2019

A Qualitative Content Analysis of The Impact of the Media on the Opioid Crisis

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A Qualitative Content Analysis of the Impact of the Media on the Opioid Crisis

by

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A Dissertation Presented to the
College of Arts, Humanities, and Social Sciences of Nova Southeastern University
In Partial Fulfillment of the Requirements for the Degree of
Doctor of Philosophy

Nova Southeastern University
2019

Nova Southeastern University
College of Arts, Humanities, and Social Sciences

This dissertation was submitted by Mark Haskins under the direction of the chair of the dissertation committee listed below. It was submitted to the College of Arts, Humanities, and Social Sciences and approved in partial fulfillment for the degree of Doctor of Philosophy in Conflict Analysis and Resolution at Nova Southeastern University.

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Dedication

This work is dedicated to the late Dr. John Ebersole, Former President of Excelsior College, for without his brief words of encouragement some years ago upon the conferral of my Master's Degree; I would not be here today.

"If *Courage* is the quality of mind or spirit that enables one to face difficulty, danger and pain with firmness and without fear, and *Learning is* knowledge or skill acquired by instruction, study or experience, then *Courageous Learning* is the demonstration of mental or moral strength to venture into the world of lifelong learning, while withstanding fears of failure and the difficulties of life, in search of new skills and new knowledge."

Dr. John Ebersole and William Patrick

Courageous Learning: Finding a New Path Through Higher Education

Acknowledgments

No part of this momentous undertaking would have been possible without the support and encouragement from my family. Always encouraging and supporting this endeavor forced me to continue when discouraged, completing when almost giving up, and instilling in me the belief that nothing is impossible. For without them, there would be just another day.

I would also like to thank the faculty at Nova Southeastern, especially my Chair Dr. Dustin Berna and committee members Dr. Ismael Muvingi and Dr. Elena Bastidas. What they have taught me, and their guidance throughout my time here, can never be overstated. I would also like to thank the program support staff for keeping me on schedule during the process. To my cohorts; we drove, encouraged and supported each other never giving up and always seeing that light at the end of the tunnel no matter how small of a flicker it may have seemed at times. Finally, I would like to thank Dr. Robin Cooper whose guidance and assistance encouraged me from beginning to end.

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Abstract

This study examined the systematic shift in the decades-old ‘war on drugs’ from its roots in criminality to what is now viewed as a public health crisis due in part to the media framing of the crisis. This research utilized a qualitative content analysis approach to examine print news media articles from the top producers of print news in the United States. Through the analysis, these articles were examined, and several patterns emerged, and the themes explored further. Some of the more critical themes emerging from the data analysis were epidemic, crisis, substance abuse disorder (SUD), opioids, disease, prescription drugs, victim(s), and accidental overdose and treatment. The results demonstrate a shift from a model where illegal drugs and the abuse of these drugs has transitioned from one in which was addressed within the criminal justice system to one which has now demanded treatment and compassion toward those engaging in this activity. Whether viewed as a disease, mental disorder, or other reasons, the shift from the incarceration and demonization of drug users appears to have changed to one of a public health crisis. The study examined societal change and found that many often based on media infused hyperbole and misinformation. This study emphasizes the role that socioeconomic status has in this shift and underscores the need for future research in examining the long-term impact of this shift on both the individual and the criminal justice system.

Chapter 1: Introduction

Controlled Substance History in the United States

Drugs and the problems that go along with them certainly do not represent a new phenomenon in the United States or any other country and -in some form or another- have been present since prehistoric times for the euphoria associated with them (Guerra-Doce, 2105). Although prohibition on alcohol can be traced back to the 7th century, the first known laws regarding the use of certain drugs, such as opium and opium-derived remain relatively new. Enacted in the United Kingdom, the Pharmacy Act of 1868 is thought to be the first known law regulating drugs. Similar to today's drug laws, the 1868 Act placed control on drugs and their distribution. Furthermore, after the passage of the Act, the United Kingdom saw a decline in opium-related deaths from 6.5 million to 4.5 million in the first 12 months (Berridge, 1981).

In 1914 the United States passed a law prohibiting the sale of opiates and cocaine without a license. The Harrison Act was thought to be the solution to the widespread abuse of an addiction to cocaine and heroin. Some years earlier, the U.S. Congress imposed a tax on opium and cocaine in perhaps what could be considered the first known legislation related to controlled substances, which criminalized the possession of such substances mentioned within the tax law. In 1923 the nation's first federal drug enforcement agency was created from within the U.S. Department of Treasury. During that period a ban on all legal sales of narcotics was enacted. Consequently, individuals addicted to narcotics were now forced to illegally obtain the drugs through black-market sales. For example, New York's black-market for opium and heroin at that time was in the Chinatown district because most of those drugs originated from China.

In 1937 the U.S. Congress passed the Marijuana Tax Act, which placed a tax on the sale of cannabis and marijuana. Although the Act did not criminalize marijuana, the fines for not paying the tax were high, and failure to paying the dues could have resulted in prison time. In the late 1940s, the “mafia” gained control of the heroin market by importing Turkish opium, which became available citywide, and the black market was no longer controlled by the Chinese monopoly. As the United States entered the Vietnam War, raw opium from Burma and Laos was processed into heroin and trafficked to the United States; such, by early 1970s, Burmese and Lao opium became the primary source of heroin that was supplying the U.S. market.

In 1971 the U.S. Congress passed and President Richard Nixon signed into law the Controlled Substances Act (CSA), which not only regulated certain drugs and controlled substances but also placed them into five schedules (listed as I though V) that classified drugs based on factors, such as medical applications and abuse potential. Schedule I was reserved for drugs having little or no medical application but the highest abuse potential, such as heroin. It should be noted that currently the federal government still classifies marijuana as a schedule I drug, despite being legalized or decriminalized in many states. At the other end of the scale, schedule V was established for drugs with various medical applications and which were at the time deemed to have little or no abuse potential. All other pharmaceuticals requiring a prescription -but with no potential for abuse- were classified as non-controlled or nonscheduled drugs; therefore, possessing these drugs without required prescription was not deemed as a criminal act. All other drugs, such as aspirin and cold medicines, commonly found in markets and retail outlets, were considered over-the-counter drugs and were not regulated.

The term, *controlled substances* was established in the idea of tracking these regulated narcotics from the manufacturer to the end user. Therefore, if someone was receiving morphine, a schedule II drug, authorities would be able to identify the manufacturer, the distributor, the prescriber, the pharmacy that dispensed it, and finally, the user. However, because there was no acceptable medical use for schedule I drugs, referring to them as controlled substances was more for subsequent classification and future penalties associated with their sale or possession.

Given that, two years after the passage of the CSA, the use of heroin and other drugs was rising at alarming rates, President Nixon addressed the Congress on Drug Abuse Prevention and Control to declare drugs as "public enemy number one;" in a subsequent press conference, President Nixon referred to the new campaign to fight the scourge of drugs as the war on drugs.

As the war in Vietnam came to an end, many U.S. members of the armed forces returned home addicted to cheap and widely available opium and heroin. In part and as a result of other illegal drug uses at the time, President Nixon created the Drug Enforcement Administration (DEA) under the U.S. Department of Justice. In doing so, the President consolidated and gave all federal powers related to enforcing drug laws to one agency. At first, DEA had just over 1,400 agents and a budget of approximately $75 million; today, this agency has extended to over 5,000 agents and an annual budget of over 2.01 billion dollars (Sacco, 2014). By 1975, although the Vietnam War was over, the supply of heroin imported to the United States did not end; concurrently, Mexico emerged as the new primary source of raw opium. Realizing the potential problems associated with the increased production, the United States and Mexico collaborated to

eradicate the source by spraying the fields with Agent Orange, a potent herbicide used to eliminate ground cover and crops during the war in Vietnam. Exposure to Agent Orange resulted in mental and physical disabilities and death for many members of the military who had served in Vietnam.

The success of the eradication program all but eliminated the supply of Mexican opium at the time but also succeeded in opening a new source known as the Golden Crescent of Iran, Afghanistan, and Pakistan. Today, opium from Afghanistan accounts for over 90 percent of the world's illegal opium and heroin (UNOSC, 2010).

The use of heroin slowly diminished but remained prevalent in minority communities where it initially began. In the late 1970s and early 1980s, the U.S. drug scene brings in cocaine and a new type of drug user. Widely consumed by middle and upper-class elites, cocaine spread throughout the United States like no other drug in recent history. Although initially not believed to be of concern due to its high price and availability, the demand by U.S. customers soon helped expand the coca production in South America. By the mid-1980s, cocaine was a yearly multibillion-dollar business run by organized crime families or cartels in countries, such as Columbia and Bolivia. Although most cocaine users snorted cocaine, some engaged in smoking or injecting it, either by itself or mixed with other drugs.

During the late 1970s through the better part of the 1980s, when the market in the United States was flooded with cocaine from South America, prices dropped, which caused dealers to find other ways to maximize their profits. The answer was to convert powder cocaine (generally snorted) into a highly addictive solid, called *crack*. Crack was then broken into small pieces (often referred to as *rocks*) which were smoked to produce

an instant and intense high. From the mid-1980s through 1990, the United States experienced a crack epidemic that created a crime wave. Violent street gangs dominated the trafficking and sale of crack; thus, the soaring number of addicts seeking money to buy it led to an increase in murder, prostitution, and robbery in inner-city neighborhoods (Carvalho, 2009). For these reasons, the government appeared compelled to act.

The Anti-Drug Abuse Act of 1986 imposed mandatory minimum penalties based on the quantity and the type of drug possessed. The most significant is that the new law differentiated between cocaine and crack. To trigger, the mandatory minimum sentence required possession of 100 times the weight of powdered cocaine than that of crack. For example, five grams of crack would result in a five-year mandatory minimum prison sentence, while that same condemnation required possession of 500 grams of powder cocaine. Similarly, 50 grams of crack and 5 kilograms of powder cocaine would result in a 10-year mandatory minimum sentence.

Although the government claimed that crack was more dangerous than cocaine, that it generated more violence and was the cause of a bigger crime problem, many people saw the 1986 Anti-Drug Abuse Act as discriminatory, for most crack users were minorities and poor, while those known to use and abuse cocaine powder were more often White, middle, and upper class. Therefore, cocaine was seen as the party drug of the affluent even though the sources of its powder and crack were both manufactured and distributed through the same violent organizations. By 2010, half of all federal prisoners were incarcerated for drug offenses and most of them involved trafficking. Despite claims that people were being locked up for simple possession, less than one percent of all federal prisoners were incarcerated for drug possession alone (Sacco, 2014).

Cocaine and heroin were not the only drugs wreaking havoc on the U.S. streets during the latter part of the 20th century. The 1960s saw increased use in psychedelic drugs, such as LSD, amphetamine, and methamphetamine. By the 1990s, methamphetamine (also known as *meth*) became the second most abused substance after marijuana (Gailbraith, 2015). Trafficked and produced mainly by outlaw motorcycle gangs at the time, meth users were most often White, male, unemployed, and blue-collar laborers, although its use also spread to white-collar workers and students. Some believe that the rise in meth use was "associated with its rise in the media" (Galbraith, 2015). The popularity of shows like the television drama series *Breaking Bad* (first appearing in 2008) in some ways glamorized the use of meth and downplayed its harmful effects by portraying a married high school teacher who was manufacturing and selling the drug. Consequently, the government was running active campaigns about the dangers associated with methamphetamine. Although methamphetamine has been described by many as a more dangerous drug in both its use and manufacture, the penalties associated with it were often not as harsh as those for crack. Habitually, those convicted of crimes involving meth were afforded the opportunity of what is called the *safety valve provision* in sentencing (Schlesinger, 2017).

While many believe the current opioid crisis began around 2003 and 2004, opioids' use and abuse has been around much longer. Although some in the media as well as in government consider opioids as the pills that were the cause of the current crisis, the use of opioids and opiates is also widely misunderstood. Opiates are naturally occurring chemicals known as alkaloids and are found in the opium plant. More than 20 opiates are found in opium, but only four of them are used for medical purposes and manufactured

for medical use. These opiates are morphine, codeine, Thebaine, and papaverine. While morphine and codeine are the most common among the four opiates, they are also two of the oldest and often prescribed pain relievers by doctors today.

Drugs such as hydrocodone and Oxycontin -while referred to as opiate and opioids by some in the news media- are not an opiate as they are made by synthesizing Thebaine and thus semi-synthetic opioids. Although heroin is often confused as an opiate for deriving from the poppy plant, it in fact is a semi-synthetic opioid because it is manufactured by boiling morphine and adding acetic anhydride. Finally, synthetic opioids are drugs, such as methadone and fentanyl, which were created in laboratories and mimic opiates, yet synthetic opioids have no poppy plant or opium derivatives.

At the onset of the opioid crisis, drugs like hydrocodone and oxycodone were and still are often prescribed by doctors and dentists for the relief of pain. Some patients began abusing these drugs once experiencing the ‘high’ associated with them. However, although these painkillers became widely prescribed, individuals who took them as prescribed rarely became addicted. Most people who became addicted ended up receiving these drugs from family members and/or friends or purchased diverted prescriptions from street dealers. Before long, these same opioids that up until now were abused most often by people working in hospitals and nursing homes had become mainstream.

It took about ten years to realize that the markets became flooded with these medications online, from bad doctors, pharmacists, or those who stole them; thus, by 2010 the government stepped in and increased regulations in the prescribing and dispensing of these drugs. With little regard to what would happen to those individuals already suffering from addiction, these tighter controls meant the drugs were more

difficult to obtain and the available supply was far more expensive. Such, the result for many consumers was a shift to heroin.

Before long, heroin as well began experiencing supply problems; as a result, illegally manufactured fentanyl -a synthetic opioid 100 times more powerful and far deadlier- was used to 'cut' or dilute heroin. As the strength could never truly be determined, heroin users began overdosing and dying at record numbers from the combination of heroin and fentanyl. Today, the opioid problem, epidemic, or crisis is a heroin and fentanyl crisis (Bloom, 2017). Despite the deaths and dangers associated with its intake, the demand continues and so does the lack of facts and information which surrounds it.

Statement of the Problem

The current opioid crisis has been one of the most talked about problems society currently faces. The problem has been considered so severe that it has caused the life expectancy of Americans to decrease for the second year in a row (Kochanek, 2017). Despite the research, media coverage and public awareness, there is little agreement as to the cause of the current crisis and more importantly, whether or not it is as bad as it is portrayed in the media.

While few can argue the marked increase in overdose deaths attributed in part to this crisis, is it any different than this country's past drug crises or has the media helped create or -at the very least- contributed to the panic through misleading narratives and hyperbole? This research will examine media narrative and the commonly referred to *facts* and explore how this narrative has helped shape the public view on drug use and abuse.

Misleading narratives and hyperbolized rhetoric used to increase awareness to the opioid crisis may also have unintended negative consequences, such as increased conflict within communities, between citizens, and their elected representatives. When parties are engaged in this conflict, those they seek to help can be ignored. As a result, they create a situation where finger-pointing and blame lead to an endless cycle of family and personal tragedies. Current research on the cause and effect of the opioid crisis appears lacking and, at times, driving solely to particular agenda. For example, demanding more money for treatment and long-term rehabilitation appears to be a temporary fix, for little evidence exists on the widespread success of most of these programs. This research will instead seek to identify the underlying reasons for the opioid crisis and ask if this drug crisis is intentionally portrayed more horrific than it is by those in the media to control the narrative for the benefit of those with a higher socioeconomic status (SES).

Purpose of the Study

The purpose of this study is to examine why U.S. media portrayed the opioid crisis as a larger than life epidemic. Some researchers feel the public has awakened to find that “whiteness” has come home to roost in the world of drugs and drug abuse (Netherland, 2016; Fitch, 2017; Nunn, 2002). These same researchers point to the disproportionate penalizing of drug offenders sentenced to prison and the number of minority and people of color in the criminal justice system compared to the overall present-day population.

To be certain, one cannot argue that racial disparities in the treatment of drug users during the crack crisis were disproportionate when compared to White users of powder cocaine existed. How did the country arrive at what appears to be the same

inequity within the current opioid crisis, or does this crisis ignore race and encompass socioeconomic status as a whole? While some may believe that society benefits from treating drug abuse more like a disease than a crime, by doing so, are we merely condoning bad behavior, which ultimately becomes a burden to society? Are Americans being told the truth, and have we been dealing with drug abuse in the wrong way, or is the narrative merely a way to protect the middle and upper class from being treated like criminals? Perhaps it is neither, and drug abuse is a systemic result of decreasing socioeconomic status throughout the country. This research will look beyond the narrative to determine why this crisis has been treated differently, how the country arrived at this juncture, and the underlying reasons why this what has led to our insatiable appetite for drugs.

Research Questions

RQ1: Is the current opioid crisis another moral panic, defined as "the process of arousing social concern over an issue – usually the work of moral entrepreneurs and the mass media" (Scott, 2009), and -in the process- has the media changed the narrative of drug use and abuse from a criminal problem to a public health issue?

RQ2: What role does socioeconomic status (SES) has in the media framing of the current drug crisis and the treatment of drug offenders?

Theoretical Framework

This study seeks to consider how and why Americans have witnessed the shift in both the way the current drug crisis is framed in the media and the public's perception of the problem. In an attempt to answer these questions, it is believed that conducting a qualitative content analysis is the appropriate model for the study. Several plausible

theories are examined that may be used to explain the phenomenon and provide context to the research questions. While these theories may support the underlying reason for the changes in how people view the current drug crisis, these principles are just a few of many assumptions that exist, and in no way do I attempt to imply these premises being the only theories.

Exemplification Theory

Exemplification theory can be used not only to explain the negative consequence and its contribution to the social construct of moral panics but also accomplish just the opposite, which we also see in the opioid crisis. In health journalism, exemplars or definitive examples of what something should be are also used to humanize negative news or put a sympathetic face on the problem. Amanda Hinnant (2013) explains that the use of exemplars in health journalism "is a common, albeit contested, practice" (p. 1). Through the use of exemplars, journalists shift back and forth between their duty to provide accurate information regarding health issues and gain enough interest of a particular audience in order to increase their audience size. In some ways, one can see how exemplars in health journalism have assisted in changing the perception of the public toward those addicted to drugs.

Although considered almost exclusively to be the dregs of society, lacking self-worth, control, or responsibility, addicts are now portrayed as victims suffering from physical or mental illness in search of help for a problem they never wanted. The image imprinted on drug abuse today removes terms and portrayals of the past and replaces them with a kinder, gentler view that depicts more of America and its values. Therefore, whether to soften the stigma or to create social discourse or panic, the use of exemplars

and exemplification theory becomes essential to fully understand the opioid and our country's past drug crises.

Framing Theory

As defined by Gregory Bateson (1972), the framing theory is a "spatial and temporary bounding of a set of interactive messages" (p.186) Framing in the media is often based "on narrative conventions that offer an explanation about who is doing what, and with what purpose" (Ardèvol-Abreu, 2015, p 424.). "Framing essentially involves selection and salience. To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described"(Entman, 1993, p.52).

Tuchman (1978) describes news as a window whose frame restrains the perception of reality by limiting the awareness of different realities and focusing on a specific piece of it. As a result of these processes, some aspects of the reality perceived through the news will be more prominent than others.

While similar to agenda setting, framing focuses on the bigger picture of an issue or issues rather than a particular topic. Entman (1991) identified five common ways that news stories are framed.

- Conflict - Conflict occurs between parties as opposed to the actual decision made is prioritized.
- Human Interest/Personalization - Personality is promoted over more essential aspects by presenting a story with a human face.

- Consequence - Consequences can be wide-ranging. For example, pursuing a policy may be unwise in terms of unity within a party/coalition or for the global status of a nation.
- Morality - Media coverage can often moralize, sometimes due to the indiscretions of political actors; coverage can be morally questionable, as with Michael Moore's editorializing of the U.S. Patriot Act or a critique of U.S. foreign policy, for all take a moral tone.
- Responsibility -Responsibility is assigned for a cause or a solution to a problem. In the wake of the Asian tsunami, the disaster was framed in terms of the need for "global responsibility" to find solutions and blame placed upon local governments for their lack of preparedness.

In my research of the opioid crisis, much like other drug crises, we can see the use of these common kinds of framing used by the chosen media sources. While numerous techniques within framing theory exist, metaphor and contrast are widely exploited in the framing of a drug crisis. According to Fairhurst and Sarr (1996), metaphor is used "to frame a conceptual idea through comparison to something else" (p. 577). With the crack crisis, the drug and its users were most often linked to violence and people, specifically minorities, prone to violent or aberrant drug-seeking behavior. However, with the opioid crisis, drug use is compared to a health crisis or epidemic, and its users are viewed in a more sympathetic role as if their drug use began unintentionally. It is within this frame where it appears that the public is persuaded to accept treatment and rehabilitation over incarceration. When crack and methamphetamine are framed more toward public safety, violence, and crime, it is easier for the public not only to demand but also to accept

incarceration as the logical outcome. Fairhurst and Sarr (1996) see the use of contrast as an effort to describe an object in terms of what it is not. Contrast appears to be widely utilized in all drug crises in an attempt to maximize its potential for harm or distress.

Social Conflict Theory

Social conflict theory argues that the social classes in society, both individuals and groups, interact because of conflicts rather than mutual agreements. In its traditional Marxist roots, the theory posits that, to attain or maintain power or resources, the elite will use these resources (for instance, their ability to control the media) and the narrative regarding social issues to achieve that power or its resources. “Social conflict theory is also considered a macro-theory that focuses on how structural factors in society affect rates of drug use” (Lo, C.C. 2003) which emphasizes that a higher number of drug users will be found more often in marginalized communities of lower class and income individuals. Historically, these communities were most often people of color, living in widespread poverty where hard drug use and arrests would occur frequently (Lo, C.C. 2003). Unemployment and upward mobility in these areas was often limited if at all. During the earlier decades, it was said that, “serious drug use is not evenly distributed: it runs ‘along the fault lines of our society.’ It is concentrated among some groups and not others, and has been for at least half a century” (Currie, 1994, p.).

The landscape of drug abuse changed about two decades ago together with the surge of prescription drug abuse. No longer was it found in poor inner-city neighborhoods among the predominately minority communities, but -in its new form- drug abuse now spread to the U.S. suburban and rural areas and affected people of all income levels who -unlike those in urban areas- were almost all White. In 1999, the drug-

related death rate in rural areas was 6.4 per 100,000 people while in rural areas it was reaching to 4 per 100,000 (CDC, 2107) However, by 2015 the number of deaths in rural areas skyrocketed to 17.0 per 100,000 inhabitants, surpassing those in urban areas where it remained at 16.2 per 100,000 which is slightly above where it had been (CDC, 2017). Currie's belief (1994) that drug use was found along "the fault lines of society" still appears to be correct. Many of the rural areas experienced enormous downward mobility as a result of factories, steel mills, and coal mine closures. As so many people were forced into poverty, these rural areas began to see a similar pattern as their inner-city counterparts. although the numbers do not compare to those minority populations in densely populated cities, the trend toward drug abuse by those more socioeconomically disadvantaged appears similar.

Using social conflict theory to explain the media coverage of drug abuse by those from an upper socioeconomic status may be explained by the struggle to maintain status and depends on changing the narrative of drug use from a problem of criminality to that of a public health issue. Shoemaker (2009) considers this a form of "gatekeeping" or a "process through which events are covered by the mass media, explains this process by considering concepts on five levels of analysis, and shows just how difficult it is to predict anything involving people. In other words, the people in charge of the media decide what the public is exposed to (p. 3).

Shoemaker and Voss (2009) see the advent of the "new media," such as YouTube and Facebook from where people receive information, as a way to diminish the power and control of the gatekeeper. In this case, media's message can be controlled or imposed in an effort to take control over a social cause or agenda. While the belief that

new forms of media allow people to share information more freely, sharing more complex subjects, such as addiction and pharmaceutical knowledge, may still originate in the traditional media and, therefore, merely provide new avenues to assist in spreading its agenda and narrative (Shoemaker, 2009).

From a conflict theory perspective, the media may be viewed as a tool or instrument of social control and, at times, as a conduit for social control or coercion. In some ways, this explains how easily the media could take a crisis like the opioid abuse and frame it in a way that best suits the needs of those in power or, in this case, drug users who are often the family members of this dominant middle and upper class. As a result, rather than being subjected to the criminal justice system, those caught up in the opioid crisis now receive treatment while simultaneously, the derogatory terms associated with drug use have been replaced with softer, more acceptable terms (Shoemaker, 2009).

Definitions of terms

- *Opioid(s):* A class of drugs that includes the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin©), hydrocodone (Vicodin©), codeine, morphine, and many others (NIDA, 2018).
- *Crack*: The name given to cocaine that has been processed with baking soda or ammonia and transformed into a more potent, smokable, *rock* form. The name refers to the crackling sound heard when the drug is heated and smoked (CESAR, 2019).
- *Meth, methamphetamine, crank*: A very addictive stimulant drug. It is a powder that can be made into a pill or a shiny substance (called a crystal). The powder

can be eaten or snorted up the nose. It can also be mixed with liquid and injected with a syringe. Crystal meth is smoked in a small glass pipe (MedlinePlus, 2018).

- *Benzodiazepine:* A commonly prescribed depressant medication. More than 15 different types of benzodiazepine medications are used to treat an array of psychological and physical ailments based on dosage and implications, including but not limited to use in anxiety relief, hypnotic, muscle relaxant, anti-convulsant, or an amnesiatic (mild memory-loss inducer). Due to their sedative properties, benzodiazepines have a high potential for abuse, primarily when used with other depressants, such as alcohol or opiates. Benzodiazepines include Xanax© (alprazolam), Librium© (chlordiazepoxide), Valium© (diazepam), and Ativan© (lorazepam). Another benzodiazepine that has been the focus of a great deal of media attention is flunitrazepam, trade name Rohypnol©, which is known widely as *the date-rape drug* due to its involvement in sexual assault cases in recent years. Benzodiazepines are classified as Schedule IV in the Controlled Substances Act (CESAR, 2019).
- *Addiction:* "A condition in which a person engages in the use of a substance or in a behavior for which the rewarding effects provide a compelling incentive to repeatedly pursue the behavior despite detrimental consequences. Addiction may involve the use of substances, such as
- alcohol, inhalants, opioids, cocaine, nicotine, and others, or behaviors such as gambling" (Psychology Today, 2019).

- *Epidemic:* "Affecting or tending to affect a disproportionately large number of individuals within a population, community, or region at the same time" (Merriam-Webster, 2019).
- *Prescription drug:* A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. These drugs are prescribed by a doctor, purchased at a pharmacy, and prescribed for and intended for use by one person. The FDA regulates prescription drugs through the New Drug Application (NDA) process (FDA, 2019).
- *AAS, anabolic-androgenic steroids*: "Synthetic derivatives of the male hormone testosterone. They can exert strong effects on the human body that may be beneficial for athletic performance" (Hartgens, 2004).
- *Controlled substances:* Drug(s) that are regulated by state and federal laws. The purpose is to control the danger of addiction, abuse, and trafficking by illegal means. The term refers to both legal and illicit drugs.
- *Oxycontin:* A brand of sustained released oxycodone manufactured by Perdue Pharma.
- *Doctor shopper:* An individual who visits numerous doctors regularly to gain prescriptions for controlled substances.
- *Ice:* A form of methamphetamine.
- *Mandatory sentencing:* A policy of minimum sentences given to federally convicted drug offenders established during the crack crisis. Judges have no leeway* and are required by statute to impose the prescribed sentence.
- *Whiteness*: An ideology tied to social status.

- *White privilege*: Refers to an array of perceived societal advantages that benefit people identified by society as white.
- *Pharmaceutical:* Refers to drugs legally manufactured by pharmaceutical companies consisting of controlled and non-controlled substances.
- *Centers for Disease Control and Prevention (CDC):* The federal government agency whose goal is to protect public health and safety in the United States and abroad. Its principal role is the control and prevention of disease, injury, and disability.
- *National Institute on Drug Abuse (NIDA)*: A federal government research institute that uses science and research to address drug abuse and addiction.

Chapter 2: Literature Review

Introduction

This chapter will offer a historical view of opioid and prescription drug use in the United States, reviewing both current and historical literature. More specifically, I have investigated the role of the media in creating the nation's latest drug scare while examining the function of socioeconomic status of current drug users. The research will attempt to determine who is at risk or whether or not socioeconomic status and the current opioid narrative have helped redefine the war on drugs from a war to a public health crisis. This chapter is organized in nineteen sections.

The first two sections cover past and current drug crises and how their portrayal and framing in the media create community fear and moral panic. The third section explores the literature of past moral panics, its similarities, and the current opioid crisis. The fourth section analyzes not only the tactics used by the media to create the current drug scare but also the use of government statistics in its effort to move legislation or generate support for programs to combat the crisis. Sections five, six, and seven research the history of opioids in America, their propensity for use, and how the marketing of these substances may contribute to the overall trends in overuse and abuse. Section eight, nine, and ten cover the role of socioeconomic status (SES), stratification, and their relationship to the current conflict when it comes to treatment within the healthcare system, drug laws, and addiction. Sections eleven, twelve, and thirteen encompass what has and has not worked during the current conflict. These sections discuss how the failed war on drugs has done little for addiction or drug use overall; additionally, these units consider how the war on drugs often conflicts with the calls for legalization call treatment

over enforcement. The remaining six sections cover emerging and contributing trends in the opioid crisis, including internet access to opioids, pharmaceutical treatment options, and inconsistent reporting that have led to a widening of the crisis.

Substance abuse in the United States and around the world is not a new phenomenon. Historically, priests have used psychoactive substances during religious ceremonies, healers exploited them for medicinal purposes, and the general population of the United States handled them in other socially approved ways (Crocq, 2007). Over the centuries, people have found ways to refine and extract substances to create more potent euphoria. Beginning with alcohol, continuing with present substances like fentanyl and even substances created for medicinal use, they have all found their way to individuals whose only desire is to use these drugs for the intense highs or a more intense sense of euphoria. Crocq (2007) explains that the definition of addiction has evolved in much the same way as the drugs that addicts use. Many caught up in the cycle of addiction are now being told that it is not their fault as their addiction is a result of societal changes, socioeconomic status, and medical problems.

Understanding the problem of addiction in the United States may also be a significant roadblock in the search for solutions to the opioid problem today. According to Crocq (2007), “The etiological complexity of addiction is illustrated by a history of pendulum swings of social and medical opinion. There is no resting equilibrium on unanimous beliefs” (p. 360). It is this pendulum that is perhaps changing the way people see addiction not only in the medical sense but also from the perspective of the criminal justice system.

The Framing of a Drug Crisis

"The media is a form of education as it provides information and shapes people's worldviews" (Schirch (2005)). Part of the hysteria caused by the recent opioid crisis may be attributed to media portrayal and more specifically the misreporting of facts, pharmacology, and an overall understanding of the current drug problem in the United States. It is this framing and often agenda-setting that may have a direct impact on how people perceive the problem. Chong and Druckman (2007) describe framing as the "process by which people develop a particular conceptualization of an issue or reorient their thinking about an issue" (p.104).

