

2018

Nothing about us without us: the politics of race and compassion in heroin epidemics

Ann Tartakoff
Vassar College

Follow this and additional works at: https://digitalwindow.vassar.edu/senior_capstone

Recommended Citation

Tartakoff, Ann, "Nothing about us without us: the politics of race and compassion in heroin epidemics" (2018). *Senior Capstone Projects*. 773.

https://digitalwindow.vassar.edu/senior_capstone/773

This Open Access is brought to you for free and open access by Digital Window @ Vassar. It has been accepted for inclusion in Senior Capstone Projects by an authorized administrator of Digital Window @ Vassar. For more information, please contact library_thesis@vassar.edu.

Vassar College

Nothing About Us Without Us: The Politics of Race and Compassion in Heroin Epidemics

A Thesis submitted in partial satisfaction of the requirements for the degree

Bachelor of Arts in Sociology

By

Ann Tartakoff

Thesis Advisors:

Marque Miringoff

Jasmine Syedullah

Nothing About Us Without Us: The Politics of Race and Compassion in Heroin Epidemics

As attitudes about drug use are changing in the wake of the current opiate epidemic, many believe that we are adopting a softer approach to the war on drugs. This research aims to explore the cyclical nature by which racial caste is maintained in the United States. Through this lens, this thesis seeks to analyze the relation of racial caste to governmental responses to various drug epidemics, and the cyclical nature by which drug policy is mobilized as a means to white supremacist ends. To do this required content analysis of literature about community responses to heroin epidemics in the Bronx in the 1970s and in the rural Midwest currently. This research aims to compare small towns and inner cities, analyzing factors that make those places ground zero in various drug epidemics. The overarching argument being made is that community-based, non-carceral responses that come out of these places are the ones we should look to in responding to the current epidemic, as they are the best means to subverting the capitalist, white supremacist borders in which governmental responses to drug policy have typically existed.

Table of Contents

Acknowledgements.....	iv
Preface.....	v
Introduction.....	1
Chapter 1 — Legislating Caste.....	6
<i>Pre-Emancipation of Slavery</i>	7
<i>Post-Emancipation</i>	8
<i>Jim Crow</i>	9
<i>Mass Incarceration and the War on Drugs</i>	12
Chapter 2 — The People’s Drug Program.....	20
<i>Old Lincoln</i>	20
<i>The Takeover</i>	22
Chapter 3 — Heroin in the Heartland.....	29
<i>OxyContin</i>	32
<i>Xalisco</i>	35
<i>Collision</i>	37
Chapter 4 — Small Towns, Inner Cities.....	43
<i>Pain</i>	45
<i>Isolation</i>	48
<i>The Morphine Molecule</i>	51
Chapter 5 — Looking Forward.....	53
<i>Drug-Induced Homicide Laws</i>	55

<i>Medication-Assisted Treatment</i>	57
<i>Harm Reduction: Best Practices</i>	59
Appendices.....	61
Glossary.....	64
Works Cited.....	66

To Cheryl Tartakoff, my mom, my inspiration, the person who encouraged me to be curious about the world around me and to put my heart into all that I do. May she rest in peace.

Acknowledgements

As I conclude this project, I would like to thank the following:

My dad, for his unconditional support throughout this process. For listening to me work through ideas on the phone, for encouraging my interest in harm reduction, and for keeping me on track during this difficult year. Greg Scott, for getting me my first job in a syringe exchange four years ago and continuing to mentor me both in sociology and harm reduction all these years. The Vassar College Sociology Department, for fostering my love of this work. More specifically my advisors, Dr. Miringoff and Dr. Syedullah for their guidance and support throughout this process. VOCAL-NY, for adopting me into their family and showing me the ropes of harm reduction. Kassandra Frederique and the Drug Policy Alliance New York Policy Office team, for opening my eyes to the importance of this topic and for helping me find resources as I constructed this project. My housemates: Ari, Sumaiya, Gabi, and Sara. I consider you family and I would never have made it through this year without your infinite love and encouragement.

Preface

My interest in harm reduction, at an individual level, began when many of my friends started using heroin while we were in high school. Though I did not know that what I was practicing at the time was harm reduction, the community of support that was sustained by our relationships to one another certainly was a form of harm reduction in its essence. Through watching many of them cycle through rehabilitation facilities that boasted 3% success rates yet seemed like the only option, I became curious about services that existed for people who were not yet ready to quit- services that aimed to keep people alive rather than force them into sobriety. That initial interest and a chance acquaintance brought me to a summer internship with an organization in Brooklyn, Voices of Community Activists and Leaders (VOCAL-NY). VOCAL is a grassroots, participant-led social justice organization and is also home to a syringe exchange and drop-in center that serves clients in downtown Brooklyn five days a week. I spent the summer after my freshman year of college working directly with participants of the program- people who used heroin, mostly, who came to the program in search of clean works,¹ treatment referrals, or just an air-conditioned space with free coffee and a supportive community.

The next summer I interned with the Drug Policy Alliance in New York, where I worked more on the legal and administrative sides of harm reduction advocacy. I helped to organize a conference titled “White Faces, Black Lives” which focused on history of policing of heroin use in black communities and problematized the wave of compassion for white opiate users in recent years. I had the privilege to sit in on interviews with people who understood these issues intimately- specifically two professors from Columbia: Dr. Alondra Nelson, author of “Body and Soul: The Black Panther Party and the Fight against Medical Discrimination” and Dr. Samuel K.

¹ Supplies with which to inject drugs- including, but not limited to: sterile syringes, cookers, sterile water, alcohol pads, arm bands, sharps containers, straws for safer snorting, and clean pipes for smoking crack.

Roberts, who is currently working on a book about the history of drug politics from the 1950s to present, specifically looking at radical care communities and harm reduction responses. As part of our research I was able to visit a facility called BOOM! Health, a multifaceted service organization located in the Bronx, which includes a syringe exchange, pharmacy, drop-in health center, and housing and food assistance. My research for that conference is largely what inspired this project, as I think this conversation is both timely and incredibly important to continue. Since my work with the Drug Policy Alliance I have volunteered in syringe exchange programs in Washington Heights and Chicago and have attended several drug policy reform conferences around the country.

I am fairly well connected on social media to people who work in harm reduction, and in late 2017 my Facebook feed was full of articles about an underground supervised injection facility that has been operating in a major US city, secretly, for several years. Supervised injection facilities, or supervised consumption spaces,² are facilities within which it is legal to possess and use drugs. They exist in 66 cities in nine countries but are not yet legal in the United States (DPA 2018). Medical staff are on hand in case of an overdose, or simply to counsel clients who use the space about other concerns, medical or otherwise. I have met the people who run the facility in passing, and they are doing incredible work. Because these facilities are still illegal in the United States, they have turned an existing social service agency into a radical public health intervention without assistance or permission from the state. The facility is a safe haven where people can inject drugs in a well-lit, unrushed environment with staff on hand ready to administer naloxone³ in case of an overdose. Due to the facility's illegality, participants can only be given access to the space in small numbers and through referrals from other participants.

² The difference in phrasing aims to indicate inclusion of people who use drugs via other routes (i.e. smoking, snorting, etc.)

³ Naloxone is the generic of Narcan, the antidote to opiate overdose. See glossary.

About 2,500 injections and two overdose reversals have taken place in the space since it opened three years ago (Kral and Davidson 920). Such facilities are legal in Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland. They have been shown to improve health outcomes for clients as well as public safety for the broader population by reducing public injection and syringe disposal (Bayoumi and Zaric 2008). Studies on a SIF in Vancouver, Canada, showed significant increases in rates of enrollment in further detoxification services among people who used the facility (Wood et al. 2007).

Harm reduction, which I use here as a blanket term to describe responses to drug use which seek to reduce the harms involved in drug use in a noncoercive manner, is one of the most important tools we have in this current opioid epidemic. Harm reduction programs seek to meet a person who is using drugs where they are, provide the resources necessary for that person to take charge of their own health and wellbeing, and most importantly to keep that person alive. Keeping a person alive who is using heroin means clean needles, access to safe places to use drugs, access to naloxone, and access to healthcare settings in which they are not stigmatized for their drug use. In most traditional treatment settings, recovery is defined as full sobriety. Harm reductionists see recovery as any positive change whether that be safer injection practices, controlled use, and/or medication-assisted therapy.

The feeling of using heroin is commonly described as a feeling of complete security; like being wrapped in a warm blanket, while simultaneously feeling sure that everything is okay. And although tolerance does build over time, and achieving that feeling requires higher and higher doses, it does not become entirely unachievable the way much anti-drug propaganda would have us believe. The National Institute on Drug Abuse estimates that 23 percent of people who try heroin eventually develop dependence on the drug (NIDA 2018). When physical dependence

does develop, that feeling of euphoria is accompanied by a feeling of complete physical and emotional agony without the drug after 6 to 24 hours of cessation of use- anxiety, depression, despair, crawling skin, rapidly fluctuating temperature, sweating, and an upset stomach that feels like food poisoning (DPA 2018). This all applies to opioid painkillers as well.

Before I begin, I feel it is important to explicitly acknowledge my own biases in constructing this project, and in selecting the sources that I did. Overdose statistics are not just numbers to me. Some of them are people that I know, people I have worked with, but above all else they are human beings and they are worth every bit as much compassion and consideration as a person who does not use drugs. I feel strongly about the need to prioritize harm reduction not only because I have seen the difference it can make in people's lives, but because people that I know who use opiates support it, and I believe that they are the most important voices to consider. This may make my view subjective, but I do not consider that subjectivity a strong enough influence that it would prevent me from doing quality research; if anything, I think my involvement in this work makes my research more meaningful and adds perspective that many researchers might not have.

Introduction

By all accounts, we are in a moment of crisis. The opiate epidemic reaped a death toll of 64,000 in 2016, a number which is only expected to rise this year (NIDA 2017). More people are dying of overdose than ever before (NIDA 2017), and in response to these shocking numbers it seems that public attitudes toward drug use are changing. In many ways, finally, governmental approaches to drug use seem to be becoming more compassionate. Politicians are talking about public health-centric approaches. Naloxone, the antidote to opiate overdose, is being seen in the public eye less as “enabling” and more as a tool with which to save lives. Trump even embraced its use in his most recent speech on the matter. Legislators in San Francisco and Philadelphia are moving toward creating the first supervised consumption spaces in the country. Programs like LEAD (Law Enforcement Assisted Diversion), where people who use drugs are encouraged to turn themselves over to police who will connect them with treatment, are being endorsed by the White House.

These ideas certainly are not unheard of. Scholars and medical experts alike have long been calling for drugs to be considered a public health issue, rather than something to be dealt with through the criminal justice system. For decades it seemed that their pleas fell on largely unsympathetic ears. In the 1980s and 1990s politicians were far more focused on pathologizing and criminalizing people, blaming drug use on personal flaws (Alexander 2010). Drug use was a criminal issue, one that was destroying lives and communities and turning people into monsters that needed to be dealt with harshly. Finally, though, it seems politicians might be challenging these biases. President Trump has declared a national emergency (Allen and Kelly 2017). The United States will likely open its first supervised consumption space this year (Lurie 2018). Nine states and the District of Columbia have legalized recreational marijuana in the last few years

(Lopez 2018). And it is easy to look at all of this and think that, finally, after a decades-long drug war, we are headed in the right direction.

But one has to wonder where the support for evidence-based, public-health centric intervention was before this. One has to sense irony in the fact that our jails and prisons are full to bursting with nonviolent drug offenders, who are overwhelmingly black and brown, when people who use heroin are now being diverted to treatment over prison. One has to marvel at Trump telling the story of his brother's struggle with alcoholism with compassion and some attempt at understanding, while condemning "criminals" from "south of the border" and claiming that building a wall will "greatly help this problem" of overdose that we are facing (Diamond and Ehley 2018).

This is not to negate the positive change being created now- far from it. We should have been providing compassionate, non-coercive treatment to everyone who wanted it in the first place. But as this change is happening, it is imperative that we remain cognizant of the political context in which it is occurring, and that we are constantly vigilant to the effects that new policies will have for those who have had to bear the brunt of criminalization of drug use historically. Aside from numbers, what makes opioid use a public health crisis now when heroin was seen arguably the most dangerous, and unarguably the most heavily criminalized drug, for decades?

Opiates, a category of drugs all derived from opium poppies, have a long history of both licit and illicit use. Heroin was initially marketed by Bayer as a cough suppressant, variations of which were sold in pharmacies for a range of ailments (DPA 2018). The "non-medical" use of heroin was outlawed by the Harrison Act of 1914, and medical heroin was outlawed in 1924 (DPA 2018). Concerns about the addictive potential of morphine, another derivative of opium,

were on the rise around this time. Researchers were on the search for a cure for pain that was not addictive- something that would have the same benefits as morphine without its downfalls. With the passage of the Harrison Act in 1914 came the criminalization and subsequent incarceration of many people who used drugs, something we now can identify as an early and continuing driving force behind mass incarceration (DPA 2018).

