increased professional standards for medical professionals.⁸⁶

Simultaneously, however, a growing number of medical professionals in the 1920s and 30s began to see addiction as a problem of delinquency and moral rot.⁸⁷ No longer was addiction viewed as a physical reliance or habituation issue.⁸⁸ Previously, opiate addicts were viewed with some measure of sympathy, as victims suffering terrible bondage, felled by an unfortunate twist of fate.⁸⁹ By the early decades of the 20th century, however, *illicit* opioid addiction began to be characterized as a manifestation of psychopathy or some other form of twisted personality.⁹⁰ “The average doctor came to think of the average addict as somehow beyond the pale, an unstable and compulsive personality better left to the management of the police or other authorities.”⁹¹ As a result, medical professionals began to support mandatory institutionalization of certain types of addicts, and refused to supply opiates to suffering addicts (especially the nonmedical type).⁹²

The increase in regulation and criminalization of opiates gained popularity in part because government regulation was believed to provide a solution to the problem of the autonomous, uncontrolled individual,⁹³ particularly when that individual was neither white nor wealthy. This second kind of narcotics user, who used opiates for pleasure and not medical necessity, was not only seen as psychologically deficient, but also possessing an inborn susceptibility or weakness to addiction from the beginning.⁹⁴ The nonmedical addict, then, was viewed as inferior, becoming “a profound symbol of deviance to mainstream conventional Americans.”⁹⁵

This concern about undesirable addicts occurred at a time of rapid industrialization and urbanization, which brought together a mix of people and

⁸⁴ See HICKMAN, *supra* note 5, at 60.

⁸⁵ Herzberg, *supra* note 3, at 594.

⁸⁶ *See id.*

⁸⁷ *See* COURTWRIGHT, *supra* note 6, at 3.

⁸⁸ *See* Gabriel, *supra* note 28, at 328.

⁸⁹ *See id.*

⁹⁰ COURTWRIGHT, *supra* note 6, at 3.

⁹¹ *Id.*

⁹² *See id.*

⁹³ *See* Gabriel, *supra* note 28, at 316.

⁹⁴ *See* CAROLINE JEAN ACKER, CREATING THE AMERICAN JUNKIE: ADDICTION RESEARCH IN THE CLASSIC ERA OF NARCOTIC CONTROL 126 (2002); Acker, *supra* note 49.

⁹⁵ Acker, *supra* note 49.

classes in a way that alarmed many middle class and elite Americans.⁹⁶ Early 20th century fears about rising numbers of degenerates or feeble-minded individuals led to the belief that positive selective breeding was needed to prevent the hereditary inheritance of certain negative traits.⁹⁷ An innate weakness towards addiction was one of them.⁹⁸

Some eugenicists even suspected that opiates were tools used by Asians to overthrow the Anglo-Saxon race.⁹⁹ One way to ensure that those individuals with inferior breeding did not mix with proper American stock was to criminalize the substances, such as morphine and heroin, used by these undesirable addicts.¹⁰⁰

As the number of white, native-born, middle class Americans suffering from opiate addiction began to drop, many nonmedical drug users continued to use these narcotics, simply shifting from legal to illegal substances, such as heroin.¹⁰¹ As a result, the consensus around addiction transformed into a problem of poor, non-native, inner-city “junkies” using heroin.¹⁰² Medical use of opiates, on the other hand, was deemed under control, and thus far less problematic.¹⁰³

Although strongly promulgated by doctors, drug reformers, and the federal government, this narrative of decreasing iatrogenic users was not entirely correct.¹⁰⁴ “White” medical markets enabled long-term narcotics use for iatrogenic addicts, with only mildly therapeutic reasons.¹⁰⁵ These continuing opiate users, who were white and native-born, tended to live in the Midwest or South,¹⁰⁶ in the suburbs and more rural areas, and obtained their opiates from mostly informal, noncommercial transactions.¹⁰⁷

Thus, although the standard argument was that the typical face of an opioid addict had changed by the late 1920s and early 1930s, this was not precisely

⁹⁶ *See id.*

⁹⁷ Paula Larsson, *Alcoholism and Drug Use*, EUGENICS ARCHIVES (Apr. 28, 2014), <http://eugenicsarchive.ca/database/documents/535eeaa27095aa000000020f> [https://perma.cc/32R8-RMNF].