In a study conducted by DeVreese (2005), five news frames were examined. These five frames include, "conflict, human interest, attribution of responsibility, morality, and economic consequences" (p.56). The current opioid crisis is best reflected in the conflict frame, which DeVreese (2005) states that it "emphasizes the conflict between individuals, groups, institutions, or countries" (p. 56). The group and individual conflict might be best seen between those who advocate drug legalization and those who seek stricter penalties for drug offenses. The institutional conflict could be viewed among those organizations that prefer more treatment and those that seek more control or enforcement. Therefore, according to DeVreese (2005), conflict is a result of the frame's impact on the viewer, and it depends on who is watching or listening to the news or from what news outlet one is reading. Furthermore, when reporting on crimes caused by the current opioid crisis, "both television and newspapers consistently have been observed as distorting crime information" which often catalyzes conflict (Durham, Elrod, & Kincaid, 1995).

In the book *Folk Devils and Moral Panics*, Cohen (1972,1987) first used the term "moral panic" to describe an array of conditions leading to "a threat to societal values and interests" (p. 9). In the same book, panic is described as "a sudden and excessive feeling of alarm or fear, usually affecting a body of persons, and leading to extravagant or injudicious efforts to secure safety". Currently, the opioid crisis is framed in such a way that it encompasses all parts of the definition. Constant reminders of the number of deaths and overdoses have created a frame of fear or alarm as demonstrated among a body of people, and it resulted in extravagant efforts to make things safer or, at the very least, appear so by declaring national emergencies.

The framing in the media of illicit drugs and their use does not represent a new trend. As far back as the late 1800s and early 1900s, the news media has framed opioid and illicit drug use in the United States. In the late 1870s, *Harpers Weekly* depicted opium was used to help babies cope with teething. In 1914, cocaine use was growing to a point where newspapers ran front-page articles portraying an apocalyptic view of the country's growing cocaine problem.

Figure 1. Article in Harpers Weekly Regarding opium use in 1870's.

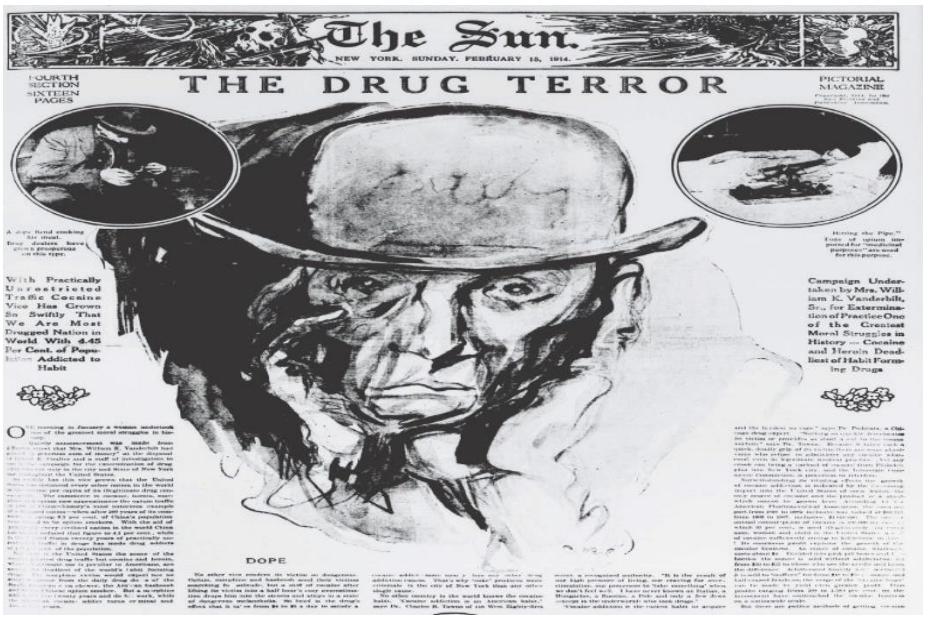
The Sun.
NEW YORK, SUNDAY, FEBRUARY 15, 1914.
THE DRUG TERROR
DOPE

Figure 2. 1914 Sun Article depicting drug scare.


MAGAZINE SECTION
THE OGDEN STANDARD
MAGAZINE SECTION
OGDEN, UTAH, SATURDAY, MAY 22, 1915.
DEPRIVED OF "DOPE"—CRIME WAVE BEGINS
Government Secret Service Agents In Desperate Battle With Drug Users Since Harrison Act Went Into Effect—Frightful Conditions Reported By U. S. Officers In Making Numerous Raids
TYPES OF DOPE USERS
A TYPICAL ALLEY WHERE "DOPE FIENDS" THRIVE.

Figure 3. Article Depicting drug panic in 1915.

In a 2014 study, Robinson analyzed a similar framing of the 1980s crack cocaine epidemic. When crack first started appearing on the streets in 1985, the *New York Times* ran a story, proclaiming it a new crisis. The crack problem then became a news story

everywhere as evidenced by *Time Magazine* and *Newsweek* that, between the two, ran five cover stories on crack, designating it the "largest issue of the year" in 1985 (Robinson, 2014). By 1986, over 1000 stories were written in newspapers and magazines throughout the country. Many of those stories referenced the crisis as "the biggest story since Vietnam," a "plague," and a "national epidemic" (Robinson, 2014). What Robinson's study uncovered about the media framing of the crack epidemic is eerily similar to what people witness today. Not only did Robinson's study find much of the reporting "dishonest and inaccurate" but also realized that it did not "reflect reality" (p. 19-50). During the period the media coverage of crack cocaine was growing, the use of powder cocaine was declining. However, some media coverage claimed an increased use despite lacking any evidence indicating the increase (Robinson, 2014).

During the 1870s, the first laws against the smoking of opium resulted from the country's anti-Chinese sentiment and some people's belief that Chinese workers, brought to do work on the railroads, were taking away American jobs. Reinarman (1997) explains that "The campaign against smoking opium (but not against other, non-Chinese uses of opiates) included lurid, fictional newspaper accusations of Chinese men drugging white women into sexual slavery" (p. 6).

Leading up to the passage of the Harrison Act of 1914, cocaine and opioid use was more predominant among White, middle-aged women, but soon it began to shift to "working-class men and others labeled as disreputable groups resulting in sensationalized reporting. In turn, what followed was a new wave of drug use among "blacks, prostitutes, criminals, and transient workers" (Reinarman, 1997, p. 4).

Despite these claims, there was little if any evidence found that African Americans used as much cocaine as did the White population (Reinarman, 1997). When the issue of states' rights pertaining to the Harrison Act became an issue, the myth of a "black rebellion" and Black drug-related crime was the new narrative. It became so widespread that articles were making claims that "some Southern sheriffs even switched from .32 to .338 caliber pistols because they claimed that their old guns could not stop the 'cocaine-crazed' Negro" (Reinarman, 1997). Finally, a quarter of a century later was to yield a new drug scare that led to the passage of the Marijuana Tax Act. Some saw this as a result of the "reefer madness" scare; thus, frightening stories of rape and violent crimes were attributed to the use of marijuana.

One common denominator in many of the drug scares, according to Reinarman (1997), may be attributed less to drugs and more toward issues of race and socioeconomic status. Today, the opioid crisis resembles in some way to be just another drug scare. It is not to say that opioid use is not a legitimate problem or that the numbers of deaths are being exaggerated. Instead, the narrative appears to have shifted, and the new media narrative has evolved from a drug crisis to a public health crisis.

The framing of the opioid crisis may benefit the media, state, local, and the federal government, but all have the potential for adverse effects on the user and society; still, more importantly it can deny the public of the facts surrounding the crisis. For example, those who oppose the mass incarceration brought upon by the war on drugs continue to engage in supportive actions and call the current crisis a "National Emergency, Public Health Crisis, and Opioid Epidemic." However, Gostin (2017) posits that a potential side effect of declaring such an emergency "is the potential for more

punitive responses focused on incarceration" (p. 1539-1540). Therefore, arguing or overstating any emergency might lead to more of the very issue or problem of incarceration that people may be against. Emergencies and crises require immediate action, and -up until now- the result has been in the form of punitive action through law enforcement and the criminal justice system. Gostin (2017) points out that deploying resources in such a dramatic way as found, for example, in the declaration of a national health emergency could potentially steer funds from other national health concerns, such as diabetes, cardiovascular disease, and cancer. Federal emergency declarations would also require effective agreements between state and federal partners as well as those in the private sector.

When the media engages in the practice of scaring the public through their use of terms such as *crisis, epidemic*, or *emergency*, adverse results could develop. Studies conducted by Timberlake et al. (2001) and McGinty et al. (2015) found that the media only engaged in stories regarding substance abuse treatment programs in about 3% of news stories on substance abuse from 1998 to 2012". Additionally, the studies indicated that, in general, the American public "supported and favored criminal justice initiatives over drug rehabilitation programs". In another recent study carried by Dunne (2017), research indicated that "framing and tone of the media coverage leads to the social construction of drug epidemics and can cause intense media frenzies, like during the crack epidemic and now during the rise in opioid addiction and overdoses" (p. 28).

Finally, conflict theory posits that those in power or control tend to manipulate and control the media as a way of escaping criticism or perhaps even avoiding criminal accusations (Nathan, 2010). For example, the pharmaceutical industry spent $4.6 billion a

year in direct consumer advertising for their products through the media. One might question the vast amount of money injected into the media, and media's influence in the industry's overall portrayal to viewers. Thus, could portraying their products as safe or non-addicting as well as lobbying Congress for more favorable regulations regarding the manufacture, use, and distribution of pharmaceuticals, create this power or authority? If so, does this maximization of power contribute to social and political change? For example, money influences many political campaigns, and the money donated by pharmaceutical companies to particular political parties or candidates might then have the ability to influence the winner or loser of an election. The result might lead to this exercise or maximization of power by pharmaceutical companies and media conglomerates.

Another Moral Panic

> *Societies appear to be subject, every now and then, to periods of moral panic. A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible*
>
> *(Cohen, 1972, p. 1)*

In part one of the study "Moral panic, revisited," Hamilton (2015) describes the phrase as a "disproportionate social reaction to a given threat or behavior" (p 8.). The

theory of moral panic is not new, nor is it only associated with drug waves or crises. Lemert and Becker's labeling theory was perceived as having a significant influence on *moral panic*, and Cohen (1972) "used labeling theory and the idea of deviance amplification to develop the concept of moral panic"

Although first developed by Cohen, the attributional model of a *moral panic* developed by Goode and Ben-Yehuda (2009) explores "social constructionism." Ben-Yehuda (2009) associated *moral panic* with deviance and crime, resulting in a "heightened level of concern over the behavior of a certain group or category". Furthermore, Ben-Yehuda outlined "concern, hostility, consensus, disproportionality and volatility" as the five defining elements of a *moral panic*.

In viewing the opioid crisis as a *moral panic*, we see how and where these five criteria are present in the creation of the opioid crisis. Ben-Yehuda (2009) describes this matter as the "heightened level of concern over the behavior of a certain group or category" (p.37). The public's knowledge of the adverse effect of opioids through both media coverage and the personal experiences of those affected have caused a heightened level of apprehension amongst Americans today, as evidenced not only by the print media but also on television and social media where public service announcements and advertisements are plentiful.

The hostility required for a *moral panic* is described as "collectively designated as the enemy, or an enemy, of respectable society" (Yehuda, 2010, p38). While this has been well documented in studies surrounding other drug crises (Cohen, 1972; Reinarman, 1997; Ben-Yehuda, 2009), few studies if any have been conducted to investigate whether or not the opioid crisis may well be a *moral panic* created by the media.

In some of the literature, the ‘devil’ created by a moral panic can be both bad and good, as indicated by the opioids case. Pharmaceutical companies are relied upon for the discovery of life-saving drugs every day; these drugs, which keep people alive and cure illness, would not exist if not for these companies. However, at the same time, there are those in the media and the government who blame the pharmaceutical companies for their role in the crisis.

There appears to be little doubt that, within the United States, opioids have resulted in a crisis where the “threat is real, serious and caused by the wrongdoing group members and their behavior” (Critcher, 2008). “The concept of moral panic rests on disproportion,” as evidenced by exaggerated or fabricated statistics (Ben-Yehuda, 2009).

Finally, moral panics have historically subsided as quickly as they erupt. In the case of the opioid crisis, however, the crisis has lingered on for more than a decade and does not appear to be diminishing as it occurred with previous crises. Thus, one might ask if its notoriety as an epidemic or crisis, outlasting those in the past, may be exasperating the slow decline.

This volatility can also be responsible for the “vilifying of opponents” and, in the case of the current crisis, for its discrete or unnoticed collusion with other groups, such as the police (Yehuda, 2009). This ‘collusion’ may be demonstrated by the police who administer life-saving drugs like Narcan or take a drug user to rehab or hospital rather than jail.

Is the current crisis merely a moral panic or a reaction to what may be described as another wave of drug abuse? Through the review of this literature, one might believe that it is somehow a new or different type of crisis than those preceding the current drug

crisis. However, when looking back less than 100 years ago, one can see that the issue appears more like history repeating itself. The only difference is that the drugs have changed and there are not only more of them, but there are also more people using them. Many drugs today are more powerful and easily obtainable, but in retrospect not much different than those in years before. For example, heroin has been around for a century and just as deadly for those who used it. Drugs such as Oxycontin are new and more powerful, yet taken as directed, they are not likely to cause death. While fentanyl is a relatively new drug, the pharmaceutical version of the drug -when used as directed- is also not likely to cause someone's death. However, the current form of fentanyl is illegally manufactured, the strength not verified, neither tested, nor is it manufactured according to conditions specified by the FDA in the United States. The vast majority of fentanyl comes to the United Stated illegally from China via Mexico, and because of its above stated origin, when used to cut or mixed with heroin to make it stronger, the likelihood of death or overdose is inevitable.

Herzberg (2016) discusses the three waves of prescription drug epidemics in the United States, beginning during the late 19th century with cocaine, "God's own medicine." Popular among many in the immigrant class, the use of opiates was synonymous with "saloons, brothels, and other aspects of a new and often disreputable popular culture" (Herzberg, 2016, p.408).

The newfound affection for cocaine and opiates led to the first anti-drug campaign in the country, and -although most of the compliance was voluntary- it led to the first drug legislation and the rise of the Food and Drug Administration (FDA). However, as Herzberg (2016) points out, "once established, drug markets were difficult to eradicate"

(p.408). The widespread use of drugs like cocaine and heroin in major metropolitan areas pushed reformers into passing the Harrison Narcotics Act of 1914 (Pub. L. No. 63-223).

The Harrison Act did not make drugs like heroin and cocaine illegal but only required a prescription to possess and use them. This legality of drugs was a short-lived experiment in drug control policies and was eventually repealed as the federal government began to focus on supply-side enforcement tactics to combat manufacturing and use.

Drug use, although tolerated as part of a particular public culture, would now be viewed as deviant behavior and punished. These *new deviants* were referred to as *junkies* like part of the government's campaign against drug use. These junkies were portrayed as hopeless, with no chance of recovery and so characterized to instill fear in the public. Those doctors, many of whom were considered respectable and who once prescribed heroin and cocaine to their patients, now turned to prescribe drugs less demonized or less known to the government and public.

Herzberg (2016) explained that the first crackdown on cocaine and heroin led to the transition into the second wave of the prescription drug epidemic, the use, and abuse of barbiturates and amphetamines. The widespread use of these anti-depressants and diet aids became mainstream and widely prescribed, beginning with the millions of soldiers returning home from World War II (Herzberg, 2016). However, once again, it did not take long before legitimate prescribing and use led to widespread abuse, and -like cocaine and heroin before them- the effort to control barbiturates and amphetamines was voluntary.

Although it was initially believed that education and training would help decrease the poor prescribing practices and abuse, the review of the literature indicates that it failed as well. Much in the same way as through the Harrison Act of 1914, the Congress now looked to control these drugs similarly. However, Congress faced resistance from the pharmaceutical companies that, similar to the current situation, sought weaker and less controlling measures. Primarily demonstrating that the consumers of these drugs were middle-class White users and not the perceived threatening *junkies* who were to be feared, fierce lobbying was successful and resulted in no new laws or regulations.

A willful blindness toward barbiturates and amphetamines abuse persisted until the 1960s when their non-medical use skyrocketed. As a result, this widespread use resulted in the passing of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Pub L No. 91–513). Furthermore, this legislation placed all drugs with potential for abuse "under the Drug Enforcement Administration and its Schedule of Controlled Substances" (Herzberg, 2016).

The term, *controlled substances* essentially meant that prescription drugs could now be traced from the manufacturer, distributor, prescriber, and pharmacy and ultimately to the end user. The United States had now officially declared *war on drugs*, which set the start point for the policing and punishment of manufacturers, prescribers, and users. Herzberg (2012) indicated that, despite what many perceived as harsh regulations and restrictions on doctors, in fact the non-medical use of barbiturates and amphetamines plummeted. The end or at the very least diminished drug culture of the '60s and early '70s did not last long.

The 1980s brought back the demonization of the *junkie* once again; thus, media attention focused on the new epidemic: crack cocaine. While law enforcement and the media focused on that new war, the pharmaceutical industry was busy with research and development. New drugs were developed, and new classes of amphetamines and opioid pain relievers were coming to market at a rapid pace. Many of those drugs were touted as *abuse-resistant* or containing *non-addictive compounds*, and, therefore, the pharmaceutical lobby once again met little resistance to bring these drugs to market.

The new development, led to what Herzberg (2016) identified as the third wave of prescription drug abuse, which is the moment where the American society finds itself today. Once again, the use and abuse of prescription drugs are found to be the highest among White, middle-class suburban Americans. As in the case of the two previous attempts, education, training, and regulations were envisioned as a solution and thus put into place to control the widespread drug abuse.

However, unlike in the previous waves, the new wave brought in enormous profits for many engaged not only in the manufacturing but also for the doctors prescribing and diverting the drugs. When first released and during the peak of the Oxycontin crisis, the drug came in the form of tables of 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, and 160 mg. OxyContin was classified as a Schedule II Federally controlled drug, and -due to its expense- many insurance plans and Medicaid considered it a prior approval or pre-authorization drug. This meant the prescriber would have to articulate a medical need or necessity for the prescription. However, once approved and paid for, the drug could then be sold on the street for $1.00 per milligram for those

choosing not to abuse but rather to profit from others' abuse. This meant 60 tablets of OxyContin prescribed twice a day for 30 days could yield the seller a profit of $3600.00.

It was not just OxyContin, however, which found its way to the street markets. Hydrocodone, a lesser controlled, Schedule III controlled substance at the time, was more widely prescribed and, therefore, more readily available as well as significantly cheaper. While the likelihood of an overdose death from Hydrocodone alone was far less than that of OxyContin, it offered a similar high to many who took it. Soon, unscrupulous doctors got into the diversion game, charging patients in *pill mills* a fee for the prescription as well as the strength and quantity of the drug, which became widespread in areas, such as Appalachia and the rust belt states. More entrepreneurial doctors took to the Internet under the guise of *telemedicine* and reached a more extensive array of prospective patients (Llosa, 2007).

Then, how does this current epidemic stack up against the previous and other drugs currently being abused? First, higher opiate use is not indicative of a decrease in other drugs, such as cocaine, methamphetamine, and other non-opiate prescription drugs like benzodiazepines and stimulants. Many individuals using prescription opiates and heroin also consume these other drugs simultaneously; Williams (2014) indicated in a research study that "Worldwide, 18-50% of patients receiving methadone in Opioid Treatment programs (OTPs) are dependent on benzodiazepines. At the same time, the United States began to see a decline in prescription drug abuse and diversion in 2010; we began to see an increase in the use of methamphetamine between 3% and 4% across the country (SAMHSA, 2016; Vestal, 2017). To complicate matters further, unlike opioid abuse, there are no approved medications used for methamphetamine cravings and

treatment. Although the death rate attributed to methamphetamine use has risen over 30% in one year, addiction and abuse of methamphetamine does not result in as many overdose deaths but instead takes years to destroy internal organs and shut down vital organs (Vestal, 2017). Nonetheless, it becomes notable that media coverage and emphasis on the methamphetamine crisis appears to receive far less attention than opioids.

In *Folk Devils and Moral Panics*, Cohen (1972) introduces the term *moral panic* to describe an array of conditions leading to "a threat to societal values and interests" (p. 6). Currently, the opioid crisis is framed in such a way that it encompasses all parts of the definition. The frame appears to have created fear or alarm through the constant reminders of the number of deaths and overdoses as demonstrated among a body of people and resulted in extravagant efforts to make things safer or, at the very least, appear so through declaring national emergencies.

When examining the phenomenon of moral panics, it is essential to understand what propagates it and the catalysts which drive it. Goode and Ben-Yehuda (1994) identifies that Grassroots, Interest-Group, and Elite-Engineered are the three models of societal groups responsible for the creation and expansion of the moral panic. However, Goode and Ben-Yehuda (1994) and Reinarman and Levine (1989) posit that the "elite engineered model, small and powerful group(s) create(s) the moral panic [and] these elite crusades can be intended to refocus the public's attention to other issues not related to legitimate societal problems" (p. 51-72). Hence, within this model, the power of the elites influences and controls over "media, legislation, law enforcement initiatives, and the resources of action groups and social movements" (Goode and Ben-Yehuda, 1994; 2009). Therefore, it was not be uncommon to see a nexus between the elite-engineered

model of moral panic and the shift from crime to treatment in the latest drug crisis, particularly when the current crisis has had a significant impact on citizens of higher socioeconomic status.

The framing of *illicit drugs* by many in the media is not a new phenomenon. Robinson (2014) analyzed the similar framing of the crack cocaine epidemic of the 1980s. When crack first started appearing on the streets in 1985, the *New York Times* ran a story proclaiming a new crisis. Subsequently, the crack problem became news everywhere and was covered shortly after by *Time* and *Newsweek* that ran five cover stories on crack, designating it the "largest issue of the year [1985]" (Robinson, 2014). By 1986, over 1000 stories were written in newspapers and magazines throughout the country and were referred to as "the biggest story since Vietnam," a "plague," and a "national epidemic" (Robinson, 2014). Robinson's study revealed that the media framing of the *crack epidemic* was dishonest, inaccurate, and did not reflect the reality, which is eerily similar to what society witnesses today. While the media extensive coverage of crack cocaine was growing, in fact the use of cocaine was declining (Robinson, 2014).

According to Reinarman (1997), the common denominator in most of these drug scares seems to be less attributed to drugs and more to other issues, such as race and socioeconomic status. Today, the opioid crisis appears, in many ways, just as another drug scare. It is not to say that there is not a legitimate problem or that the numbers of deaths are being exaggerated. Instead, the narrative is often based more on a media chronicle that has taken the storyline from a *drug crisis* to a *public health crisis*, and possibly a crisis, which would garner more public support and empathy than a more significant number of drug users dying of overdoses.

Tactics Used in the Drug Scare

Very few things scare people more than the possibility of their death or the death of a loved one. In much of our daily lives, whether it is putting on a seat belt to protect from severe injuries or death while in a motor vehicle, promoting the benefits of exercise to prevent heart-related diseases or death, or scaring people into compliance has been utilized by many sectors within society. Currently, the endless parade of parents, specifically mothers who have lost children to drug overdoses are more familiar in the news and social media than ever before. “This could happen to anyone” and “why my child” are common statements used by the media during interviews of parties affected by the opioid crisis, while parading endless suffering parents and loved ones in what might be an effort to influence individuals with little knowledge of the crisis and create a greater sense of importance.

While no one can help but feel sorry for those affected by this crisis and try to understand the pain and despair they feel, some ask “how or why is this my problem?” Perhaps this is media’s reasoning behind the endless stories of overdose deaths: the worse the narrative, the more people may care and advocate for changes. In the world of illicit drug use, methods such as this occur daily. To get a better understanding, on may consider the crack scare of the 1980s. As previously discussed, the element of criminal activity and death associated with crack use was prevalent throughout the period; according to Bahaman (2014), the crack epidemic was not merely about crack use itself, but it was rather characterized by several symptoms, which portrayed along gendered lines.

Instead of merely focusing on drug use, attention was switched to portrayals of women prostituting themselves out for pieces of crack cocaine, young men dying on the street during turf wars for the territory to sell crack, and perhaps the most prolific tale played out in the media was that of the *crack baby*. Visions of young children born addicted to mothers who were crack addicts created an epidemic that affected even those never exposed to drug use or abuse (Coles, 1993). After all, what could bring more awareness: the call for harsher penalties and an end to a problem or the faces of shaking, sick, drug-addicted children? However, both professionals and the media were responsible for creating the *crack baby* myth, the results of which led to the labeling of mothers and children (Coles, 1993).

Reinarman (2004) asserts that "Once the myth of the 'crack baby' had become part of public discourse, no amount of medical science to the contrary seemed able to dislodge it" (p194). In what appears to be yet another effort to garner more attention, the myth of the crack baby has been 'reborn' in the current crisis. In 2017, the media's new campaign again focused on opioid addicted moms and babies born addicted to opioids. By 2018, over 300 stories were published online and in newspapers regarding addicted babies and opioid addicted mothers (Media Cloud, 2018) even though alcohol and nicotine have proven to be more dangerous to the health of the fetus and infant. In August 2017, The American College of Obstetricians and Gynecologists published the article "Tobacco, Alcohol, Drugs, and Pregnancy" which warned about the dangers of those substances. However, of the 21 bullet points on their page, more than half spoke to the dangers of opioid prescription drugs. It should be noted that they did not include illicit drugs, such as heroin and cocaine. The remainder of the articles referenced to the

following components: four about smoking, two on illicit drugs, and two on alcohol even though alcohol and smoking were proved to cause more damage to both the long- and short-term health of a fetus and infant. Furthermore, studies such as those carried recently by the CDC (2016), measuring Neonatal Abstinence Syndrome (NAS), derived its statistics from only 28 states, including those with the highest opioid use.

As I examined the opioid crisis today, we see similarities in the scare tactics. However, unlike the portrayal of young African American men killing each other during the crack crisis and those stealing and committing crimes to feed their addiction, today those images are replaced with stories of death and family tragedy. Accordingly, individuals who have succumbed to prescription drugs and heroin are now considered victims. Although the vast majorities never started on the path to addiction through a doctor or hospital, the current narrative appears to need sympathetic victims, much in the same way the myth of the crack baby became the mainstay of the anti-crack campaign.

The victims of today's opiate crisis are the users or abusers of the drugs as well as families, communities, and the economy. However, unlike in the past years, the narrative has shifted from demonizing users as it was done a century ago with crack, heroin, and opium. In many of the reports and narratives regarding opioid abuse, some might wonder if anyone consciously takes these drugs. Today's narrative describes the impact of opioid use on innocent families, young kids, and other vulnerable groups in society, but all too often this narrative rarely holds any user accountable for his or her actions. However, this does not appear to be a new phenomenon when we make socioeconomic comparisons. Historically, it often appears that when someone of higher socioeconomic status overdosed or abused illicit drugs or pharmaceuticals, it was widely attributed to

something other than personal choice. When one overdosed and died as a result of the abuse, the overdose was rarely considered other than a tragic accident and the person was never deemed at fault.

The media often appears to assist and further promote this narrative. Historically, however, society is not as quick to apply the same so-called *accidental treatment* to other substance abuses. When someone is driving drunk and hits another person and kills him or her, is it an *accidental death* or is it *criminally negligent homicide*? One could assume there were no intent in driving the vehicle into another and taking someone's life, yet through the negligent conduct of consuming too much alcohol, the assumption of individual risks is known. For this particular reason, Holden (2012) sustains that "Criminal courts do not hand down verdicts of 'not guilty by virtue of mental illness' to drunk drivers who kill pedestrians" (p. 679).

Over the past several decades, the media has latched onto the endless number of Hollywood stars, musicians, and other celebrities to assist putting forth their agenda. For example, one may consider the death of Janis Joplin in 1970. Most Americans were well aware of Joplin's and others' rampant drug use during that period. When Joplin died, *New York Times* (1970) published an article titled "Death of Janis Joplin Attributed to Accidental Heroin Overdose;" the publication notified the public that Joplin "[was] found dead in her Hollywood hotel apartment Sunday night of what a coroner has determined to be an accidental overdose of heroin" (Gent, 1970, para. 1). Being a long-time substance abuser, one might ask if there was inherent or known risk associated with her behavior and, at the very least, negligence involved in her death? Furthermore, the article stated that there was no evidence of suicide (Gent, 1970). Does this imply that the mere absence

of a note or a previous conversation, suffice as evidence that the death by overdose was accidental?

The National Institute for Health (NIH) characterizes an unintentional overdose as follows:

> Unintentional drug poisoning deaths include cases where: a drug was taken accidentally, too much of a drug was taken accidentally, or the wrong drug was given or taken in error, or an accident occurred in the use of a drug(s) in medical and surgical procedures. (NIH, 2017, p. 1)

Except for accidents occurring during surgery, for which heroin is never prescribed, how can a drug be taken accidentally? While there is widespread evidence of heroin adulterated with other potent narcotics such as fentanyl, most addicts understand the risk. Therefore, some may wonder if an overdose was truly unintentional when it resulted from the act of an addict putting a needle into his or her vein. The term *accidental* resembles, at the very least, a term used to soften or defend the use of certain drugs.

Drugs have been adulterated and altered for decades. It has been a common practice among drug dealers who, like any other businessperson, see drugs as a way to corner a particular market or stretch their product further by cutting or weakening the drug with inert ingredients to maximize profit. Many try and gain new customers by offering a better product or one that encourages repeat business.

During the early 1990s, the medical community began prescribing opioid pain relievers to patients at a brisk pace, arguing pain was the “fifth vital sign” (Mularski, 2006). When the pace picked up and soon became a full-blown drug crisis, “the U.S.

news coverage primarily framed opioid analgesic abuse as a criminal justice issue rather than as a treatable health condition" (McGinty, 2015, p. 409). However, when the crackdown on doctors writing prescription pain relievers caused the primary and secondary markets for prescribed and diverted medications to dry up, some users moved to a more readily available and cheaper alternative. Although the drugs transitioned from regulated pharmaceuticals to hard drugs like heroin, bootleg, or counterfeit fentanyl, the media's coverage still seemed to remain with the softer "opioid approach" when discussing the problem.

Austin's study (2014) on articles published in the *New York Times* from 2012-2013 found that news "limit the scope of how substance abuse is viewed socially and perpetuate stereotypes and stigmas of substance abusers" (p. 114). Therefore, the relationship between the scope of the problem and any aspect of rehabilitative care appears to be absent. Instead, the media prefers to frame drug addiction as a criminal act. Those who used or sold addictive substances needed to be removed from society and viewed as evil in the media. This framing led to an increase in law enforcement and stricter penalties for those engaging in related activities. Thus, for individuals from disadvantaged, poor, and marginalized neighborhoods the penalization meant prison sentences. Alternatively, few calls for treatment were provided. The affected communities, mostly comprised of African Americans and Latinos, gave rise to at least the appearance of a racially motivated *war on drugs*.