Heroin was the perfect storm for proponents of racial caste in the 1970s as John Ehrlichman, a former aid to the Nixon administration, admitted in no uncertain terms (as quoted in Baum 2016):

By getting the public to associate hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.

Heroin has been used this way for decades since. Incarceration has long been our primary response, and legalization of harm reduction interventions have involved extensive legal battles, many of which are ongoing, with plenty of roadblocks along the way.

Due to a number of factors which will be explored in chapter 3, heroin has now found a prominent place among the white middle class. Before we begin, one important factor to call attention to is the demarcation of “legitimate” versus “illegitimate” use of opiate-based drugs. One reason for heroin’s rise in popularity among populations historically injection drug-averse has to do with the classist differentiation of drugs prescribed by a doctor and drugs purchased by other means. Both among people that I have talked to throughout the process of constructing this project and in my empirical research, the idea that prescription drugs and heroin were very different things has come up many times. Many people who start with prescription painkillers do not see themselves on par with people who use heroin because the drugs they were using came in controlled doses from a doctor.

This is a similar phenomenon to the cultural differentiation of meth and Adderall, which are also nearly chemically identical (Hart 2015). The perception of the populations who use them are wildly different though, as most of us will remember the “before and after” meth photos of the late 90s yet hear about college students consuming Adderall without flinching. In many ways the same is true of painkillers and heroin, though it is important not to oversimplify that matter. The story of pain patient-turned-heroin user is sometimes true, though recent studies have suggested that people starting off with painkillers as initiating opiates are now in the minority (Cicero et al. 2017). This could be due to restrictions recently placed on prescribers, but could also point to the fact that the lines between “legitimate” and “illegitimate” drug user are blurrier than many are comfortable to admit.

In this thesis I will argue that drug policy has long been used as a tool to uphold racial caste, and that the way the United States government is responding to the current opiate epidemic is symptomatic of that. By examining a unique community response to rampant heroin use in the Bronx in the 1970s alongside community responses to heroin in the current epidemic, I will argue that the unique positions of small, rural towns and inner cities hit hardest by drug epidemics and the grassroots harm reduction movements that develop out of them show the most promise of subverting the capitalist, white supremacist borders within which governmental responses in the United States typically exist. To do this requires breaking down the ways in which racial caste has functioned in this country, which I will examine in detail in Chapter 1. Drawing on Michelle Alexander’s seminal writing in *The New Jim Crow*, alongside several other critical race theorists, I will illustrate the cyclical nature by which systems for enforcing racial caste are created and sustained. Chapter 2 will focus on Lincoln Detox, a radical care model developed by the Black

Panthers and Young Lords in the Bronx in the 1970s. Chapter 3 will tell the story of the current opiate epidemic, focusing on small South-Midwestern towns which served as ground zero for an epidemic that proceeded to sweep the rest of the country. Chapter 4 will analyze the two epidemics, looking more closely at community responses that developed out of each one as well as factors in both places that made them particularly vulnerable. Chapter 5 will look to policy recommendations, proposals to be wary of, and anti-carceral models under which we should attempt to operate as we move forward from this epidemic so that our newfound compassionate responses to drug use do not only apply to white, middle class people.

To begin to examine this issue it is important to understand the history of drug policy in this country, and of the systems that exist to enforce it. An understanding of drug policy must be grounded in the idea that the politics of crime are the politics of race. The fluid definition of “crime” has been used time and again as a tool of social control and, more broadly, I will argue that drug policy is only one part of a larger political system predicated on white supremacy, a “Racial Contract” as termed by theorist Charles W. Mills.

Chapter 1: Legislating Caste

Mills, from the standpoint of critical race theory, defines racism as a global political system. The Racial Contract, he explains, is the political system whose central goal is to uphold white supremacy, ensuring dominance over people of color on a global scale. Mills writes:

The Racial Contract establishes a racial polity, a racial state, and a racial juridical system, where the status of whites and nonwhites is clearly demarcated, whether by law or by custom. And the purpose of this state. . . is. . . specifically to maintain and reproduce this racial order, securing the privileges and advantages of the full white citizens and maintaining the subordination of nonwhites (Mills 1997:13).

Mills explains that the notion of morality “is just a set of rules for expediting the rational pursuit and coordination of our own interests without conflict with those other people who are doing the same thing” (Mills 1997:15). Morality is fluid, especially when it comes to highly politicized issues like drug use. It can be said of crime more generally, even, that what is considered wrong in two different times is flexible and has a tendency to change radically. Morality has been mobilized against people who use drugs repeatedly throughout history, whether to justify their incarceration or to support coercive treatment. Currently we are in a moment where moralistic views of opiate use are being widely reconsidered; more and more politicians are expressing sympathy for people struggling to manage their substance use under the justification that addiction is a disease which requires treatment. This is despite the fact that that addiction is a disease has been prominent since the 1940s (Jellinek 1960).

The following section will lay out the history of racial caste in this country in some detail, largely drawing on Michelle Alexander’s indispensable analysis of the history and modern iteration of racial caste in this country, which will be used as basis for thinking about the rest of this paper. As this is only one chapter I will attempt to be brief, but I believe that illustrating the cyclical nature by which racial hatred is mobilized to maintain racial caste is important to the

further analysis of the opiate epidemics in this country, which will be fleshed out in more detail in the following chapters.

Pre-Emancipation of Slavery

To begin, I would like to highlight one of the first instances of solidification of racial hatred between enslaved black people and poor whites, which in many ways marks the way that racial animosity would continue to be mobilized for years to come. Bacon's Rebellion, an organized uprising against the planter elite in 1676, united black slaves, white indentured servants, and other poor whites. Seeing unity for a cause across racial lines instilled a fear in the white planter elite, and because they so deeply feared multiracial unity among bondsmen and slaves, those in power shifted toward heavier reliance on importing African slaves and deliberately drove wedges between white servants and enslaved Africans by giving servants power over enslaved people. Thus, they ensured that poor whites had a stake in maintaining a racial hierarchy, effectively erasing any chance of further interracial alliance (Alexander 2010:25).

White supremacy, aptly described by Michelle Alexander as a "religion of sorts" (Alexander 2010:26), allowed slavery to flourish for as long as it did and has endured as an ideology far beyond the limits of the specific institution that gave rise to it. By believing that Africans were not fully people and that whiteness equates superiority, whites at the time could justify slavery as not in opposition to the assertion made in the Declaration of Independence that "all men are created equal" (as quoted in Alexander 2010:26). Kimberlé Crenshaw, another fundamental critical race theorist, described the power of that normalization of whiteness in "Race, Reform, and Retrenchment," when she wrote:

having accepted a common interest with slaveholders in keeping blacks subordinated, even those whites who had material reasons to object to the dominance of the slaveholding class could challenge the regime only so far. The power of race-consciousness convinced whites to support a system that was opposed to their own economic interests. . . racial privilege could and did serve as a compensation for class disadvantage (Crenshaw [1988] 1995:113).

Post-Emancipation

After the emancipation of slavery and the end of the Civil War, the South was in a precarious state. Without the institution of slavery on which they had relied for so long, the economy was sure to collapse, and there was no longer a concrete divide in status between poor whites and former slaves. Black codes were established as a way to maintain racial control post-slavery, including things like peonage, segregation of schools, and vagrancy laws (Alexander 2010:28). Vagrancy laws, which required a person by law to have a job, were adopted by nine states in the South and were racially enforced. Eight of those nine states also adopted laws that allowed for convict leasing, effectively establishing another system of forced labor in the absence of slavery (Alexander 2010:28).

Black codes were eventually outlawed and were followed by the Reconstruction Era, which constituted a short but remarkable period of legislative gains for African Americans. Slavery was outlawed by the Thirteenth Amendment (*except as punishment for a crime*), and black Americans gained full citizenship in 1866. As full citizens, they were guaranteed equal protection, due process, and the right to vote under the Fourteenth and Fifteenth Amendments. The Ku Klux Klan Acts made attempting to prevent someone from voting as well as the use of violence to infringe upon civil rights a federal crime. The Freedmen's Bureau, which provided assistance with basic needs to former slaves, expanded, and public education for both blacks and poor whites was established. Three years after the beginning of Reconstruction, fifteen percent of

elected officials in the South were black (Alexander 2010:29). Some of these new laws had loopholes which were used to undermine their power- poll taxes and literacy tests were implemented to prevent black people from voting (Alexander 2010:30). Enforcement of civil rights could not be guaranteed for the many African Americans who did not have the money to hire legal representation and sue for the violation of those rights, so though these rights existed in theory often they were not upheld in practice (Alexander 2010:30). As these reforms were taking shape, support for racial separation was growing. Segregation, though not yet mandated by law, was becoming normalized in the South as it had in the North after they abolished slavery (Alexander 2010:30).

Jim Crow

Jim Crow was born out of reaction to Reconstruction Era gains by African Americans (Alexander 2010:30). Whites felt the foundation beneath their superior status start to shake and reacted with panic- Southern conservatives sought to overturn the changes brought by reconstruction, and the KKK led a violent campaign of terrorism which aimed to “redeem” (Alexander 2010:31) the South. Their violent intimidation tactics led to the desertion of African Americans and their allies by the federal government, who ceased enforcement of the newly won civil rights and effectively defunded the Freedmen’s Bureau (Alexander 2010:31). Vagrancy laws reemerged and laws defining acts so small and indefinable as “insulting gestures” as criminal were racially enforced (Alexander 2010:31). Those convicted were subjected to convict leasing, essentially legalized slavery as punishment for those minor “crimes,” where conditions were often worse than they were during slavery because contractors had no stake in the well-being of their laborers, as plantation owners once had (Alexander 2010:31).

Several schools of thought about race relations emerged at the time, but the one that seemed most promising, and with the most potential to benefit Black people at the time, was populism (Alexander 2010:33). Populism was predicated on the idea that the elite were conspiring against poor people of all races to maintain their position of superiority (PBS 2002). At the time, populists supported racial integration and were committed to a movement of working-class people across racial lines, against the white elites in power. Segregation laws came to be as “part of a deliberate effort to drive a wedge between poor whites and African Americans” (Alexander 2010:34) and, just as they had after Bacon’s Rebellion, the insecure position of poor whites was used as a tool by white elites to establish a new racial caste system. This one looked entirely different from the last but operated under the same set of racist guiding principles.

Jim Crow could not have been struck down without the comprehensive, grassroots work of the Civil Rights Movement (Alexander 2010:36). As political and social gains were being made, though, Civil Rights activists became increasingly focused on economic issues, which aligned their goals with those of many poor and working class whites. The Civil Rights Movement shifted toward a greater vision of liberation- a “Poor People’s Movement” (Alexander 2010:39) that would unite white, black, Latinx, and Native Americans to demand the right to better living conditions as poor people in a nation run by wealthy elites. As this vision took shape, white conservatives began devising a new method of maintaining racial hierarchy. This time, though, it would have to be race-neutral at face value. This marked the beginning of modern-day colorblindness and mass incarceration.

The transition to colorblindness may have meant the end of verbally explicit racism in the form that the country was used to hearing it, but it did not equate the demise of racism, or racial

caste. Kimberlé Crenshaw describes this transition in “Race, Reform, and Retrenchment,” saying that “the end of Jim Crow has been accompanied by the demise of an explicit ideology of white supremacy. The white norm, however, has not disappeared. . . it continues in an unspoken form as a statement of the positive social norm, legitimating the continuing domination of those who do not meet it” (Crenshaw [1988] 1995:115). Though we are no longer in an era of explicit separation of black and white people, and outright discrimination is largely illegal, whiteness remains as the standard that all people, regardless of race, are commanded to aspire to lest the wrath of society and the various institutions that exist to support it be unleashed against them. The way this is spoken about is what has shifted, and though we no longer acknowledge race as basis for the continued domination of Black people in this country, it is still the determinant factor in how a person is treated by various institutions. Most important of these is the criminal justice system.

The language of “law and order” was first used by Southern politicians and law enforcement in opposition to the civil rights movement, but can still be heard today in the rhetoric of conservatives like Ted Cruz, who spoke on the campaign trail about returning to law and order after eight years of Obama’s presidency, or Attorney General Jeff Sessions as he discussed the approach that the Trump administration plans to take in response to crime (DOJ 2017). After the fall of Jim Crow, the concept of “law and order” was mobilized by supporters of white supremacy (Alexander 2010:40). Direct action tactics used during the civil rights movement were characterized as criminal by opponents of racial equality, and federal courts were accused of being too “soft” on those who disregarded laws (Alexander 2010:41). Segregationists insisted that integration caused crime, and while it was true that crime rates were on the rise in the 1960s, to attribute that to integration is to ignore the fact that the baby boom

generation was between the ages of 15-24, the age group most likely to engage in criminal activity, and unemployment among black men was rising sharply (Alexander 2010:41). These factors were ignored in the media which, instead, attributed crime rates to a “breakdown in lawfulness, morality, and social stability in the wake of the Civil Rights Movement” (Alexander 2010:34).