⁹⁸ *See id.*

⁹⁹ *See* EMILY F. MURPHY, *THE BLACK CANDLE* 188 (1922). Murphy argued, “It is hardly credible that the average Chinese [peddler] has any definite idea in his mind of bringing about the downfall of the white race, his swaying motive being probably that of greed, but in the hands of his superiors, he may become a powerful instrument to this very end.” *Id.*

¹⁰⁰ *See* Larsson, *supra* note 97.

¹⁰¹ Herzberg, *supra* note 3, at 596. As Courtwright further explains, “After 1915 the number of nonmedical addicts continued to increase relative to the total, because of the progressive die-off of medical addicts and the continued recruitment of young users, especially in the slum areas of large cities.” COURTWRIGHT, *supra* note 6, at 111.

¹⁰² Herzberg, *supra* note 3, at 596.

¹⁰³ *See* COURTWRIGHT, *supra* note 6, at 119.

¹⁰⁴ *See* Herzberg, *supra* note 3, at 598.

¹⁰⁵ *See id.* at 610.

¹⁰⁶ *See* COURTWRIGHT, *supra* note 6, at 122.

¹⁰⁷ *See* Herzberg, *supra* note 3, at 604.

true. Middle and upper class iatrogenic addicts tended to be quite secretive about their use, especially if their narcotics were obtained through the help of a sympathetic physician.¹⁰⁸ “Good faith” medical practice allowed doctors to prescribe opiates to those in medical need, such as incurable addicts, those approaching the end of life, and temporary relief for the “ordinary addict.”¹⁰⁹ In other words, doctors continued to enjoy considerable leniency in the prescribing of narcotics, which led to an estimated 35,000 medically supplied addicts nationwide.¹¹⁰ Despite this leniency regarding medically enabled opiate access, however, most doctors and citizens believed narcotics addiction had transformed into an urban underworld issue.¹¹¹

Iatrogenic addicts continued to be supplied by their doctors until at least the 1950s and 60s.¹¹² In California, the state AG claimed to have discovered 32,000 licit opiate users, while in Virginia, the majority of addicts obtained their opiates from doctor prescriptions.¹¹³ Likewise, a federal study of Kentucky in the late 60s found that a large number of addicts were “white, Anglo-Saxon Protestants” from “long-established families,” using physician-provided morphine for long-standing addictions.¹¹⁴

This divided system of treating opiate addicts—turning a blind eye to the many middle class iatrogenic narcotics users who were supplied by their physicians while punishing and criminalizing the urban poor’s illicit use of narcotics—did not end until the 1970s.¹¹⁵ Addictive medicines and prescription opiates finally joined heroin and cocaine as controlled substances in the Comprehensive Drug Abuse Prevention and Control Act of 1970.¹¹⁶ Use and abuse of opiates was now regulated by the Drug Enforcement Administration (DEA).¹¹⁷

IV. LESSONS FOR TODAY

What can we learn from our nation’s first interaction and bout of addiction with opiates? There are many equivalents to today’s opioid crisis, as well as distinct patterns from which we can learn. First, and most obvious, the sharply rising narcotic and opioid consumption in the late 19th century sparked a major

¹⁰⁸ COURTWRIGHT, *supra* note 6, at 123.

¹⁰⁹ Herzberg, *supra* note 3, at 599; *see also* BUREAU OF PROHIBITION, TREASURY DEP’T, REGULATIONS NO. 5 58–59 (1927).

¹¹⁰ Herzberg, *supra* note 3, at 601–02.

¹¹¹ *See* COURTWRIGHT, *supra* note 6, at 123.

¹¹² *See* Larsson, *supra* note 97.

¹¹³ *See* Herzberg, *supra* note 3, at 603.

¹¹⁴ JOHN A. O’DONNELL, NAT’L INST. MENTAL HEALTH, NARCOTIC ADDICTS IN KENTUCKY 65 (1969).

¹¹⁵ *See* Herzberg, *supra* note 3, at 616.

¹¹⁶ Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, § 202, 84 Stat. 1236, 1249–50.