The media is not the only source of the often misleading, framing of the opioid crisis. It is worth mentioning that government entities frequently use the media narratives when attempting to gain support for new initiatives, which habitually involve spending.

Regularly, it is not always about what is said, but the way it is portrayed. A sound example is a report from the New York State Office of the Comptroller (2016) on the opioid crisis which states on the first page, “Overdose deaths in New York related to heroin use reached a record high of 825 in 2014, a jump of more than 23 percent from the previous year and nearly 25 times the number of a decade earlier” (p.3) While one might not dispute the facts, one should question the numbers compared in two distinctly different ways; first, the report utilizes a “percentage” of 23% and then in a bigger than life “25 times the number?” Next, the report notifies, “deaths in which prescription opioids were a contributing factor also reached a new peak in 2014, nearly four times the level in 2005” (p. 2). What is interesting about this statement is that figures were lower in the 2015 published report, as well as the available 2013 report.

Furthermore, like many other states in the national average, New York State had begun to see a steady decline in the rate of prescription opiate use from the 2010 peak through 2016, except for the year 2014. One might ask then, why the State of New York chose to include an outlier, as a basis for their so-called ‘increase’ when averaged overall would have shown a decline? Finally, to strengthen this argument, The Comptroller’s Report (2016) stated, “comparing the death rates in 2005 and 2014 for both substances, New York’s increased more than almost any other state for which such data were available” (p. 1).

In a study conducted by Turner and Orcutt (1993), the authors attempt to explain the distortion of not only government but also other research entities’ statistics during the cocaine and crack crisis in the mid-eighties. Turner and Orcutt (1993) found that there were “ample grounds for the claim that media workers lie”; but we have also tried to

understand the creative choices and skills that are entailed in the fabrication of these distorted images of drug problems." Sadly, Turner and Orcutt's findings (1993) "offer a sociologically pertinent account of how media workers use drug data to construct the social reality of national epidemic" (p. 50), but the study depicts little to answer what occurred during the 80s drug crisis.

America's Intolerance for Pain and Discomfort

Why are so many Americans in pain? The proliferation of pharmaceuticals just within the United States today, comprising to a large extent of pain relievers and stimulants, has been explored through numerous studies, indicating America's decreased tolerance for pain and discomfort. These same studies are also indicative of a society in which increased use of prescription drugs is marked by higher rates of abuse and misuse of these medications (Gilson et al., 2004). Does the rest of the world's population suffer in pain each day, and are American doctors the only ones to diagnose and successfully treat pain?

Some estimates reveal that 126 million adults, which represent 55.7%, indicate having some degree of pain during a three-month period, and 23.4 million (nearly 10%) claim having experienced much pain (NIH, 2015). It has been said that "pain is a study of social cognition" (Hadjistavropoulos, 1994, p 485-491.); thus, clinical determination and recognition of pain vary not only from physician to physician but also by their training and education. However, of those receiving pain medication from doctors, it becomes difficult to estimate the number of individuals who "fake" pain in an effort to receive pain medications.

Various studies provide different reasons these patients go undetected, but overall it is difficult when doctors are trained in medicine and not in detecting lies. Furthermore, in America's fee for service world of medicine, doctors spend little if any time, getting to know their patients; as such, often little is known about the person's background and history other than what the physician learns from the patient. Research conducted by Jung (2007) indicated that "the experience with standardized patients shows deception is difficult to detect. In the naturalistic setting of an office encounter, genuine patients can be mistaken for fake patients as well as fake patients accepted as real ones" (p. 433-437). Another key factor is the physician's own clinical experience. For example, Hadjistavropoulos' study (1994) "suggests that a physician's clinical experience influences clinical judgments of patients who present with chronic pain" (p. 485-491). Therefore, a physician who treats patients in an area with known high abuse rates and *doctor shoppers* will distrust a more significant number of patients complaining of pain.

In the current legal climate surrounding prescribing opioids, accepting patients' reports of pain can have significant legal consequences for the doctor if they fail to properly diagnose but also prescribe opioids erroneously. Thus, the separation between who is in pain and who is drug seeking has become significantly more difficult and creates an atmosphere where those in legitimate pain may unknowingly underestimate leaving some to lack proper treatment.

Much of the literature reviewed regarding the use and eventual abuse of opioids originates from an injury, surgical procedure, or from a complaint of physical pain. The definition of *pain*, defined by Merriam-Webster (2018) includes not only the physical pain caused by disease or injury but also mental or emotional suffering or sadness caused

by stress, loss, or other types of mental disabilities. This is important when we look for causes of not simply opioid abuse but addiction, in general. For example, in areas of the country hardest hit by job loss, poverty, and bleak futures for many of the residents, drug and alcohol abuse are not only outcomes of the socioeconomic depression but may also create pain as it is defined. A study carried by Gatchel (2004) found that "psychiatric and medical pathologies interface prominently in pain disorders" (p. 2). Therefore, this research might suggest that individuals affected the most (as a result of drug abuse) might consider Gatchel's approach to a more "comprehensive biopsychosocial (BPS) model, which emphasizes the unique interactions among biological, psychological and social factors required to better understand health and illness" (p. 6). In doing so, it would consider not only physical causes of pain but also psychological and social aspects, which often lead to issues with chronic pain.

The Opioid Crisis

While there has been an increasing amount written and researched on this current trend in drug abuse, there seems to be no consensus as to its cause, its long-term effects, as well as any way in which to curb the current widespread use and abuse. Compton and Volkow (2005) attribute the rise in abuse to "several forces." First, the authors cite the increase in the number of prescriptions for opioids. Second, the researchers hold responsible the Internet access, which opened the market for illegal opioids to anyone with a computer and a credit card. This market was further opened during the last decade when major credit card companies began selling pre-paid versions of credits cards at cash registers in almost every big-box store; in this way, it opened up the market to teens and -

in some cases- pre-teens unable to obtain a credit card on their own. Other studies point to a variety of other factors, which also lead to the abuse of opioids.

In a study led by Hassan (2017), anabolic steroids were found to be a possible gateway to opioid use, especially among younger users. On another hand, Darke (2017) remarked opioids were detected in 37.5% of cases where males were engaged in anabolic-androgenic steroids (AAS). Darke (2017) also found that more than half of those injecting AAS were also injecting other substances. More alarming was that approximately 25% were found to be injecting preparations made from tablets, which most often results in the crushing or liquefying the pills with water. Mhillaj et al.'s research (2000) is perhaps one of the most significant studies indicating a correlation between AAS and opioid abuse; the investigation found that patients were introduced to opioids through AAS use and bodybuilding physical activity.

The use and abuse of alcohol have also been a contributing factor in overdoses and overdose deaths from those who abuse opioids. Jones (2014) states that, despite the known use of alcohol and its contribution to these overdoses and overdose deaths, "it was not possible to ascertain the amount of alcohol consumed, which limited the ability to look at outcomes by alcohol consumption level" (p. 881-885), making it very difficult to determine which component contributed more to the problem. Compton and Volkow (2005) cite the formulation of drugs and the prescribing practices of physicians. All three have perhaps accounted for individual and collective increases but also impacted on state regulations and prescription drug-monitoring programs (PMP, PDMP), which dictate tighter controls and regulations of controlled substances along with existing federal regulations.

Other researchers choose to blame the medical communities and pharmaceutical companies, but they do so along racial lines and believe that the current drug problem is a "white prescription opioid epidemic" (Netherland 2017). Netherland used this argument to bolster the belief that "whiteness" is associated with the use and abuse of prescription drugs; he then makes the following assertion,

White drug war' has carved out a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern the drug use of people of color. (p. 217-238)

Netherland (2017) further adds that OxyContin was the "primary driver of the dramatic rise in prescription drug abuse through the 2000s" (p. 217-238). Although this may have been true in some areas of the country, other research indicated that in other parts it was more a result taken from easily obtainable opioids, which finally led to driving the rise in addiction.

As previously noted, those states with PMPs witnessed a less significant impact with OxyContin, while still experiencing a dramatic rise in opiates related to those drugs more easily acquired by drug seekers. Drugs such as hydrocodone and to some extent smaller doses of oxycodone found in drugs such as Percocet and Percodan. Hydrocodone products are by far the most prescribed opioid analgesics in the country, and their use is significantly expanding, reaching over 4 million people per calendar quarter by the end of the second quarter of 2005, which was nearly twice of that recorded in 2002–2003. Next, by a substantial margin, the remainder of the drugs are presented in rank order: IR oxycodone, ER oxycodone, morphine, methadone, and hydromorphone (Cicero, 2007).

Furthermore, Cicero (2013) found that people who abuse prescription opiates "favor one drug over another [and] oxycodone and hydrocodone are the drugs of choice for 75% of opioid-dependent individuals" (p. 157-170). Regardless of the opioid chosen, it remains clear that Americans consume more opioid medications than any other country as reported in 2016 by the International Narcotics Control Board.

However, opioid epidemic narrative omits the fact that many other drugs are not opiates although they are equally addictive and dangerous. Benzodiazepine use and abuse has also grown and is quite often found in the system of many of those who overdose on opioids. A study conducted by Park (2015) indicates that among veterans, "58% of total deaths from drug overdoses in 2010, 75% involved opioid analgesics. Thirty percent of overdose deaths related to opioid analgesics involved benzodiazepines, drugs commonly prescribed concurrently for patients who receive opioid analgesics" (p. 1). Jones (2014) also points to the Drug Abuse Warning Network (DAWN) statistics, which in 2010 demonstrated evidence of poly-substance abuse with over 438,718 emergency department (ED) visits related to opioid abuse and 408,021 ED visits related to benzodiazepine abuse alone or in combination with other drugs. Moreover, Jones (2014) adds that "Of the opioid ED visits, an estimated 81,365 (18.5%) involved alcohol; of the benzodiazepine ED visits, 111,165 (27.2%)" (para. 6).

Some discussion of prescription drug abuse may seem to ignore or, at the very least, downplay the use and abuse of dangerous prescription drugs, such as benzodiazepines, which appear to be a contributing cause in the number of opioid-related drug overdose cases. These contributing factors are often insignificantly mentioned, if at all in the current narrative regarding opioid abuse in the United States. Furthermore, there

appears to be insufficient research on a problem referred to as an epidemic, health crisis, and national emergency, which consider the correlation between opioids and other substances in the totality of the problem.

Much of the research on opioids and the opioid crisis casts blames the medical community for an overprescribing wave of prescription pain-relieving drugs, which led to addiction throughout the country. Recent statistics indicate the sources exploited by drug abusers to acquire the substances:

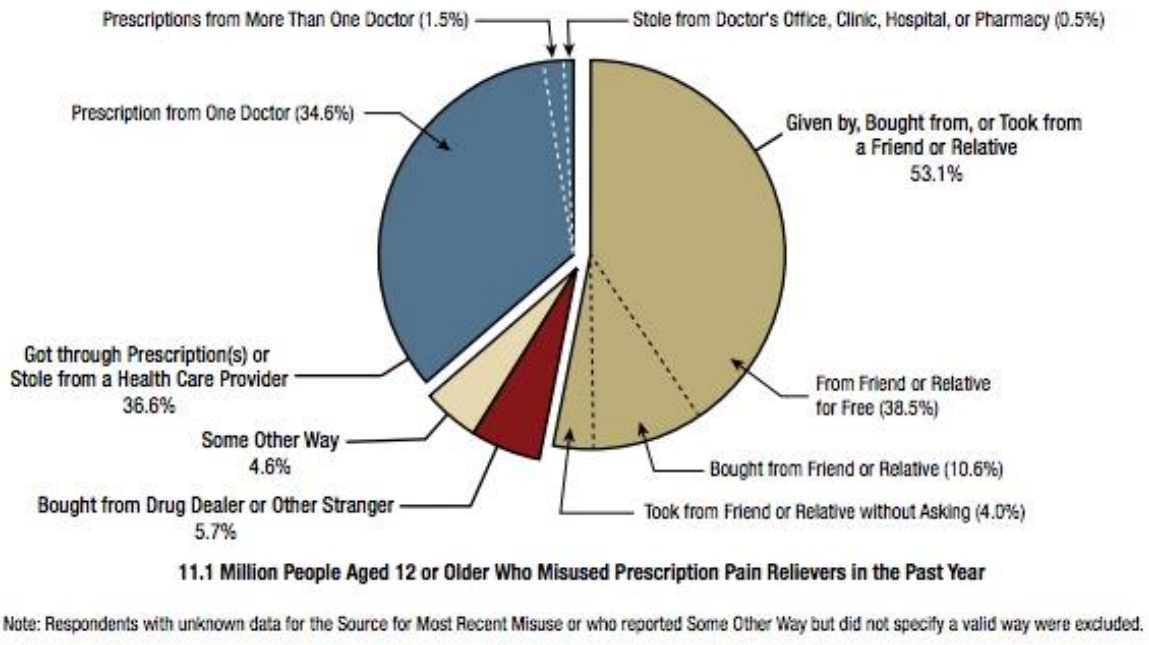

Figure 4. Source of pain relievers obtained.

These statistics show that most of the issues portrayed in the opioid crisis are not generated from a "prescription" but rather from sources other than doctors.

Some professionals blame pharmaceutical companies for their aggressive marketing to doctors with limited emphasis on known abuse potential or addictive properties. Whatever the reason cited may be, there is little doubt or argument that, since late 1990s, no problem has been more publicized as the opiate crisis in the United States.

According to the Office of National Drug Control Policy, in 1992 there were 898,000 chronic opiate users in the United States (Kreek, 2002). In 2014, it was estimated that 2.1 million people were "suffering from substance use disorders related to prescription opioid pain relievers" (Volkow, 2014, para. 2). Volkow's study figures certainly fit the narrative of the crisis but may fail to take into consideration several key findings in the latter part of the investigation. First, the diversion of prescription opiates has not increased since 2010. Based on information provided by Guy (2015) and CDC (2015), "In the United States, annual opioid prescribing rates increased from 72.4 to 81.2 prescriptions per 100 persons from 2006 to 2010, was unchanged from 2010 to 2012, and then decreased by 13.1% to 70.6 per 100 persons from 2012 to 2015" (para. 2).

While certain cities in more rural parts of the country are still experiencing some rise in opiate use, the overall use nationwide has declined. In a later study, Volkow and McLellan (2016) stated, "two major facts can no longer be questioned: First, opioid analgesics are widely diverted and improperly used, and the widespread use of the drugs has resulted in a national epidemic of opioid overdose deaths and addictions." If true, Volkow (2016) argues against some government studies and data gathered by others (Guy, 2015) (CDC.gov, 2015). However, Volkow and others believed the *epidemic* might not be solely related to the use and abuse of prescription drugs. Volkow (2016) describes diversion as "the transfer of opioid analgesics by patients who have received legitimately prescribed opioids to family members or friends who are usually trying to self-medicate a generic pain" (p.1253-1263).

According to O'Connor (2017), the vast amounts of "synthetic opioids" fueling the epidemic today come from China. "China is the primary source of the illegal fentanyl

consumed in the United States today. Therefore, while the onset of the opioid crisis involved prescription drugs manufactured or legally distributed in the U.S. and were dispensed from pharmacies, the majority today is neither produce, prescribed, or dispensed here in the United States (Physiciansweekly.com, 2016). As a result, while legally manufactured prescription drugs have declined in the United States, it is much more difficult to determine where users are getting their drugs from and the extent to which illegal importation has increased. However, current statistics on emergency room mentions, rehab admissions, and law enforcement seizures all point to a marked increase in the use of illegally imported drugs and not legally prescribed drugs.

Along with shipments sent directly to the United States, fentanyl is shipped from China to Mexico and -to a lesser degree- to Canada before being trafficked across the U.S. border. CDC (2017) indicates that the current rise in deaths related to fentanyl and other drugs mixed with fentanyl have increased over 500% since 2015.

These figures are prominent and contradict a great deal of the narrative today with regards to the sources of opioid abuse that casts blame upon the pharmaceutical industry and the doctors who prescribe the drugs. However, restrictions on manufacturing and prescribing enacted over the past five years have limited or greatly reduced the culpability of these manufacturers and prescribers when related to opioids but not the prescription drugs overall.

The Marketing of Pharmaceuticals

In an October 2017 issue, *Esquire Magazine* published a new article on Perdue Pharma and the Sackler Family, whose fortune is said to have come in large part from the manufacturing and sale of OxyContin; soon after, the family was blamed in large part for

the entire opioid crisis. As a result, the Sackler's and Purdue Pharma paid hundreds of millions in fines for the deceptive marketing of their product, which were cited in complaints, leading to the rise in OxyContin abuse.

Although few can debate on the dangers of and the addiction caused by OxyContin, the article appears to hold Perdue and the Slacker's liable for a great deal of the current opioid crisis. Much of this is again accomplished with the media narrative, but now it appears to focus on an actual cause or culprit. To those uninformed, this is often easily achieved. However, one can see how the confusion with the opioid crisis is promoted through the following narrative:

Opioid withdrawal, which causes aches, vomiting, and restless anxiety is a gruesome process to experience as an adult. It is considerably worse for the twenty thousand or so American babies who emerge each year from opioid-soaked wombs. These infants, suddenly cut off from their supply, cry uncontrollably. Their skin is mottled. They cannot fall asleep. (Glazek, 2017, para. 47.)

This quote speaks of opioid withdrawal, not simply OxyContin withdrawal or the plethora of other prescription opiate pain relievers and heroin. The article ends by stating, "In May, a dozen lawmakers in Congress, inspired by the L.A. Times investigation, sent a bipartisan letter to the World Health Organization warning that Sackler-owned companies were preparing to flood foreign countries with legal narcotics. "Purdue began the opioid crisis that has devastated American communities" (Glazek, 2017).

More recently, we have witnessed the latest round of blame in states such as New York and a group of others that have chosen to sue pharmaceutical companies for the deaths and overdose costs associated with their drugs. At first glance, many equate it to

the lawsuits, which crippled the cigarette companies a decade ago. Healthcare costs and the deaths attributed to cigarette smoking reached billions of dollars in settlements and health costs because cigarette companies withheld the risks of smoking. The same premise appears to be applied with opioids, and -while it may seem sound to those affected by opioids, taxpayers, and the trial lawyers- there still appear to be some significant differences.

Freudenberg (2016) illuminates on the distinct difference between the two industries. As he points out, tobacco companies produce and sell a product, which is undeniably a leading "cause of premature death and preventable illnesses, associated with 100 million deaths in the 20th century and an estimated one billion deaths in this century if current smoking patterns continue" (p. 84-88). To the contrary, "Pharmaceutical companies, on the other hand, produce essential medicines that save millions of lives each year and reduce the burden of suffering for tens or hundreds of millions" (Freudenberg, 2016, p. 84-88). It is not to say that death or long-term health issues associated with their products do not occur, but instead Freudenberg points to a distinct difference between the two businesses. In a recent lawsuit against a cigarette company, a judge stated:

[…] it is about an industry, and in particular these defendants, that survives, and profits, from selling a highly addictive product which causes diseases that lead to a staggering number of deaths per year, an immeasurable amount of human suffering and economic loss, and a profound burden on our national health care system. The defendants have known many of these facts for at least 50 years or more. (Freudenberg, 2016, p. 84-88).

More importantly, the judge stated, “Defendants lied, misrepresented and deceived the American public, including smokers and the young people they avidly sought as ’replacement’ smokers about the devastating health effects of smoking and environmental tobacco smoke” (Freudenberg, 2016, p. 84-88).

The difference is, that even if we were to believe that pharmaceutical companies withheld risks related to their products, such risks were not made aware to the general public. All narcotic pain medications are controlled substances within the United States. and -as such- purchase of these substances requires a prescription from a doctor for a diagnosed condition. While it may be true that some unethical doctors engaged in practices that violated not only their ethical canons but also state and federal laws, any deception about the drug's risks were marketed only to the medical community and not to the general public, in the same way cigarettes did it. Nonetheless, despite the differences, there are still some lessons the pharmaceutical industry can learn from the mistakes the tobacco companies made.

Why then are these states and larger cities suing pharmaceutical companies? According to some legal scholars, not only do the cities and states face an uphill battle in this endeavor, but such action may also be contributing to an epidemic of law firms, looking to sue pharmaceutical companies on behalf of individual patients. In a recent Google search, when *drug injury lawyer* keyword was typed in, it yielded over one million hits.

Internet sales become more problematic as more and more families and addicts also look to hold someone responsible for a family member or their drug abuse. Family members would not doubt calling or, at the very least, inquire after reading promising

legal ads, “If you or your loved one were injured or became sick after taking a prescription medication, the drug injury lawyers at Ferrer, Poirot & Wansbrough can help you file a drug injury lawsuit to get compensated for your pain, suffering, and injury-related expenses” (Lawyers Network). However, although there are dozens of companies involved in the manufacturing and distribution of opiate pain medications, only two, Perdue Pharma and Cephalon were among the top twenty largest settlements involving all prescription drug settlements since 1991 (DOJ, 2016). The other 18 companies settled suits regarding non-controlled, non-opioid drugs.

While both doctors and the pharmaceutical companies may share equal blame during the early years or in what may be considered ground zero for the initial rise or outbreak of prescription drug abuse, one should argue that currently they are accountable only for a small number in the overall diversion equation. Herzberg (2016) argued:

This narrative is wrong. Today’s “epidemic” is just the most recent of three waves of mass abuse of psychoactive pharmaceuticals in America that stretch back over a century. Placing the current prescription drug “epidemic” in a longer historical context is important because it provides a social laboratory of past approaches for dealing with the problem whose successes and failures have much to teach us. (p. 2).

Therefore, if the current drug problem is not as bad as many believe it to be and prescription opiate use has steadily declined during the past six or seven years, why then we cannot open a newspaper, turn on the television, or browse the Internet without hearing about this epidemic of epic proportion?

One could argue that the *opioid epidemic* is not what it is being hyped to be. Moreover, it is rather another of what Reinarman and Levine (1997) called a “demon

drug scare" when "newspapers, magazines, and television networks regularly carried lurid stories about a new 'epidemic' or 'plague' of drug use" (para. 1). This drug was crack cocaine. Crack was not a new drug but more so, a newly marketed drug. Smoking crack was exercised regularly by heroin users and the same population of minorities who were the primary demographic of its distribution and use during the 1980s. Here again, its predominant use was among the nation's most impoverished and marginalized citizens. Despite the demonization and scare tactics focused on crack cocaine, it never became widely used among the general population within the United States or anywhere else in the world for that matter (Reinarman, 1997).

For decades now, pharmaceutical companies have been marketing their products to doctors and hospitals exclusively. However, during the past decade, direct-to-consumer (DTC) advertising of these prescribed drugs have increased dramatically. While prescription narcotics and pain relievers are not marketed directly to consumers on the television or radio, marketing other drugs meant to cause a conversation between doctor and patient may also make patients less apprehensive about asking not just for the drug advertised but also other drugs, including pain relievers. Harvard Health (2015) informs that prescription drug ads are advertisements whose goal is to sell a product, "The information is designed to tell you what it is for and why you need it—but not if you need it" (p. 13).

In a series of surveys conducted by the Food and Drug Administration (FDA), "eight percent of physicians said they felt very pressured to prescribe the specific brand-name drug when asked and 58% agreed strongly that DTC ads make the drugs seem better than they really are" (Food and Drug Administration, 2004, para. 4). While some

may believe that a better-informed public may reduce the risks associated with prescription drugs and physician care, one study indicated "the average American television viewer watches as many as nine drug ads a day, totaling 16 hours per year, which far exceeds the amount of time the average individual spends with a primary care physician" (Ventola, 2011, p. 671). Creating consumers who seek to gain total control over their medical care when it comes to prescribing drugs, in some ways eliminates the expertise of the physician and the underlying reasons for calling these drugs *prescription drugs*.

Although narcotic pain relievers were heavily marketed, other controlled substances like sleeping medications and controlled, non-opiate pain medications continued to be marketed just as aggressively. Commercials with butterflies circling and happy families enjoying life are seen by some to be indirectly targeting young children. In a society where one may seem to have a pill for mostly everything, why would the youngest of consumers not believe these drugs could not help them? Of course, this is not to say that the consumer should be uninformed; to the contrary, an informed consumer is a smarter consumer. However, with products as complex and with as many side effects of today's drugs, a patient perhaps needs to remain just that and not one engaged in the pressuring of doctors or self-medicating based on a marketing campaign.

Although no studies can be found documenting any correlations, it is worth noting that having only five percent of the world population, the United States consumes approximately 80% of the global opioid supply (Guskovsky, 2016). Furthermore, only two countries in the world allow direct to consumer advertising of pharmaceuticals, New Zealand and the United States (Donohue, 2007). In some ways, the government plays a

role worth noting in the drug crisis. It regulates the companies who manufacture these drugs, allows them to advertise direct to consumer, approves the drugs that can be brought to market, and more importantly, received over $247 million dollars in 2016 from pharmaceutical lobbies to influence legislation and over $19 million dollars in contributions to individual house and senate members (Opensecrets.org, 2018).

Socioeconomic Status and Stratification

Saegert (2006) argues that "Socioeconomic factors and social class are fundamental determinants of human functioning across the life span, including development, well-being, and physical and mental health" (p. 275-294). SES is not only about the income levels as it also encompasses other factors, such as educational achievement along with other opportunities and certain privileges attainable by those in society. Inequality due to stratification occurs when resources or opportunities are not distributed equally among society and favor those of higher SES and social hierarchy.

Stratification may be a key factor when focusing on opioid treatment and why some might incorrectly perceive that treatment and how the current opioid crisis approached, is the by-product of racial bias or discrimination. While true, SES, race, and gender are three stratified classes in society; SES may play a more critical role than race alone. In the past, low SES has been a valid predictor of both mental and physical health as well as the quality of life one experiences (Saegert, 2006).

Home environment and neighborhood influences that previously seemed to be critical determinants in drug use, drug dealing, and criminal activity are currently beginning to take hold on those among higher SES families. The stressors of individuals from lower SES are now more generic and more challenging to identify. However, the

health care field is where SES still seems to favor those in the higher realm. Past studies may have shown that stressors among those of lower SES led to greater substance abuse rates, nevertheless, more recent studies have found that children from families with higher SES experience a greater risk for anxiety and depression related to substance abuse (Patrick, 2012). It must be noted that Patrick's study (2012) "documented that higher occupation status among adults is associated with more alcohol and substance use disorders and higher income predicts more frequent drinking and less smoking" (p. 772-782). In a previous study, Hatter (1995) specified that "Whites were the race most likely to abuse drugs, followed by Latinos" (p. 91).

Today, some studies also indicate that adolescents and young adults with the highest family SES are more likely to use alcohol and marijuana (Patrick, 2012; Humensky, 2012). Those adolescents whose parents have a higher education were also found to binge drink and engage in both marijuana and cocaine use at an early age. Humensky (2102) also found that students with access to spending more money from their parents were more prone than those without financial sustenance to become involved into substance abuse as adults. This abuse appears to carry over through adulthood as Young (2012) suggests the non-medical use of prescription drugs (NUPM) may be more prevalent as a result of parental SES rather than individual SES.

The portrait of the *drug addict* for decades has been one of a poor, more often inner-city, or rural individual with limited level of schooling. This cultural stereotype could not be further from the truth. While one cannot say that those with lower SES are not prone to addiction to alcohol and drugs, the gap between upper and lower SES may not be significant. Previous studies have examined the effect of low SES drug use and

abuse, and until recently, few have looked at the effect of higher SES on patterns of drug abuse.

As one might expect, indications are that the more money one has to spend, the more means to purchase drugs. Luthar (2017) found that the cycle stayed the same among higher SES, while the "psychiatric diagnoses of alcohol/drug dependence" were more disturbing. Finally, when examining the recent rise in heroin addiction, those who used prescription drugs -both medically and non-medically- were far more likely to have used heroin as well.

SES and Healthcare

In an attempt to understand how people become addicted and where they first obtain prescription opioids, one could look to hospital emergency rooms. In doing so, one can also better understand the relationship between low SES and healthcare, and perhaps why there are more White users of prescription opioids than Blacks and Hispanics. Some studies choose to use terms like *white privilege* or *whiteness* (Netherland, 2017) when describing how society is approaching the opioid crisis. However, "racial/ethnic differences are likely to reflect unmeasured socioeconomic differences [and] an observed racial/ethnic disparity in health cannot be considered independent of SES" (Braveman, 2005, p. 1029). While race seems to be studied more frequently when discussing health care and health outcomes, it does not appear to have a more significant impact than SES or a combination of both SES and race. Crimmins (2004) states that "Although socioeconomic status better predicts most aspects of health within the white population than within other racial/ethnic groups" (p.347), SES was related in some way to almost all health outcomes.

In some ways, there may be a similar correlation in the educational system. Whether they are in poor, minority inner-city neighborhoods or poor, White rural areas of the country, quality schools and quality teachers are lacking in the same way the lack of hospitals and quality healthcare exist in the same places, and thus, the SES stressors attributed by both lead to substance abuse within these areas. Like most drugs, illicit or not, availability often determines who uses and -more so- who becomes addicted. According to Rojas-Burke's study (2009), "Hospitals in the U.S. have been abandoning inner cities for years. By 2010, the number of urban hospitals still operating in 52 big cities had fallen to 426, down from 781 in 1970" (p.6).

The availability of healthcare should also be an important factor when exploring the availability of these drugs. When examining the way some have become addicted to prescription opioids, one can see that SES may have a direct impact. Joynt (2013) explains that "Black patients were prescribed opioids less frequently than White patients across all measures of SES and patients from poorer areas were less likely to receive opioids after accounting for pain-level, age, injury-status, and other covariates" (para.1). Partly, it may be attributed to the availability of healthcare and more so to those seeking rehabilitation after first receiving care in a hospital emergency room for an injury or illness.

In populations with lower SES, this would appear to be important as the median number of pills prescribed in an emergency room (ER) visit is 15, making it difficult for one to become addicted through continued ER visits. This same may hold true for dentists who on average prescribe only 20 pills after procedures, such as an extraction (Denisco, 2011).

The ability to obtain these drugs would appear to be one factor conflating SES and opioid use. Even in areas with higher prescription opioid abuse issues, one may see evidence that the prescriptions written for White users of lower SES do not originate from hospitals or larger healthcare centers but from small or independently owned medical practices which are 'off the radar' from state regulators. Nonetheless, there is similar correlation between low SES populations among Whites in rural areas and those of minority populations in the inner city where access to medical care is limited.