Prominent actors from the anti-Civil Rights Movement were often at the head of the ensuing push against crime (Alexander 2010:42). Alexander cites the example of George Wallace, a famous segregationist, who claimed that “the same Supreme Court that ordered integration and encouraged civil rights legislation was now bending over backwards to help criminals” (as quoted in Alexander 2010:42). Although law and order rhetoric could not stop the repeal of Jim Crow, it did work in appealing to poor whites who had been anti-integration and saw the Democratic Party as anti-segregation (Alexander 2010:43). In the following years, conservatives adopted the stance that poverty, especially poverty amongst black people, was at the fault of culture rather than structural disadvantage, and that “social pathologies” (Alexander 2010:45) of poor people such as “street crime, illegal drug use, and delinquency” (Alexander 2010:45) were rooted in the over-distribution of welfare benefits.

Mass Incarceration and the War on Drugs

The most recent iteration of racial caste in this country began to take concrete shape in 1971 when Richard Nixon declared a “war on drugs” (as quoted in Alexander 2010:48). Nixon implemented mandatory sentencing for drug law violations and approved legislation to allow no-knock warrants, but his war was short-lived and consisted of more discussion than direct action. Public opinion shifted toward decriminalization of marijuana, and Jimmy Carter was elected on a

platform that included decriminalization (University of California Santa Barbara 1977). It was not until 1982, when Ronald Reagan was in office, that the drug war was revitalized. A common misconception is that the war was launched in response to the spread of crack in poor Black neighborhoods, but in fact it was announced before the emergence of crack was even being publicized (Alexander 2010:52). At the time, the CIA was actively providing support to and preventing investigation of the Contras in Nicaragua, who they were ferrying arms to in exchange for a free pass to smuggle drugs into the US (Boullosa and Wallace 2010). In 1985, the Reagan administration hired publicity staff to make news of the issue of crack cocaine with the hope of developing support for the ongoing drug war (Alexander 2010:52). Around the same time, anti-drug spending on law enforcement efforts increased at unbelievable rates- the FBI's anti-drug budget increased from \$8 million to \$95 million between 1980 and 1984; the Department of Defense increased from \$33 million to \$1,042 million between 1981 and 1991 and DEA spending increased from \$86 million to \$1,026 million in the same period. Contrastingly, the National Institute on Drug Abuse had their budget slashed from \$274 million to \$57 million in the period between 1980 and 1984, and in the same three years the Department of Education had their anti-drug funds cut from \$14 million to \$3 million (Alexander 2010:49).

Crack and cocaine vary only slightly in chemical structure and are entirely identical in effects, though the speed at which their effects are felt does vary by route of administration (Hart 2015). Despite this, the Anti-Drug Abuse Act of 1986 created a 100-1 disparity in mandatory minimum sentencing for distribution of crack vs. cocaine (Hart 2015). Until 1988, the maximum penalty for possession of *any* quantity of *any* drug was 1 year served in prison. That changed with legislation passed by Congress in the form of a new Anti-Drug Abuse Act (Alexander 2010:53). The new law allowed for tenants to be evicted from public housing for allowing drug

activity to occur on or near the premises, banned anyone convicted of a drug offense from eligibility for student loans, and created a five-year mandatory minimum for possession of crack *without* intent to sell. It also allowed for the use of the death penalty in “serious drug-related offenses” (Alexander 2010:53).

Until the late 1980s, conservatives were at the forefront of “get tough” approaches to drug policy. In an attempt to win over swing voters, however, Democrats joined the charge around this time. Tellingly, the Ku Klux Klan pledged to join the fight against drug use by becoming vigilantes for the police (Alexander 2010:55). Thus began the collapse of opposition to the new emerging racial caste system of mass incarceration. Similar to the collapse of populist opposition to Jim Crow when Redeemers won over poor and working class whites who felt their already uncertain status being threatened by racial reform, conservatives won over the same group by demonizing black people yet again, this time identified only by the seemingly race-neutral label of “criminal” (Alexander 2010:55).

In 1992, Bill Clinton pledged to be tougher on crime than any Republican (Alexander 2010:56). He even took it a step further, bringing in the issue of welfare reform to entice white swing voters. He replaced Aid to Families with Dependent Children with a block grant, Temporary Assistance to Needy Families, which imposed a life-long ban on welfare eligibility as well as food stamps for anyone found guilty of a felony drug charge, even possession of marijuana (Alexander 2010:57). Though it was claimed that these reforms were mainly concerned with fiscal conservatism, this was blatantly not true; rather, he was redirecting money originally used for public benefits to the criminal justice system (Alexander 2010:57). During Clinton’s tenure, funding available for public housing was slashed by 61% and redirected to prison construction. The corrections budget was increased by 171% (Alexander 2010:57).

The difference with this caste system is that it was explained in race-neutral terms; so though 90% of people imprisoned for drug offenses were black or Latinx (Alexander 2010: 58), this fact was largely hidden from the public. It is difficult to grasp the scale at which this system operates, as there are many factors that make it difficult to analyze. For one, state prison data does not include federal prisoners (Alexander 2010:101). Additionally, most people who are under control of the criminal justice system are not in jail or prison but are on probation or parole- institutions that seem less punitive at face value but in reality impose restrictions that can range from difficult to impossible to follow. A person on probation or parole faces the constant threat of jail time if they violate any one of the many rules imposed on them. The most common crimes that place people under control of probation are drug offenses (Alexander 2010:102).

The race-neutrality of this system allows for racial discrimination in the many institutions that fall under the umbrella of criminal justice to go almost entirely unchecked. Michelle Alexander explains the racially discriminatory results of a formally colorblind system as a two-step process (Alexander 2010:103). The first part is that law enforcement has absolute discretion over who they stop, allowing conscious and unconscious bias to flourish. Second, largely “all claims by defendants and private litigants that the criminal justice system operates in a racially discriminatory fashion” (Alexander 2010:103) are prevented from coming to fruition. In *Whren v. United States* the Supreme Court ruled that minor traffic stops constitute a justifiable reason to initiate a drug investigation (Oyez 1996). This essentially gave the go-ahead for racial profiling in community policing. Additionally, the Supreme Court later ruled that claims of racial bias cannot be brought under the 4th Amendment (Alexander 2010:109). Victims of racial discrimination in the criminal justice system are further barred from alleging such a claim by *McCleskey v. Kemp*, in which the Supreme Court ruled that racial bias in sentencing cannot be

challenged under the 14th Amendment without evidence of “conscious, discriminatory intent” (Alexander 2010:109) As of 2012, when *The New Jim Crow* was updated, not one successful challenge of sentencing bias had been made (Alexander 2010:111). Thus, prosecutors are essentially immunized from claims of racial bias with no check on their discretion at any step of the process. Additionally, the Supreme Court ruled in *United States v. Brignoni-Ponce* that it is “permissible under the equal protection clause of the Fourteenth Amendment for the police to use race as a factor in making decisions about which motorists to stop and search” (Alexander 2010:131). The case that sealed the deal and truly barred racial discrimination allegations was *Alexander v. Sandoval*, in which the Supreme Court ruled that the anti-discrimination bill Title VI does not indicate a “private right of action” (Alexander 2010: 137) to citizens or civil rights groups, meaning that suing for racial discrimination was no longer possible. This “virtually wiped out racial profiling litigation nationwide” (Alexander 2010:137). This means that suits which aim to enforce Title VI’s anti-discrimination rules can only be brought by the federal government which, at least in our current political climate, seems unlikely.

Dorothy E. Roberts addresses the ideology that underlies these rulings in “Punishing Drug Addicts Who Have Babies” as a problem in the fundamental theory under which government operates to combat discrimination. She refers to the research of Paul Dimond when discussing one approach- the antidiscrimination approach- as one which sees the principal threat to equality as a failure on the part of the government to treat black people primarily as individuals, regardless of race (as cited in Roberts 1991:394). The other approach, an antistatist principle, by contrast “rather than requiring victims to prove distinct instances of discriminating behavior in the administrative process. . . considers the concrete effects of government policy on the substantive condition of the disadvantaged” (Roberts 1991:395). The

difference in these two approaches marks the difference between a government that approaches inequality with the intent to repair damages done by its history and one that simply states its commitment to equality without having to do the substantive work necessary to repair disadvantages created by centuries of institutional roadblocks put in place by earlier iterations of racial caste within that same government. The antidiscrimination approach credits inequality as a result of individual acts rather than societal norms (Roberts 1991:395). Thus, discriminatory acts become impossible to prosecute because “the court’s vision of equality acquiesces in racist norms and institutions by exempting them from a standard that requires proof of illicit motive on the part of an individual government actor. The inability to identify and blame an individual government actor allows society to rationalize the disparate impact of the prosecutions as the result of the mothers’ own irresponsible actions” (Roberts 1991:395).

A key part of our current racial caste system has to do not with the astonishing lack of rights that people under correctional control have, but with the aftermath of involvement in the criminal justice system. Having a felony on your record bars you from most jobs, loans, and welfare benefits. Applications for schools and drivers licenses require you to check a box if you have ever been convicted of a felony (Alexander 2010:141). Because of this, many ex-offenders are unable to attain such basic necessities as a job, transportation to work, or housing. And without these things, they will often have their children taken away from them. As Dorothy E. Roberts explained in “Punishing Drug Addicts Who Have Babies,” though rates of drug use do not differ between black and white people, black women are far more likely to be under the eye of social service agencies; thus, they are ten times more likely to be reported for substance use while pregnant (1991:390). Although prenatal drug use is no higher (in fact is somewhat lower) among black women, they are far more likely to be prosecuted for it. Thus, prosecution is no

more about prenatal drug use than it is about prosecuting black women for having children (Roberts 1991:388).

All of the above examples are just outside of prison. In prison, people are forced to work for far below minimum wage and their accounts are charged for basic expenses, meaning they are unable to save money (Alexander 2010:157). In all but two states, prisoners are barred from voting while serving time, and many states also impose lifelong bans post-release (Alexander 2010:158). This is just another way of disenfranchising people convicted of felonies and preventing them from having a voice in a political process that so often victimizes them. A political process that does not take the voices of those most marginalized into account is not a democratic process at all, nor can it hope to address the roots of racial caste in this country if it cannot even recognize its role in perpetuating it.

All of this is to say that the politics of drug policy are not, and never were, about drugs. And it is important to go into the following chapters, which are concerned with differing governmental responses to grassroots movements surrounding heroin use, through this lens. Right now we are in a moment where media attention to illicit drug use is being trained on white people, and we are seeing the blatant differences in public opinion when the people perceived to be using opiates are white. For Trump to express compassion for opiate users is not only shocking, but should give us pause. People who use opiates deserve our utmost compassion, surely. We live in a society that in many ways perpetuates conditions that lead to higher rates of opiate use, yet our government so often refuses to implement the public health responses necessary to grapple with that. If we have any hope of moving forward to a movement that will not only deal with the current epidemic, but also with the racial caste system that drug policy in the last few decades has been instrumental in supporting, the opiate epidemic must be examined

skeptically and with a keen eye for the role of white drug exceptionalism in the shifting attitudes toward people who use drugs. Drug policy is formally colorblind, but has almost always been enforced racially. This has made it difficult to see the larger political system at work in the criminalization of drug use. When the language of policy and law enforcement procedures is seemingly race-neutral, the Racial Contract is easy to deny, especially for those on the privileged side of it.

This chapter has covered various iterations of racial caste in the United States in attempt to illustrate the cyclical nature by which they have been mobilized. The next chapter will focus the heroin epidemic of the 1970s. By examining a radical care movement developed by the Black Panthers and Young Lords in the Bronx, Chapter 2 will discuss the importance of community-based responses to drug epidemics as a means to combat the racism and inadequacy that has been prevalent in governmental responses to these epidemics in the past. I will argue that this program, created for the people of the South Bronx by activists and revolutionaries from the same community, is a fundamental example of radical care that should be aspired to as we think about how to respond to the current epidemic. The chapter will also examine community responses in the Bronx during the current epidemic, which have their legacy in community responses from the 1970s.

Chapter 2: The People's Drug Program

“The existence of the program was a thorn in the government's side. We were revolutionaries and radicals doing work, recruiting people to do work the government didn't want to happen”

-Vicente “Panama” Alba, Member of the Young Lords

We begin our story in the South Bronx of the 1970s. Accounts of rates of heroin use at the time vary slightly, but it is estimated that one in four people in the South Bronx and Harlem were using the drug at the time (Nelson 2016). Treatment services were all but inaccessible, and it was not uncommon for patients seeking detoxification or rehabilitation to be kept waiting for a year or more (Mitchell 1995). Heroin was being used very publicly by young people, so much so that it was termed and described as a “plague” by Michael Cetewayo Tabor, a member of the Black Panther Party and one of the New York 21 (Tabor [N.d.] 2006).⁴ Panther publications from the time indicate that heroin use by the younger generation was in many ways seen as an impediment to the fight for freedom. Heroin laws were strict, and police presence in the Bronx was heavy and constant. Given the lack of access to drug treatment or even more basic healthcare services, heroin was perceived as a death sentence to the movement because it had the power to entirely halt a young person's involvement.