¹¹⁷ Herzberg, *supra* note 3, at 617.

set of concerns and legal and medical reforms, paralleling the crisis today.¹¹⁸

Like today's opioid crisis, the realization first arose that a large number of people were iatrogenically addicted to opiates, which were prescribed in great amounts to treat chronic, painful conditions.¹¹⁹ Similar to today, when the extent of the addiction was realized, both regulators and physicians sought to severely limit opiate supply and accessibility, lobbying for harsher state and local laws to control narcotics sales and misuse.¹²⁰ The amount of opiate prescriptions from the late 1890s to the early 1900s dropped precipitously,¹²¹ as it has today. And, comparable to the 21st century opiate crisis, a black market in heroin and other drugs quickly arose to serve the desperate, dependent individuals who were now cut off from the opioid supply.¹²²

In addition, the opiate crisis around the turn of the 20th century sparked an unresolved debate about the utility and propriety of long-term maintenance for users, a debate that still currently rages.¹²³ A majority of prisons, jails, and probation/parole programs support an abstinence-based addiction treatment. This dominant abstinence-only model has never recognized medication-assisted treatment (MAT) as an acceptable form of recovery.¹²⁴

The reality, however, is that treatment for opiate addiction requires long-term management, and it is best managed with help from opioid maintenance programs,¹²⁵ as politically unpopular as that may be. Medical studies have shown that behavioral interventions alone have very poor outcomes, with more than 80% of patients returning to drug use.¹²⁶ Psychosocial interventions also lead to death far more frequently than maintenance programs.¹²⁷ Similarly limited results have been noted with medication-assisted detoxification.¹²⁸ The harsh physical and psychological effects of withdrawal often require more than

¹¹⁸ See David T. Courtwright, *Preventing and Treating Narcotic Addiction—A Century of Federal Drug Control*, 373 NEW ENG. J. MED. 2095, 2095 (2015).

¹¹⁹ See *id.*

¹²⁰ See *id.* at 2096.

¹²¹ See *id.*

¹²² See *id.* at 2097.

¹²³ See *id.*

¹²⁴ Maia Szalavitz, *The Rehab Industry Needs to Clean Up Its Act. Here's How.*, HUFF. POST, https://www.huffingtonpost.com/the-influence/the-rehab-industry-needs-clean-up_b_9210542.html [<https://perma.cc/2WDS-VMMH>] (last updated Dec. 6, 2017).

¹²⁵ See *FDA Takes New Steps to Encourage the Development of Novel Medicines for the Treatment of Opioid Use Disorder*, U.S. FOOD & DRUG ADMIN. (Aug. 6, 2018), <https://www.fda.gov/news-events/press-announcements/fda-takes-new-steps-encourage-development-novel-medicines-treatment-opioid-use-disorder> [<https://perma.cc/G5TE-XVPP>]. See generally U.S. FOOD & DRUG ADMIN., OPIOID USE DISORDER: ENDPOINTS FOR DEMONSTRATING EFFECTIVENESS OF DRUGS FOR MEDICATION-ASSISTED TREATMENT (Aug. 2018), <https://www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/UCM615743.pdf> [<https://perma.cc/57TH-RSA8>].

¹²⁶ Gavin Bart, *Maintenance Medication for Opiate Addiction: The Foundation of Recovery*, 31 J. ADDICTION DISEASE 207, 207 (2012).

¹²⁷ See *id.* at 209.

¹²⁸ See *id.* at 207.

abstinence-based programs.¹²⁹

The majority of drug rehabilitation offered in criminal sentencing, however, lies strictly in abstinence regimes, with most parole and probation programs discouraging methadone maintenance and resisting the use of new pharmaceuticals that contain buprenorphine, a partial opioid agonist.¹³⁰ Although buprenorphine is a type of opioid, like methadone, and possesses some usual opioid reactions, such as euphoria and respiratory depression, its maximal effects are less than those of full agonists like heroin and methadone, and it carries a lower potential for abuse and addiction.¹³¹

In September 2002, the DEA increased the classification of buprenorphine from a Schedule V narcotic to a Schedule III narcotic, claiming that the narcotic's potential abuse "may lead to moderate or low physical dependence or high psychological dependence."¹³² This two-level upwards classification was over the strenuous objection of many physicians and addiction specialists, who argued that it was inconsistent with "the pharmacology and the intended clinical use of the buprenorphine/naloxone sublingual tablets," which were to help wean addicts from existing opioid abuse.¹³³ Ironically, about a month later the FDA approved two buprenorphine-based drugs, Suboxone and Subunex, as safe and effective for prescription-based use.¹³⁴

Most detoxification programs in correctional facilities, which treat a high number of addicts, refuse to consider maintenance treatment, whether with methadone or buprenorphine, due to claimed concerns over safety and security.¹³⁵ In 2016, only forty jails and prisons across the country offered

¹²⁹ *Id.* at 210.