The difference in rural and inner city may be that of the individual practitioner and the smaller mom and pop pharmacies that either no longer exist in the urban areas or are, at the very least, scarce due -in large- to their economic viability with larger companies and Medicaid healthcare providers. Declining availability of doctors and healthcare would logically mean there would be (at least at the local level) a reduction in the number of legitimate prescriptions for opiates originating from those sources. Therefore, one reason minority populations may be less affected by prescription opioids is not merely because of race but rather SES and the lack of healthcare providers in many urban areas.

SES and Drug Laws

Much has been said and written on what many researchers point to as the disparaging treatment of minorities and the so-called *war on drugs*. These researchers point to the sentencing guidelines and mandatory sentencing during the crack crisis of the 1980s whereby -at least statistically- it would appear that minorities faced longer and harsher treatment for drug crimes than Whites (Clark, 2005; Crewe, 1976; Reiman, 2015). However, in what appears an attempt to keep the moral panic alive by the fear of

criminal charges and lengthy prison terms, many in the media are now calling for treatment over punishment. While prison was once one of many failed approaches to reduce the number of those addicted, there are again similar accusations as those in the past that this new trend in drug policy is racist by favoring more lenient treatment than in previous crises.

Sending White middle-class individuals to rehab while the poor people of color to jail appears to have some measure of truth. However, discrepancies between the illicit drug war of the past and the current crisis may be determined more by SES rather than merely race. SES may be the key contributing factor to those imprisoned for drug crimes during the 1980s as well as the change in direction currently experienced as to how current opioid crisis is handled.

Few can argue that sentences for crack cocaine crimes unfairly incarcerated young Black men from urban areas of the United States, and that the sentencing guidelines at the minimum offered the appearance of being racially motivated. If examining carefully the events leading up to the Drug Abuse Act of 1986, which gave mandatory sentencing guidelines for crack cocaine, arguments that the guidelines were created through racial animus are seemingly not accurate. When inner-city communities (most of which were composed of African American and minority inhabitants) started becoming war zones and taken over by street gangs engaged in crack sales, minority elected representatives from these communities demanded harsher penalties. Murch (2015) states that, when the House of Representatives held hearings to deal with this ‘new crisis,’ those like Representative Charles Rangel of New York emerged as a vocal

antidrug warrior and advocated for the expansion of sweeping police and prosecutorial powers (p. 162-173).

At these hearings, one assertion was that crack: (a) was more addictive than powder cocaine; (b) produced physiological effects that were different from and worse than those caused by powder cocaine; (c) attracted users who ‘could not afford powder cocaine, especially young people;' and (d) led to more crimes than powder cocaine did (Graham, 2010). Because of these unproven assertions and the media narrative surrounding crack, not only did the Anti-Drug Abuse Act of 1986 quickly pass the United States Senate with a vote of 92-2, but it also passed Congress with a resounding vote of 392-16. A significant detail of the House vote was the fact that a majority of the Congressional Black Caucus members voted for its passing. At least one member of Congress at the time believed that had they not acted and passed the law, Congress would have been deemed racist for disregarding a drug crisis that was destroying minority neighborhoods (Graham, 2010).

Therefore, while the disproportionate numbers of African-American men sent to prison were a result of the Anti-Drug Abuse Act of 1986, it would appear that, through the eyes of many in Congress at the time, it was probably not its intention. However, although the sentencing guidelines and the intention of the Act may have been to save these communities or, at the very least, keep them from sinking deeper into the abyss, it pales in comparison to the current opioid crisis. Moreover, while the previous laws may not have enacted as a result of race or SES, the lack of punishment with the current crisis leaves people wondering if race or SES are affecting current response or if it is due to the realization that drug use and abuse has not been appropriately handled.

Opioid Addiction

Depending on the particular study read, the opinions of what addiction would vary greatly. Medically speaking, the Diagnostic and Statistical Manual of Mental Disorders (DSM) previously used the term *dependence* over the previous term *addiction* when "referring to uncontrolled drug-seeking behavior" (O'Brien, 2010, p. 1). However, as O'Brien stated, dependence had a dual definition and had led to some confusion throughout the medical community, especially among clinicians treating chronic pain. Physicians feared to create addiction, and thus the term was changed to *Addiction and Drug-related Disorders* (O'Brien, 2010). What is perhaps the most interesting of the changes was the removal of the term *committing illegal acts* within the dependence diagnosis.

It is not because those responsible for the edits to the DSM believed that people no longer committed illegal acts in furtherance of their drug-seeking, but perhaps instead, there was an effort to remove the stigma of drug abuse and dependence on illegal substances. Despite the changes, when training medical students, educators found that "there is 'addiction,' which is drug-seeking behavior called 'dependence' in the DSM. There was also an erroneous or false implication that 'dependence' in the DSM was not physical or physiological" (O'Brien, 2010, p.2). Regardless of the confusion, the terms *substance abuse disorder* and *heroin use disorder* were used even though there was unwavering support to return to the use of the word *addiction* (O'Brien, 2010).

Today, clinicians and especially the media have publicized and pushed forward the *brain disease model of addiction* (BDMA). In a report published in 1997, Alan Leshner "argued that addiction was best conceptualized as a chronic, relapsing, brain

disease" (Hall, 2015). This theory appears to move in the same direction as the DSM changes as Hall (2015) points out when noting that the "acceptance would also reduce stigma and increase treatment seeking by explaining that addicted individuals had a brain disease that was in need of science-based treatment" (p.1).

Although accepted by many within the medical community, BDMA is not without those who disagree. While Leshner (1997) acknowledges that one becomes addicted or dependent voluntarily, meaning the addiction begins with the voluntary act of someone taking a drug on his or her own volition. However, another renowned neuroscientist, Marc Lewis (2105) argues against why addiction is not a disease and rather an "unintended consequence" of the brain seeking pleasure or relief or what it is supposed to be happening when things are not going as they should. More directly to the point, Tim Holden (2102) points out "The statement, in a CMAJ editorial, that addiction is a disease that is not supported by the evidence and reads more like a political policy statement than a reasoned intellectual argument" (p. 679).

> In furtherance of his argument and in very simplistic terms, Holden (2012) states,
>
> Treatment consists of little more than stopping a given behavior. True diseases worsen if left untreated. A patient with cancer is not cured if locked in a cell, whereas an alcoholic is automatically cured, "no access to alcohol means no alcoholism". […] This aberrant behavior has traditionally been viewed as bad 'choices' that are made voluntarily by the addict. (p. 679)

Others believe that labeling addiction as a disease -whether or not based on significant evidence- "seems to carry far more weight with people trying to recover, and those surrounding them" (Kime, 2017). Holden (2012) argues:

[…] at best, addiction is a maladaptive response to an underlying condition, such as depression or a nonspecific inability to cope with the world. Addiction is self-acquired and is not transmissible, contagious, autoimmune, hereditary, degenerative or traumatic.

Treatment consists of little more than stopping a given behavior. (p.679)

Holden further says that the utilization of the BDMA model is slightly more than an attempt by the NIDA and other government agencies to have exploited this false dichotomy by guilting their opponents. Holden (2012) asserts that "If you don't take our word for it when we say addiction is a disease, then you are blaming addicts for their addiction" (p. 679). Finally, Heyman (2013) holds true that “much of what we know about quitting drugs has been provided by researchers who study addicts who are not in treatment. This is because most addicts do not seek treatment” (p. 2).

Over the last century, blaming, disparaging, and punishing addicts has only led to more suffering, and since it clearly has not helped fix the problem, then it would be wrong-headed at best and "intellectually dishonest," or even cruelly punitive otherwise to reject the disease model and accept the choice premise in its place.”

Other researchers, such as Lewis (2015) found that (para. 15) through a possible correlation between traumatic childhood experiences, which would support the addressing of addiction as a consequence of a more significant social problem rather than a brain disease. Lewis also notes that of the 29 developed countries in the world, the United States is at or near the bottom, for it ranked 25th in its record on child welfare and poverty. These would, at the very least, demonstrate a significant correlation between psychological suffering as a child and addiction later in life. Whether someone prescribes to the BDMA model, personal choice, or as a result of other underlying psychological

condition, the conflict within the medical community should leave little doubt that, unless some agreement or definitive research indicates otherwise, treatment of those *addicted* or *dependent* will continue.

Substance Use Disorder has also become a popular diagnosis within the medical community. Revised in 2013, the diagnostic manual for mental disorders (DSM-5) outlines the criteria for a diagnosis of substance use disorder based upon the ten classes of drugs:

- Alcohol
- Antianxiety and sedative drugs
- Caffeine
- Cannabis (including marijuana and synthetic cannabinoids)
- Hallucinogens (including LSD, phencyclidine, and psilocybin)
- Inhalants (such as paint thinner and certain glues)
- Opioids (including fentanyl, morphine, and oxycodone)
- Stimulants (including amphetamines and cocaine)
- Tobacco and nicotine products
- Other (including anabolic steroids and other commonly abused substances)

The terms *addiction*, *abuse*, and *dependence* have been removed from the descriptions and diagnoses although they had traditionally been used regarding people with substance use disorders. Some believed that these terms were too loosely defined and used judgmentally. Merck (2018) defines that “Thus, doctors now prefer to use the more comprehensive and less negative term ‘substance use disorder’” (para. 4). Within

the diagnosis are all the reasons one may develop substance abuse disorder and cover such factors from personal to social situations, crossing all socioeconomic lines.

Failed Strategies, The War on Drugs

War, as defined by Merriam-Webster is "a state of usually open and declared hostile armed conflict between states or nations, a state of hostility, conflict, or antagonism, a struggle or competition between opposing forces or for a particular end, class war and finally, a war against disease." Many consider 1971 as the official start of the "war on drugs" as declared by President Richard Nixon who stated that drug abuse was "public enemy number one" (Friedersdorf, 2011, para.1).

During the past four decades, many theories and opinions have risen on what exactly the war on drugs is. One must clarify, however, that it does not represent a conflict between nations or opposing forces and, up until the last decade, was not considered a war on disease. To some, the war on drugs is racially motivated and to others is represents a way for the government to militarize the nation's police forces. To be specific, many of the arguments about what the war on drugs is and how effective or ineffective it may be can be compelling, depending on the evidence used to frame or prove a particular theory.

Does framing the problem as a *war* gives it more credibility or instill fear in those who may engage in drug use or trafficking? Critics on all sides would have to agree at least on that point; it has not. To better understand, one can take a look at the Office of National Drug Control Policy (ONDCP) created by Congress and whose self-defined role is "to reduce drug use and its consequences by leading and coordinating the development, implementation, and assessment of U.S. drug policy" (Whitehouse.gov). The agency

claims to use evidence-based research in the effort to reduce drug use, early intervention, break the cycle of drug use to prison, disrupt international drug use, and improve information systems to address drug use as well as increase the availability of treatment and early intervention programs. (Obamawhitehouse.archives.gov).

These efforts also include the funding of the High-Intensity Drug Trafficking Area program (HIDTA) and their mission, which -according to the ONDCP- it is "to enhance and coordinate America's drug-control efforts among local, state, and Federal law enforcement agencies in order to eliminate or reduce drug trafficking and its harmful consequences in critical regions of the United States" (USDOJ, 2016).

However, HIDTA now covers part or all of at least 40 states and Puerto Rico. As stated by one ONDCP official, "We used to keep track of the HIDTA program by listing areas that had HIDTA; now, we just list areas that don't have HIDTAs" (NCJRS, 2001, p. 2). Furthermore, the same source explains that:

The HIDTA program can no longer be seen directing funds to specific regions; it is de facto a national program. And the purpose of the program has indeed changed. The mission is now to enhance America's drug-control efforts by improving coordination among local, state, and Federal law enforcement agencies. (p. 2)

However, its mission and funding appear to be another arm of law enforcement created to fight a war that has yet to yield any significant victory.

To date, the ONDCP has failed in all but one of their goals, despite their annual budget of over 350 million dollars (GAO, 2015). Funds allocated to federal, state, and local law enforcement for the war on drugs were estimated at 51 billion dollars last year. Within the figure, 1.3 billion were allocated to the Substance Abuse and Mental Health

Services Administration and 7 billion were spent on incarceration of drug offenders in federal, state, and local facilities.

With such enormous sums of money poured into this effort, one would expect at least some modest reductions in drugs coming into the country illegally as well as their use. Hatter (1995) explains that United States District Judge Sterling Johnson of the Eastern District of New York theorized that law enforcement would have to increase drug seizures at the borders by more than 1400% to have any impact at all on the drug trade, and that was assuming no corresponding increase in world production. (p. 89)

Furthermore, from the Reagan years forward, the mission and purpose of our national drug control policy have been to increase and strengthen law enforcement, which has appeared to have created a plethora of new problems.

The first was the disproportionate number of African-Americans imprisoned for drug crimes. The second came the militarization of law enforcement and the use of the military for illicit drug interdiction abroad and on our borders, which some feel may come dangerously close to violating the Posse Comitatus Act. which clearly states that this civil war era act makes it a felony for the Army to perform the law enforcement functions of civilian authorities. Finally, the current drug war and policies impact the foreign policy of the United States.

For example, the United States relies heavily on support from the government of Afghanistan in the fight against terrorism. However, most of the world's heroin is processed from Afghan opium, and the proceeds of the crop sales are vital to the country's economy. This positions the United States in a quagmire when aggressively pursuing the elimination of the main ingredient for heroin. The United States consumes

over 65% of the world's illegal drugs but, to make demands against countries such as Afghanistan or to attempt eradication of the poppy crops, could have a devastating effect not only on the relationship with the country but also a more significant implication on global terrorism.

When former U.S. Attorney General, Jeff Sessions re-declared the war on drugs, President Trump called for the possibility of the 'death penalty' for those convicted of dealing drugs, such as fentanyl. The President stated, "We have pushers and we have drug dealers that kill hundreds, and hundreds of people and most of them don't even go to jail" (Angell, 2018 para. 4). In the same 2018 publication, *it was argued*, "If you shoot one person, they give you life, they give you the death penalty. These people [who sell drugs] can kill 2,000, 3,000 people and nothing happens to them" (para. 4).

Whether this was merely rhetoric or not, more than 88% of U.S. criminologists see no deterrence to homicide as a result of the death penalty (Lacock, 2009). Why, then, would one believe that implementing it for drug crimes would have any positive effects? There is no comparison at all when contrasting the U.S. justice system with what is occurring in places such as the Philippines where drug dealers are summarily executed on the streets. Establishing tougher penalties and reinvigorating what many have perceived as a failed war on drugs may only distract from finding real solutions to the problem.

Opioid Legalization

There are those who feel that one possible way to get out of this crisis is to legalize drugs, making them available in corner stores and having them regulated by the government. However, while it may reduce the violence attributed to drug dealing, the

likelihood that it would do much more than that may be minuscule at best. Ignoring the arguments for and against, one should look at what *legalization* is advocating.

The United States has more access to prescription drugs than any other country, for which we consume more, and as a result, we have more addicted people than anywhere else in the world. Legalizing the opioid market would not hold as compared to marijuana where the costs of legalization outweighed by far its enforcement and made the legalization argument more palatable. The more pills made available, the more addicts we create (French, 2017). If this were not true, governments would not be suing big Pharma despite whether we believe they are solely responsible or not. Holding doctors more accountable and attempting to limit the number of pills one can receive at any given time without thorough documentation is also necessary.

As previously indicated herein, the healthcare costs for one opioid addicted person is greater than eight to one over a non-addicted person (NIDA, 2019). By adding that to the economic costs, one would be hard pressed to show how legalizing drugs like heroin and other opioids would be beneficial.

Opioid Treatment

When the medical and treatment community cannot agree as to what causes addiction or dependence, there will no doubt issues with treatment. Currently, the BDMA model emphasizes on treating addiction or dependence with drugs such as methadone, naloxone, and suboxone, while those arguing against BDMA believe in pursuing abstinence and determination and treatment of the underlying causes.

Despite the fact that the media and many in the healthcare community are calling for the greater availability of these *lifesaving drugs* such as naloxone, Holden (2012)

points to the fact that “medicalizing addiction has not led to any management advances at the individual level. The need for helping or treating people with addictions is not in doubt, but a social problem requires social interventions” (para. 6.). While it is true that naloxone can save the life on a specific occasion of one who has overdosed on heroin, it is not doing much more than allowing him or her to live long enough for the next ‘fix.’

Whereas the overdose may be a wake-up call for some, naloxone is not a cure, nor are the other drugs used for addiction treatment. Furthermore, it is the media and some who support this *medicalization of addiction* who have ostracized the pharmaceutical community for the opioid problem; hence, media’s misinformation campaign ignited the overprescribing opioid problem. However, there are those who discount this ‘medical model’ and believe the time has come to abandon it. In support of this belief, Heyman (2013) states: It does not fit the facts. The matching law, melioration, and hyperbolic discounting predict that drugs and similar commodities will become the focus of destructive, suboptimal patterns of behavior. These same choice models also predict that individuals caught in a destructive pattern of behavior retain the capacity to improve their lot and that they will do so as a function of changes in their options and/or how they frame their choices.

The battle appears to occur between the groups fighting to claim the high ground over the definition and cause of addiction rather than engaging in an all above approach to help those in need. Why condemn those who have successfully stopped using drugs merely because they are the product of a twelve-step or abstinence program, those who were successfully treated with drugs, or those who on their own merely quit? Heyman (2013) expands by explaining that, The relevant research shows most of those who meet

the American Psychiatric Association's criteria for addiction quit using illegal drugs by about age 30, that they usually quit without professional help, and that the correlates of quitting include legal concerns, economic pressures, and the desire for respect, particularly from family members.

Whether the medical community seeking to corner addiction treatment through pharmaceuticals, the rehab communities holding firm on treatment, or those blaming individuals for poor personal choices, why do third parties need to dominate when it comes to helping others?

Internet and Opioids

Although the blame for the opioid crisis appears to be widely shared, few studies examine the effect of drug availability on the Internet. Despite the rhetoric and framing of this crisis, evidence indicates that doctors are not responsible for the creation of the majority of those addicted to prescription drugs (Ahrnsbrak, 2017). Furthermore, a 2016 national survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found 87.1 million U.S. adults used a prescription opioid—whether prescribed directly by a physician or obtained illegally—sometime during the previous year. Only 1.6 million of them or about 2%, developed a "pain reliever use disorder" (SAMHSA, 2016), which includes behaviors ranging from overuse to overt addiction."

Some speculate that two possible scenarios exist. First, media overplays the belief that doctors and pharmaceutical companies have created far more prescription opioid addicts than there are. The second, many more people are addicted and are receiving their drugs on the Internet from sources overseas or made illegally within the United States.

More importantly is the fact that teenage children -who are too young to buy anything from opioids to anabolic steroids- are now purchasing these drugs in the safety of their own homes and often unknowingly assisted by their parents through the use of significant credit gift cards received as gifts from their parents and family.

The theory behind the name *controlled* substances is that the government can track down the drug from the manufacturer through the distributor, prescriber, pharmacy, and the end user. However, if illegally imported or manufactured, there is no way of pinpointing the origin of the drugs. Such is the case with illegally imported fentanyl. While the governments both here and abroad have acknowledged that the majority of illegal fentanyl comes from China, there is no way of knowing the amount manufactured in the United States with chemicals imported from other parts of the world. The information is known to be true based on investigations involving other controlled substances such as anabolic steroids and growth hormone and whereby doctors engaged in illegal sales were buying drugs made not only in the United States but also in China, Pakistan, and other overseas locations (Llosa, 2007). Lastly, it is not only the drugs and the precursors for the drugs that are of concern but also the availability of pill presses, pharmaceutical bottles, cappers, and labels which can lead to a false belief that those addicted to drugs are buying pharmaceutical grade products which often lead to overdoses and death.

Policing the Prescribers

Why do some doctors end up resorting to the illegal prescribing of prescription opioids and fall under the radar of law enforcement? Despite what is believed by many, traditional law enforcement and, up until the last decade, even the DEA’s enforcement

division engaged in criminal investigations against doctors. Part of the reason was due to HIPAA, which prevented doctors from sharing patient information with law enforcement without a court order or subpoena. Another reason was that for years, traditional law enforcement was not trained in conducting health care investigations. Judging by the apprehension rates of offending physicians, the advanced opioid training currently employed appears to have a positive effect on prescribing problems.

Schnell and Currie (2017), for example, find that doctors from the lowest ranked medical schools write 33 times more opioid prescriptions per year than doctors from the highest ranked schools. However, there appears to be no evidence that any of these prescriptions are written unlawfully or negligently. Monitoring individuals engaging in *doctor shopping* or the practice of obtaining prescription drugs from multiple doctors simultaneously makes things more difficult (Sansone, 2012). As of 2019, all states have established prescription-monitoring programs to fight doctor-shopping, although states rarely share information across state lines. Also, some states' PDMPs are weaker than others' which may result in higher abuse rates and higher prescribing rates. In fact, the chart below indicates that slightly more than half of all U.S. states have a PDMP that reports having set in place good to excellent measures.

States with very good to excellent reporting (n = 27)													
Alaska	94	12.5	102	13.9	1.4	11.2	51	6.8	51	7.0	0.2	2.9
Connecticut	855	24.5	955	27.7	3.2***	13.1***	264	7.2	273	7.7	0.5	6.9
District of Columbia	209	30.0	244	34.7	4.7	15.7	66	9.3	58	8.4	-0.9	-9.7
Georgia	918	8.8	1,014	9.7	0.9***	10.2***	536	5.1	568	5.4	0.3	5.9
Hawaii	77	5.2	53	3.4	-1.8	-34.6	55	3.6	40	2.5	-1.1	-30.6
Illinois	1,947	15.3	2,202	17.2	1.9***	12.4***	479	3.7	623	4.8	1.1***	29.7***
Iowa	183	6.2	206	6.9	0.7	11.3	92	3.1	104	3.4	0.3	9.7
Maine	301	25.2	360	29.9	4.7***	18.7***	154	12.5	100	7.6	-4.9***	-39.2***
Maryland	1,821	29.7	1,985	32.2	2.5***	8.4***	812	13.1	711	11.5	-1.6***	-12.2***
Massachusetts	1,990	29.7	1,913	28.2	-1.5	-5.1	351	4.9	321	4.6	-0.3	-6.1
Nevada	408	13.3	412	13.3	0.0	0.0	275	8.9	276	8.7	-0.2	-2.2
New Hampshire	437	35.8	424	34.0	-1.8	-5.0	89	6.5	62	4.8	-1.7	-26.2
New Mexico	349	17.5	332	16.7	-0.8	-4.6	186	9.2	171	8.5	-0.7	-7.6
New York	3,009	15.1	3,224	16.1	1.0***	6.6***	1,100	5.4	1,044	5.1	-0.3	-5.6
North Carolina	1,506	15.4	1,953	19.8	4.4***	28.6***	695	6.9	659	6.5	-0.4	-5.8
Ohio	3,613	32.9	4,293	39.2	6.3***	19.1***	867	7.7	947	8.4	0.7	9.1
Oklahoma	444	11.6	388	10.2	-1.4	-12.1	322	8.4	251	6.7	-1.7***	-20.2***
Oregon	312	7.6	344	8.1	0.5	6.6	165	3.9	154	3.5	-0.4	-10.3
Rhode Island	279	26.7	277	26.9	0.2	0.7	114	10.5	99	8.8	-1.7	-16.2
South Carolina	628	13.1	749	15.5	2.4***	18.3***	381	7.8	345	7.1	-0.7	-9.0
Tennessee	1,186	18.1	1,269	19.3	1.2	6.6	739	11.1	644	9.6	-1.5***	-13.5***
Utah	466	16.4	456	15.5	-0.9	-5.5	349	12.5	315	10.8	-1.7	-13.6
Vermont	101	18.4	114	20.0	1.6	8.7	35	5.9	40	6.3	0.4	6.8
Virginia	1,130	13.5	1,241	14.8	1.3***	9.6***	400	4.7	404	4.7	0.0	0.0
Washington	709	9.4	742	9.6	0.2	2.1	388	5.0	343	4.3	-0.7***	-14.0***
West Virginia	733	43.4	833	49.6	6.2***	14.3***	340	19.7	304	17.2	-2.5	-12.7
Wisconsin	866	15.8	926	16.9	1.1	7.0	382	6.7	362	6.4	-0.3	-4.5

Figure 5. States controlled substance reporting grades

Consequently, when doctor-shopping takes place along or crossing state lines, it is more difficult for doctors to determine if their patient is receiving multiple prescriptions. While testing drug levels might help, the cost and time to conduct these tests in a fee for service world are difficult to employ.

Economic Costs of Opioid Use

Prescription opioid abuse is costly to the economy, and it is estimated that nonmedical use of opioid pain relievers alone costs insurance companies almost $72.5 billion annually in health-care costs (Volkow, 2014). Broken down, the cost to care for an opioid user for 'all-cause' healthcare is estimated at $15,884 to $18,388 compared to non-users in the same demographics of $1,830 to $2,210 annually (Strassels, 2009). While these figures represent the cost to the healthcare system and insurance, the statistics do not consider the cost effect on the employment sector.

In a recent study, evidence indicates that almost half of prime-age non-labor force (NLF) men were taking pain medication and in follow-up survey found 40% of the same prime-age men reported they were unable to work a full-time job as a result of pain (Kreuger, 2017). Aside from those not working as a result of opioid use, employer's costs of lost work or diminished workplace productivity continue to rise. In 2014 it was estimated that these workplace costs alone were of almost 26 billion dollars a year (Rice, 2014).

The increased cost of other pharmaceuticals will most certainly add to the cost of healthcare. Given that many of the states hardest hit by prescription drug abuse are in the process or have already filed lawsuits against pharmaceutical companies, there should be

little doubt that losses suffered from settlements and jury verdicts will be passed along to consumers.

Inconsistent Reporting

Whether we are examining SES and the opioid crisis, race and the opioid crisis, the causes of the opioid crisis, the sheer, or the number of individuals affected, there appears to be a contradictory study for every research offering a glimmer of hope for those impacted by opioids. For example, a 2017 report by the National Institute on Drug Abuse (NIDA) entitled 'Addressing the Opioid Crisis Means Confronting Socioeconomic Disparities' addresses opioids and SES through the theory that addiction is a brain disease and "considers people on Medicaid and other people with low-income to be at high risk for prescription drug overdose" (para. 8.), yet the publication starts by stating that "opioid addiction is often described as an 'equal opportunity' problem that can afflict people from all races and walks of life" (para. 2.). While pointing out that the opioid crisis has affected poor areas of the country such as Appalachia, it fails to explain why urban inner cities with more impoverished and disadvantaged inhabitants are not being hit by opioid abuse in the same way as suburban and rural areas of the country.

In another report on opioid addiction issued in 2017 by the Department of Health and Human Services, the first bullet indicates that 42,249 people died in 2016, which translates to 116 daily deaths attributed to opioids. Somewhat mixed into these figures is the number of those who died from 'commonly prescribed' opioids, to which the report makes no specific mention. In another statement, National Center for Health Statistics -as reported by CNN- informed that "More than 63,600 lives were lost to drug overdose in

2016 and of this number 42,249 US drug fatalities -- 66% of the total -- involved opioids" (CNN, 2017; CDC, 2017).

Finally, the report states that much of the increase came from synthetic opioids, other than methadone. However, nowhere in the lengthy report does it list those who died as a result of heroin or prescription drugs alone. How, then, can American address a problem if not willing to acknowledge what precisely the problem is? Although many of these overdose deaths are a result of polysubstance abusers or a combination of drugs and alcohol, matters little when a crisis needs a culprit. "In 2005 more than 22,000 American lives were lost due to overdoses," reports CDC (2006). Nonetheless, the evidence also suggests that unintentional overdoses deaths are related to use of prescription drugs, specifically opioid painkillers. However, the majority of overdoses are also attributable to alcohol rather and not opioids. (Peel, 1999)

After examining prescription opiate abuse, Lewis (2017) indicates:

[…] that most of the abuse of prescription pain pills is not by those for whom they're prescribed and among those for whom they are prescribed, the onset of addiction (which is usually temporary) is about 10% for those with a previous drug-use history, and less than 1% for those with no such history. (para. 9.)

These statistics are indeed not what people are led to believe and yet the topic is at the forefront of many studies and media stories. Still, it remains troubling the fact that the vast numbers of individuals overdose and die because of heroin and non-medically prescribed synthetics and not because of prescribed opioids. Nevertheless, few reports refer to the deaths as heroin overdoses, and more often they are called *opioid deaths*. Is it related to the fact that the term *opioids* may not have the stigma associated with heroin or

other illicit drugs? Might something as insignificant as how we describe certain drugs be part of a larger narrative to re-identify those considered criminal and of a lower SES, to a category of people now considered to be suffering from disease?

Conclusion

The prescription opiate problem, like many other drug problems of the past, appears to have gone un-noticed until becoming a full-blown crisis. However, unlike many of the previous problems, American now are dealing with drugs, which quite often have dual use in society. When used correctly, they afford many with an increased quality of life and, when abused, are capable of taking away everything, including one's life. Complicating matters further creates a barrage of misinformation, conflicting statistics, and an unwillingness to accept what has been a pre-defined view of drug abuse for over a century. Poor, uneducated, minorities, and often prone to criminal activity are no longer stereotypical descriptors of the current drug abuser. Today, they are often White, middle and upper class, educated individuals, or those with a much higher SES than their counterparts of the past.

This literature demonstrates the confusion surrounding the current crisis and how agenda setting and framing may act more to exacerbate the crisis than it does to diminish it. Distancing itself from past models, the current literature demonstrates how the *war on drugs* is now a public health crisis, and drug abusers are now disabled due to a disease or disorder rather than through free will. Is it because society truly believes that drug addiction is a disease or rather an unwillingness to accept addiction among those with higher SES? If the latter is correct, the current crisis may continue to expand as there is a degree of difficulty addressing a conflict that many in society are unwilling to accept.

The literature also demonstrates the numerous other factors, which have impacted and created more difficulties by addressing the current conflict.

My research will attempt to demonstrate the role that SES plays in the media's framing of the current crisis. It will also attempt to demonstrate a correlation between the current framing of the crisis and its effect on other social issues, such as the racial unrest due to what many perceive as discriminatory treatment among drug offenders.

Chapter 3: Research Method

Qualitative Content Analysis

Introduction

The purpose of this study was to examine how the media and the socioeconomic status of drug users have influenced not only the public's perception of the current drug crisis but also why the drug crisis continues to be perceived in an unprecedented way. With the shift from the criminal attributes of drug abuse to that of a public health crisis, it is essential to understand the significance, as well as other reasons or causes for such a shift.

The implications appear to go beyond that of race or some newfound awareness of the roots of drug abuse. Is it possible that the paradigm shift can be attributed more to socioeconomic status than any other cause or merely a combination of various factors? This paper examined the drivers of this shift and will attempt to determine who benefits from this change.