Old Lincoln

The only hospital in the area at the time was a teaching hospital by the name of Lincoln. Lincoln Hospital was known for its unsanitary conditions and inadequate care. Originally opened by abolitionists in 1839 as the Home for the Colored Aged, Lincoln had since moved from Manhattan to the South Bronx. Though it had once been New York's first school for African

⁴ The New York 21 were a group of 21 members of the Black Panther Party indicted on conspiracy charges in 1969.

American nurses, it had not been modernized on par with other hospitals in the city since. Often referred to as “the butcher shop” (Narvaez 1970), there were reports that children came to Lincoln and left the rat-infested emergency room with lead poisoning (Aronczyk 2014). Due to the lack of adequate medical services in the area, many locals only had access to medical care through Lincoln’s emergency room. Despite being situated in a primarily Puerto Rican community, the hospital had no translation services (Aronczyk 2014). According to Pablo Guzman, a former member of the Young Lords, there was a running joke in the neighborhood that if you were stabbed on one side of the street you were better off crawling to the other side if it meant you could avoid being taken to Lincoln (as quoted in Aronczyk 2014). Money was laid aside in the New York City budget to improve the hospital for 25 years in a row but was used for other things each time (Narvaez 1970).

The anti-oppression struggle taking place at the time, led largely by the Black Panther Party and the Young Lords, included the need to revolutionize health care in its platform (Porzig 2013). One of the central groups in this struggle was the Young Lords, a collective of radical Puerto Rican activists who set their sights on taking over Lincoln Hospital. One of their goals was to create a methadone-based detoxification program which would serve the specific needs of the community. Based on the work of one Butch Ford, a Bronx resident who had been running a detoxification center in the basement of his home using methadone (Nelson 2016), they set out to create and run a similar detoxification program at Lincoln. In recognition of his successes, the Young Lords based their treatment model on similar principles- methadone used as a way to detox rather than as maintenance therapy, which was the model used by the other methadone clinics in the area, and community-based care.

The Takeover

Following the death of Carmen Rodriguez, a woman in her early thirties killed while receiving an abortion at Lincoln, the Young Lords and Black Panthers decided to take over the hospital. Attributing her death to inadequate medical care, as she was an asthma patient with a heart condition whose chart was not examined closely enough for doctors to realize that a particular asthma medication they were administering was contraindicated with her heart condition (Young Lords Organization 1970), they demanded better healthcare for the community. They set up a station with translators where people could document their experiences at Lincoln, and identified the lack of treatment for people struggling with heroin addiction as one of the central needs at the time. Despite their demands for treatment, the hospital added no additional services (Porzig 2013).

On November 10th, 1970, several months after the initial takeover, the Young Lords returned to Lincoln along with members of the Health Revolutionary Unity Movement and staged a takeover of the Nurses' Residence building with the help of a few radical doctors and nurses. They used the space to create a drug treatment center called The People's Drug Program, more widely known as Lincoln Detox (Porzig 2013). That day the police surrounded the building, but the People's Drug Program was there to stay. The activists made it clear that they were not leaving, and the next day hundreds of people showed up seeking treatment (Porzig 2013). The administration finally acquiesced to some of their demands and a month later they released money that had been set aside for treatment but never used (Porzig 2013). They hired staff from Lincoln Detox and kept the program running for nine years.

With the support of doctors in the hospital, they had a ready supply of methadone which they would give to clients over ten days before slowly decreasing their dose (Porzig 2013). They

also used acupuncture. Another key part of the program was that they acknowledged and grappled with environmental factors that made addiction so common in the community-- oppression, poor living conditions, etc. They hosted political education classes on topics like what it meant to be a stateside Puerto Rican and the psychological effects of being devalued by individuals and institutions as a colonized subject (Porzig 2013). They generally aimed to educate clients of the People's Drug Program about the role of the government and police in pushing drugs, and the socioeconomic roots of addiction. They recognized that drug use did not exist in a vacuum and also did work to organize rent protests, improve women's healthcare, and fight for labor rights for construction workers (Come! Unity Press N.d).

A key part of the Lincoln Detox model was that there be no law enforcement presence whatsoever, and participation had to be completely voluntary. As part of their therapeutic sessions and educational services there were opportunities for participants in the Program to get involved in community activism after their initial detox, and many of the Program's staff had detoxed there as well. They hosted political education classes and instructional sessions on how to navigate often hard-to-access social services (Porzig 2013). Participants from Lincoln Detox went on to advocate for people in welfare centers, train people on welfare recipients' rights, work as translators, found a coalition of minority construction workers, and join groups like the Young Lords, Black Panthers, and the Republic of New Afrika (Porzig 2013). The Lincoln Detox program was such a success that it received recognition from the United Nations, and people from several surrounding states came seeking their services (Porzig 2013). A key reason this program was so successful was because treatment was given by compassionate, caring people who clients could relate with, black and Puerto Rican people from the community who

were not speaking down to them or disregarding their experiences. Lincoln Detox was a space free of police, but just as importantly free of stigma about drug use.

In 1979, people came to work one morning to find the entire building surrounded by police who were checking identification as people entered. They had a list of members of the Young Lords, Black Panthers, and Republic of New Afrika, and were arresting people if they tried to enter without permission. Lincoln Detox in its original form was shut down that day; while a place by the same name still exists, it is a watered-down version of what it once was (Porzig 2013). As a result of the attention drawn to the hospital's poor conditions by the takeover, Lincoln Hospital was eventually rebuilt.

The Bronx has continued to be plagued by high rates of overdose during the current opiate epidemic, with more residents dying within its borders in 2016 than in any other borough of New York City (Del Real 2017). Official data is only available as far back as 2000, but as of October 2017 fatal overdoses in the Bronx were higher than they had been in the last two decades (Del Real 2017). With the proliferation of fentanyl, a powerful opiate sometimes mixed in with or sold as heroin, responsiveness to the overdose antidote naloxone can be unpredictable, and sometimes more than one dose is needed to revive a person. 85 percent of the 308 overdose deaths in the Bronx in 2016 involved opiates, with 76 percent involving heroin or fentanyl specifically (Del Real 2017).

13 million prescriptions for opioid painkillers were filled in New York in 2012- the state's population is 19.4 million (Kolker 2014). A chain of medical clinics which functioned as pill mills (more on this in Chapter 3) were shut down by the DEA and NYPD in 2014. The doctor behind these clinics, Kevin Lowe, had 5 clinics in Queens, Hempstead, and the Bronx. He never prescribed opioids himself but is alleged to have paid his doctors \$300 per prescription at

the two Bronx clinics while keeping the other three clinics functioning as ordinary doctors offices (Kolker 2014).

The reality of high rates of overdose in the Bronx has remained fairly constant though the increase in recent years has still been dramatic, with a 47% spike between 2014 and 2015 (Svab 2016). One would not necessarily know this given media coverage of the opiate epidemic in New York City. Much more publicized have been the rising rates of overdose in Staten Island, where opiate overdose is affecting white, affluent families. That being said, it is important not to portray the Bronx vs. Staten Island as black/brown vs. white. The highest rates of overdose in the Bronx in 2016 were among white people even though whites make up only 9% of the Bronx's population.

As with Lincoln Detox, some of the most important resources available in the current epidemic are community-based, non-judgmental spaces in which law enforcement is not allowed. Included under this umbrella are syringe exchanges, peer-based outreach programs, and health clinics geared towards the Bronx's most vulnerable- people who are insecurely housed, HIV or Hepatitis-C positive, and using drugs. New York is somewhat progressive in this regard, as syringe exchange is able to be funded by government grants, something not allowed in many states. One such program is the Washington Heights Corner Project, a syringe exchange program which operates both from a building on 181st Street and as a mobile van. WHCP provides syringes and works to clients in addition to free HIV and Hepatitis C testing. The project employs a counselor and a nurse who visit the center weekly. The building has a space where clients can come to relax, a well-lit, sterile bathroom with an intercom so that staff can check on clients in case of overdose, and lunch is provided for clients certain days of the week.

Spaces like this are of the utmost importance and have the most potential to make an impact on people in the thick of drug use because they are far more accepting, and far less intimidating, than average rehabilitation centers. The people who work there are not judgmental, and many of them use or have used drugs themselves. Their aim is not to correct a person's behavior but to facilitate access to any services that that person wants. There is also no threat of arrest, as the people who work there recognize that police have no place in a space that is supposed to facilitate community and be therapeutic for people who uses drugs. Moreover, their services are free so that they are accessible to people without the money to pay for treatment and other medical care.

In attempting to confront criminalization of drug use, something that has primarily targeted poor communities of color, models like WHCP and Lincoln Detox are who we should look to for guidance. Under the philosophy of meeting people where they are and helping them work toward any positive change that they desire for themselves, these programs hold the most promise not only in keeping a person who uses opiates alive but in facilitating any further change they might seek. That can mean housing and employment assistance, referrals for further treatment, or assistance in managing their use.

The criminalization that the People's Drug Program was met with speaks to the fact that the government was not looking to help people who were using drugs in the Bronx at the time in any real way. Syringe exchange was still illegal at the time, and there were not nearly enough methadone programs to meet the demand for treatment that existed at the time. Methadone as long-term medication-assisted therapy was also viewed quite negatively by some activists involved in the People's Drug Program at the time (Come! Unity Press N.d.), as the long-term effects were not known and many people saw it as replacing one addiction with another.

Detoxification from methadone on one's own can be agonizing and withdrawal symptoms can last for weeks; even so, the existing methadone programs in the area did not aim to aid their clients with detoxification but rather were maintenance programs which required daily visits to keep a patient out of withdrawal. The People's Drug Program, on the other hand, only kept people on methadone for 10 days and used alternative therapies such as acupuncture to aid long-term recovery.

It is important to problematize the view that methadone used as substitution therapy for other opiates replaces one addiction for another. Many people credit methadone, and more recently buprenorphine,⁵ with their ability to stay sober and control their own lives. In my view, if a person is able to achieve their goals using substitution therapy, then they should be able to do that without the stigma that comes with labeling non-problematic use of a medication as addiction. That being said, many people involved in the People's Drug Program did not feel that methadone substitution therapy being provided in the Bronx at the time was adequate, nor were the long-term effects known, and thus creating alternate methods of treatment was valid and laudable.

This chapter has covered community responses to heroin in the Bronx in the 1970s and in the current epidemic, arguing that these grassroots examples are imperative to follow as models for community responses moving forward. The following chapter will examine the modern-day opiate epidemic beginning with the medical and pharmaceutical revolution that led to more liberal prescribing of opioid painkillers. From there, I will focus on the proliferation of painkillers in small, rural towns in the Southern Midwest. As part of this we will examine the influx of stronger heroin, and innovative models of selling drugs which led to its proliferation in places that previously had not had heroin markets. This will be followed by an analysis of the

⁵ Buprenorphine is an alternate opiate substitute. For more information, see the Glossary.

community responses that have developed in the wake of those this most recent epidemic, many of which share philosophies with programs like Lincoln Detox and the Washington Heights Corner Project. That comparison will be useful in chapter 4, which seeks to examine the common factors between small towns and inner cities that make them particularly vulnerable to drug epidemics.

Chapter 3: Heroin in the Heartland

For the majority of the twentieth century, the use of opioids in medicine was all but prohibited. Prescribing opioids, even to a dying patient, involved signatures from several doctors and was a last resort. This started to shift when a hospice center in London by the name of St. Christophers opened, whose mission was to treat dying cancer patients with opiates. Their philosophy was that addiction was irrelevant if a person was dying anyway, and if the tools to relieve their pain were available then it would be inhumane not to use them (Quinones 2015:80). Around the same time, a Swedish doctor named Jan Stjernsward was elected chief of the World Health Organization's cancer program in 1980. Stjernsward had seen thousands of cancer patients suffering before death while working in Kenya earlier in his career, and as a result of that experience had decided that if a patient could spend their last days pain-free, then they had the right to do so (Quinones 2015:81). Under his leadership, new guidelines for treating pain in terminally ill cancer patients were developed which indicated the use of opioids to treat pain when non-opioid pain relief was no longer working. These new guidelines claimed "freedom from pain as a universal human right" (Quinones 2015:82). This planted the seed for a broader movement that would change our view of pain treatment for decades to come.