¹³⁰ See John Keilman, *Giving Addicted Inmates Opioid Meds Behind Bars Can Reduce Overdose Deaths. Why Don't More Jails Use Them?*, CHI. TRIB. (July. 6, 2018), <http://www.chicagotribune.com/news/ct-met-jail-inmates-opioid-addiction-20180703-story.html> [<https://perma.cc/M55R-FFVA>]. Partial opioid agonists such as buprenorphine are constructed to provide less euphoria and physical dependence on opioids, along with a lower potential for misuse, a ceiling on opioid effects, and a relatively mild withdrawal profile. *What Exactly Is Buprenorphine?*, NAT'L ALL. ADVOCS. FOR BUPRENORPHINE TREATMENT, https://www.naabt.org/faq_answers.cfm?ID=2 [<https://perma.cc/G5S3-L2UJ>].

¹³¹ See *What Exactly Is Buprenorphine?*, *supra* note 130.

¹³² *Schedules of Controlled Substances: Rescheduling of Buprenorphine from Schedule V to Schedule III*, 67 Fed. Reg. 194 (Oct. 7, 2002) (to be codified at 21 C.F.R. pt. 1308) DRUG ENFORCEMENT ADMIN., DEP'T OF JUST., 62355 (Sept. 7, 2002), <http://www.naabt.org/documents/DEA-reschedule-Buprenorphine-schV-to-schIII.pdf> [<https://perma.cc/CLB9-XKGC>].

¹³³ *Id.*

¹³⁴ Letter from Cynthia G. McCormick, Dir., Ctr. for Drug Evaluation & Research, to Alan Young, Dir. Regulatory Affairs, Dep't of Health & Human Servs. (Oct. 8, 2002), https://www.accessdata.fda.gov/drugsatfda_docs/applletter/2002/20732,20733ltr.pdf [<https://perma.cc/55RJ-E35W>].

¹³⁵ See Beth Schwartzapfel, *When Going to Jail Means Giving Up the Meds that Saved Your Life*, MARSHALL PROJECT (Jan. 29, 2019), <https://www.themarshallproject.org/>

methadone, and even fewer offered any type of buprenorphine, even to those who were in treatment for opiate addiction.¹³⁶

There is a nationwide focus on abstinence in sentencing rehabilitation programs, particularly when prisoners are being paroled or released on probation. This makes treating addicted offenders particularly difficult, given that correctional facilities harbor so many inmates who suffer from drug addiction and dependence.

In Ohio, for example, the state jails function as the state's largest detox center.¹³⁷ Most jail detainees do not get any medications to help address their drug withdrawal symptoms, which can be acute.¹³⁸ Only those who rise above a certain threshold of withdrawal receive any medication, which itself only encompasses anti-nausea drugs, anti-diarrheal medications, and over-the-counter painkillers.¹³⁹

Some of the resistance to using either maintenance treatment generally or buprenorphine specifically can be traced to fears that the treatment narcotics will find their way to the street, taking the familiar path from licit to illicit drug. Reports have surfaced that Suboxone pills, a form of buprenorphine combined with naloxone, are being sold on the streets of Cincinnati, Ohio, purchased by those who wish to get intoxicated or to self-medicate.¹⁴⁰ For those addicts who are incarcerated, many corrections officials are hesitant to offer maintenance medications due to the combination of cost, bureaucratic difficulty in obtaining and dispensing the narcotics, and the possibility that the drugs could be misused inside correctional facilities.¹⁴¹

And yet there is a serious danger of going cold turkey for the roughly 30% of inmates who enter correctional facilities addicted to opioids.¹⁴² Not only are opioid withdrawal symptoms brutal and extremely painful, but abstinence-based treatment can endanger an offender's life. Individuals who undergo these abrupt and agonizing withdrawals from heroin and other opioids without an appropriate detoxification process often suffer overdose and death when they are released

2019/01/29/when-going-to-jail-means-giving-up-the-meds-that-saved-your-life
[<https://perma.cc/MJA7-3BTM>].