Methodology

This study utilized a qualitative content analysis method. Qualitative content analysis is a research method, which uses a "systematic and objective means of describing and quantifying phenomena" (Elo, 2007 p. 1). Content analysis is a research method, which has been used in many types of qualitative studies examining existing information to gain cultural perspectives on many areas and perhaps best for this research on the media (Hess Biber & Leavy, 2011). While there are many ways to conduct a qualitative content analysis, after studying these numerous methods, my research appeared best fit for one of three types. When comparing three approaches, both

conventional and summative content analysis could have both served my research purposes, however, directed content analysis was considered best suited for the research.

A directed content analysis with codes defined before, during, and after the data analysis best served my research requirements and was the process, which guided me throughout. Nonetheless, the most significant about the directed approach is the fact "sometimes, existing theory or prior research exists about a phenomenon that is incomplete or would benefit from further description" (Hsieh, 2005, p. 1281).

Content analysis can be defined in three different ways. First, content analysis is "a research technique for the objective, systematic and quantitative description of the manifest content of communication" (Berelson, 1952, p.15). Second, content analysis is "an interpretive and naturalistic approach. It is both observational and narrative in nature and relies less on the experimental elements normally associated with scientific research (reliability, validity, and generalizability)" (Ethnography, Observational Research, and Narrative Inquiry, 1994-2012, p.1). Lastly, content analysis is "Any technique for making inferences by systematically and objectively identifying special characteristics of messages" (Holsti, 1968, p. 608). Perhaps the most important to this research was that content analysis is also used to examine social behavior, and it is the studying of a behavior -in this case that of the media and the driving forces influencing their behavior- which was most important to my research. The study examined the current opioid crisis and its portrayal by online media sources, government, and the general public. Qualitative content analysis is best suited for this research as it affords the researcher to identify themes and Narratives, which appear to shape the public view not only on the

current opioid crisis but also how it has transformed the criminality of drug use into what is now seen as a public health crisis or epidemic.

The methodology explored the relationship between this dramatic change from crime to a health crisis and the socioeconomic status of today's drug users. Furthermore, the method is appropriate for this study as "Additionally, content analysis provides an empirical basis for monitoring shifts in public opinion" (Stemler, 2011, para. 4). Public opinion is critical to this study, for it assists in understanding substantial shifts in how people view this problem and its importance. Qualitative content analysis is more than merely counting words and examining language for the classification of text from categories into smaller distinct groups representing similar meanings (Weber, 1990). Hsieh (2005) confirms that "Qualitative analysis is a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (p. 1278).

This study examined over 600 news reports from print media sources from four of the most viewed sources in both the crack crisis and the opioid crisis during its peak, from 1998 through 2018. This study also examined numerous journals and peer-reviewed sources during the same period. For a historical comparison of race, SES, and drugs, the research also examined the same sources during the peak of the crack cocaine crisis from 1985 through 1994.

This study explored how the war on drugs has evolved into a public health crisis even though many other so-called drug epidemics of the past were not. Furthermore, using directed content analysis, I examined these narratives, their origin, and validity in

the attempt to determine their relationship between factors such as class and economic status as influences on the historical change.

This content analysis begins by examining articles drawn from search queries during the different periods of the current opioid crisis and crack crisis. Fraenkel and Wallen (2006) have defined content analysis as "a technique that enables researchers to study human behavior in an indirect way, through an analysis of their communications" (p. 483). The examination of this written material allowed my research to achieve a qualitative, objective analysis of the characteristics of the writings.

The study utilized a keyword search and incident-to-incident coding to develop themes, which were instrumental when explaining when and how the shift in the narrative began. These keywords, attributed to both the criminal aspect of drug use and abuse, were compared to those associated with health and treatment, and from this, the patterns began to emerge and develop. Analyzing the news coverage from the beginning of this opioid crisis (2003 through 2018) and the crack cocaine crisis (1985 through 1994), inferences were concluded from several factors.

For the opioid crisis, articles and news reports focusing on *opiates*, *opioid epidemic*, *opioid crisis*, *substance abuse disorder*, *heroin*, and *fentanyl* served as the keywords for the initial article search. The keywords *crack crisis*, *crack cocaine*, and *crack* were used to search and identify articles on the crack crisis. Once these articles were chosen, the coding process began to develop themes used to demonstrate any narrative changes between the two crises. For example, articles drawn from the crack crisis were read and coded initially using keywords such as *health*, *crime, epidemic*, and *treatment*.

The same keywords were also utilized during the analysis of articles drawn from the opioid crisis. These themes were used in an attempt to demonstrate how both opioids and crack were crisis, but how the media coverage of the crack crisis was more often portrayed in the terms *violence*, *crime*, and *incarceration*; for example, the opioid crisis appeared more often portrayed in the terms *disease* and *health issue*.

Finally, I also sampled coverage and responses to methamphetamine. The reports on methamphetamine are essential when attempting to prove a correlation with the current "opioid panic" and what some see as a paradigm shift solely on racial lines from amongst crack and opioid users. The study examined a crisis that some believe is due to the "whiteness" of the current drug problem but may also be a more effective way to bring attention to other underlying problems in the decades-old war on drugs.

Data Collection

While qualitative methods are widely used in research today, the methods vary, and the quality of the research is often graded on the rigor in which the data is collected and analyzed (Rowan, 1997). This research began by analyzing online news articles from four of the most read print news organizations through the use of Media Cloud, an open source platform of the MIT Center for Civic Media and the Berkman Klein Center for Internet & Society at Harvard University. Media Cloud tracks millions of stories published online and enables the researcher to track stories and ideas throughout the media.

The study utilized ProQuest, which provides tools for the detection and management of scholarly citations to gather and analyze articles overlapping the opioid and prescription drug crisis. This research gathered articles chosen specifically to

compare and contrast the opioid crisis with the crack cocaine crisis. ProQuest was utilized as it offered news stories of the crack crisis which Media Cloud could not retrieve because the crack crisis pre-dated the creation of the Media Cloud platform.

For the research purposes, major newspapers were chosen instead of television, social media, and Internet news sources for several reasons. First, consumers believe they gain a deeper understanding of the story when reading from newspapers; as indicated in a study completed by Two Sides Network, it found that 56% of those interviewed "trust the news they read in printed newspapers (Gonenextpage, 2018). The study reports that the 55+ age group was less trusting of both printed and online news sources: just 39% said they trust the news stories from printed newspapers, and only 7% said they trust the news stories on social media.

The sources chosen for the research are believed to be the most trusted and longest running national papers, covering the nation from coast to coast from a geographical perspective as well. These newspapers are those historically read by more educated and so-called *power elite*. It is the power elite that are capable of shaping narratives most often printed in the news and covered by the U.S. 'mainstream media'. Rodrigues (2017) asserts that individuals with positions of power, including business leaders, politicians, and governmental officials are often used as sources for news media because most often they are the primary source of all the information.

The research collected over 600 articles on the crack crisis, opioid crisis, and several on methamphetamine. The collection consisted of those published by four of the largest national newspapers:

- *The New York Times*

- *Washington Post*
- *The Wall Street Journal*
- *Los Angeles Times*

During the process of collecting my data, several factors were considered before beginning to code and analyze them. The object of this content analysis was also to reach a point of saturation. While there may be hundreds of thousands of articles in my categories, despite the omission of many, I am "empirically confident" that nothing new or substantive was excluded. Many of these articles were reprinted from other articles already being utilized or quoted research of the findings of other authors. The selected articles contained *opioids*, *crack cocaine*, and *methamphetamine* as the predominant themes and were drawn from the periods in which these drugs were most prevalent in the United States during the periods previously outlined in this research. Once these articles selected, they were uploaded and analyzed with NVivo®.

NVivo®

"NVivo® is a software package for digitally coding texts or images that allows the user to synchronize evidence and make analytically richer intersections" (Oliveira, 2019). NVivo® gives the researcher the ability to manage the empirical material in a single location, allowing for modifications, such as additions, connections, or cross-references, as well as the integration of memos (Oliveira, 2013). NVivo® enables greater data organization, especially when dealing with large amounts of data.

Once coded and the themes for the research are considered, using NVivo®, I then developed the patterns and themes from the coded and themed articles. In most qualitative analyses, software is utilized for efficacy purposes and, in a limited manner,

for data organization, retrieval, creation of codes hierarchy, and simplification of memo writing (Alemu, 2017). “NVivo is a powerful tool that, if used appropriately, can facilitate many aspects of the content analysis process from the design and early sampling procedures, through to the analysis of data, theoretical development and presentation of findings,” emphasized Hutchison (2010, p. 1). In analyzing the media coverage of these articles, I attempted to identify the period(s) when media coverage increased and the patterns in coverage. For example, during which time did the emphasis shift from a criminal crisis to a health crisis and from a drug problem to a nationwide epidemic? I believe identifying these patterns and seeking explanations was paramount in my analysis and research.

Data Analysis

The content analysis process in this research began by analyzing over 600 news articles on both the crack crisis and the opioid crisis. My research utilized Schilling’s (2006) “spiral model” for content analysis. The spiral model consists of the following five phases for interpreting texts:

1. Convert gathered texts into raw text data or transcripts for content analysis,
2. Convert raw data into first coded texts,
3. Re-read and conduct a more focused coding,
4. Use the focused codes and undertake the theming process, and
5. Analyze themes to generate interpretations about the phenomenon of interest.

Schilling (2006) explains that this process is not a random one, but rather one where the most relevant texts are selectively chosen. That is why use of NVivo® was beneficial in examining large data sets such as in this research, which involved hundreds of articles,

many of which were lengthy. Using this model, my research began as demonstrated in the chart below.

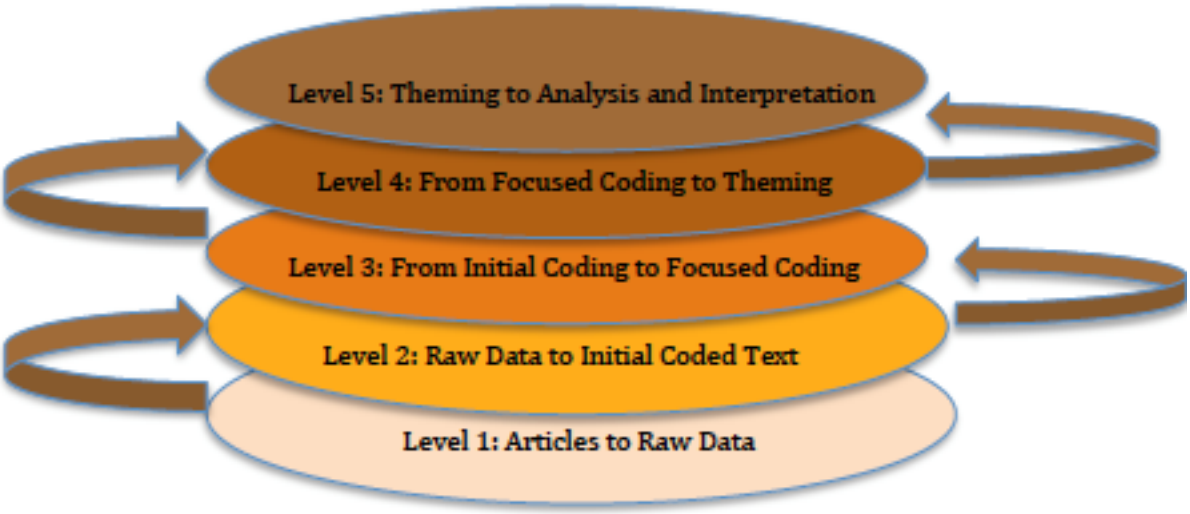

Figure 6. Coding Process Diagram

While Schilling's method for content analysis is one of many, others such as Krippendorf (2004) utilize tools which are equally as applicable and, in some ways, reinforce this analysis. For example, after collecting the articles and identifying the keywords, a close reading of these selected texts was performed. Overlapping and duplicative themes, as well as those not pertinent to the study were identified and, when necessary, were merged. While not indicated in the diagram above, this process was still vital to reaching the conclusions and interpretations of the analysis performed.

Coding the Articles

Achieving quality results in content analysis is heavily dependent on the coding process. This coding process involves meticulously organizing large quantities of text into small content categories (Weber, 1990). In similar fashion, the coding in my research was conducted according to Schilling's spiral model of the five phases. The first involves an initial phase utilizing a process of taking the articles and converting them into raw

data. In this phase, all documents, whether originating from ProQuest or Media Cloud were converted into MS Word documents. Once completed, these documents were uploaded and analyzed using NVivo®. In the second phase or initial coding process a keyword search was used. Initially, the top 50 words in the articles were identified and weighted percentages noted. In the third phase or in the focused coding process was conducted again where keywords were limited to the top 25 frequent words, including stemmed words.

The visualization of these keyword searches is demonstrated in the 'word cloud' figure below where an example of an initial 50 most frequent word search was conducted with NVivo®.

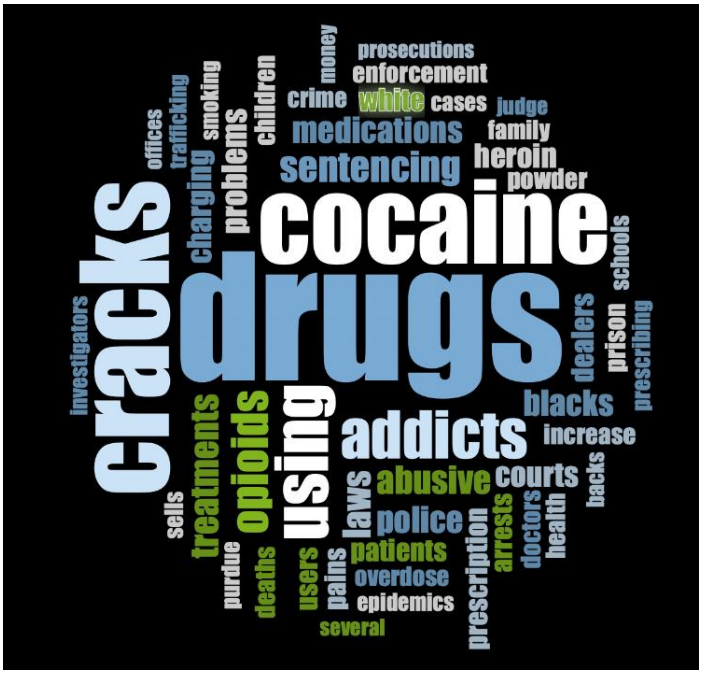

Figure 7. Cloud Visualization Chart

In the fourth phase analytical memos were made during this process and utilized in the remainder of the analysis process. Once this process was completed, the articles were re-read and themes were identified which assisted in determining the final themes.

These themes were then used in the fifth phase to interpret and finalize all data previously analyzed.

Reliability and Validity

While validity is more often a term associated in evaluating quantitative research, it is also used in other types of research, including the qualitative. According to Patton (2001), sound qualitative research often dictates that validity and reliability are two factors, which any qualitative researcher should be concerned about when designing and analyzing the results of the study and ultimately judging the attributes of the study. In other words, validity within a qualitative study depends on whether the method for analysis is appropriate to answer the research question(s) (Leung, 2015). Lincoln & Guba (1985) ask, “How can an inquire, persuade his or her audiences that the research findings of an inquiry are worth paying attention to?" (p. 290). In response to this, Lincoln and Guba (1985) use the term *dependability* rather than *reliability*, as it is as intently related.

Establishing reliability or dependability is also accomplished through the search for trustworthiness (Seale, 1999). To achieve trustworthiness, the usual canons of ‘good science” are relied upon throughout (Corbin and Strauss, 1990). In this study two of the four primary sources of errors or of risk to the study’s reliability and validity are of concern. The first one is the researcher, and second represents the methods of data collection and analysis. No real situational or social context are seen as influencing factors and no subjects participating in the study emphasis on two of the four are critical (Brink, 1993). The risk of the researcher within this study is most certainly used to avoid bias. Creswell & Miller (2000) caution that the researcher’s own perception of validity

affects his or her choice of paradigm assumption. The separation between the researcher's experience and knowledge must remain independent and preserve the accuracy of the collected data and of the results in the data analysis. To accomplish this, the methods and analysis must be clearly and concisely stated. While validity may be the standard for predicating trustworthiness, it is also essential for critical analyzation goals and the extent of the methods used in the study (Moret, 2007).

The importance of error and bias cannot be understated, and while neither is eliminated through any elimination paradigm (Norris, 2007), there are steps, which may be taken to reduce the likelihood of either or both occurring. For this reason, Norris warns that "A consideration of self as a researcher and self in relation to the topic of research is a precondition for coping with bias" (p. 174). With my research, it became paramount the need to establish potential scenarios where bias may occur.

Bracketing was another effective way to help identify and avoid bias. Tufford (2012) explains the term by stating:

Bracketing as a reflexive process can assist social work researchers to gain awareness of power differentials between themselves and research participants, to hear participant resiliencies in the face of classed and racialized challenges, to develop a new appreciation for the context or person in the environment, as well as for their social location and the impact of this location on research. (p. 80-96)

The bracketing process began through integration of the researcher's personal and professional 'self' into the research process and continues to be cognizant of any presuppositions regarding the topic.

During the data collection process, my research strived to clarify emerging perspectives while at the same time monitoring their emotions regarding the topic. Memo writing is one of the methods used to accomplish this. Through memo writing, the researcher documented issues, which might create bias or conflict within the research (Norris, 2007). During the data analysis stage, the researcher -while attempting to achieve data saturation- continued to reflect on the collection process, assuring that any preconceptions or 'unconscious' form of bias does not influence the analysis of the data. In this research, the background of the researcher and knowledge of the topic are of chief concern for bias, emergence, or presupposition toward the outcome of the research. Therefore, the extensive memo writing during the iterative process with data collection and analysis was vital to limit bias.

Finally, in my attempt to boost the validity of the study, the research relied upon the use of NVivo®, which enhanced the quality of the study and provided a more transparent account of the processes. NVivo® has been described as "extremely valuable especially from the design and early sampling procedures, through to the analysis of data, and the presentation of findings" (Hsieh, 2005, p. 1277-88).

Limitations of the Study

This study was limited to four of the most read and believed to be trusted news sources in the United States. While they may represent the largest demographic in their respective industries, they may not be representative of the overall view and perception of the population. For example, some areas where reporting may be lacking but nonetheless significant would be underserved areas or not seen as mainstream, such as remote rural

areas, LBGT and ethnic communities where much of the coverage is local or community-based.

While the coverage of drug issues like methamphetamine are rising rapidly, some people outside of these communities hear little from the media about them. While these areas are most undoubtedly crucial in the identification of the problem, they fall outside the ‘mainstream’ media coverage. Conversely, this also demonstrates another area where media coverage may not be just skewed, but instead all together missing or lacking, warranting further study on its own.

Finally, many people get their news through online sources. While numerous stories are run by the same mainstream outlets from where the research data is coming, there is just far too much information to consider for this research. One reason is that much of the ‘news’ on many of these online sites consists of news already reported by other outlets and is merely regurgitated on these sites. Regardless of the limitations, this study sought to introduce data that demonstrated the role of the media to shape the view and perception of society toward the current drug crisis. Furthermore, it demonstrates that -despite some people’s contradicting beliefs- the enforcement of drug crimes is not as heavily impacted by race only.

Background of the Researcher

The researcher is a male born and raised in New York. He spent over 20 years in Law Enforcement, the bulk of time, working narcotic investigations and more explicitly investigating the diversion, sale and illegal manufacturing of prescription opiates and other controlled prescription drugs. Many of his investigations began well before the

current opioid crisis and as such, has given him an in-depth understanding of the origins of the crisis, what has worked and what has not.

The researcher spent over three years working in an undercover capacity. First as a typical drug user than as a pharmacist and finally over 18 months as an undercover doctor working with a criminal organization selling opioids and anabolic steroids over the internet. During his career, he seized over 15 million dollars in illegal drugs and initiated an investigation which resulted in the prosecution of a compounding pharmacy which generated over $40 million a year in illegal anabolic steroids, opioids, and benzodiazepines. The researcher has lectured extensively nationwide on the topic and has been considered a law enforcement expert in the field of not only prescription opioids and painkillers but also in performance-enhancing drugs, steroids, and HGH.

In 2005 while giving a speech before 400 doctors and pharmacists, explained that the effort spent apprehending ‘bad doctors’ pharmacists and pursuing pharmaceutical companies would do little in decreasing the prescription opiate problem. He told the crowd that at issue was the ‘cutting off’ of the source for drugs and doing little to address the insatiable appetite Americans had for drugs. The researcher explained that this concept, most evident in the decades-old ‘War on Drugs’ provided no better example.

Pursuing drug dealers merely replaced them with other drug dealers and cutting off or limiting the supply of one drug just shifted drug use to another product. This was the paradox of the early days of the prescription opiate crisis. The researcher told the crowd that within three or four years we would see an uptick and then a full-blown heroin crisis. The reasons were two-fold. First, the fewer sources for prescription drugs mean the price for what was available would increase, pricing many users out of the market.

The second, the problem of addiction was not being addressed but merely shifted. In many ways, this has been the common denominator with most drug crises as the dealers and manufacturers are pursued yet the customers always remain and in doing so merely shift their focus on a new drug.

During his career, the researcher witnessed firsthand, the failure rate of drug treatment, having placed more individuals in treatment than he did in jail. However, and tantamount to this study, the researcher witnessed the changing views toward prescription drug addicts during the early years. Lawyers, doctors, teachers and stay at home moms were among the many users and abusers.

For the first time in almost in recent memory, the vast majority of the 'new' drug using public was white and from a much higher SES than that of what the public conceived as the 'normal' drug user. It was during this period where the researcher began to believe past drug wars were less about racial disparity within the criminal justice system and more about SES. The distinction appears to be more noticeable when compared to today's current drug crisis.

The country was not ready to send its educated, professionals or more classically described 'bourgeoisie" to jail or prison and even less so their children despite. However, the effect was less noticeable in poor predominately white areas of the country where widespread methamphetamine use was observed. Here, similarities between the treatment of inner-city minorities and poor rural whites in some ways is similar. What followed, in part led us to where we are today, a drug problem that has shifted from prescription drugs to heroin and synthetics illegally imported from China and Mexico and spiraling death rates as a result. As a result, what has not changed, are the failed policies and the belief

that the only more money can solve the problem. Perhaps this research can shed some new light on an old problem and in doing so significantly impact not only out of control drug use and abuse but on criminal justice reform.

While conclusive evidence of unfair drug sentencing along racial lines for past drug problems exists, it appears that race alone is not the only reason, but rather a part of the overall decay on the ongoing socioeconomic status of many people in the United States. By learning from these mistakes and understanding that there are many causes, which led to the disparaging treatment of marginalized people, perhaps we can move to prevent unnecessary incarceration in the future.

Chapter 4: Findings of the Study

Introduction

This research began as an effort to study the effect of the socioeconomic status on the current opioid problem in the United States and more specifically how the media framed this problem, shifting the perception of drug use and abuse from a criminal problem to one of a public health crisis. Framing and agenda setting are not new phenomena nor are they unfamiliar in sociological research.

Agenda setting or framing is described as "the process by which a communication source such as a news organization, defines and constructs a political issue or public controversy" (Nelson, 1997, p. 221). The analysis of the framing of drug crises is presented from a constructivist approach, which examines the news discourse of the crisis. The primary focus of this constructivist approach is "conceptualizing news texts into empirically operationalizable dimensions—syntactical, script, thematic, and rhetorical structures—so that evidence of the news media's framing of issues in news texts may be gathered" (Pan, 1993, p.55).

In the current drug crisis, the framing differs significantly from past crises when drug use and abuse was a scourge, one tearing apart our cities and giving rise to crime waves throughout the country. In general, it is this social constructionist approach that has helped re-frame the current drug crisis. According to Nišić (2014), "One of the functions of the media must be to inform about the events, phenomena, processes and developments in society, and to warn of the impending danger" (p. 77). However, media's explanation and view of many of these dangers and phenomena allow them to construct their own social reality. In doing so, the information can be manipulated or

added in an effort to “meet certain requirements or the expectations of the centers of power, or some other interest groups” (Nišić, 2014, p. 75).

Although little has changed in the way in which drugs are distributed, sold, and used, the call for incarceration has quickly been replaced with the demand for treatment and, thereby, attempt to erase the stigma associated with drug abuse. Most importantly, this research sought to address the following research questions, which are paramount to the study.

RQ1: Is the current opioid crisis another moral panic created by the media, and has the media narrative of drug use and abuse changed from a criminal issue to a public health issue?

RQ2: What role does socioeconomic status (SES) have in the media framing of the current drug crisis and the treatment of drug offenders?

Chapter 4 is presented in two separate sections. The first will discuss the news articles used in the analysis, including relevant themes observed. The second will consist of the analysis in support of the themes and theory uncovered in the analysis.

Overview of Findings

My research relied upon Media Cloud and ProQuest to examine three periods of the current drug crisis spanning fifteen years (from 2003 through 2018) to identify narrative and criminal justice shifts in society’s view of the crisis. Then, I closely examined and re-examined all articles to ensure that they fit into the parameters of the study.

Following Schilling’s “spiral model” for content analysis, articles in the crack and opioid were converted and analyzed using an NVivo® frequent word search. These most

frequent words were then used to develop the themes of the analysis. NVivo® allows for the compilation of stemmed words, which concede a narrower focus on keywords noted in the analysis.

The articles considered non-pertinent for the purposes of this study were those that may have included opioids, for example, but may have been about pharmaceutical research and not related to this study. Once complete, I began searching for the relevant themes identified after re-reading the articles and conducting the focused coding. Many of these themes were brief mentions, meaning one or two words, while others were more in-depth, involving more than one sentence and often paragraphs. During this process, I began to eliminate some of the themes and phrases, which were duplicates or overlapping themes and words. From this point and based on the frequent or keywords, I formulated several inferences to develop the following themes:

- Opioid as a Crisis, Epidemic or Moral Panic (OEMP)
- Accidental Overdose and Unintentional Overdoses (AOUO)
- Opioids as Public Health Crisis (OPHC)
- Prescription Opiates and Prescription Drugs (POPD)
- Treatment and Opioids (TO)
- The whiteness of Drug Use (W)
- Cocaine as Crisis (CC)
- Crack Babies (CB)
- Cocaine as a Public Health Crisis (CPHC)
- Treatment and Cocaine (TC)
- Crime or Criminal (CR)

- Cocaine and Minorities (CM)

Second, the themes and codes allowed me to focus on specific concepts within the data and not merely on words or phrases alone.

The examination of these themes also was revealed through trends in the paradigm shift as well as peaks in the coverage and narrative changes. Themes within the articles chosen were placed in appropriate files, using NVivo® 12. Duplicate themes were combined, and those not relevant to the coding scheme were removed. All articles used in this research came from two sources — the first, from the top four news organizations, as reported by Media Cloud. Media Cloud is an open source consortium and collaborative project of Harvard University and the Massachusetts Institute of Technology (MIT).

Generally, the data indicated a stark difference between the media coverage of the current opioid crisis, which has continued for over 15 years and the crack crisis of the mid ’80s and ’90s. The most predominant theme is the shift from criminal use of drugs to that of a public health issue. After examining the more than 600 articles on each crisis during the period, data revealed a softening tone toward those involved in drug use. Tables 1 through 4 examine the research themes found in articles published during the crack crisis, while tables 5 through 8 show the themes found in articles published during the current opioid crisis.

When examining the hundreds of articles during the crack crisis, much of the narrative was centered around *violence*, *crime*, *minorities*, and the *criminal justice system*. While *treatment* was mentioned in a large portion of the crack news articles, most

articles were more about the lack of treatment. When it came to funding to fight the crack crisis, the primary use was for *law enforcement*, *prisons*, and *courts*.

When I looked at the articles from the onset of the opioid crisis, which began in the late 1990s-2001 through the present day, I observed distinct differences. The media appears to focus more on someone to blame more than other issues. First, it appears the focus was on *doctors*, *pharmaceutical companies*, and certain *government agencies*, such as the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA). The news looked to fault weak or non-enforced regulations, lack of training, and -more than anything- misleading marketing of pharmaceuticals. The money demanded and claimed as desperately needed was to fight against opioids, for treatment programs, and for studies to find ways to decrease overall use. A substantial transformation was observed: this time, there was no longer an appetite to put people in jail or enact mandatory prison sentences. New "diseases" and mental health diagnosis were created while the underlying stigma associated with drug use, such as the terms *junky* and *addict*, seemed to be no longer politically correct.

When the *whiteness* or *White people* are discussed in the context of opioid use, it appeared more in articles about crack cocaine use. However, most of the articles mention *race* or *whiteness* in crack use to point out that Whites do not use crack as much due to its prevalence in poor, inner city and African-American neighborhoods. To the contrary, when mentioned within the opioid argument, the articles suggest that one of the reasons the crisis garners the attention it does is because many users are White. Furthermore, some of the opioid articles speak directly to White privilege and whiteness.

Today, many scholars also believe that opioids are a *White* phenomenon. Netherland show the interest in the topic by publishing a series of articles: "The War on Drugs That Wasn't: Wasted Whiteness," "Dirty Doctors, and Race in Media: Coverage of Prescription Opioid Misuse," "White Opioids: Pharmaceutical Race and the War on Drugs that Wasn't;" although Netherland mentions the media's role in framing the opioid coverage, she says little about the role of SES.