In the early 1990s, many doctors viewed pain treatment as something that should be evaluated holistically. Many clinics utilized models for treating pain which involved modifications to a patient's diet, exercise, and lifestyle before medication was brought into the plan (Quinones 2015:87). This changed with the managed care movement of the 1980s and 1990s when insurance companies became more restrictive in what they would cover. Many patients were forced to leave their longtime doctors for others on a list of physicians approved by their insurance companies. Many doctors, for their part, had to take on additional patients to

make up for those they lost. This meant shorter appointments, and often less thorough evaluation of each patients' specific needs (Quinones 2015:88). Studies have shown that doctors who feel rushed are likely to write more prescriptions than doctors who do not (Grol et al 1985).⁶

The medical community became concerned that they had been undertreating pain (Quinones 2015:94). As discussions around that idea grew, the pendulum swung the other way. In 1996 the American Pain Society introduced their new slogan: "Pain: The Fifth Vital Sign" (Baker 2017) and used that idea to encourage doctors to more actively attend to pain while treating their patients (Quinones 2015:95). By definition pain is not a vital sign because it cannot be measured objectively like the other four (Quinones 2015:97), but this idea caught on. In 1998 the Veterans Health Administration adopted pain as a fifth vital sign (Baker 2017). The Joint Commission for Accreditation of Healthcare Organizations, responsible for the accreditation of sixteen thousand healthcare organizations in this country, followed suit (Baker 2017). Around the same time, Russell Portenoy and Kathy Foley published a paper which became foundational to the pain revolution in a way that it was never intended to be (Quinones 2015:92). Portenoy and Foley reviewed 38 cancer patients with acute chronic pain who had received opioids in treatment and found that only two became addicted, both of whom had histories of drug use. The conclusion that they drew was that opioids themselves were not necessarily addictive, and that outcomes depended on the person taking the drug (Portenoy and Foley 1986). Years later, Portenoy reflected on the paper saying that it was based on "weak, weak, weak data" (Quinones 2015:99), and that it was not meant to be nearly as important as it became.

⁶ Grol et. al. surveyed general practitioners in the Netherlands and found that those who described feeling rushed with their patients wrote more prescriptions than those who did not feel rushed. Another study by Davison et. al. in New Brunswick, Canada, found that local family practitioners who had higher than average rates of prescribing also saw more patients per day and worked more days each year than their counterparts.

A second unintentionally important piece of writing that became a driving force behind the pain revolution began as a letter to the editor (Hawkins 2017). Dr. Hershel Jick penned this letter to the *New England Journal of Medicine*, and it rose to notoriety when Portenoy and Foley cited it in a footnote of their study (Quinones 2015:99). The key claim made in the letter was that “less than 1 percent of patients treated with narcotics developed addictions to them” (Quinones 2015:107). Missing from this statement was that the database the statistic was drawn from “consisted of *hospitalized* patients from years when opioids were strictly controlled in hospitals and given in tiny doses to those suffering the most acute pain, all overseen by doctors” (Quinones 2015:107). In other words, these patients were not necessarily given the resources to form addictions- the ready supply of opioids offered by month-long, take-home prescriptions, or the excessive number of pills often given post-surgery (Shah et al.), for example.⁷ Jick actually meant to imply the contrary: that opioids were unlikely to be misused in such a supervised setting for acute pain, under strict control (Quinones 2015:107). What ensued could not have been farther from Jick’s expectations. The footnote in Portenoy and Foley launched Jick into notoriety- the problem was that no one knew that the less than 1% statistic came from a paragraph-length letter to the editor, and people began citing it as if it were a full study (Hawkins 2017). A researcher writing for *Scientific American* in 1990 referred to Porter and Jick as “an extensive study” (Quinones 2015:108), and in an article called “Less Pain, More Gain,” *Time* magazine called it “a ‘landmark study’ showing that the ‘exaggerated fear that patients would become addicted’ to opioids was ‘basically unwarranted’” (as quoted in Quinones 2015:108).

Fueled partly by these studies, a “conventional wisdom of sorts emerged” (Quinones 2015:109), which dictated that “addicts” and patients who used opioid painkillers for legitimate

⁷ 67% of patients do not take all of the opioids they are prescribed post-surgery. For more info, see <https://www.sciencedirect.com/science/article/pii/S0022534717671878>

pain were different, and that pills would improve the lives of one the latter while destroying the lives of the former (Quinones 2015:109). Based on that logic, there was theoretically no limit to how many opioid painkillers a pain patient could be prescribed. Some even believed an emerging theory that pain patients could experience a phenomenon called ‘pseudoaddiction,’ where one would present with the signs of addiction only because their pain was being undertreated (Keefe 2007). Enter OxyContin.

OxyContin

OxyContin, released in 1996 by Purdue Pharmaceuticals, was not the first drug of its kind. Other pills containing similar doses of opioids had been on the market in the past (MS Contin, Lortabs, Vicodin, etc). All were opioid painkillers contained in a pill manufactured with a time-release formula which would allow the drug to be absorbed into the body over a number of hours. All were combined with other drugs, intended to deter misuse- usually acetaminophen, which meant the drugs could cause a considerable amount of damage to the liver if taken in excess. OxyContin was different in this regard- it carried the same time-release seal but contained no such deterrent. The other key difference was that it was longer-lasting than other drugs on the market, boasting 12 hours of pain relief (Ryan et al. 2016). The scale at which OxyContin would come to be misused was both unexpected and unprecedented- MS Contin hadn’t had the same problem (Quinones 2015:124). But MS Contin was released in an era where opioids were shied away from except in the most dire circumstances, and obtaining a prescription for something like chronic back pain was unheard of. OxyContin entered the picture in a moment where doctors were finally free to prescribe opioids without the fear of addiction because now they knew that less than 1% of patients became addicted, thanks to the rampant

citing of Porter and Jick. And, inadvertently, the label on OxyContin told people how to misuse it by instructing patients not to crush the pills as a potentially toxic amount of the drug might be released (Quinones 2015:126).

On top of all of this, Purdue was utilizing a marketing strategy whose legacy came from Arthur Sackler, a man many consider to be the father of modern pharmaceutical advertising. Sackler worked for years at Pfizer, another large pharmaceutical company, and saw huge successes with his campaigns around Valium and Terramycin. These campaigns largely centered around the strategy of sending drug representatives straight to doctors, especially those they already knew to be liberal opioid prescribers (Keefe 2017). Representatives from the company would bring doctors gifts, meals, and samples of the drug they were selling. They would hire prominent doctors to speak to other doctors about their product, realizing that a key aspect of marketing was appealing directly to prescribers, not just their patients (Keefe 2017). Purdue picked this strategy up and used it to market OxyContin (Quinones 2015:31). When the FDA approved the drug, Purdue had not conducted any studies about the drug's addictive potential. Even so, a package insert was included with the drug and approved by the FDA which claimed that the time-release seal on the drug made it less likely to be misused (Keefe 2017). The FDA examiner who approved that claim quit his job not long after and went on to work at Purdue two years later (Keefe 2017).

The first several years of the marketing of OxyContin were completely unrestricted. Purdue representatives were told to market the drug as “virtually” non-addictive, and not out of dishonesty; many of them believed this to be true (Quinones 2015:139). Primary care doctors, for their part, were not receiving much training in pain management at the time except at medical conferences where supporters of liberal prescribing of opiates were citing Porter and Jick

(Quinones 2015:135). Purdue targeted doctors using lavish gifts, all-expenses-paid vacations, and other incentives to prescribe OxyContin (Quinones 2015:134). Legislation was enacted in 2002 to limit the gifts and incentives that drug companies could use to intrigue doctors, but by then Purdue had been marketing OxyContin for six years (Quinones 2015:134). By 2002, 90% of Purdue's revenue was being generated by sales of OxyContin (Quinones 2015:134).

In Southern Ohio, addiction specialists were starting to notice the trend. Pill mills, or cash-only pain clinics known for cursory doctors visits and high rates of opioid prescriptions, first started to pop up in the area around a small town called Portsmouth (Quinones 2015:147). Some of these offices functioned more brazenly than others, with long lines out the door and into the parking lot. Many patients would come from out of state to visit these clinics, the most prolific of which was owned by a doctor named David Proctor. Proctor was one of the first to open a pill mill, and others soon followed suit. His clinic in South Shore, Kentucky, just over the Ohio border, was one of the most prolific pill distribution centers that this country has seen (Quinones 2015:154). By the end of the pain revolution there were many such clinics in the Rust Belt, convenient for people in towns where industry had flourished and died out, many of whom now worked manual labor-intensive jobs. Injury in that line of work is common, and there was no lack of people looking for monthly disability income (Quinones 2015:154). Proctor's clinic was known for helping patients register for disability; they charged cash for each visit and were known for their readiness to prescribe drugs like OxyContin and Xanax (Quinones 2015:154). Clinics like this were easy to open in Rust Belt states with little regulation, such as Ohio and Kentucky. Prescriptions had to be refilled each month, and at \$250 per visit these clinics were an extremely profitable business model (Quinones 2015:156). When OxyContin came along it was the perfect storm: a drug that created addiction not just in people intending to use the drug

recreationally, but in some unsuspecting patients who sought it for pain relief as well (Quinones 2015:155). David Proctor retired after a car accident left him unable to practice medicine⁸ and hired fifteen doctors in his place, many of whom went on to open their own clinics in the region (Quinones 2015:158). Pill mills quickly spread across the Rust Belt and Appalachia. Proctor's clinic was eventually investigated, resulting in him being sentenced to 11 years in prison. By that time, though, a region devoid of economic opportunity had seen an incredibly successful business model take hold, and many other such clinics opened over the next several years.

Xalisco

In the early 1980s, migrants from a small town in the northern Mexican state of Narayit began selling heroin in the San Fernando Valley. Their technique of doing so was different than most in that it functioned more like a pizza delivery service (Quinones 2015:40). Clients placed their orders with a person at a centralized call center, usually an apartment in the area. The person that they spoke to would then page one of a number of drivers working for him. These drivers were young men from Xalisco, Narayit, who would come to the US for several months and deliver heroin, then return home. They never carried more than very small amounts with them, contained in balloons which they held in their mouths and swallowed if they were pulled over. They were given cell phones upon arrival, the numbers to which were changed at the slightest hint of suspicion (Quinones 2015:44).

Conditions in the mountains surrounding Xalisco were ideal for growing opium poppies, from which black tar heroin was made (Quinones 2015:57). Runners, often women, would bring heroin across the border to be sold in the U.S. With the help of their clients, dealers from Xalisco

⁸ The circumstances surrounding David Proctor's retirement were questionable, and many think he left the business because his practice was being investigated.

began expanding their operation to small towns across the West, many of which previously did not have established heroin markets (Quinones 2015:105). This part was key- because they were not a part of any established cartel, it was in their best interest to stay away from large cities where there was already established control of the drug trade. These dealers from Xalisco never employed violence, as they aimed to avoid the attention of law enforcement, but instead competed by offering low prices and high quality heroin to their clients. And because the drivers were paid in salary there was no advantage to cutting the drugs or skimping bags (Quinones 2015:102). Though there was some risk involved, the sentences drivers received if caught were usually minimal if they were sentenced at all; usually they were deported, but there was always someone waiting to replace them⁹ so this did not disrupt the function of the operation (Quinones 2015:176). If one driver was arrested, another would quickly come up to replace him. There was strong incentive to get involved in the heroin trade because economic opportunity in Xalisco was otherwise limited to labor-intensive farming, the trade of the previous generation. Many of the young men who came up to work in these heroin cells had bigger dreams- dreams to increase their family's economic standing, to make a name for themselves. Heroin made that possible. Their model was so successful because they almost exclusively set up operations in small towns where they had no risk of conflict with existing drug selling operations (Quinones 2015:105). Purdue released OxyContin in 1996, and by the late 1990s Xalisco crews had begun to explore towns east of the Mississippi. By the mid-2000s they were operating in 17 states (Quinones 2015).

⁹ The heroin trade soon came to dominate the economy of Xalisco, allowing previously lower and middle-class families to raise their status in a way that was largely not possible before. Many people who lived there, but particularly young men, were eager to get involved in the US heroin operations; thus, with each deportation there was another person eager to take the place of whoever had just returned home. For more, see Quinones 2015:101.

The novelty of these heroin cells also existed in their convenience. Whereas before people in small towns and suburbs looking for heroin usually had to venture out of their own neighborhoods, now heroin would come to them (Quinones 2015:70). And at a time where more and more people were able to access opiate painkillers, many of them began to seek out heroin as well (McGreal 2016). As small towns in the midwest began to see more pill mills, they also came to have more demand for heroin. OxyContin could go for \$1/mg (as much as \$80/pill), and since heroin was cheap and convenient it had strong appeal as an alternative (McGreal 2016). Dealers from Xalisco relied on their clients to connect with potential new markets as many of them spoke little to no English and did not use the drugs themselves, limiting their ability to connect with a subculture that could lead them to potential new clients (Quinones 2015:257). One way that they did this was to offer deals to clients who brought them new customers.