¹³⁶ See Rachel Dissell, *Ohio Jails Accept Role as State's Busiest Opioid Detox Centers*, PLAIN DEALER (Oct. 1, 2017), https://www.cleveland.com/metro/index.ssf/2017/10/ohio_jails_accept_role_as_states_busiest_opioid_detox_centers.html [<https://perma.cc/D55U-ZVZ6>].

¹³⁷ See *id.*

¹³⁸ See *id.*

¹³⁹ *Id.*

¹⁴⁰ See Terry DeMio & Sarah Brookbank, *Suboxone: Prescribed for Addiction, Diverted to the Streets—An 'Instant Relief' for Withdrawal*, CIN. ENQUIRER (July 21, 2018), <https://www.cincinnati.com/story/news/2018/07/20/opioid-addiction-suboxone-found-streets-gets-attention-cops-users/755559002/> [<https://perma.cc/GSE8-6E34>].

¹⁴¹ See Keilman, *supra* note 130.

¹⁴² See Brian Barnett, *Jails and Prisons: The Unmanned Front in the Battle Against the Opioid Epidemic*, STAT (July 2, 2018), <https://www.statnews.com/2018/07/02/opioid-epidemic-jails-prisons-treatment/> [<https://perma.cc/Y666-RSJM>].

from detention, as they have lost their tolerance to the narcotics while incarcerated.¹⁴³ During the first two weeks after correctional facility release, in fact, the risk of dying from overdose is 13 times higher than normal.¹⁴⁴

Despite these grim realities, it is currently only Rhode Island that allows its prisoners to all available opioid medication treatments for opioid addiction.¹⁴⁵ Following this change in treatment options, post-incarceration overdose deaths in Rhode Island plummeted over 60%, helping reduce the rate of death from overdose statewide by 12%.¹⁴⁶ These useful maintenance treatments, however, continue to be shunned by most states and counties, due to fear of misuse, disdain for illicit/criminal addicts, and general disapproval of substituting “one drug (say, heroin) with another (methadone),” especially for those addicts using heroin or other illegal narcotics.¹⁴⁷

A few other states have followed Rhode Island’s lead, although in a much less comprehensive way. New York has a methadone clinic at Riker’s Island; Philadelphia has a methadone program for city jails; Vermont and Connecticut run maintenance programs for those offenders who have previously been on methadone or Suboxone; and Massachusetts is currently setting up a system which allows offenders to continue their maintenance treatment.¹⁴⁸ In addition, the federal government has made a commitment to expanding medication-assisted treatment as a major strategy to help reduce overdose deaths.¹⁴⁹

The majority of states, however, stick to abstinence-based programs in their jails, prisons, halfway houses, and drug treatment programs, at most providing addicted offenders Vivitrol, a long-lasting opioid reversal medication, which blocks the effects of opioids but does nothing to treat the withdrawal.¹⁵⁰ In addition, most state corrections systems only provide Vivitrol upon release from detention, denying even this limited tool to those addicted offenders still

¹⁴³ *See id.*

¹⁴⁴ *See id.*

¹⁴⁵ *See* Erick Trickey, *How the Smallest State Is Defeating America’s Biggest Addiction Crisis*, POLITICO (Aug. 25, 2018), <https://www.politico.com/magazine/story/2018/08/25/rhode-island-opioids-inmates-219594> [<https://perma.cc/LP8C-6YDZ>].

¹⁴⁶ Barnett, *supra* note 142.

¹⁴⁷ German Lopez, *There’s a Highly Successful Treatment for Opioid Addiction, But Stigma is Holding It Back*, VOX (Nov. 15, 2017), <https://www.vox.com/science-and-health/2017/7/20/15937896/medication-assisted-treatment-methadone-buprenorphine-naltrexone> [<https://perma.cc/ZE7K-FJUJ>].