Table 1

Themes Observed in Text Analysis of The Washington Post Articles, Dates- 1983-1995, Article Count 600, Crack Cocaine

	Theme in Text	Frequency
1.	Cocaine as an Epidemic (CC)	243
2.	Crack Babies (CB)	153
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	0
4.	Cocaine as Public Health Crisis (CPHC)	7
5.	Treatment and Cocaine (TC)	586
6.	Implied Whiteness of Drug (W)	37
7.	Crime of Criminal (CR)	128
8.	Cocaine and Minorities (CM)	266

Table 2

Themes Observed in Text Analysis of The Wall Street Journal Articles, Dates- 1983-1995

Article Count 600, Crack Cocaine

	Themes in Text	Frequency
1.	Cocaine as an Epidemic (CC)	243
2.	Crack Babies (CB)	96
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	2
4.	Cocaine as Public Health Crisis (CPHC)	18
5.	Treatment and Cocaine (TC)	19
6.	Implied Whiteness of Drug Use (W)	29
7.	Crime or Criminal (CR)	114
8.	Cocaine and Minorities (CM)	61

Table 3

Themes Observed in Text Analysis of LA Times Articles, Dates- 1983-1995

Article Count 600, Crack Cocaine

	Themes in Text	Frequency
1.	Cocaine as an Epidemic (CC)	44
2.	Crack Babies (CB)	52
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	6
4.	Cocaine as Public Health Crisis (CPHC)	11
5.	Treatment and Cocaine (TC)	563
6.	Implied Whiteness of Drug Use (W)	146
7.	Crime or Criminal (CR)	283
8.	Cocaine and Minorities (CM)	229

Table 4

Themes Observed in Text Analysis of The New York Times Articles, Dates- 1883-1995

Article Count 600, Crack Cocaine

	Themes in Text	Frequency
1.	Cocaine as an Epidemic (CC)	243
2.	Crack Babies (CB)	96
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	1
4.	Cocaine as Public Health Crisis (CPHC)	6
5.	Treatment and Cocaine (TC)	563
6.	Implied Whiteness of Drug Use (W)	5
7.	Crime or Criminal (CR	324
8.	Cocaine and Minorities (CM)	58

Table 5

Themes Observed in Text Analysis of The New York Times Articles, Dates- 2003-2018

Article Count 600, Opioids

	Themes in Text	Frequency
1.	Opioids as an Epidemic (CE)	48
2.	Opioids and Babies (CB)	422
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	66
4.	Opioids as Public Health Crisis (CPHC)	199
5.	Treatment and Opioids (TC)	176
6.	Implied Whiteness in Drug Use (W)	46
7.	Crime or Criminal (CR)	32
8.	Opioids and Minorities (CM)	5

Table 6

Themes Observed in Text Analysis of the The Wall Street Journal, Dates- 2003-2018

Article Count 600, Opioids

	Themes in Text	Frequency
1.	Opioids as an Epidemic (CE)	29
2.	Opioids and Babies (CB)	0
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	93
4.	Opioids as a Public Health Crisis (CPHC)	51
5.	Treatment and Opioids (TC)	40
6.	Implied Whiteness in Drug Use (W)	17
7.	Crime or Criminal (CR)	38
8.	Opioids and Minorities (CM)	10

Table 7

Themes Observed in Text Analysis of The Washington Post Articles, Dates- 2003-2018

Article Count 600, Opioids

	Themes in Text	Frequency
1.	Opioids as a Crisis (CC)	36
2.	Opioids and Babies (CB)	18
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	9
4.	Opioids as Public Health Crisis (CPHC)	36
5.	Treatment and Cocaine (TC)	127
6.	Implied Whiteness of Drug Use (W)	136
7.	Crime or Criminal (CR)	23
8.	Opioids and Minorities (CM)	12

Table 8

Themes Observed in Text Analysis of LA Times Articles, Dates- 2003-2018

Article Count 600, Opioids

	Themes in Text	Frequency
1.	Opioids as a Crisis (CC)	6
2.	Crack Babies (CB)	8
3.	Accidental Overdose and Unintentional Overdoses (AOUO)	138
4.	Cocaine as Public Health Crisis (CPHC)	86
5.	Treatment and Cocaine (TC)	179
6.	Implied Whiteness of Drug Use (W)	44
7.	Crime or Criminal (CR)	23
8.	Cocaine and Minorities (CM)	59

Findings

RQ1: Is the current opioid crisis just another moral panic created by the media?

Using the previous definitions and examples of moral panics created by the media, this research indicates that the current opioid crisis possesses many of the same characteristics of past moral panics involving drug use and abuse. However, unlike those in the past, this panic is unique for the framing of the panic appears to have been created in a way to humanize abuse and protect those with a higher socioeconomic status. Goode and Ben-Yehuda (1994, 2009) assure that "Ideology and morality are tools used by the elite to protect their interests" (p. 165) and, in this case, exercise their influence over the media to facilitate the moral panic.

Although this research (and the articles reviewed in its analysis) is derived from the moral panics of the most current drug crisis and is viewed from a socioeconomic perspective, I would be remiss by failing to point out the existence of early moral panics created by drugs which involved cocaine in the early 1900s. In 1914 *The New York Times*

published an article written by Dr. Edward H. Williams. The article, “Murder and Insanity Increasing Among Lower Class Blacks Because They Have Taken to ‘Sniffing’ Since Deprived by Whiskey Prohibition” stated that:

Most of the Negroes are poor, illiterate and shiftless...Once the Negro has formed the habit, he is irreclaimable. The only method to keep him away from taking the drug is by imprisoning him stories, unfortunately, were false.

Moreover, this is merely palliative treatment, for he returns inevitably to the drug habit when released. [Cocaine] produces several other conditions that make the “fiend” a peculiarly dangerous criminal. One of these conditions is a temporary immunity to shock -- a resistance to the “knock down,” effects of fatal wounds. Bullets fired into vital parts that would drop a sane man in his tracks, fail to check the “fiend” (p. SM12).

Those who read this article in the newspaper, which is where the majority received their news at the time, believed what they read and, in part, served to reinforce the fear that many still had regarding African-Americans. Despite this myth being proved wrong, it did not prevent further moral panics created by the media. Not at all dissimilar, the crack cocaine crisis of the early 1980s and 1990s instilled much of the same fear. However, unlike the problem at the turn of the century, the media had a new weapon in the creation and spread of new panics. The weaponization of television news bolstered the reports in newspapers when it came to the crack cocaine crisis. Crack, which was nothing more than free-based cocaine smoked decades earlier on a much smaller level, was found mainly in the inner city where resided poor and minority populations.

When comparing the media coverage of the crack cocaine crisis with that of the current opioid crisis framing appeared to be the most significant influencer in how people

viewed the crises. In the early part of the crack crisis, the media framed crack use in a frightening and, at times, more evil ways than any crisis preceding it. However, references to violence, feigns, and addiction alone was not enough to gain the attention needed to move the crisis to the front pages of the largest newspapers and weekly magazines.

While readers and news watchers heard and saw quotes such as “Crack is by far the most addictive drug we’ve ever had to deal with” and “these experts say, it is nearly impossible for them to stop using crack and never go back to it again” (Kolota, 1988, p. 2), other news articles told stories of young girls prostituting themselves for five dollars as well as people selling their cars for thirty dollars all for a small piece of crack cocaine. Still, some of the stories, although true, were not enough to capture the nationwide audience that competitive news outlets sought with vigor. Showcasing violence worked for a while: street gangs shooting each other for control of the crack trade on a city block and stories of crack feigns robbing and killing people, even their family members, for any amount of money to feed their habits.

Although disturbing, middle and upper-class America saw this as an inner-city problem among minorities and one which affected them very little. After all, crack had not yet spread into their neighborhoods, and -as long as it remained in the inner city among the poor, mostly comprised of the African-American population- it was just another crime story. As crack use expanded, so did the myths created by the media in their fight to win the coverage wars.

In the late ’80s, a new myth emerged, one which would grab the attention of many who sat out during the early part of the crisis. The *crack baby* was born. Middle

America started reading stories describing premature and underweight babies prone to strokes. Dunn (1990) described that “Many hate being touched, which makes them hard to care for. They are also set apart by their cries - an unnatural keening from a creature for whom even the womb was not safe” (p. 1). “Could America turn their backs on the baby girl making little baby sounds as she slept quietly, her rosebud mouth moving every now and again, perhaps dreaming of her next bottle” Dunn (1990) believes this was now more than merely an inner-city problem?

These myths created by the media helped generate one of the most significant moral panics in recent history. The myth of the crack baby was debunked in later years through countless studies, which found that “alcohol and cigarettes, in particular, have been determined to have an equal or greater detrimental impact on the newborn” than crack cocaine (Brodkin and Zuckerman 1992; Richardson et al. 1993).

Crack Babies

My research examined over 600 news articles from 1985 through 1994, the period in which crack cocaine was the most widespread throughout the United States. Coding was limited to the terms *crack* and *crack cocaine*. The themes developed from these articles were as follows:

- Crack baby
- Criminal
- Gang violence
- Addict

During this period, the research found 30 stories whose headline contained the *crack baby* theme. Of these, four stories mentioned the terms *death* or *died* in the title,

and 13 cited *criminal charges*. *Addicted* and *abuse* were the next most utilized words in titles, with the term *abuse* relating to that of the child and not the alleged drug abuse of the parent. The mothers of these children were predominately African-Americans and subjected to scientifically baseless, often ugly rhetoric where their children would frequently be labeled as future criminals with below average mental capacities.

Furthermore, law enforcement and prosecutors arrested and incarcerated pregnant women or those who had given birth while using cocaine even though many of the babies were born healthy. “One clever thing about using drug cases this way,” said Sara Zeigler, a feminist scholar and dean at Eastern Kentucky University, “is that the average person is not going to be at all sympathetic” to a pregnant woman who gets high (Martin, 2014).

The image of the crack baby became ingrained everywhere in the media and the minds of the readers. With pressure from their constituencies, politicians joined in the call to arms with legislation that focused on jailing drug-addicted mothers.

Violence and Crime Attributed to Crack

The media myth of excessive violence constructed by *crack feigns and zombies* created by the crack crisis was also a scare tactic that helped fill prisons with poor, mostly minority males. Crack was deemed so powerful and addictive that it drove its desperate users to commit violent crimes to support their addiction. However, in a groundbreaking study in New York City in 1988 conducted by Dr. Paul Goldstein and funded by the National Institute of Justice, it was found that crime related to crack cocaine was attributed to three distinct categories: psychopharmacological, economic compulsive, and systemic (Reinarman, 2004). While one cannot dispute the crime related to systemic crack cocaine crime which was created over turf wars and the control of the

street drug trade or the economic compulsive committed to finance one's expensive drug problems, the study found that only 7.5% of the murders committed in New York City that year to be related to the psychopharmacological criterion.

The vast majority, almost 75% were a result of systemic and competitive business in the crack marketplace. Still, this portrayal was hardly the narrative of the media during the crack crisis. The following headline presents an example of a common media narrative, "Crack cocaine addict who threatened to eat his seven-month pregnant girlfriend before hacking her to death in scissor attack which also killed their unborn daughter is jailed for 26 years." While true, it is indeed not the norm, as indicated in Goldstein's study, yet media depiction of this crack induced violence reverberates throughout society. Much of the same could be said about the research conducted here.

My review of over 600 articles during the crack crisis found similar results. When crack-related violence was examined after removing references to crack babes and addicted mothers, it was found that violence and crime related to crack to be the predominant theme. Gang violence, murder, turf wars, and drug trade were the predominant themes in the articles. Most articles called for harsher penalties, increased law enforcement, and more government funding for the *war on drugs*.

Opioid-Addicted Babies - 'Oxytots'

More than two decades later, the media appears to be using the playbook from the crack crisis. The rebirth of the *crack baby* is now referred to as the *oxytot* and *drug-addicted infant*. While there has been an increase in babies born with some degree of opioid dependency, they are not born addicts. However, the "media then uses such language to shock and reinforce the myth that babies are born addicted. They are not;

they have Neonatal Abstinence Syndrome, (NAS) which is treatable" (Pawlowski, 2017, para 2). Nevertheless, the media's attempt to create a moral panic over the birth of opioid-dependent babies is not having nearly the impact of their success achieved in their creation of the *crack baby*.

Due to the large numbers of articles written daily on the opioid crisis and the numerous drugs involved, stories published in 2018 were examined and coded. Of the 600 stories examined using both ProQuest and Media Cloud, codes were limited to the following keywords regarding addicted babies:

- Opioid Babies
- Addicted Babies

Of the 600 stories examined in this study, all four news outlets printed headlines consisting of the following: "every 19 minutes, a baby is born addicted to opioids in the U.S.," "nearly 22,000 babies were born drug dependent, one every 25 minutes," "a baby is born in withdrawal from opioids every 15 minutes in the U.S." (Kristof, 2019), "every 24 minutes, a baby is born suffering from opioid withdrawal," and finally "A child is born with NAS about every half hour in the U.S."(Sutter, 2014). Despite headlines depicting a significant increase in the number of opioid-dependent births, which few seem able to agree upon, many medical professionals are avoiding pressing the panic button. Even though opiate abuse has surpassed any drug society witnessed in the past, the treatment of opiate-dependent newborns and their mothers is almost immeasurable when compared to the babies and mothers of the crack crisis.

Today, we see a kinder and gentler approach in the treatment as well as the stories of late. Whereas many attribute this to nothing more than the fact that crack users of the

1980s and 1990s were -for the most part- Black, today's opiate users are White, middle and upper class, yet many of the articles written about the opioid-dependent babies often compare the similarities to the crack crisis while at the same time admitting the errors made in the treatment. Gone are the terms *addict*, *poor, criminal neglecting,* and *jail*.

In my review of the articles with opioid-dependent babies, perhaps one of the few similarities is the suffering endured by many of the children born into dependency. This review found no articles calling for the jailing of addicted mothers who passed their addiction onto their unborn children. Instead, the articles warned of the dangers of labeling infants as addicted and denounced the "assault on pregnant women" (Pawlowski, 2017, para. 2).

The forced treatment either through the criminal justice system or other public means is no longer seen as sound. At the same time, politicians on the state and local levels, under pressure from social justice and other advocacy groups demand a more comprehensive way of non-coercive treatment options. In a side-by-side review, one cannot ignore the disparaging media coverage of opioid-dependent babies compared to the crack cocaine-addicted babies.

In the chart below, we can see how the tone in the sampling of articles written in 2018 portrays a more sympathetic view of drug-dependent babies from the previous crack crisis and the current opioid crisis. Condemned babies and society with babies deemed to have no future have been replaced with compassion and the seeking of help for a vulnerable population. On the other side, one can still observe the precedent image of those unfortunate enough to be born to addicted mothers, mostly Black children of the 80s and 90s, who were deemed to have lower I.Q.s, "be unable to feel love" (Copeland,

2014), and destined to a life almost judged not worth living. The chart below demonstrates examples of the differences in articles on crack babies and opioid babies. The differences art stark and despite the narrative being largely debunked it continued throughout the crisis.

Table 9

Infant coverage comparison

Opioids and Babies	**Crack Cocaine and Babies**
Article Titles	**Article Titles**
BARLETTA BILL PROTECTING OPIATE-ADDICTED BABIES UNANIMOUSLY PASSES HOUSE	Experts Say Crack Babies Will Strain Public Schools
Drug Addiction; Helping opiate addicted babies	Schools Not Ready for Crack Children
Eastham mother's journey to help her opiate-addicted baby	Cocaine Babies Lift Hospital Costs, Researchers Find
What happens to drug-exposed babies? Mothers and their babies in Providence are part of an attempt to separate the effects of prenatal drug exposure from the effects of poverty.	Cocaine Babies: Area's New Tragedy
GUEST COMMENTARY: Help drug-addicted mothers make changes	Hearings on Neglect Upheld In Newborn Cocaine Cases
Born addicted. For these babies, coming into the world is no easy beginning	Cocaine's most innocent victims // A new wave of birth defects linked to drugs:
NICU first home for addicted babies EMMC Neonatal unit treats children whose mothers abuse opiates	Mother of Cocaine-Addicted Infant Indicted on Drug Charge
Bipartisan anti-heroin plan helps women,	Hooked and Pregnant: A Time Bomb
Born with a drug problem: Play hopes to raise public awareness about babies born to drug addicts	The First Generation of Crack Babies: Who Will Care for Them?

Violence Attributed to Opioids

In reviewing articles on ProQuest and Media Cloud regarding violence related to the opioid crisis during the past decade, the research found most articles on opioids

devoid of the violence the media attributed to the crack crisis. While it is understood that the current opioid crisis did not begin among the poor, inner-city, and minority communities, the violence attributed to the use of crack and opioids is vividly different.

Even though the media has covered the overwhelming addictive properties of opioids as well as the death and breakdown of families as a result of their use, it is missing information on what addicts will do to get these drugs. To be sure, crimes are committed to obtaining these drugs, yet the media has been hard-pressed to cover them, and when they do, here again, we see a softer side of criminal acts committed.

In an article published in the *Pittsburgh Post-Gazette* (2009), the following statements were buried within the article:

Violent crimes and property crimes associated with prescription drug diversion and abuse have increased in all regions of the United States over the past five years. […] Children aged 12 to 17 abuse prescription drugs more than they abuse ecstasy, crack cocaine, heroin, and methamphetamine combined.

Both statistics are and should be alarming to most. However, the same article began by communicating the following:

The tragic death of Michael Jackson has brought out evidence that he had a history of prescription drug abuse. It is so sad. Many people still do not realize that these drugs are just as powerful and dangerous as street drugs.

In this article, the media attempts to acknowledge both violence and drug use, but while mentioning extreme addiction, violence, and crime- it attempts to advocate for a more sympathetic view toward opioid abuse with sadness, despair, and of course the sad death of Michael Jackson.

In an all too similar portrayal of opioid-related crime in the media, *The Wall Street Journal* (2013) published an article titled "Heroin Makes a Comeback; This Time, Small Towns are Increasingly Beset by Addiction, Drug-Related Crimes." The reader would have to read almost half of the 1000-word article to get to the 'crime' attributed to the opioid crisis described as follows:

A former Marine who lives in Ellensburg said he switched to heroin after getting hooked on oxycodone prescribed to him for an injury suffered while serving overseas. "To me, it was identical," said the 28-year-old. "It's mind-numbing, an instant antidepressant." He was eventually arrested for writing bad checks; if he successfully completes drug treatment, charges will be dropped (para. 9).

While the article mentioned drug seizures at the Mexican border, the only crime mentioned was the passing of a bad check.

In yet another example published in the *Columbian News*, (2012) titled "Crime increases a drug use does," indicating that a greater percentage of drug-addicted young adults are responsible for the area's property crimes, including burglaries, commercial robberies, vehicle prowls and mail and auto thefts. Drug addicts looking to get a hit will do whatever they must to afford their habits.

While it may seem technical, robbery is defined as the forcible taking of property of another, and most often this is accomplished by the threat use of a weapon which is vibrantly described in many of the articles referring to violence and crack cocaine. In the above-stated article, robberies receive this single mention instead of providing a more accurate description of what is a violent crime. The following citation provides an example of the narrative describing a home burglary:

A typical drug-addicted burglar will nab jewelry, guns and small electronics such as iPods and iPhones, but they will also go for larger items such as flat-screen TVs. It all depends on what their motivation is and what the market demands. Some burglars will compile a "shopping list" of items wanted by those buying stolen goods. (para. 12)

Nowhere does it state that burglary of a residence in most states is classified as a violent crime.

My evidence indicates that the media attempts to portray violence among opioid users on the softer side. After all, they are not out committing their crimes to fuel their addiction, but -as the article states- rather to "afford their habit, they have to steal" (para. 16). In "Drug use contributes to a rise in thefts citywide" published in *The Times Recorder* (2013), burglaries, thefts, and other break-in crimes are mentioned, yet one sentence seems to imply the victim is at fault for choosing to live in a particular area. The article explains that "The numbers reaffirm a long-standing demographic stereotype: People who live near or below the interstate are more susceptible to crime". Is the media implying people need to live somewhere else to avoid being a drug-related crime victim?

While most people living in the impoverished areas of the inner city during the crack crisis would most certainly have chosen not to live there, no evidence was found to imply they were not open to opportunities to become more successful. In the vast majority of stories regarding opioids, seldom mentioned is any violence or crime as a result of opioid use or sales. . While there are stories focusing on pharmacy robberies or thefts, these stories pale in comparison to those crimes attributed to crack users trying to feed their habits.

RQ2: How does the media change the narrative of drug use and abuse from criminal to that of a public health issue?

Today, professionals from the law enforcement, public health, medical, and behavioral health fields have provided numerous opinions and theories by describing their thoughts on the root cause of opioid abuse. Whether one prescribes to one particular theory or opinion or a combination of several, it remains certain that the media has not taken the same approach as that embraced during the crack crisis. Some may say that, due to advances in science, beliefs have changed, and new proof has steered a change in the perception of drug abuse. Still, others will see the narrative as being influenced by the socioeconomic status of the user in the attempt to disassociate the new drug user -mainly coming from a higher socioeconomic status- from the disparaging treatment experienced by their less fortunate or lower status counterparts.

Crack Users

By coding articles from 1985 through 1994 using the keywords *crack*, *public health*, *health*, and *disease* to find my articles in the media outlets chosen, the research uncovered a plethora of publications regarding the crack crisis. After the elimination of duplicates and reprints in other news outlets, my focus was on the articles where keywords appeared. One of my initial findings indicated that there was little belief or presupposition that crack use was perceived as a disease or public health concern. Instead, most of the articles collected discussed ancillary health, disease, and public health problems created as a result of the crack crisis. Lung disease, HIV, heart disease, and sexually transmitted diseases were the predominant themes in the articles. When the terms *crackhead* and *feign* appeared, they were not associated with the stigma in name

association but rather as a disparaging sub-human term used to describe the addicted. To get a better understanding, one should consider the titles of the following articles published in *The New York Times* (1989, 1990) and *The Washington Post* (1991):

- "Rats, Leaks, Crackheads and All, Apartments Beat Welfare Hotels: Rats, Leaks, Crackheads and All, City Apartments Still Beat the Martinique"
- "Old, Weak and a Loser: Crack User's Image Falls"
- "Crackhead' Guilty of 2 Slayings"

Nowhere in the articles did I find sympathy for the addicted person, the need for drug or behavioral health treatment, or any social assistance. During the crack crisis, cravings, feigning, and the commission of crimes were the activities often mentioned prior to drug use. Although fewer people died as a direct result of crack use, there was no call to soften or to downplay the activities engaged in to obtain drugs. Crack users were viewed as evil, violent, and whose lives matter less.

Opioid Users

In contrast, the opioid crisis almost appears devoid of the blame found in past crises and casts dispersion on those who refer to the addicted as *addicts*, *junkies,* or anything that may create a critical view of opioid abusers. The review of articles written by only substituting *addict* and *junkie* for *crackhead* and *feign* indicate the media's more sympathetic view of the opioid abuser. The demand for more and innovative treatment, recovery, help, brain disease, and substance use disorder are the predominant themes. Blame associated with the rise in abuse and addiction rates is shifted from the user to doctors, pharmacists, pharmaceutical companies, and the federal government. A sampling of the distinct differences when covering the opioid crisis appears below:

- Anti-addiction groups call for FDA chief to step down
- Recovery involves more than just drugs: [All Edition]
- Treatment a challenge
- Dealing With Opioid Abuse Would Pay for Itself
- Addiction to Prescription Painkillers and Heroin Surges in Pittsburgh,
- Most Widely Abused Drugs Citywide; -- Heroin causing more than half of overdose deaths; resources on private office-based treatment available for Pittsburgh consumers

The use of language exploited in the narrative can also have an impact on how people view the current opioid crisis. For example, not only have the words *junkie*, *feign*, and *addict* disappeared from the narrative but so too have the drugs themselves. The terms *opioid* and *opioid crisis* are universally used to categorize all opioids and synthetic opioids. When people overdose and die, regardless of the cocktail of drugs that may exist in their system, they are said to have died of an accidental overdose related to opioids. Although the individual may have died solely from a heroin overdose, heroin is replaced with opioids because, in many ways, it is much softer and more acceptable to the middle and upper-class users and their families who refuse to grip with the fact that their child or family member is a heroin addict.

In many of the articles on opioids studied in this research, I found evidence of numerous drug-related overdoses and deaths. However, even in these situations, the blame appears to shift from the individual to the drugs as if somehow the drug has mysteriously found its way into the system of the user. Hence, the majority of the articles

portray opioid users more often as victims in need of help or treatment than criminals or deviants.

One should consider the below-exemplified narrative in which a heroin addict from the 1970s stated the following during an interview:

Way back in the 50s, 60s, and 70s, hard drugs were mainly a ghetto thing. No one cared, but when white middle-class kids began to get more involved, it began to change the face of addiction. All of a sudden, diversion programs popped up, alternatives to jail time began, programs and treatment centers abounded. (Hardy, 2017, para. 11).

The public see a much different portrayal of a drug abuser and one, which continues today.

Although it is true that a significant number of people became heroin addicts when their supply of prescription drugs and the doctors prescribing them dried up, the clear majority never obtained any drug legally. Muhuri (2013, 2016) concluded that "a study of young, urban injection drug users interviewed in 2008 and 2009 found that 86 percent had used opioid pain relievers non-medically prior to using heroin". Reading this, one might focus on opioid pain reliever and attribute the issue to pills prescribed by a doctor. However, the most important word here is "non-medical," meaning the particular drug was not supplied, used, or obtained legally for any medical purpose and, therefore, is no different than if opioid users had just gone out on the street and started using heroin from the beginning.

When examining other parts of the two studies, I realized that Muhuri also noticed that less than 4 percent of people who had misused prescription pain medicines started using heroin within five years (p.1). However, this statistic was not found in any of my

chosen articles. Instead, some of the articles used the following; found in the same study which stated, “Nearly 80 percent of Americans using heroin (including those in treatment) reported misusing prescription opioids first” (NIDA,2018). Misinformed readers may be fooled by the 80% figure to believe that prescription drugs lead to heroin addiction, which is not valid. Therefore, this narrative may have contributed to the public’s misconception in its belief that prescription drugs supplied by doctors started this entire opioid crisis.

Furthermore, NIDA (2018) documented that “according to the U.S. National Survey on Drug Use and Health study, stated, “75% of those suffering from opioid addiction did not start out abusing painkillers obtained legally from a physician. Instead, they purchased opioids on the black market or got them from family, friends, or other acquaintances, with the intent of using them for recreational purposes” (p. 4). Again, are doctors or pharmaceutical companies to blame, or are these merely drug-seeking individuals who started with a preference for a drug that eventually disappeared or became too costly?

The media coverage of the opioid crisis, unlike that of the crack crisis, has turned from the violence and crime associated with crack use to that of a public health crisis, epidemic, disease, and other medical terminologies, such as the brain disease model of addiction and numerous other medical theories of addiction. I believe the change in the addiction narrative is again related to the drug user’s socioeconomic status. Portraying one who became addicted because of surgery, an injury, or ‘a trip to the dentist’ (as indicated in a few reviewed articles) implies that the user is not at fault and was doing what he or she was told. After all, these are people with jobs careers or academically

educated: they are students, doctors, lawyers, not *junkies* or *addicts* and, therefore, their status within their communities and society cannot be damaged by such disparaging terms and treatment. Therefore, their addiction cannot be associated or compared with that of the poor Whites from Appalachia or the poor minorities from the urban ghettos. While my research cannot say with certainty as the narrative is never accurate or true, it appears to be far less true that those addicted became so due to no fault of their own. The demand for treatment rather than the criminal justice system has become the talking point amongst many politicians and those working in the growing treatment industry.

Socioeconomic status (SES) has been defined as a multifarious measure of one's economic and sociological standing. It is measured in a variety of ways and considers one's position in the social hierarchy compared to others. Factors considered in this determination include, but are not limited to education, income, and occupation. When comparing many of the drug crises during the past century, the underlying theme in most articles in the media is related to the racial component of drug use or abuse: Asians and opium at the turn of the century, African-Americans with marijuana during the first part of the 20th century and again with crack in the latter, and Whites with the opioid crisis today. However, is race the only factor when we look at these drug crises or do underlying social and economic factors favor particular races at particular times, inferring a racial tone?

The manners and sources people use to get their news may also have an impact on overall policy-making and the direction the media narrative takes toward a drug crisis. A study by Pew (2012) indicates that readers of the major newspapers are overwhelmingly male, highly educated, more than half have college degrees, and almost one half of the

readers have incomes of over $75k per year. The demographics of these individuals place them in the middle and upper-middle class and are often seen as the decision makers and influencers of their own rights.

Many of these people have been directly impacted or have a friend or family member impacted by opioids. Therefore, when educated people hear statistics that appear to reinforce what they already have heard or experienced, they may agree with the call for more treatment, more government programs, and most likely are the people whose voices are heard amongst the political establishment.

In the more than 600 articles reviewed and coded from each of the four major newspapers chosen in this study regarding the opioid crisis, the word *treatment* appeared 192 times, ranking third behind the words *drug* (356) and *addiction* (238). The underlying theme in these articles was *crisis* or *epidemic* yet were often related to the lack or need for more treatment. As a result, in the past two presidential election cycles, candidates from both parties campaigned on providing more funds for drug treatments. Little was mentioned in any of these articles about increased law enforcement or allocating more money toward the criminal justice system.

Second in line, following the demand for more treatment, was the request for increased availability of opioid reversing drugs, such as *naloxone*. Naloxone is not a cure, nor is it used in drug treatment, yet it is a drug that -when used soon after a near-fatal overdose- can reverse the effects of the opioid and, thereby, save the drug user. Even though many call it a life-saving drug, naloxone is more a life-prolonging drug as the vast majority return to drug use immediately upon being revived.

In contrast, people directly impacted by the crack cocaine crisis experienced an entirely different scenario. In this study, when I examined the articles appearing in the newspapers regarding crack cocaine, the underlying theme was *crime*. *Treatment*, *health crisis*, or *families* were not the most frequently used words. Instead, keywords were *violence*, *addict*, *police*, and *crime*, which appeared more often in the articles on crack cocaine alone.

People in neighborhoods impacted by the crack crisis saw their government intervention in the form of more law enforcement, mandatory minimum prison sentences, and little in the way of drug treatment. The politicians that represented them supported the call for the same penalties and increased law enforcement action; it was already too late, when they realized the merely continued the cycle in these poor neighborhoods of mass incarceration of young men, many of whom were fathers. In some way, the need to remove drugs and drug dealers from the primarily Black communities appeared more important than finding solutions to the economic issues that drove many to the drug culture.

During the past two decades, the United States has experienced the shrinking of its middle class. Fewer people are financially secure and less optimistic about their own and their children's future. Young people have accumulated more student loan debt than ever before, and the available jobs do not pay enough to cover loan payments and the cost of living on their own. As a result, many are forced to stay living at home with a parent or in a situation where they have two or more roommates to make ends meet. These concerns are coupled with the fear over healthcare costs; there is little wonder how stress can lead to problems with drugs, alcohol, and other addictions, such as gambling.

While acknowledging these socioeconomic indicators, before assuming that drug use is primarily based on SES more than anything else, this study then looked closer at previous drug crises and those affected at the time. The crack crisis took hold of poor minority communities with bleak prospects for jobs, healthcare, and even things taken for granted in more suburban areas like a robust public education. Once the cycle of incarceration began, children found themselves in fatherless homes as a result of drug use and mandatory prison sentences.

Although there may be similarities in the two drug crises, some questions remain unanswered. What, if any, effect has SES had on drug use among the failing middle class? Why, then, has the opioid crisis not had the same effect on the minority populations of the inner city? Job and wage growth have improved little, public schools are still failing, crime and gang activities are high, and yet these communities have lower prescription drug and opioid problems than their suburban counterparts.

The reason for this phenomenon can still appear largely attributed to SES. When the prescription opioid problem began, it did so in doctor's offices and hospitals. Joynt (2013) exemplifies the occurrence as follows:

Opioids were prescribed more frequently at visits from patients of the highest SES quartile compared to patients in the lowest quartile, including percent poverty, household income, and educational level. Conversely, black patients were prescribed opioids less frequently than white patients across all measures of SES. In adjusted models, black patients and patients from poorer areas were less likely to receive opioids after accounting for pain-level, age, injury-status, and other covariates. (p. 1604-1610).