Collision

Opiates became, and still are, the most prescribed drugs in the United States. Portsmouth, OH once had a pill mill for every 1800 residents, and an entire underground pill economy to match (Quinones 2015:197). Many residents of this area also had Medicaid cards, which greatly reduced the cost of prescriptions. With a Medicaid card a person could go to a pharmacy and pick up a month's supply of OxyContin for \$3. Those pills were worth up to \$10,000 on the street; though Medicaid cards were nothing new, "with OxyContin, they became licenses to print money" (Quinones 2015:211). With a convenient heroin delivery system in place on top of the economic incentives on each subsection of the supply side, it should be no surprise that opiate use ballooned the way that it has. The Rust Belt, in many ways, was ground zero for the epidemic that proceeded to sweep the entire nation (Quinones 2015:193).

Heroin dealers from Xalisco reached southern Ohio around 2003 (Quinones 2015:193), right around the time that pill mills were taking over the Portsmouth (and surrounding Scioto County) economy. A key part of the model pioneered by Xalisco dealers was that they almost exclusively sold to white people (Quinones 2015:163). This meant that just as opioid painkiller use was starting to take off, white people in small towns like Portsmouth¹⁰ suddenly had easy access to heroin when many of them previously had not, and because pills were so expensive, people who previously might not have sought out heroin began to. Though the current opiate epidemic is not nearly as white as the media portrays, this is an important part of the explanation of how we arrived at the current situation. Pills and newly cheap, stronger-than-ever heroin converged in rural white towns and were so readily available that OxyContin and similar pills often functioned as sort of currency. Black tar heroin from Xalisco was much stronger than the China white variety that most people were used to. China white, or white powder heroin, was often cut multiple times before it got to someone who would use it. This was before the proliferation of fentanyl, another opiate which now is often mixed in with heroin, but even so overdose rates were already increasing.

In 2012, Washington State became the first to attempt regulation of how many pain pills a patient could be prescribed after researchers began to notice in 2000 that workers were going to doctors offices with complaints of minor injuries and later dying (Quinones 2015:204). When the regulations went into effect, the number of deaths in the state dropped by half (Quinones 2015:310). By that time, drug overdoses had surpassed auto accidents as the leading cause of accidental death (Katz 2017). National attention was drawn to the problem when Philip Seymour Hoffman, beloved actor and cultural icon, died of an overdose in 2014. Suddenly the media began piecing together a national crisis that had been killing unprecedented numbers of people

¹⁰ Portsmouth's population is 90% white (AreaVibes 2016).

for more than a decade. After Hoffman's death, then-Attorney General Eric Holder called for naloxone to be carried by all EMTs and police officers, calling the situation a public health crisis. In the 2016 Presidential race, many conservative candidates described loved ones' struggles with addiction and moved away from the tough-on-crime language that has so long been the standard in conservatives' discourse on drug use.

In some ways, many traditionally tough-on-crime white conservative politicians have adopted a gentler approach to drug policy in the wake of people they know and identify with being affected. Governor John Kasich of Ohio expanded access to naloxone, the antidote to opiate overdose, statewide in 2014. He also extended Medicaid to every Ohioan, giving many families a way to pay for long-term treatment. Many politicians are supporting increased funding for treatment, though what is meant by treatment varies. Most police departments and emergency medical services now carry naloxone. The police force in Gloucester, MA has established a program where a person seeking treatment, even if they are in possession of drugs, can turn themselves over to the police and be connected to treatment through a local hospital rather than facing arrest (Dwyer 2016).

Some of the more concerning political developments in the wake of the current epidemic have to do with Len Bias cases and drug-induced homicide laws, which will be examined more closely in Chapter 4. Len Bias cases allow for a person who supplies drugs to be held responsible for conspiracy resulting in death if a person they supply drugs to overdoses. Drug-induced homicide laws function similarly, the key difference being that Len Bias cases include incentive for a person to rat out someone higher up than them in order to avoid the charges against them. These laws target dealers rather than users, and in some iterations include extra provisions for

treatment, but the distinction between user and dealer is often blurry and it is imperative that we examine how, and against whom, these laws are actually used.

In the wake of opiate use being declared an epidemic, thinking about opioids in the medical community has swung to the opposite extreme. Many doctors have eschewed opioids and have become much stricter in their prescribing practices in an attempt to reduce supply. The effectiveness of such an approach is questionable, as it results in hardships for chronic pain patients who rely on the drugs to make life bearable. Many states have implemented prescription monitoring systems and have limited the number of opioids that patients can obtain per prescription, meaning more trips to the pharmacy but not necessarily less drug supply overall. And, given that most people who become addicted to prescription opioids are not the pain patients themselves but rather friends and relatives (Szalavitz 2017), policies that restrict medical supply probably do more harm than good. A person who problematically uses illegally obtained prescription medication could be pushed to an alternate, less predictable source (namely heroin) if their supply of drugs of a known dose and purity runs dry.

As before, the most important responses to this epidemic have largely taken place at the grassroots, community level. In Portsmouth, a syringe exchange program opened in 2014 and managed to cut new cases of Hepatitis C by nearly half in its first year. As of 2016 the program was entirely funded by donations (Lebeau 2016). In Portsmouth, OH, a group of parents who had lost children to opiate overdose developed what at first was an anti-drug organization but eventually developed into a community-based treatment facility (Quinones 2015:288). After an HIV outbreak largely attributable to needle sharing occurred in nearby Scott County, Indiana, Mike Pence approved legislation that legalized syringe exchange in the state, though many politicians in the rest of the state have been slow to catch on. In another part of the country, the

public health commissioner in Boston implemented a requirement that fast food workers perform bathroom checks and be trained to recognize the signs of an overdose because so many people were dying on their watch. Several cities including Philadelphia and San Francisco are hoping to open supervised consumption spaces, or facilities in which clients are allowed to use drugs with medical staff present in case of an overdose. City officials in Philadelphia announced last month that they will approve such a facility within city limits this year (Gordon 2018).

The convergence of OxyContin and heroin in southern Ohio speak to the driving force that capitalism is behind drug epidemics. As Purdue sought ever-rising revenues and made every attempt to hide their knowledge that OxyContin might be more addictive than they let on, people in deindustrialized towns and inner cities seeking subsistence in one form or another were the first to fall. Both pharmaceutical companies and the government have prioritized profits over the wellbeing of their people in creating and responding to this epidemic. It should be abundantly clear when the United States consumes 80% of the world's legal opioids despite being home to only 5% of the world's population (McGreal 2017), that this epidemic speaks to a cultural problem and not individual choices. Yet Trump continues to express compassion for the "new" image of opiate users while promoting "Just Say No" rhetoric which places the blame squarely with individuals. Negating the role of institutions driven by capitalism will eventually land us right back where we started. A government which cannot acknowledge its own role in creating this epidemic should not be trusted to treat it, especially when they have given every indication that they intent to employ disproven prevention tactics. If this is the path that we follow, we will soon end up back where we started in one form or another.

In this chapter we have covered the rise of OxyContin and the role that Purdue Pharmaceuticals played in its proliferation in the southern Midwest, followed by the rest of the

country. This, in areas devastated by deindustrialization, led to entire economies developing around painkillers. Similar motives drove people from a small town in Mexico to develop heroin selling operations which concentrated in small towns that previously had not had heroin markets, around the time that OxyContin was taking over many of the same places. The end of the chapter began to touch on the inadequacy of the Trump administration's response, something that will be explored further in Chapter 5. The following chapter will focus on a comparison of opiate epidemics in the Bronx and Southern Ohio, specifically comparing small towns and inner cities in order to examine the factors that make both places vulnerable to such epidemics. That analysis will be used to inform the fifth chapter, which will focus on issues in the current governmental response to this opiate epidemic, and suggestions for transformative policy moving forward.

Chapter 4: Small Towns, Inner Cities

If Black lives mattered, our government would not have tolerated a decades-long defeat in the war against drugs. If Black lives mattered, Naloxone would have been available in every urban, health clinic starting in the 1970s. If Black lives mattered, today's overdose crisis would be ameliorated by decades of public health policies focused on reducing stigma and promoting treatment over punishment. . . It is precisely because Black lives didn't matter for decades that White upper middle class people are dying in staggering numbers today.

-Kassandra Frederique, "The Role Race Plays in the War on Drugs"

The logic behind the importance of harm reduction falls in with the importance of grassroots, community-based responses. If a person can seek recovery by their own free will amongst people with whom they identify and are comfortable with, the likelihood of their seeking further treatment greatly increases. One study of a supervised injection facility in Vancouver found a 30% increase in use of further detoxification services among their clients (Wood et al. 2007). Many syringe exchange programs are entirely staffed by peers, people who currently or formerly have used drugs, who provide support to clients through their own lived experience. Although legally sanctioned supervised injection facilities are still an unrealized end-goal in the U.S., community-based support systems for people who inject drugs exist in many forms.¹¹

The work of Butch Ford and the Young Lords at The People's Drug Program (Lincoln Detox) are prime examples of such community-based support systems. The People's Drug Program was entirely non-coercive and sought to fill a need for treatment where none was available. Its successes speak to the fact that recovery is always done better in community than in isolation, but also to the fact that recovery does not happen in a vacuum. People from Lincoln

¹¹ For a great example of this, readers should watch the documentary "The Family at 1312" by Sawbuck Productions. The director follows a woman in Chicago named Kat, the matriarch of an unofficial safehouse for a group of friends who use heroin and other drugs.

helped clients advocate for themselves in social service settings and worked on campaigns related to workers' rights for the people that they served. In doing so they were onto a crucial idea that sobriety is meaningless and often unattainable if a person has no access to other necessities such as secure housing, food, and a job that pays a decent wage. Any attempt to respond to drug use must prioritize those things.

Another key to Lincoln's success was that police were entirely barred from the premises. With law enforcement present, spaces intending to serve people who have been criminalized for their drug use cannot be considered non-coercive *in any form*. Services like LEAD (Law Enforcement Assisted Diversion), which allow people seeking treatment to turn themselves over to police who will then connect them to a treatment center, to many seem like a step in the right direction, and in some ways they are. If viewed as a step toward incremental change, these programs are valuable. The problem is that such programs acknowledge drug use as a public health issue while still leaving control of the response to that drug use in the hands of the criminal justice system, the same system that has terrorized and traumatized people who use drugs — but especially people of color who use drugs — for decades. A similar issue exists with drug courts, or courts exclusively reserved to deal with nonviolent drug charges. The way such courts function is often by placing extensive requirements on defendants that they must follow in order to avoid serving time in jail. Jail is a constant threat held over the defendant's head if any of the court's rules are broken, and ultimately many defendants end up serving equal or more time in jail than they would have for their original offense (Tiger 2012).

My point is that programs like LEAD and institutions like drug courts should not be seen as radical reforms. They both have potential for abuse and exist within systems with legacies of violence against black people. They acknowledge the fact that drug use is a public health issue

but continue to handle it in a criminal justice setting. As we move forward from the moment that we are currently in, reforms like LEAD and drug courts cannot be end goals. Their outcomes must be constantly monitored and held to rigorous standards of reparative justice, and they must be seen as stepping stones on the way to full legalization if we hope to ensure that the Drug War and mass incarceration are the final iterations of racial caste systems in this country.

Pain

We live in a culture that expects instant gratification much of the time. Many of us quite literally carry the internet in the palm of our hands. We perform transactions online and have products delivered to our doorstep, something that once required planning and trips to the store. We can queue any book, song, movie, or TV show within seconds. Oftentimes we can conduct significant portions of our relationships over text messages and social media. It has become incredibly easy to distract oneself from real life at the push of a button.

I can remember meeting someone my freshman year of college who had never taken any medication in her life. I was shocked by that, having grown up in a family where the go-to solution for any physical discomfort was an Advil, and in that moment I had a cognitive shift. I realized that I had been consuming pharmaceuticals for years without question, assuming it to be normal. Many of the people I know who grew up in the late 90s felt similarly. As I've been doing this research I have thought about that moment, and the presumption many of us have in this culture that we have a right to be free from pain.

The pain revolution of the late 1990s culminated in the idea that pain relief was a right, rather than a possibility. The advent of OxyContin, at the time viewed as the greatest achievement in pain management to date, radically changed the medical community's approach

to pain treatment. Rather than reserving opioids for last-resort acute pain management, they were prescribed for a broad range of conditions (anecdotally, I was once prescribed an opioid for strep throat). Some patients were prescribed them without fully understanding what they were. Others sought them out. Most doctors were well-intentioned, genuinely believing the Porter and Jick statistic that less than 1% of their patients would become addicted to the drugs they were prescribing. Some, like David Proctor, were not so well-intentioned and saw the opportunity for a profitable business model in places like Portsmouth, charging patients cash and prescribing whatever they asked for without any follow-up or discussion of alternative treatments.