¹⁴⁸ *See* Trickey, *supra* note 145.

¹⁴⁹ *See* Michele Merritt, *Prison Drug Treatment Saves Lives and Makes Us Safer*, N.H. UNION LEADER (June 22, 2018), <http://www.unionleader.com/apps/pbcs.dll/article?AID=/20180622/OPINION0204/180629849/0/SEARCH> [<https://perma.cc/M983-HREA>].

¹⁵⁰ *See* Abraham Gutman, *People in Pa. Prisons Are Smuggling Medicine to Treat Their Addictions Because the State Won’t Provide It*, PHILA. INQUIRER (Sept. 21, 2018), <http://www2.philly.com/philly/opinion/commentary/pennsylvania-department-corrections-prison-lockdown-drugs-mat-buprenorphine-suboxone-addiction-treatment-20180921.html> [<https://perma.cc/3M9J-BGQT>].

incarcerated.¹⁵¹

It is not difficult to draw a line from most states' strict abstinence models in criminal justice addiction treatment to our history of discrimination and eugenic philosophy in addressing opioid use. Once the typical user of opioids changed from a white, middle class woman, using legally, to a poor, urban male, often of "the dangerous races," using illegally, treatment policies transformed accordingly. No longer would either the federal government or the medical establishment look the other way when a long-term addict requested maintenance for their habit; instead, a combination of increasingly harsh drug laws and disdain for narcotic addiction took its place. Our understanding of the stereotypical opioid user has entirely transformed from licit pain sufferer to illicit drug abuser.

In the end, what should be our primary goals in treating opioid abuse, such as "reducing fatal overdoses, medical and social complications, and injection-drug use and related infection" are almost impossible to achieve if we rely only on abstinence-oriented treatment.¹⁵² Viewing opioid addiction as a moralistic failure in willpower¹⁵³ rather than a disease returns us to the turn of the 20th century, where street "junk" addicts were criminalized but middle-class morphine addicts were quietly permitted.

We must learn from our past mistakes of demonizing opioid addiction, particularly for those criminal offenders who suffer from addiction, and allow these individuals to be treated both humanely and with dignity. Whether an opioid user came to their addiction iatrogenically or through street use, whether at home or imprisoned, there is no call to require them to treat their addictions without the proper maintenance medication. To do so is to implicitly endorse the eugenic philosophy that landed us here in the first place.

V. CONCLUSION

Studying our history of diagnosing and treating opioid abuse can teach us how to avoid the mistakes and pitfalls of the past. Like today, the early 20th century divided opioid addicts into two classes: the licit and the illicit. Although licit users were allowed to quietly continue their maintenance regimes, illicit users were forced to go on the black market to obtain their narcotic, with criminal consequences when they were caught. This artificial division of addict types, reified by gender, class, and race, is replicated in our current criminal justice and sentencing system, with middle class opioid addicts who iatrogenically became addicted to narcotics through over-prescription being

¹⁵¹ See Anna Gorman, *Doing Time on Drugs: Jails Are Slow to Dispense Meds that Curb Inmates' Cravings*, WASH. POST (Aug. 19, 2018), https://www.washingtonpost.com/national/health-science/doing-time-on-drugs-jails-are-slow-to-dispense-meds-that-curb-inmates-cravings/2018/08/17/e07881fe-9592-11e8-a679-b09212fb69c2_story.html?utm_term=.2e2ab6dcb974 [https://perma.cc/VYV5-TBD7].

¹⁵² Courtwright, *supra* note 118, at 2097.

¹⁵³ See Lopez, *supra* note 147.

treated far more sympathetically than impoverished heroin addicts, who often turned to street drugs to maintain their habit.

This division is illuminated most dramatically in our treatment of opioid addicts in both sentencing and correctional facilities. Although those with money and resources can enter rehabilitation services that provide long-term maintenance narcotics such as methadone and Suboxone—the gold standard of treating long-term opioid abuse—those who enter the criminal justice system are forced to go through brutal withdrawal from opioids, with no treatment besides abstinence. It is time to require the criminal justice system to provide clinically proven treatment to addicted offenders, and put aside the class, race and gender biases that have once again unwittingly shaped our treatment of our current opioid crisis.