However, while SES may explain the relationship to a decreased level of opioid abuse in the urban areas, drawing on race to explain the higher rates of rural opioid abuse is more challenging. While unemployment, poverty, and low educational levels are lower in these areas, so is quality medical care. Why were rates for prescription drug use much higher? One of the reasons appears to suggest that small rural-area communities had doctors who cared for the community at large; many of these doctors were less informed on the dangers of opioid prescribing and, as a result, of aggressive marketing by pharmaceutical companies, for which they soon began prescribing at alarming rates.

By the time the dangers began surfacing, and supplies began to dwindle, many people began traveling to states like Florida where pill mills were abundant. After visiting four or more clinics each day, the drugs received were then mailed home where they were sold within these small communities, as experienced numerous times throughout my previous career. The fact that many of these areas already had alarming rates of alcohol and methamphetamine abuse compounded the problem.

The media focused mainly on the prescription drug problem in these areas for a time and its relationship to large pharmaceutical companies. Methamphetamine was rarely mentioned during that period primarily because it was not a product of doctors or Big Pharma. The narrative had to remain on point and illicit drugs at this time -by all account- were not part of the equation.

Constructing the Narrative

How does the narrative or the framing of a drug crisis begin? What is at the forefront of the media hyperbole and inaccuracies that is often misleading information from government sources? For example, during the peak of the initial “prescription drug

crisis" during 2010, the information presented (such as that in the chart below) was and continues to be very misleading. State of New York's Annual Opioid Report (2017) indicates that deaths related to opioid pain relievers increased from 2010 to 2015. However, as evidenced in *Figure 8*, prescription drug use began to decline after 2010 and continues to do so today.

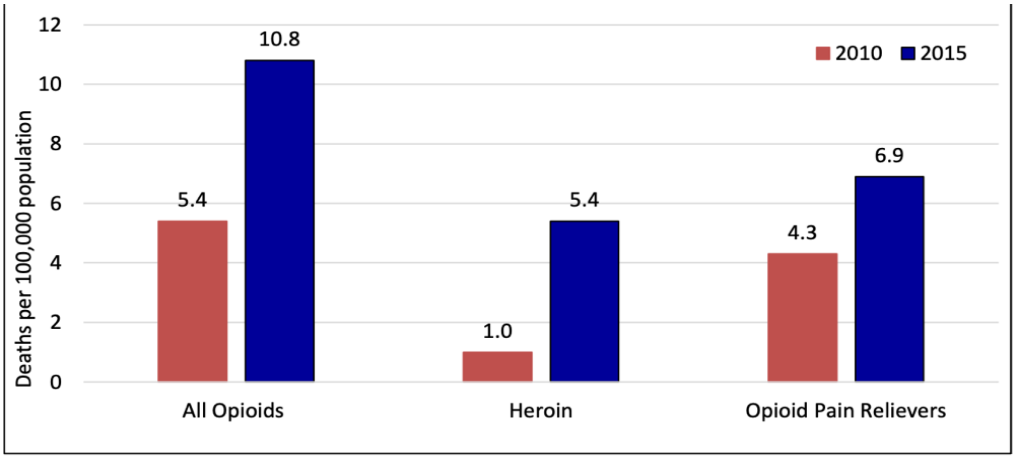

Figure 8. Overdose Death Statistics

Why, then, does the chart not indicate this decline? Baked into this number are the overdose deaths resulting from fentanyl, the clear majority of which is illegally made in and imported from China and Mexico; therefore, fentanyl has no pharmaceutical use when it arrives in the United States, and none of it contains the three fentanyl compounds approved for human use in the United States.

According to the CDC (2017), drug overdoses killed 63,632 Americans in 2016. Almost two-thirds of deaths (66%) involved a prescription or illicit opioids. The CDC further confirms through its analysis that drug overdose deaths are fueled by a dramatic increase in deaths involving synthetic opioids, specifically illicitly manufactured fentanyl (CDC, 2017). The same drug, fentanyl is also included in the 'all opioids' numbers. If the

fentanyl compounds illicitly manufactured are not approved for use in humans and have never been prescribed for said use, then CDC cannot include them in the statistical reports dealing with prescription drug overdoses and deaths.

Furthermore, the categories of heroin and opioid pain relievers are not entirely accurate as "Deaths in these categories are not mutually exclusive, since individuals may have multiple substances in their system at the time of an overdose, such as heroin and opioid pain relievers together" (NYS, 2017). In the chart below, data gathered by the CDC (2016) indicates the number of overdoses are far greater among heroin and illicit, synthetic opioid users. The rate of individuals who overdosed and died from fentanyl, cocaine, and heroin combined is five times greater than the combined death rate of oxycodone and hydrocodone. In other words, illicit opioids and cocaine far surpassed any prescription pain relievers.

	Unintentional (n = 54,793)			Suicide (n = 5,086)			Undetermined (n = 3,643)		
Rank[1]	Referent drug	Number of deaths[2]	Percent of deaths[3]	Referent drug	Number of deaths[2]	Percent of deaths[3]	Referent drug	Number of deaths[2]	Percent of deaths[3]
1	Fentanyl	16,981	31.0	Oxycodone	648	12.7	Fentanyl	1,185	32.5
2	Heroin	15,075	27.5	Diphenhydramine	576	11.3	Heroin	766	21.0
3	Cocaine	10,618	19.4	Hydrocodone	472	9.3	Morphine	619	17.0
4	Methamphetamine	6,448	11.8	Alprazolam	468	9.2	Cocaine	579	15.9
5	Alprazolam	5,510	10.1	Acetaminophen	343	6.7	Oxycodone	322	8.8
6	Oxycodone	5,225	9.5	Quetiapine	297	5.8	Methadone	264	7.2
7	Morphine	4,122	7.5	Morphine	268	5.3	Alprazolam	225	6.2
8	Methadone	3,110	5.7	Tramadol	266	5.2	Methamphetamine	195	5.4
9	Hydrocodone	2,556	4.7	Bupropion	264	5.2	Hydrocodone	169	4.6
10	Diazepam	1,723	3.1	Zolpidem	251	4.9	Diphenhydramine	152	4.2

[1]Ranks were not tested for statistical significance.
[2]Number of drug overdose deaths involving the referent drug.
[3]Percentage of drug overdose deaths involving the referent drug.

NOTES: Drug overdose deaths are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), and Y10–Y14 (undetermined). Only deaths with at least one specific drug identified are included in the analysis. The results for 110 deaths with an intent of homicide (X85) are not shown due to small numbers. Deaths may involve other drugs in addition to the referent drug (i.e., the one listed). Deaths involving more than one drug (e.g., a death involving both heroin and cocaine) are counted in both totals.

SOURCE: NCHS National Vital Statistics System, Mortality files linked with death certificate literal text, 2016.

Figure 9. Drug Type Overdose Deaths (Hedegaard, 2018)

Along with the many reported overdose deaths, World Health Organization's report (2018) does not include alcohol on the list of contributing factors or, at the very least, present in the system of those going to hospitals as a result of an overdose. In some

states, almost one-third of the deaths are caused by alcohol consumption or one other drug (OCHealth.com). In fact, when substance use and abuse is looked at in its entirety, the abuse of other substances such as alcohol appear to indicate a larger problem in the United States. The below indicated figure details it:

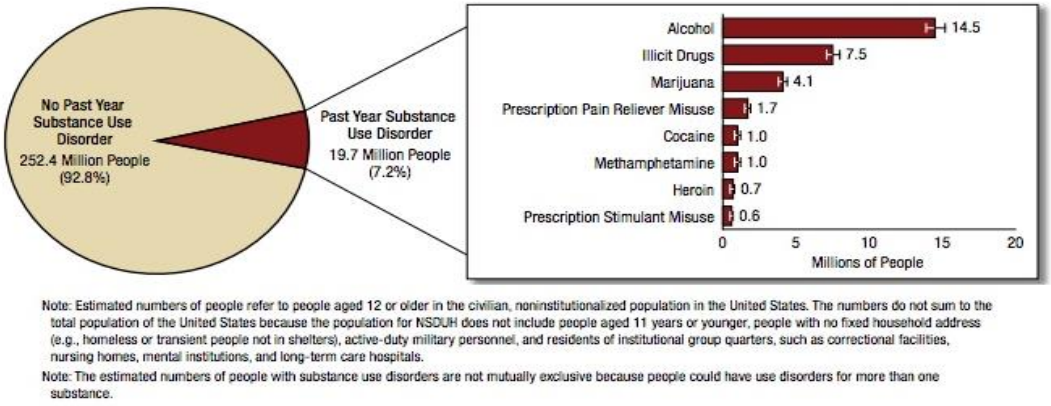

Figure 10. Individuals Over 12 Years Old Identified Substance Disorder in Past 12 Months (Ahrnsbrak, 2017)

As shown in the chart, alcohol abuse is almost 15 times greater than prescription drug misuse, illicit drugs, and marijuana.

The CDC reported that, of the 36,667 drug overdose deaths that mentioned at least one specific drug, 52 % involved only one single drug, 26% included two drugs, 12 % consisted of at least three different drugs, 6% contained at least four or more different drugs, and 4% mentioned five or more drugs in the body of the decedent (Warner, 2016). When the media reports on these figures, what was gleaned is not necessarily what is in, missing or possibly incorrect in the report, but rather the number of overdose deaths because of prescription opioids.

According to information retrieved from the many studies, it appears that many cases involved poly-substance abusers. Therefore, one might ask what percentage of

these cases involved benzodiazepines? It should be noted that benzodiazepines are not opioids, yet it is often a contributing factor that is omitted. One reason for such report omissions may be an example of contrast or perhaps an attempt to describe an object in terms of what is not (Fairhurst, 1996). In this instance, the report contrasts and compares 'apples and oranges,' particularly *all drugs* to describe this problem in terms that are not quite what they appear to be. These reports, like many of the news articles, repeatedly frame a problem or push a narrative that either fits a policy or creates concern or a moral panic, as in the case of drug crises.

Media reports and government statistics, such as those in the chart above, tell just the part of a story that fits the narrative that opioids are a plague; these incomplete portrayals worsen the problem and create the need for immediate action. Once the readers are bombarded with misleading and inaccurate stories, the moral panic is kept alive by outdoing the last worst-case scenario. Clear examples of this narrative are shown in the below presented stories that were written in one week:

- Earlier this week, two California men who operated a similar drug mill out of a Michigan condominium were sentenced to prison. In the summer of 2017, authorities seized 10 kilograms of pure fentanyl and 20 kilograms of heroin-laced fentanyl and more than a half million in cash. The seizure contained enough fentanyl to kill ten million people, Federal authorities said. (CNN, 2019)
- Inside a truck in Nebraska, troopers found enough fentanyl to kill millions of people. In a record-breaking drug bust in Nebraska, state troopers seized 118 pounds of fentanyl — containing enough lethal doses to kill tens of millions of people. (WTNH, 2019)

- A home in a quiet Westchester County, New York, neighborhood was hiding enough fentanyl to kill 2 million people, the U.S. Drug Enforcement Administration said. Federal agents found five kilograms (just over 11 pounds) of fentanyl and six kilograms (13.2 pounds) of heroin Friday when they raided a fentanyl mill operating out of a home in Ardsley, the DEA said. (FOX40, 2019)

Reading these stories, one might believe that fentanyl was going to kill everyone in sight, and that the entire country was at risk. However, according to the CDC (2018) there were 28,000 deaths involving synthetic opioids, including fentanyl last year, meaning not all deaths were fentanyl-related deaths. Furthermore, CDC estimates that there are roughly 948,000 people who have used heroin in the U.S. during the last year or 0.4% of the population. This indicates that such numbers mean little when used in this context, except for times when using contrast to sensationalize something by comparing it to figures that are not true or perhaps to instill fear in people.

According to the last U.S. census, the country's population is of approximately 325 million people. Approximately 339 million guns are in the hands of this population. Consequently, one can see that more guns exist in this country than people. Are we to assume that a civil war is going to break out or a shooting on every corner is going to occur at any time? The point is that, while there may be gun violence because of too many guns, there will also be drug overdose deaths because of too many drugs. However, it does not mean that everyone is at risk. People who use drugs are at risk of dying from a drug overdose just as quickly as those who use or travel amongst people, or criminals who use firearms are at risk of gun violence or death. Regardless, each day, the news media and law enforcement together try and beat their last, biggest drug seizure.

Not just Opioids

Although many people believe that the current crisis is the result of prescription drugs and the over-prescribing and marketing of these substances by doctors and pharmaceutical companies, the facts do not back up this claim. While it is true that some people started down this road to harder drugs through prescription drugs, far many more did not. Why, then, we omit referring to heroin overdoses, which are currently at record highs as opioid overdoses? Perhaps it is because educated middle and upper-class users and their families have not yet accepted the fact that they or their loved ones are addicted to heroin. Much in the same way, the media and society have stopped using the terms *junkie* and *addict*, referring to heroin as an opioid does several things (Ford, 2018). First, it leaves open the manner someone overdosed or died. Was it pills, heroin, or fentanyl? Maybe it was a combination of all or some of the drugs mentioned. Regardless, the media has softened the way they have covered these stories. In the clear majority of stories, *overdose* is most often preceded by the word *accidental* or *unintentional*, implying something or someone else was responsible for the overdose or death and not the ultimate user (Drugfree.org, 2017).

Whether through blame or the creation of new syndromes or diseases, the SES of drug abusers today limits responsibility from their addiction as they are not willing to accept it. It is much easier to blame a doctor or drug company than to admit personal or a family member's addiction.

Drug Addiction and Race

There is ample evidence that the majority of opioid users and opioid deaths are highest among Whites. However, the narrative in several of the stories reviewed in this

study implies that race is responsible for the differential treatment received by the White opioid users when compared to minority drug users. There is little doubt that those arrested for crack received much harsher sentences as a result of mandatory minimum sentences created through legislation. It is also true that the vast majority of the recipients of mandatory sentences were African-American males. Is it so simple to say, however, that those guilty of crimes or the laws related to crack were imprisoned solely along racial lines?

Race has always been a factor in drugs and drug abuse, and -while it continues today- the factors in which conflates race and drugs appears to be permeating within the population of drug users and abusers. For example, Basford (2003) carried out a needs assessment study among 47 Black and minority groups, regarding drug education, treatment and prevention; the most significant findings were as follows:

- Low levels of awareness and knowledge about drugs
- The impact of drug use on families (lack of knowledge about services confounds the problems)
- Deprivation, disadvantage, and discrimination increasing the risk of developing drug problems
- Community fears regarding crime and drug dealing
- Low levels of awareness and knowledge about available drug services are a fundamental barrier to accessing help and support

While considered common, especially among those socioeconomically disadvantaged, many more needs can be identified in the poorest areas with high drug use, regardless of race. However, while race may not predispose someone to drug use,

racism by a White majority could impact or deny the services and economic assistance needed to lift minorities from these socioeconomic situations that lead to drug use. Therefore, it is important to remember that this research, while pointing out that SES appears as a more significant cause of drug use, racism itself stagnates those in the communities most often plagued by drug use.

Does the narrative offer an explanation as to why or merely using the statistics to contrast the difference in the manner in which this crisis is addressed? Shihipar (2017) invites the readers to consider the following headlines: “The Gentrification of Addiction” read one headline in The Philadelphia Inquirer, “Why Is the Opioid Epidemic Overwhelmingly White” asked NPR? Teen Vogue followed with yet another headline titled “The Opioid Crisis Only Became a Crisis When It Affected White People” Such articles may serve to deepen racial divides but have little effect on reducing the drug crisis. Furthermore, Shihipar (2017) adds “Labeling the opioid crisis as “white” risks overlooking the substantial damage experienced by black, Latino, and Native American communities.” These statistics are best demonstrated in the chart below, which lists the 2017 opioid addicted population, by race.

Race and Hispanic origin**												
White, non-Hispanic	33,450	17.5	37,113	19.4	1.9***	10.9***	14,167	7.0	13,900	6.9	-0.1	-1.4
Black, non-Hispanic	4,374	10.3	5,513	12.9	2.6***	25.2***	1,392	3.3	1,508	3.5	0.2	6.1
Hispanic	3,440	6.1	3,932	6.8	0.7***	11.5***	1,133	2.1	1,211	2.2	0.1	4.8
American Indian/Alaska Native, non-Hispanic	369	13.9	408	15.7	1.8	12.9	173	6.5	187	7.2	0.7	10.8
Asian/Pacific Islander, non-Hispanic	323	1.5	348	1.6	0.1	6.7	131	0.7	130	0.6	-0.1	-14.3

Figure 11. Hedegaard, 2018 Opioid addicted population, by race

This is not a call to ignore the wrongs of the past. We should continue to scrutinize how attitudes toward drug users seem to change, depending on the racial identity of the people whose stories the media tells" (Shihipar, 2017). Still, many in the media and the government look to emphasize the "whiteness."

White Mortality

While an epidemic of prescription opioid abuse has swept across the United States, African-Americans and Hispanics have been affected at much lower rates than Whites. Does this mean that Whites are given preferential treatment when it comes to drug abuse and drug crimes merely because of race? In a 2016 letter to the editor in the New York Times Helena Hansen and Julie Netherland (2016) stated:

> Our research demonstrates the development of a two-tier system of drug policy and clinical practice built on racial stereotypes about who is predisposed to abuse opioids that gave whites the dubious "privilege" of unparalleled access to opioids and that ultimately led to higher death rates. This system operates through surreptitious ethnic marketing of opioid painkillers (to whites) and of white racial exceptionalism in drug law enforcement, in the regulation of clinical practice and in addiction treatment. (para.1)

What privilege is afforded to those living in poverty in rural areas of Kentucky, West Virginia, and Ohio? While one might argue there are undoubtedly racial disparities in both treatment and enforcement, is race the underlying determinant? In the same article, an anonymous reply to the editorial board of the New York Times stated the following:

These are the people who used to have good factory jobs with on-the-job training. These are the people who could build good lives for themselves and for their kids. And all of that has gone away. The factory's in Cambodia, the factory's in Vietnam, the factory's in China, wherever. (para. 3)

Both responses seem to imply that SES plays a more significant role than race. Furthermore, many non-college-educated seem to be comparing themselves to a generation that had far more opportunities than they have. Conversely, many blacks and Hispanics are comparing themselves to a generation that had fewer opportunities. While the race of the user is different, are there situations not the same? Furthermore, for decades, advocates for prison and drug law reform claimed that economic conditions and poverty forced many inner-city minorities into drug use and crime.

Shird (2017) stated the following on crime in Baltimore, "When you need to pay rent, or feed your family, or just find something to eat yourself, and there is nowhere else to turn, the poor turn to crime, and that usually means selling drugs" (para. 9). In a city that, according to the last census, had a poverty rate of 24% and was 63% Black, it would not be plausible to imply that the drug violence and enforcement of drug crimes were motivated only by race, being that the majority of the residents are also a majority of the racial makeup of the city.

Methamphetamine

During the period of the crack crisis was the crack crisis (1985–1994) another drug crisis was developing. During the early 90s, the emergence of methamphetamine was increasing in all parts of the United. States. However, this drug crisis lacked much of the coverage that the crack crisis received. There were few documentaries and

Hollywood movies based upon it, and -despite the fact- each year an increasing number of people died and continue to do so as a result of this drug.

In an article published by *The Christian Science Monitor* (1989), the drug was described as a chilling glimpse into the future of drugs in America, and substance-abuse experts recommend taking a look at the "ice" crisis in Hawaii. *Ice* or methamphetamine began its rise and quickly spread throughout the United State, most notably rural America. In many of these areas, unemployment was high, education levels low, and average family incomes at or below the poverty line. Despite the health problems, crime associated with its use, the destruction of families, and entire communities, many people outside knew little about methamphetamine.

While prescription drug use exploded in many of these same areas during the same period, there were no doctors or pharmaceutical companies to blame for the explosion in meth use. Methamphetamine use was also less predominant in middle and upper-class areas throughout the United States, making it less of a media-covered event. In 2011 the NDIC stated the following, "NDIC assesses with medium confidence that methamphetamine production by Caucasian operators of small-capacity laboratories will rise as they increase their use of organized pseudoephedrine smurfing rings to obtain the necessary precursor chemicals to produce the drug" (p.4).

Still, despite this and other warnings, the use, manufacturing, and smuggling of methamphetamine are now at record highs. What this research found most interesting was that, when newspaper coverage of methamphetamine was examined, the emerging themes were most often *illegal immigration* and *smuggling drug cartels in Mexico*. The

calls for treatment or increased awareness for methamphetamine use pales in comparison to that of opioid use.

In an analysis of factors like education, income, homeless status, and living with a spouse, it was shown that methamphetamine users were slightly less educated, significantly more likely than other drug users to have problems with a primary support group, and both had occupational and economic struggles. More significant is that "non-Hispanic Whites were approximately twenty times more likely than African-Americans to use methamphetamine, and approximately three times more likely than Hispanics and other ethnic groups" (Korte, 2010).

The findings are significant because of the following reasons: first, it dispels the belief that White drug use rarely results in jail or prison (Reiman, 2015); second, the majority of those incarcerated for meth use or possession are in fact White and not African-American nor Hispanic. One should note that more than a quarter of federal inmates incarcerated for drugs have been convicted of crimes related to methamphetamine (BOP, 2018), but more importantly, they are not included in the overall narrative as it relates to the current drug problem. These statistics are somewhat troublesome, especially since the production and use of methamphetamine worldwide has been increasing at alarming rates. For example, not only has the production amongst Mexican and Central American drug cartels increased, but also the same stays true in other parts of the world, such as Southeast Asia.

In a report released by the United Nations Office on Drugs and Crime, the agency said, "methamphetamine has become the main drug of concern in 12 out of 13 East and Southeast Asian countries, up from five a decade ago" (Bloomberg, 2019, para. 3). It is

not just the increased manufacturing and use of methamphetamine which was examined during this study. As with crack and opioids, the manner the media covers stories on methamphetamine differs significantly. The coverage of meth use is similar to the way crack use was portrayed as something only the poor minorities in urban ghettos engaged in.

Until recently, news reports covered the arrests of individuals charged with possession and sale of smaller amounts of meth. Photos of those arrested often accompany these stories. Those familiar with someone addicted to meth are familiar with the scarred faces, rotted teeth, and gaunt look. Compare that with those arrested for prescription drug or other opioid use. Photos rarely accompany opioid and prescription drug users as hard-core drug users but rather one who looks as if they are merely an average person somehow caught up in a drug arrest. While one could make the argument that those addicted to drugs are all the same, in fact, not all of them are framed the same way in the media.

As mentioned early, the media eulogizes celebrities dying of the "accidental overdose," providing that overdose is from opioids. Nonetheless, when a celebrity dies of methamphetamine abuse or an overdose, the news coverage is not as sympathetic; in fact, it is often disparaging and at times homophobic. Let's consider *Rolling Stone*'s narrative (2017) on opioid overdose death of celebrity musician Tom Petty, "He suffered cardiac arrest at his home in Malibu in the early hours of this morning and was taken to UCLA Medical Center but could not be revived. He died peacefully at 8:40 p.m. P.T. surrounded by family, his bandmates and friends" (para 2.). Now, consider the coverage of the news anchor from one of the largest local news outlets in the country, KTLA in Los Angeles,

on the death of Chris Burrous. *The Los Angeles Times* (2019) article read, in part, the following:

KTLA News anchor Chris Burrous, who was found unresponsive in a Glendale motel room in December, died from methamphetamine toxicity, the Los Angeles County coroner's office said Friday. The coroner's investigative report said Burrous was taking methamphetamine during a sexual encounter at the motel, including inserting the drug into his rectum. The other person in the motel room, a man the coroner said Burrous met on a dating site, performed CPR on him before paramedics arrived, the report said. (para 1.)

The L.A. Times article appears less sympathetic and, in fact, seems to go out of its way to paint the reporter disparagingly. Was he different than Tom Petty because of the drug he used or because he was gay? Why should that have been part of the narrative? As previously stated, the research in this article demonstrates that meth use is covered unfavorably because of its higher use among marginalized communities. Would Mr. Burrous have been eulogized if he died at home with his wife or girlfriend and the drug was OxyContin?

Furthermore, this appears to be a classic example of framing theory as described by Entman (1991) whereby the "media coverage can often moralize, sometimes due to the indiscretions of political actors" (p.). This coverage differs significantly from the "Human Interest/Personalization whereas in the case of opioids the media often presents "a story with a human face, personality is promoted over more important aspects" (Entman, 1991, p.).

While opioid use has been claimed to be a predominately White middle-class drug problem, drugs such as methamphetamine and crack have been the drugs of the poor, minority, and marginalized population for quite some time. This view has led some to incline more toward this belief than toward race:

[…] the so-called unbreakable cycle of addiction appears to result from inequity – from poverty, from discrimination, from social and economic oppression. Without opening the doors of opportunity, without access to the roles that social, economic and political capital provides, oppressed groups might find it more challenging to cease their drug use, whether they receive formal treatment in a program or not. (McKenna, 2016, p. 6-27).

According to the 2017 National Drug Threat Assessment (NDTS), 29.8% of responding agencies reported that methamphetamine was the most significant drug threat in their areas. Thirty percent of NDTS respondents nationwide reported methamphetamine as the drug that takes up the most law enforcement resources, second only to heroin with 36% of the responses. Why, then, does the media focus predominantly on opioids and the demand for more treatment?

In furtherance of the evidentiary impact of SES on the opioid problem, *Chicago Tribune* cited a study (2017) conducted by Princeton University economist Alan Krueger who found that:

Evidence presented here suggests that much of the regional variation in opioid prescription rates across the U.S. is due to differences in medical practices, rather than varying health conditions that generate pain. Furthermore, labor force participation is lower and fell more in the 2000s in areas of the U.S. that have a higher volume of opioid

medication prescribed per capita than in other areas. Regardless of the direction of causality, the opioid crisis and depressed labor force participation are now intertwined in many parts of the U.S. (p.23)

This phenomenon, however, can be traced back to Emil Durkheim's (1897/1951) study of suicide where he concluded, "To pursue a goal which is by definition unattainable, is to condemn oneself to a state of perpetual unhappiness" (p. 66). Therefore, a weakened middle class during the last part of the 20th and the first part of this 21st century may be responsible not only for the increased drug use, but also the mass increase in both drug-related and overall suicide rates in the United States.

A study by Way et al. (1994) found that "using both qualitative and quantitative data, that high SES youth (but not their inner-city counterparts) often used substances in efforts to alleviate emotional distress" (p. 332). Similarly, Feldman et al. (1995) detected associations, as did we, between "boys' high peer status and their vulnerability to substance use" (Luthar, 2004). These stressors can be attributed to college, jobs, and deteriorating family economic conditions.

According to Dreier (1982), the media has two roles. The first role is to seek profit for their company, advertisers, and suppliers. The second role is to shape public opinion on critical issues and introduce individuals to social roles and behaviors. Evidence exists showing the moral panic created by the media regarding the opioid crisis is primarily based on hyperbole and distorted figures, however, the false narrative that the opioid crisis as a White drug problem may be partially responsible for positive changes in the disastrous drug war.

When comparing the “whiteness” of opioids (W) and “crack and minorities” (CM), the presences of the themes appear to almost even, at least in the number of appearances. However, upon closer examination, the articles mentioning race, minorities, or African Americans in the articles on crack cocaine most often did so in a disparaging way while at the same time subtlety implying that Whites were as likely to use crack cocaine. The reason appears to be that most of the crack was sold in poor inner-city neighborhoods by African-American males who made the dealing of crack appear far more important than those who used it. This does not appear to be at odds with the opioid crisis.

While many of the drugs are now purchased on the street or the Internet, the media still (in an overwhelming number of articles reviewed) casts blame on doctors, pharmaceutical companies and governmental agencies rather than focus on the users themselves. While many currently addicted to heroin began their path to addiction through prescription opiates, the number pales in comparison to those who did not. As demonstrated earlier, perhaps what stirs the masses most and the root of the moral panic itself comes from the inaccurate figures. Dr. Andrew Kolodny, a psychiatrist and executive director of Physicians for Responsible Opioid Prescribing (PROP) stated the following in a recent editorial, “Drug overdose deaths, once rare, are now the leading cause of accidental death in the U.S., surpassing peak annual deaths caused by motor vehicle accidents, guns, and HIV infection” (Kolodny, 2019, p.1).

Even though no one can argue the fact that overdose deaths have and continue to have a significant impact on the current society, statements like this are not entirely accurate but, regardless, seem to frame the narrative in a “worst-case scenario.” While

over 60,000 people die of drug overdoses every year, they are not all opioid-related. However, despite that, this statistic is often mentioned in stories relating to opioid overdoses, creating an impression that perhaps data may be true. However, a large number of these deaths are a result of maintenance drugs, such as antidepressants, aspirin, and other drugs such as cocaine.

According to the National Institute of Health (NIH), in 2018 the total number of deaths from all opioids was about 30,000, and of that number 17,000 were attributed to prescription opioids. Furthermore, nearly half of the 15,000 that died of drug overdoses related to prescription opioids also had benzodiazepines in their system. This statistic could be an indicator as to why the media and government alike prefer to use the softer term *opioids* rather than using statistics from prescription opioids, heroin, and fentanyl. The truth is that more people are not dying of opioids each year but are dying of illegally manufactured and imported fentanyl. The fact that fentanyl may be mixed with heroin or disguised as counterfeit hydrocodone, oxycodone, or Xanax does not or should it be part of this hyperbolized opioid crisis.

As misguided as some of these articles appear to be, has anything positive resulted from the hyperbole on opioids? If one looks at the recent sentencing reform laws, one might say that the government finally saw the disparity in incarceration rates for drug crimes handed out during the crack crisis. Unless the government was now willing to incarcerate far more individuals on drug crimes related to opioids, change is needed to be made. As a result of some of the new changes, many non-violent inmates convicted of drug crimes under arcane mandatory drugs sentencing laws of the ’80s and ’90s had their sentences commuted and are beginning to be released.

At the onset of the opioid crisis, states operated independently when it came to drug prescribing and dispensing laws. On one hand, states like New York had strict regulations regarding the prescribing and dispensing of opioid narcotics that far exceeded those mandated by the federal government. Strict compliance and monitoring prevented the flood of OxyContin and fentanyl in the form of lozenges such as Actiq and Duragesic (transdermal patches), which were becoming widely abused elsewhere in the country. On the other hand, states such as Florida were ground zero for prescription drug abuse primarily because of their loose and largely unenforced regulations. Pill mills and pain clinics were abundant in South and Central Florida, and people were traveling from all over the country to take advantage of weak regulations and doctors engaging in criminal activity. When the DEA and the FDA stepped in and began to tighten regulations, these rogue clinics started shutting down or were indicted and the owners and doctors sent to prison. As a result, regulations on not only prescribing and dispensing but also manufacturing and distribution were tightened, forcing states to adhere to more strict laws and regulations. States were now required to have prescription drug monitoring programs (PDMPs), which mandated reporting of suspicious orders and other activity. However, while these PDMPs are now in every state, there is no mandated model and, as a result, some are far weaker than others; thus, PDMPs appear only to be present in name and not for true monitoring or enforcement purposes.