A theory emerged in 1989 that some patients given opioids experienced a phenomenon referred to as pseudoaddiction, where they exhibited certain symptoms of addiction as a sign that their pain was being undertreated (Quinones 2015:234). The man behind this theory, J. David Haddox, later went on to work for Purdue. Chronic pain was also thought to negate the addictiveness of opioids, therefore making patients who were prescribed those drugs for chronic pain somehow immune to their addictive potential. Though these two theories likely were mobilized to promote pharmaceuticals, their secondary effect was to differentiate “addicts” from pharmaceutical consumers, reinforcing classist and racist assumptions that allowed consumers of painkillers to separate themselves, both physically and conceptually, from people who shot up heroin.

Pill mills permeated Portsmouth to such an extent in the early 2000s that an underground OxyContin economy developed. While many drug markets can be described that way to a certain extent, the convergence of pill mills and Medicaid cards in Portsmouth led to far more pills making their way to the street than in the average town. Many residents who were on federal disability or state welfare figured out that their Medicaid cards would cover a prescription for

OxyContin for \$3. Those pills could be sold for as much as \$10,000 on the street. In a deindustrialized town where other opportunities were few and one prescription could bring in that much money, it's easy to see how Portsmouth, Ohio became ground zero in an epidemic that would soon spread to the entire country.

Drugs can serve as an equalizer, making success stories out of people whose lives otherwise might have looked very different. The drug trade has always provided economic opportunity to legal capitalism's outcasts. That could be said about the South Bronx in 1970, and of the area surrounding Portsmouth some time later, around 1990 when their last shoe factory closed. Drugs can redistribute power in ways that traditional hard work and bootstrap-pulling often cannot for people who lack money living in places that structurally lack the resources to change their situation. Drugs can also do the opposite, apparent in the current opiate epidemic where the media so often focuses on white middle/upper class teenagers whose lives, otherwise on track for success, were derailed by OxyContin or heroin. Michael Cetewayo Tabor, a member of the Black Panther Party and one of the New York 21, described people who sold drugs in the 1970s as "illegal capitalists" (Tabor [N.d.] 2006). The irony in that phrase is so apparent now, when no one from Purdue served any time after being convicted of falsely advertising OxyContin but untold numbers of black and brown people who sold heroin as a similar means to a similar end are still in prison today.

A commonly proposed reform today, especially among conservatives, are drug-induced homicide laws. These laws would allow a dealer to be charged with homicide for selling someone a drug that causes them to overdose. While questions of responsibility in that situation can be debated, if we have learned nothing else from drug policy we must recognize that there is seemingly infinite room for error and bias in such a case. Distinctions between dealer and user

are often blurry and racially loaded, and there is real danger in seeing an overdose as murder. To implement such laws would be to create a dividing line where there is not one, and in a moment where people who use opiates are being portrayed in the media as almost exclusively white it would be easy for such a law to be used as a means toward the end of upholding the racial status quo.

An optimist might hope that as white conservatives begin to recognize the humanity of people who use drugs, that conception of humanity might extend beyond just the users who look like them and possess a similar socioeconomic status. History has repeatedly demonstrated otherwise, however, so we must be vigilant for policies like drug-induced homicide laws as well as reforms like drug courts and LEAD. The same perceived exceptionalism that drives the user-dealer distinction may have played an important role in Portsmouth's perceived immunity from (and therefore lack of preparedness for) a large-scale drug crisis. In the 1970s and 80s, Portsmouth was prospering. There was a central swimming pool called Dreamland where the entire community converged in the summer. Parents felt safe leaving their kids, knowing that someone would keep an eye on them. The shoe industry kept the older generation employed at a decent wage. When industry abandoned the town and pain clinics took its place, families were both unprepared and embarrassed to admit that people in their homes were struggling with addiction. When someone died of an overdose their family often tried to hide it. It took nearly a decade for people to start acknowledging that there was a larger problem (Quinones 2015:288).

Isolation

The isolation of small towns tends to breed feelings of insulation. This was definitely true of Portsmouth, as a large driving force behind the OxyContin economy that emerged was the

lack of other opportunity in the town coupled with a sensation of being trapped there. Its rural setting magnified feelings of isolation, and with its prosperous past that isolation was more than just physical — Portsmouth was a bubble before the industry left. Heroin seemed like a far-off concern to most of the people who lived there, something that would never touch them. So when people in Portsmouth did start overdosing, no one was prepared to talk about it, much less respond to it on a structural level. Families felt like their struggle was their own, and that they were alone in having a family member using drugs. Though this isolation was in part physical, it was also both cultural and ideological. Drug use has long been denied as a white phenomenon despite the fact that rates of drug use between black and white people have been similar for decades (Netherland and Hansen 2016). Publications that discuss white drug use highlight its rarity and the shock that accompanies its occurrence, while publications that discuss drug use by black and Latinx people tend to highlight arrest rates, trafficking, and violence (Netherland and Hansen 2016). At that time, media discussing drug use by white people were even more rare, and the stigma surrounding drug use as a whole was palpable. To admit to partaking in drug use, then, for people in Portsmouth at the time, was to make themselves unwhite. That internalized stigma, that whiteness, equated death in many cases.

Isolation played a role in the vulnerability of the South Bronx in the 1970s, too, though for different reasons. There, isolation meant being unable to access the economic and infrastructural resources of much of the rest of the city. When every other city hospital had been modernized, the money designated to improve Lincoln continued to be diverted each year. There were no translators on staff despite the fact that the surrounding community was largely Puerto Rican, so many people could not even seek medical attention in a language that they understood. Jobs were few and living conditions in the area were often unbearable. Michael Cetewayo Tabor

points to escapism as a driving force behind addiction at the time- escapism from the garbage on the streets, the wail of police cars mixed with cries of anguish, from the realities of racism and dehumanization (Tabor [N.d.] 2006). Help, even when it was asked for, was often slow to come and often meant law enforcement rather than treatment or other forms of assistance. That systemic racism and perceived inhumanity, that stigma, equated death in the Bronx too.

In addition to that isolation, the heavy presence of law enforcement and more broadly of the prison industrial complex existed in the Bronx before heroin even got there. Heavy police presence, the repeated delays of funding for treatment, and lack of other ways to improve one's financial situation meant a vicious cycle: no matter how many people were arrested for selling drugs, more would take their place. The expectation for black people that one would eventually be terrorized by police with no guaranteeable way to avoid it, paired with the hopelessness generated by surrounding lack of infrastructure, all compiled to make the Bronx vulnerable to heroin. While Portsmouth was ground zero for the current opiate epidemic, the Bronx was ground zero for an opiate epidemic coupled with a carceral state in the beginnings of mass incarceration.

Portsmouth was unprepared to deal with a large-scale public health crisis as a result both of isolation and perceived immunity, but also because dealing with drug use from a public health standpoint had never been done on a large scale by the government before and it was unlikely that anyone in Portsmouth remembered the Lincoln Detox, several states away and nearly 30 years prior. In the Bronx, on the other hand, people knew what to do but could not access the funding they were promised for necessary responsive services until it was agreed upon in negotiations after the takeover. At the end of the day, though, it comes to much more than a lack of funding. The Bronx in the 70s is a pure example of the ways in which the drug war was built

against black people, and the fact that nothing was done about the epidemic on the part of the government becomes almost obvious at that point. Black lives historically have not mattered, or we would have had examples in place of how to respond to a heroin epidemic before this most recent one even started.

The Morphine Molecule

Important to address in this analysis are the politics of opioid painkillers as opposed to heroin in terms of how they are viewed in society and dealt with legally. In the wake of the most recent epidemic, stories of “accidental” drug addicts are very common. Most start off with someone like Susan, an imaginary high school cheerleader with perfect grades who injured her knee and was prescribed hydrocodone after surgery. Eventually when the pills became too expensive or otherwise inaccessible, she switched to heroin.

While accidental addiction stories do sometimes happen, they are the minority. Today more people initiate their opiate use with heroin rather than painkillers anyway (Cicero et al. 2017). The dichotomy of “accidental” versus “intentional” addiction is arbitrary as they have the same end result, but it is significant in the way it portrays pain patients as more deserving of sympathy than people who use heroin. This falls in with the idea of “legitimate” versus “illegitimate” use, with pain patients being legitimate users seeking pain relief while people seeking heroin are just looking to get high. In reality this distinction is arbitrary, especially when a pain patient and a heroin user can be the same person at different points in their life.

It is also important to recognize that while white middle class users are receiving attention in the media, they are not the vast majority of people being affected by the current epidemic the way the prevalence of that image in media would have us believe. In some states,

like Illinois, Wisconsin, Missouri, Minnesota, West Virginia, and D.C., African Americans are dying at rates higher than whites. In Wisconsin and West Virginia that rate is more than double (Bechteler and Kane-Willis 2017).¹² Especially in a moment where sympathy and support are being readily given to white users, it is imperative that those statistics be uplifted so that we do not move forward from this moment helping white people and leaving black people who have been bearing the brunt of this drug war, and ultimately of racial caste in this country, for centuries.

This chapter began with a focus on the politics and requirements of radical reform. From there, we analyzed the different forms of isolation that made both Portsmouth and the Bronx vulnerable to opiate epidemics. The perceived immunity upheld by whiteness that created stigma in Portsmouth, and the stigma that pervaded the Bronx in the 1970s, made both of those places unable to ask for help that was responsive to their needs, making community responses their only way out. The following chapter will delve into ideas for how we might move forward from the current epidemic, looking closely at present issues like drug-induced homicide laws, medication-assisted treatment, and best practices for harm reduction.

¹² For more on this and other helpful statistics, please visit:
https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed%20AA%20Opioid%20Crisis%2011-15-17_EMBARGOED_%20FINAL.pdf

Chapter 5: Looking Forward

“Prosecution blinds the public to the possibility of nonpunitive solutions and to the inadequacy of the nonpunitive solutions that are currently available”

-Dorothy E. Roberts 1991

The Trump administration’s most recent plan to confront the opiate epidemic includes reducing opioid prescriptions by a third in the next three years and the creation of a new task force in the Justice Department which would be responsible for prosecutions of “criminally negligent doctors” (Diamond 2018). It also includes efforts to make it easier for judges to invoke mandatory minimum sentences against people who sell drugs, including the use of capital punishment in certain cases (Diamond 2018). The administration also plans to expand access to naloxone among first responders, to screen people entering the federal prison system for opiates in order to divert them to treatment, and to redirect resources to areas hit especially hard in the current epidemic (Diamond 2018). These proposed reforms are a mixed bag. The latter few have a more progressive ring to them, and seem like they could potentially begin to distance the handling of drug use from the purview of the criminal justice system. The first four, however, should give all of us pause. Aimed largely at supply, and thus appealing to newfound conservative drug reformers, they are rife with potential for abuse.

Trump has repeatedly expressed sympathy for people who use opiates in this most recent epidemic. Couched within that rhetoric, though, are demands for stronger border control and crackdowns on drug trafficking. Such racially coded distinctions are where the white conservative balance between being “tough on crime” and having sympathy for people that use drugs who look like them has fallen in modern debate. Many well-meaning moderates accept this rhetoric as well -- since heroin and fentanyl are now proliferating in communities where drug use

was once perceived to be rare, going after the people “responsible” for these skyrocketing rates of overdose makes sense to many.

The way that drug offenses are represented in the media largely breaks down by race. When the story centers a white person, drug use is often portrayed to be surprising, even a rarity (Netherland and Hansen 2016). An otherwise good person who made a few wrong choices, or an athlete who was injured, eventually became addicted to an opioid painkiller that they were prescribed by a doctor. Their drug use is portrayed to be blameless (Netherland and Hansen 2016), often accidental, and their overdose an unforeseen tragedy. When the story centers a black or Latinx person, on the other hand, the language much more often centers around violence, trafficking, and arrest (Netherland and Hansen 2016). These stories are told without context about whom the person was, solely citing that they were arrested for heroin possession (Netherland and Hansen 2016).

Such media portrayals contribute to the dehumanization of black and Latinx people who use drugs while normalizing white innocence. The proliferation of such racialized ideas of drug use make white people who use drugs seem like outliers, while criminalization of black and Latinx people who use drugs is reinforced as the norm. This is despite the fact that rates of drug use are actually higher among whites, and rates of drug sales between blacks and whites are equal (Hamilton Project 2016). In the eyes of many, this normalizes criminalization of black and Latinx people and reinforces the idea that white people are victims of outside forces that contribute to their drug use.

Drug-Induced Homicide Laws

Thinking through this lens, we can start to unpack the often bipartisan support for drug-induced homicide laws. When the media and the government represent the victims of the current opiate epidemic as exclusively white, they further demonize black and Latinx people and associate them with trafficking and criminalization. In the popular imagination, then, when we talk about people who sell the drugs on which other people overdose, an act which is heavily criminalized, the people behind those sales are not associated with the innocent white victims that Trump expresses sympathy for. The distinction of “dealer” versus “user,” while often blurry in reality, is racially coded in political rhetoric. Effectively, then, the image of “dealer” becomes black and Latinx, while “user” remains white and blameless. If the public does not come to recognize this, legislation that further criminalizes people who sell drugs will dig us right back into a cycle of increasingly coded white supremacy that we have been repeating since slavery.