Direct to Consumer Advertising

By 2010, the changes and regulations regarding the sale and dispensing of prescription opioids had some positive effect by reducing prescription drug abuse; however, there was still more that could have been done. As a society, consumers should

be aware of the dangers of prescription drugs of all types, but pharmaceutical companies should not market them in manners that allow patients to demand certain types of drugs based upon direct to consumer advertising.

This often-deceptive style of marketing frequently paints a glowing view of the product and its benefits while the last 10 seconds of the commercial lists in rapid succession all possible hazards to taking the drug. Asking a doctor to prescribe a specific medication based upon a sixty-second television spot, in some ways, makes the patient the prescriber, from which little good can come and may create a comfort level that enables treatment seekers to ask for another drug of choice. While narcotic pain medications were never marketed directly to the consumer, marketing any medication requiring a doctor's prescription directly to the consumer should be of high safety concern.

This is important because, as previously stated, pharmaceutical companies are being sued by dozens of states for misleading doctors who prescribed prescription pain pills, which led to addiction. While these drugs have not been proven to cause addiction or any of the effects of opioids is this not merely shifting the marketing tactics from doctors to consumers?

Many drugs are taken off the market years after their introduction as a result of adverse effects, which are not learned or realized until they are felt by the patient. However, despite the absence of the drug on the market, newspapers, television stations, and radio channels are now filled with ads from attorneys and attorney referral agencies, offering to sue a pharmaceutical company if the individual had a problem with a particular drug or medical device. While consumers should have the right to know about

products prescribed to them, the delicate balance between the doctor and patient relationship could, as a result, become fragile.

Online Drug Sales

During the onset of the prescription opioid problem, hundreds of thousands of pills were obtained through Internet sources and phony consultations with rogue or fraudulent physicians under the semi-legitimate guise of "telemedicine." Prescription opioids, benzodiazepines, and anabolic steroids were widely available to anyone with a computer and Internet access. As a result, the government began to work with Internet Service Providers (ISPs) to curb online sales of prescription drugs, but -while significantly reduced- these sales remain a problem today and are now common on the unregulated 'dark web.'

To demonstrate the severity of the problem, Popper (2019) points to the extensive online market, "On Empire, one of the largest markets still online, people could have their pick of more than 26,000 drug and chemical listings, including over 2,000 opioids, shipped right to their mailbox" (para. 8). With resources stretched and the difficulty policing the Internet, never mind that of the dark web, the availability of illicit drugs and the precursors online will continue. To make things more worrisome, adolescents will continue the road to addiction as they can still purchase prescription drugs online with a major credit 'gift card' from any big-box retainer.

Chapter 5: Discussion, Implication and Conclusion of the Study

Introduction

This research examined how the current opioid crisis has been reframed from what was once considered criminal activity to that of a public health crisis, disease, or mental disorder. In large part, this reframing was accomplished through the role of the media and the political establishment in the United States. The research examined this phenomenon through the social conflict theory, framing theory, exemplification theory, and qualitative analysis to explore the role of SES in this transformation. The findings in Chapter 4 revealed that the media coverage has created the narrative that current opioid drug crisis has been primarily fueled by doctors and pharmaceutical companies and is viewed as a "white drug problem" the research shows that this is untrue. While SES and race are often intertwined, this research indicated that SES is a determining factor in drug epidemics and drug use as it has similarly been in the past.

Discussion

The themes for this research study were chosen before the data collection began and were drawn mostly from what was uncovered in my literature review. These nine themes appeared extensively throughout the data analysis, as did several others. The additional themes were as follows:

- Brain Disease Model of Addiction (BDM)
- Oxytots (O)
- Substance Abuse Disorder (SUD)
- Medication Assisted Treatment (MAT)

These themes are equally important, for they have evolved since the beginning of the opioid crisis, and -as the crisis continues- the media undertakes new efforts to portray the opioid crisis in a far different light than those in the past. New themes, demands, and proposed solutions occur regularly, yet the crisis still grows.

After viewing the incarceration rates for crack cocaine during the ’80s and 90s, it becomes clear that a disproportionate number of African-Americans were incarcerated for crimes related to crack. Crack was found in poor urban areas with high unemployment rates and within states ranking near the bottom of those on the social capital index, meaning fewer two-parent families, community involvement, as well as job and educational opportunities. The same can be held for areas hard hit by the opioid crisis; the difference is that in these areas, we see rural, poor Whites with very similar rankings on the social capital index.

Race or SES

These similarities point to SES as being the most critical or a more consistent indicator than race (Shaw, 2007; Humensky, 2010; Patrick, 2012). However, while this research does demonstrate the importance of SES on the overall patterns in drug use and abuse, it appears to have less of an impact on the overall reason for the change in the media narrative and the government’s approach to the opioid crisis. To the contrary, my research indicates that demand for money and resources for more treatment is not coming in response to the addiction rates in the underserved areas but rather from a more middle and upper-middle-class section of opioid users. For example, Leventhal (2003) argues that “neighborhood-level theories suggest that youth are particularly vulnerable to the effects of living in poor neighborhoods” (p. 309). One such effect is alcohol and drug

abuse. It is within these neighborhoods, which have been long associated with African-Americans communities, that one can see little social or economic resources. More importantly, these communities lacked the political or economic power to push for the needed social changes and, as a result, were "disproportionately represented in segregated and disadvantaged communities and are more likely than non-African American families to live in communities fraught with crime and violence" (Brenner, 2011, p.652).

While I do not imply that racial disparities do not exist, the opioid crisis has demonstrated that in some situations, when deprived of those same disadvantages, the residents did not appear better off than those in African-American communities. This research found that the opioid crisis did not differentiate based on SES but because certain drugs were made more available to those with means.

SES and drug use is not a new phenomenon but instead ignored more often because of its inability to fit both the media and society's narrative. In an article published in *The New York Times* in 1992 titled "White Poor, Black Poor," the author made a profound correlation by stating:

The problem of the black working poor is simple, and it is identical to that of the growing white poor: they do not earn enough and their low wages are declining as a result of structural economic changes and the heartless policies of the 80's that substantially widened income inequality. African Americans have been disproportionately hurt by these changes and as a result the racial differentiation in income has grown. It is a distortion, however, to neglect the convergence of this group with the white poor. (Patterson, 1992, para. 5).

Perhaps most important in this article is the assertion that the only way to overcome the issues that plague this underclass is to "demand that our frivolously distracted leaders, black and white, stop playing self-serving games of racial blame, denial and division, and address this national tragedy at once" (Patterson 1992, para. 19).

As a result, the White rural drug users from disadvantaged, poor communities have gained those with means who, in record numbers, have also been affected to advocate for treatment and solutions. Therefore, While race can and is a factor in drug use and abuse; this research indicates that, when non-African Americans are placed in similar poor disadvantaged communities with similar risk patterns, SES appears to be more important than race alone.

While the opioid crisis consumes a great deal of media time, the coverage is less when covering the marginalized population and the problems they face with drugs and addiction. Images and reporting on the opioid crisis often portray the devastation to families with addiction and overdose deaths, making what appears to be an unfair assumption that they are the only group impacted by the crisis. The media covers overdose deaths of the famous and the affluent with fervor even though they represent a small part of the victims of the current crisis.

The same is true with methamphetamine. The coverage on this drug crisis, although increasing, still lags far behind the opioid crisis. Again, meth users are often poor, from rural areas or other marginalized groups, such as the LGBT community. Another reason for this appears to be that, unlike opioids, there are currently no drugs used to treat the addiction or reverse the effects of an overdose for methamphetamine. Therefore, the media is limited as to the demands they can make, how their use is framed,

and the fact that their audience is much smaller when among national publications when disclosing crises in these communities.

Many within these groups are also of a lower SES and would appear not to fit the narrative within the media when it comes to the opioid crisis (Reeves, 2016). When the media covered the crack cocaine crisis, the emphasis was weighted heavily on the violence associated with it rather than the lives of those affected by the drug. The same relationship seems to be true with lower SES groups with methamphetamine. Amongst the articles reviewed in this study, coverage leaned toward the illegal drug trade, arrests, and Mexican cartels. Recently, while some in the media covered the methamphetamine issue to promote immigration reform, border walls, and a new war on drugs, others -in their fight against the opposition- used the methamphetamine crisis to point out that the drug comes in through other manners.

Meanwhile, those caught in the political turmoil are seeing their neighborhoods destroyed, crime rising, and the deaths of many of their family members, similar to what occurred during the crack crisis. More importantly, what makes the argument of SES and drug abuse stronger is the fact that, while many parallels can be seen between crack and methamphetamine, the distinct difference is race. Although the majority of crack and its users were African-Americans (Palamar, 2015), the majority of those abusing methamphetamine are the poor Whites (NIDA, 2017).

This research should not imply that the government has completely abandoned its war on drugs. To the contrary, those efforts to combat the illegal importation and distribution of fentanyl and methamphetamine continue, albeit without much of the previous coverage from the media. However, these efforts appear to be more on an

international and borders level than on the domestic front. More to the point, during the early months of the Trump presidency, Attorney General Jeff Sessions and President called for the death penalty for drug dealers (Johnson, 2018). This rhetoric was tamped down, and the call for treatment and interdiction once again became the preferred method of dealing with the drug problem.

The public has also witnessed states prosecuting street-level drug dealers for homicide or manslaughter because of selling the drug that an individual overdosed and died as a result of its consumption. While not addressed in this research, this on its face appears to be a slippery slope and takes any responsibility away from the abuser and merely shifts the blame.

Conclusion

While the current drug crisis is genuine, for it has taken numerous lives and has become an economic burden on society (Munro, 2015), this study reveals a more complex problem than is portrayed in the media and, at times, by government officials. The media has and continues to fuel the current moral panic with misinformation and occasionally total untruths regarding the opioid crisis. As a result, blame and responsibility have been shifted more to pharmaceutical companies, doctors, pharmacies, and regulators, while the actions of the individuals who use and abuse drugs and the demand for opioids are often ignored. Not only has the narrative helped prevent any progress in harm reduction as a result of this crisis, but it has also created tunnel vision toward the crisis.

As a result, methamphetamine abuse has been skyrocketing, benzodiazepine use is at a crisis level and becoming all too common in parts of the country where marijuana

legalization has occurred. The information is corroborated in recent study conducted by McFarlane (2019) who provides specific data on marijuana addiction, “Epidemiological surveys indicate that 8 to 9 percent of adults and 17 percent of teenagers who try marijuana become addicted and that the number of Americans who are now dependent on the drug is approximately 2.7 million, according to recent estimates” (p. 9).

The current rates for addiction by all indications will continue to rise. As old drugs leave, new drugs take their place. Playing a game of whack-a-mole is not a strategy to fight addiction and merely shifts the drug problem as witnessed by the rise in methamphetamine, benzodiazepines, and now, marijuana. With marijuana, the media has once again engaged in a narrative that does not tell the entire truth and instead provided the audience with a picture of a harmless drug, which could allegedly help people with addiction to other substances. However, the media rarely covers that hospital emergency room are on pace with the number of auto accidents reported due to marijuana-related incidents, which in turn cause loss of worktime, as well as a myriad of other social and economic problems. Part of this reason might be that much of the marijuana debate has been a political one with many conservatives and moderates arguing against its legalization while the left and more progressives making a case for the legalization. Regardless of where one stands in the argument, the media would better serve its audience by presenting the facts rather than supporting one side of the political spectrum. At the very least, the dangers or risks should receive equal coverage.

To be clear, the news media did not create addiction or the problems associated with it. However, their role in framing the problem is significant. While there may be varying opinions why this occurs, Lengauer (2012) argues that “conflict-centered

negativity is more ‘marketable’ than positive news as it is more eye-catching, adds drama, stimulates interest, and is easy to understand even by uninformed audiences” (p. 4). Thus, what cost does this stimulation have on society, especially the genuinely uninformed? The news media’s role should be to report the news in a fair and even-handed manner. Hyperbolized and politicized speech should be avoided when dealing with the health, safety, and welfare of citizens if they are to understand the significance of topics, such as a drug crisis. Reporting on the real causes of the opioid crisis and avoiding racial overtones merely to speed up a base or increase viewership only widens the racial divide of the country and does little if anything for those impacted by drug abuse.

SES has been long attributed to a plethora of social ills, and addiction to substances is just one of them. Szalavitz (2016) confirms that “The final major risk factor for addiction is economic insecurity and poverty, particularly unemployment and the hopelessness, social marginalization and lack of structure that often accompany it” (p. 12). Additionally, heroin addiction rates are 3.4 times higher among those making less than $20,000 a year than among those earning $50,000 or more (Szalavitz, 2016). The current opioid crisis, as well as the overdose deaths accompanying it, is not a “White” drug crisis nor merely a middle-class crisis. However, the research does support the theory that SES, the corresponding financial pressures on families, coupled with decades of slow economic growth, have contributed to the problem.

Despite the role of the media, SES as well as other factors affected by any crisis often turn to their leaders and government officials for help. Unfortunately, when

speaking about the opioid problem in the United States, many government officials are conflicted when dealing with the same pharmaceutical companies they condemn.

While not a part of this research, I would be remiss if not mentioning the role of government in the current drug crisis. In a recent study by opensecrets.org (2019), the average donation to a member of Congress was $49,400, while the average donation to senators was $67,922. Is their allegiance split or does it lean to one side or another? Regardless, it is disingenuous seeing politicians making speeches on the dangers of prescription drugs while at the same time taking money from the companies manufacturing these products without full disclosure.

The government's involvement in the drug crisis is not limited to pharmaceutical companies. While many politicians in the current immigration debate are quick to point out that the southern border is ground zero for smuggled heroin, methamphetamine, and fentanyl, several key facts are omitted. First, although it may be true that much of the heroin making its way to the United States comes via Mexico, the world's poppy supply (from which heroin is made) comes from Afghanistan.

It is estimated that 85% of the worlds illegal opium comes from the Afghanistan region (Hennigan, 2019). As long as heroin use is on the rise and the U.S continues to lose ground forces fighting terrorists in the region, the program to eradicate these poppy fields will come to an ended with the full knowledge that the production of opium from the Afghan poppies has been at record levels during the past two years. However, the media has rarely covered this activity and, instead, focuses on the heroin coming across the U.S. border with Mexico. Government officials as well are quick to blame the influx of illegal drugs on the border, yet they rarely speak of the source, Afghanistan.

Additionally, they seem to neglect to speak about the quantities coming directly through mail from suppliers on the dark web. While fentanyl deaths continue to rise to the level of heroin, the media and U.S. governmental officials focus on blaming the porous southern border where the lack of various resources and technology is responsible for the rise. However, because of the small amount needed when used, its ease of distribution can be attributed not only to the border, but also its effortless shipping from China to either Canada or Mexico, the use of dark web Internet drug markets, or its direct mailing from China to the purchaser's home.

In a country with the best medicine and medical minds in the world, it is hard to believe that the American society is capable of focusing only on one problem at a time. While it appears that opioid coverage could have its own 24-hour network, the next drug crises are lined up like jet planes on a tarmac with no plan on how to address them. If we continue to ignore them, Americans in particular are destined to merely move from crisis to crisis, destroying more lives and having a significant impact on our economy and society.

Implication of This Study

This study demonstrates media's impact on framing a crisis and the way people perceive its severity. The study also offers another explanation as to the importance of SES in drug abuse and other societal addictions. This research brings up a concern as to the power of the media to frame almost anything in such a way that people will get behind the narrative, should it be true or not. In this research, the media has used the recent drug crisis, in some ways, to protect the SES of the new class of drug users while at the same time generating income through its often-misleading narrative.

When framing *drug use*, *crime*, and *punishment* in racial terms, it is easier to have people fall in line with the narrative. After all, incarceration statistics need only to be stated and emphasized. However, explaining the role of socio-economic status as it relates to drug use and the correlating incarceration rates requires a massive lift, which is not as easy for many people to understand. In some ways, keeping the narrative continuous and straightforward is more comfortable than trying to tell the truth.

The same is true with the statistics used to define the crisis. One would only have to read four different papers or visit four different websites to retrieve eight different sets of statistics on the same crisis. In an age where information is available in so many forms, whether through newspapers or social media, it is essential to assure the accuracy of information and avoid fueling a crisis or problem with hyperbole and rhetoric just for the purpose to boost ratings. In order to address this and any crisis, people need not only to understand the problem but also to know the truth.

Future Research

While many continue to call for more treatment, research needs to be conducted to gauge the viability of pouring unlimited funds into an area with little empirical evidence of success. People respond to treatment in many different ways, and as such treatment cannot be a one-size-fits-all panacea to drug addiction (Fuhr, 2017). Current data from the National Institute on Drug Abuse (NIDA) has shown that relapse rates for those receiving addiction treatment are between 40% and 60%. However, some will argue that actual figures are unknown because the only way to gauge relapse is by returning to rehab. Still, many of these users return to drug use and not to rehab, and

therefore, the actual number may be unknown. Numerous studies rely heavily on self-reporting, emergency room mentions, and rehab admissions.

Despite the softening of how society is beginning to view drug users, the stigma that the user experiences has not changed as quickly, for which many are still reluctant to receive treatment or discuss their problem. Some experts believe the fear of losing careers, family, and their overall social status weighs heavily on these decisions. It should also be pointed out that many figures compiled by organizations like the NIDA, equate drug addiction to the disease model and compare it to diabetes and hypertension when developing their statistics on relapse rates.

One of the most significant drawbacks with the continuing influx of money into treatment programs is that the industry is mostly unregulated nationwide, for which it has become an area ripe for organized crime and for those looking to capitalize on a pool of free money while offering little if any drug treatment. The rise in this activity can be seen in Florida and on the West Coast where “luxury” rehabs spend millions on advertising lure to attract desperate individuals and families, looking for their last hope. Unfortunately, few find any success and often end up back into drugs when running out of money (Munro, 2017).

Recently, states and the federal government have been pouring hundreds of millions of dollars in drug treatment programs and have done so mainly on the demands of their constituencies, despite the evidence of any success rates. Consequently, would a national standard for rehab centers and tighter regulatory controls reign in those in the business to take advantage, or would it keep others from entering the business?

Others believe that the success of drug courts could be transferred over and applied in the same way as it has in the illicit drug problems of the past two decades. However, while successful, drug courts are mandated and, in most cases, are viewed as an alternative to jail or prison. Therefore, if the trend of treating addiction as a health problem rather than a criminal justice issue continues, how would one mandate drug court as a viable alternative? On the one hand, society appears to want the stigma associated with addiction and drug abuse lessened and incarceration removed as an alternative but seeks to have rehabilitation voluntary. Some experts doubt this approach could work, and perhaps this establishes an area of future research whereby some medium between the two sides could be found to mandate treatment.

Drug use is a trade that is contingent on supply and demand. As long as America has an insatiable appetite and demand for drugs, there will always be suppliers to meet consumers' needs. To truly combat addiction, we must decrease the number of users. While there are many reasons for this nation's appetite for drugs, one fact in the early years of the opioid crisis is that the United State consumed 75% of the world's prescription drugs according to the UNODC (2011). This high rate can be attributed to several factors, many of which are related to SES.

For example, Americans have more money to pay for drugs than do those in other countries. Those with a good job have private insurance that, up until recently, seemed to pay for mostly any drug prescribed by their physician. Individuals without means or private insurance still had government programs, such as Medicaid and Medicare that pays for most if not all medical care and prescription drugs. These government programs were not and, in many cases, are still not sufficiently regulating prescribers, for which

they have also contributed to the problem. Regardless, the group caught in between those with the means and those without the benefit of government programs are those who were affected then and again now, especially when it comes to the availability of drug treatment programs.

Conflict Resolution as a Tool for Drug Abuse Treatment

Nowadays, researchers believe that the key to discontinuing and remaining drug free would by teaching conflict resolution skills to addicted people, “Problems that arise when people begin to abuse substances to cope with the severe stress of emergency situations include the depletion of finite family and community resources, violence, exploitation, neglect of children and other protection threats” (Lai, 2014). Often, drug use itself is a result of latent conflict, which -when left untreated- leads to actual conflict and drug use (Fisher, 2008). Experts find it important to identify these conflicts during the treatment and resolving these personal conflicts before the drug use itself. For this reason, teaching basic conflict resolution to adolescents early in life would be worth examining. Frequently, a proactive approach in addressing any problem is more beneficial than addressing it once a person sinks into the spiral of addiction. While this may not prevent all cases of drug abuse, it could further assist specialists in treatment facilities. Many of those who enter treatment are released, discharged, or simply quit as a result of conflict within the treatment setting itself (Fisher, 2008). Having the basic knowledge of conflict resolution skills when entering a program would certainly be beneficial.

Changing Ineffective Policies and Programs

Treatment and rehabilitation alone are not enough. Early education, more parental involvement, and mental health treatment is a start. Similarly, the out of control spending

by the pharmaceutical companies on lobbying politicians, direct to consumer advertising, failure to monitor the shipments of drugs contribute heavily to the problem and often go ignored by government officials and the media. When the government attempts to get involved, the results often exacerbate the problem. Policies created too quickly and with little thought or input from professionals have had a significant impact on the current crisis, which may be one of the reasons many people view the current crisis as racially motivated.

In a 1998 interview with *The Washington Post*, Orlando Patterson stated "racism aside, an inter-group problem exists when some groups ignore the disproportionate and inordinate suffering that a policy causes others. African Americans know that a political riot would ensue if drug laws snared as many whites as they do blacks" (Scott,1998, para. 10). Society has witnessed firsthand these policies during the crack crisis and is still seeing such policies in the current opioid crisis.

An argument could be made that during the crack crisis, the United States poured money into law enforcement and the prison system in hopes to address the problem, yet with the current opioid crisis, the government's answer is to allocate more money toward treatment programs. In both cases, money was allocated to programs with little if any empirical evidence for success and thus, in many ways, it was wasted through the bureaucratic red tape.

One example is the war on drugs, which has been viewed by many scholars and professionals as a failure and a waste of money (Cardoso, 2009). Hundreds of billions of dollars were spent trying to stop the flow of drugs into the country, but the plan did not help reduce drug use in any measurable way. Public relations programs like the D.A.R.E.

(a program taught by police officers, and once the premier drug education programs in grade schools) were now discontinued. Studies proved those strategies had little to no effect on drug use; on the contrary, police officers were taken off the streets and placed in roles deemed fit for teachers and social workers. In a study conducted by Evans (1998) at Indiana University results indicated “that graduates of the D.A.R.E. program subsequently, had significantly higher rates of hallucinogenic drug use than those not exposed to the program”. Similar outcomes had the billions of dollars demanded and dumped into treatment programs which have no measurable success record, in hopes that somehow, like the war on drugs, they will cure or rehabilitate drug users (Fuhr, 2017).

In the end, the outcome will most probably not change. However, despite the current billions of dollars poured into programs, many in the treatment industry are at odds with what works and what does not. Some argue that medication-assisted treatment is needed, while others support total abstinence. Regardless of the program, success rates are primarily self-reported and, therefore, nearly impossible to gauge. Still, as per current course of action, the problem will continue, the money will be wasted, and the conflict within society that it has caused will remain the same until users either age out of drug use, quit all together, or die.

As this research demonstrated through the historical perspective on drug waves, drug use and abuse are not going away anytime soon, and it is most likely going to merge with a different drug, a new set of abusers, and another endless cycle.

Lastly, American society has dealt with drug issues and moral panics around drug crises for two centuries. While few propose limits to first amendment speech, the media must do a better job when reporting news on drug crises. Using false, erroneous, and

inflated statistics helps no one. Creating panic generates interest and may sell advertising time, but it will not save anyone's teenage child or parent.

Misleading narratives that drug overdoses kill more people than car accidents or accidental falls may be true when exhausting the entire universe of drugs, however, when used at the tail of a story on opioids, it is not merely misleading but also lying to people, especially to those who have lost family members to opiates. While there have been some positive outcomes as a result of aspects of this crisis, negatives consequences also need to be addressed. In order to understand the scope of the problem and to make informed decisions, people need to know the truth.

The public needs accurate news more than it needs stories printed to sell papers or ad time. It should not be the role of the media to dictate morality or take political side with one group or another to set an agenda. The media appears for practical purposes to have lost a true sense of journalism and has become weaponized, whether for politics, money, or both. A responsible media may be able to succeed, but more research is necessary to see how this is going to be accomplished. Continuing to put corporate and political needs above all else deprives the public of their right to truthful and accurate information. It also creates a chasm between different races within the country if the disparities depicted by the media (as in the case of the drug problem) appear at the very least, based on distorted statements and half-truths.

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Appendix A: Newspaper Articles Reviewed

1. Mother of Cocaine-Addicted Infant Indicted on Drug Charge Green, Connie. The Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga]21 Mar 1990: XJ3

2. Wave of Crack Babies Cannot Be Ignored The Atlanta Journal the Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga]08 July 1990: G6

3. Crack Babies Cost Us a Lot More Than $504 Million Dickerson, Jeff. The Atlanta Journal; Atlanta, Ga. [Atlanta, Ga]20 Sep 1991: A18

4. Homes Sought to Foster Help, Hope for Crack Babies McCreary, Michele. The Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga]12 Nov 1991: XJ1

5. Throw a lifeline to crack babies The Atlanta Journal; Atlanta, Ga. [Atlanta, Ga]29 Sep 1998: A;12

6. Crack's Toll Among Babies: A Joyless View, Even of Toys SANDRA BLAKESLEE, Special to The New York Times. New York Times, Late Edition (East Coast); New York, N.Y. [New York, N.Y]17 Sep 1989: A.1.

7. Generation of Crack Kids About to Plague Schools Gorden, Bill. San Francisco Chronicle; San Francisco, Calif. [San Francisco, Calif]24 Apr 1989: A1

8. Put Cocaine Babies in Protective Custody Charles Krauthammer COLUMN. St. Louis Post - Dispatch (pre-1997 Fulltext); St. Louis, Mo. [St. Louis, Mo]06 Aug 1989: B.3.

9. The First Generation of Crack Babies: Who Will Care for Them?
New York Amsterdam News; New York, N.Y. [New York, N.Y]09 Feb 1991: 22

10. Drug Epidemic's Tiny Victims Stone, Andrea. USA TODAY; Mclean, Va. [Mclean, Va]08 June 1989: A3.

11. Experts Say Crack Babies Will Strain Public Schools Jones, Relicia. Houston Post; Houston, Tex. [Houston, Tex.]28 Jan 1990: A1.

12. Schools Not Ready for Crack Children Ingersoll, Brenda. The Detroit News and Detroit Free Press; Detroit, Mich. [Detroit, Mich] 03 Mar 1991: A1

13. Generation of Crack Kids About to Plague Schools Gorden, Bill. San Francisco Chronicle; San Francisco, Calif. [San Francisco, Calif]24 Apr 1989: A1

14. Put Cocaine Babies in Protective Custody Charles Krauthammer COLUMN. St. Louis Post - Dispatch (pre-1997 Fulltext); St. Louis, Mo. [St. Louis, Mo] 06 Aug 1989: B.3.

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18. Schools Not Ready for Crack Children Ingersoll, Brenda. The Detroit News and Detroit Free Press; Detroit, Mich. [Detroit, Mich] 03 Mar 1991: A1

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20. Put Cocaine Babies in Protective Custody Charles Krauthammer COLUMN. St. Louis Post - Dispatch (pre-1997 Fulltext); St. Louis, Mo. [St. Louis, Mo] 06 Aug 1989: B.3.

21. The First Generation of Crack Babies: Who Will Care for Them New York Amsterdam News; New York, N.Y. [New York, N.Y]09 Feb 1991: 22

22. Drug Epidemic's Tiny Victims Stone, Andrea. USA TODAY; McLean, Va. [McLean, Va.]08 June 1989: A3.

23. Lax Florida laws draw pain-pill dealers, addicts; The state lacks a system for tracking prescription drugs, making it a haven for addicts and `pill mills,' officials say.: [HOME EDITION] Blum, Vanessa. Los Angeles Times; Los Angeles, Calif. [Los Angeles, Calif]04 Dec 2006: A.19.

24. Schools Not Ready for Crack Children Ingersoll, Brenda. The Detroit News and Detroit Free Press; Detroit, Mich. [Detroit, Mich] 03 Mar 1991: A1

25. Put Cocaine Babies in Protective Custody Charles Krauthammer COLUMN. St. Louis Post - Dispatch (pre-1997 Fulltext); St. Louis, Mo. [St. Louis, Mo] 06 Aug 1989: B.3.

26. The First Generation of Crack Babies: Who Will Care for Them?
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29. Schools Not Ready for Crack Children Ingersoll, Brenda. The Detroit News and Detroit Free Press; Detroit, Mich. [Detroit, Mich]03
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30. Cocaine’s most innocent victims // A new wave of birth defects linked to drugs: Dukess, Karen; Vick, Karl. St. Petersburg Times; St. Petersburg, Fla. [St. Petersburg, Fla]10 Sep 1989: 1A.

31. Children's Letters to Baby Pumpkin The Atlanta Journal the Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga]28 Nov 1991: E15

32. 'Babies will keep coming' Ritter, John. USA TODAY; Mclean, Va. [Mclean, Va]02 Dec 1993: A1.

33. Infant Born to Crack Addict Now 2 Months Old Bronstein, Scott. The Atlanta Journal the Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga] 28 Nov 1991: A1

34. Florida Church Offers Hope to Addicted Babies Gardner, Marilyn. The Christian Science Monitor; Boston, Mass. [Boston, Mass] 27 Feb 1990.

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38. Hooked and Pregnant: A Time Bomb Bearak, Barry. Los Angeles Times; Los Angeles, Calif. [Los Angeles, Calif]22 Aug 1989: I1

39. Drug-Baby Case Sentence Today Sharp, Deborah. USA TODAY; McLean, Va. [McLean, Va.] 25 Aug 1989: A3.

40. Cocaine Babies: Area's New Tragedy Green, Connie. The Atlanta Journal the Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga] 03 Feb 1990: XJ1

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42. Mother Is Charged for Giving Cocaine to Fetus Goldberg, David; Hansen, Jane O. The Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga] 17 Nov 1989: A1

43. Cobb D.A. Argues That Mother, 29, 'Distributed' Crack Cocaine to Fetus Vejnoska, Jill. The Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga]04 Feb 1992: B2.

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45. Baby's Cocaine Death Sparks Charges, Controversy The Atlanta Constitution; Atlanta, Ga. [Atlanta, Ga] 10 May 1989: A4

46. The color of crime Albert, J L. USA TODAY; McLean, Va. [McLean, Va] 28 Mar 1994: A13.

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57. Crack's scarcity, price seen spurring violence Meadows, Bob; Staff Writer. The Plain Dealer; Cleveland, Ohio [Cleveland, Ohio]02 June 1990

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