Twenty states currently have drug-induced homicide laws, which allow a person who delivers a drug which causes another person to overdose to be charged with capital murder. Many states that do not officially have these laws do have felony-murder, manslaughter (voluntary and involuntary), and depraved heart laws, which allow for the same charge to be made under a different title (DPA 2017). In 2017 alone, legislators from 13 states sought to introduce legislation to increase penalties for drug-induced homicides (DPA 2017). Between 2011 and 2016, there was a 300% increase in mentions of drug-induced homicide circulated in the media (DPA 2017). The reach of these laws can be vast. One man cited in a report by the Drug Policy Alliance, who had recently lost a job and was selling small quantities of heroin to make ends meet, sold heroin to a white man who gave some to his girlfriend. She overdosed, and James Linder, a black man, was sentenced to 28 years in prison by an all-white jury in a county

whose population is 1.6% black (DPA 2017). Another man cited in the report injected his girlfriend with cocaine, which he did not sell to her, and received a life sentence (DPA 2017).

These cases point to the potential that such laws have for abuse, and the indiscriminate manner in which they are often applied. Neither of the cases cited above stemmed from a direct transaction. Both came as a result of someone calling for help when someone they were with overdosed. If the purported goal of these laws is to increase public health and safety by instilling fear in people who sell drugs,¹³ they cannot be said to be effective. If people who use drugs are afraid to call for help in the event of an overdose, death rates will only continue to increase. And though drug-induced homicide laws aim to go after large-scale sellers, that rarely happens, and they much more often target people most likely to be present when a loved one overdoses (DPA 2017). The consequence of these laws, and the judicial discretion that they allow for, only allows for further racist enforcement of drug laws in the age of sympathy for white people who use drugs.

Some drug-induced homicide laws have been included in bills which also promised to expand access to naloxone, which appeals to many moderate politicians. These bills exist in Florida and Kentucky (American Bar Association 2018), and need to be watched for in other states. An important intervention that needs to be emphasized as these laws gain popularity is the use of racial and ethnic impact statements, which require policymakers to rigorously assess how a given policy will affect racial disparities in law enforcement (Netherland and Hansen 2016). This requirement exists in five states, but is something that we must fight to expand in order to combat the power of legislation that would further criminalize black and Latinx people in the name of protecting white users.

¹³ Scare tactics like these have been proven not to work by decades of punitive drug policies aimed at decreasing drug use.

Medication-Assisted Treatment

In June of 2016, then-President Obama signed the Comprehensive Addiction and Recovery Act (CARA). Three key reforms were included in CARA: it allows nurse practitioners and physicians' assistants to prescribe buprenorphine, authorizes grants to states to expand medication-assisted treatment to areas with high rates of opiate use, and authorizes state grants to agencies "to carry out pilot programs for non-residential treatment of pregnant and postpartum women" (ASAM 2016). Buprenorphine is an important tool, as it is a take-home medication that allows patients dependent on opiates to lead normal lives. It differs from methadone in that it can be prescribed and taken at home, whereas methadone patients have to go to a clinic each day to get their dose. Both medications aim to sustain an opiate-dependent patient; neither drug gets a person high, but both prevent withdrawal. Buprenorphine is largely prescribed in the privacy of a doctor's office¹⁴ while methadone clinics are more public affairs, often with long lines as people get their doses on their way to work. While buprenorphine providers in many states are numerous, sometimes these statistics can be misleading. One recent survey of buprenorphine providers in Ohio found that 1 in 5 of the doctors listed was not an active prescriber, and 1 in 2 did not accept insurance (Parran et al. 2017).

Criminalization of Doctors

Prescription-monitoring systems, or online databases used to track what drugs a patient is prescribed, have been established in 49 states, D.C., and Guam in the wake of the current opiate epidemic. Their stated goal is to ensure that a patient is not "doctor-shopping" or going to multiple doctors for the same prescription, as well as to monitor doctors for over-prescribing.

This is where the new Justice Department task force to track "criminally negligent doctors"

¹⁴ Political difficulties in legalizing buprenorphine required "associating it with less stigmatized suburban white populations, and. . . economic motivations led buprenorphine's manufacturer to market to insured, employed, largely white clientele" (Netherland and Hansen 2016).

(Diamond 2018) would come in. Though they aim to curb overprescribing, the unintended consequence of these databases is that doctors fear being tracked and accused of overprescribing even if they are legitimately prescribing opioids to patients who need them. In the end this may limit physicians' willingness to prescribe buprenorphine, as was the case in Staten Island, NY when the state required that physicians report their prescribing practices to a monitoring system (Netherland and Hansen 2016). Due to liability concerns, some doctors reported that they had been turning away patients who were dependent on opiates (Netherland and Hansen 2016). Thus, prescription monitoring may be unintentionally driving patients to riskier behaviors, like buying heroin on the street because they cannot access substitution therapies that they would otherwise seek out in a doctor's office. In turn this creates higher risk of bloodborne infections like HIV and Hepatitis, as well as leaving patients vulnerable to arrest and ultimately overdose. If physicians fear their own criminalization, people who use drugs are further stigmatized and pushed out of traditional medical settings (Mendoza et al. 2016).

I believe it would be wiser to focus on holistic interventions like training physicians in harm reduction services, housing assistance, or employment assistance. While monitoring prescriptions does seem like a reasonable response on its surface, upon closer examination it leads to unintended consequences. At the end of the day we should aim to keep people who use drugs in clinical settings, and prescription monitoring risks pushing them out. One intervention which has shown success is pairing physicians who are experienced prescribers of buprenorphine with physicians who are not (Netherland and Hansen 2016). This has led to high rates of utilization of buprenorphine (Netherland and Hansen 2016), a critical medication for people hoping to stop using other opiates.

Harm Reduction: Best Practices

As has been discussed at length in earlier chapters, noncoercive treatment approaches led by people with direct knowledge and experience with the communities that they are trying to engage is a key tool which must be emphasized in our response to this epidemic. Direct outreach programs, conducted by non-judgmental workers who can engage with clients in a way that is trustworthy and makes them comfortable, are of the utmost importance in connecting with people who use drugs (ATTC 2007). Workers must be able to engage with cultural differences without placing value judgements on them (i.e. better/worse, good/bad, right/wrong), and must have cultural understanding of the values, customs, and experiences of groups which they are trying to engage (ATTC 2007). Services which can provide tools for healthy life choices to people in their natural settings are ideal, like mobile syringe exchange vans and other types of direct street outreach work. That way, once they have established trust, they can discuss frankly with clients about their risky behaviors and any alternative options they might have. Outreach services can also provide mobile HIV and Hepatitis testing, provide post-test counseling to clients, and discuss treatment options with them (ATTC 2007). This connects clients with medical knowledge who might not otherwise have access to doctors.

Ultimately, the ideal venue to do this would be in a supervised consumption space (SCS). These spaces allow clients to use drugs in a space with medical staff on duty who are ready to respond in the event of an overdose. These are also spaces in which clients can engage with medical professionals about any other concerns they might have. They are ideal venues for connecting clients with other services they might desire like housing assistance, treatment referrals, or employment services. Or they can just be a safe, air conditioned space to in which to spend a few hours with non-judgmental peers. They are an important intervention to destigmatize

drug use, something that is key if we hope to truly engage all and not just some of the people being affected by this opiate epidemic. Ultimately they serve a dual purpose of both providing comprehensive harm reduction services to people who use drugs and increasing public safety (Kral and Davidson 2017). As has been observed in other countries, public support for such spaces tends to grow over time as people on the outside notice the difference that they make, not just in the lives of the people who use them, but to the surrounding area as a whole (Kral and Davidson 2017). The cost of opening such a space would be 3.5 million per year, which could be diverted from the Department of Corrections budget in many cities.

The goal of all of these interventions is destigmatization and, ultimately, legalization. My personal belief is that the only way to fully stop the harms of the war on drugs is to legalize all drugs. If drugs could be used publicly and talked about openly the way that alcohol is, and if the criminal justice system was barred from involvement, the treatment system would be far more open and equitable and drug use could be fully treated as a public health issue. I will not attempt to flesh out the details of legalization here, as such a discussion requires much more space than I can permit in this paper and could probably be its own thesis. Suffice to say that as we engage with these reforms, legalization should be the end goal. As we engage with efforts toward such a condition, each and every step of the way must involve reparations for the past harms of this failed war. Our reforms cannot be transactional, and our end goal must be transformative. Incremental change is important, but only as a means toward an end which sees drug policy as an avenue through which to right the wrongs of the last several centuries in this country. May we continue to push toward a compassionate, caring approach toward others, especially those who use drugs.

Appendix A: Methodological Reflection

This project was largely inspired by past research that I had done for a conference hosted by the Drug Policy Alliance which focused on the erasure of the history of heroin policy in the age of a “gentler” war on drugs. An important book, which ultimately served as a guiding light in the rest of my research, was *The New Jim Crow* by Michelle Alexander. Alexander’s framing of various iterations of racial caste throughout the history of the United States was key to my analysis of current governmental responses to the opioid epidemic as well as the opioid epidemic of the 1970s in the Bronx. From there I sought out more critical race theory, drawing on the work of Kimberlé Crenshaw and Dorothy Roberts, both of whom influenced my thinking about the politics of punishment and of reform. Content analysis was the most appropriate method for my research, and in developing my understanding of the Bronx in the 1970s I largely drew on archived pamphlets and other educational materials distributed by the Young Lords, interviews with people involved in the takeover, and newspaper coverage from the time. Material concerned with the current situation in the Bronx came from modern newspaper publications. Examples of current organizations engaged in harm reduction work came from my own experience volunteering briefly with the Washington Heights Corner Project, and other organizations like BOOM! Health, which came up in newspaper publications. Research on the current epidemic drew most importantly from *Dreamland* by Sam Quinones, in addition to recent print media about the current epidemic. Throughout this research I used several publications by the Drug Policy Alliance as a guide, including reports and issue briefs on various topics.

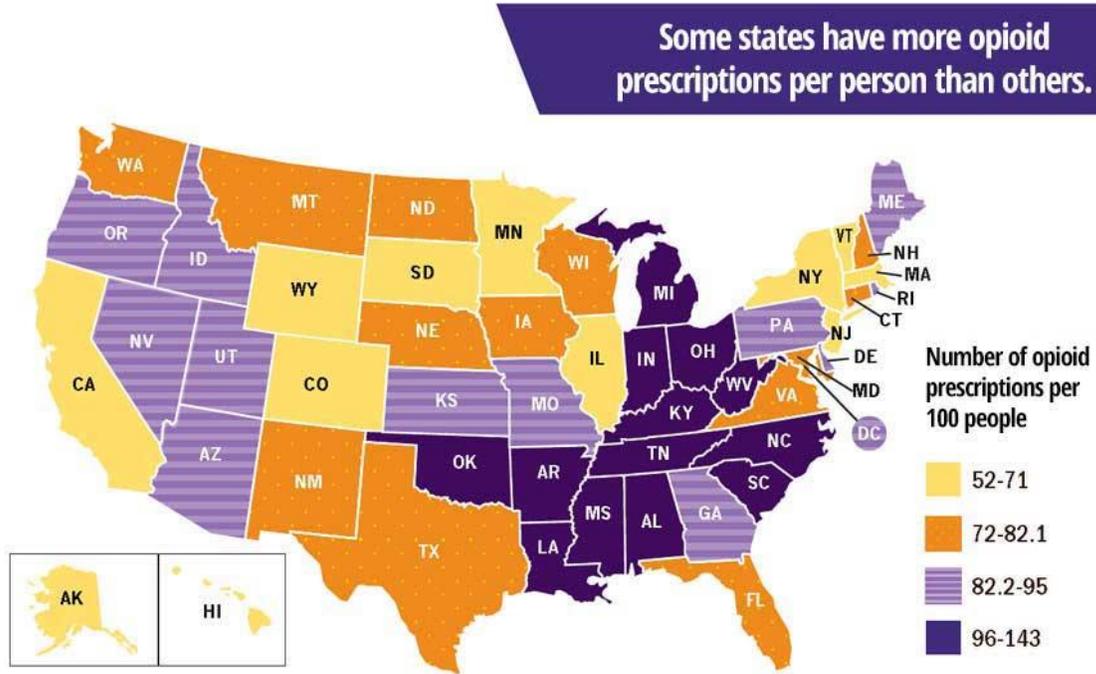
Appendix B: Style Guide

Throughout this thesis, I have been very specific about using person-centric language which aims not to stigmatize people who use drugs. Overarchingly, these have been my guidelines (Global Commission on Drugs 2018):

FIGURE 4: BETTER LANGUAGE

<input checked="" type="checkbox"/> USE	<input type="checkbox"/> DON'T USE
Person who uses drugs	Drug user
Person with non-problematic drug use	Recreational, casual, or experimental users
Person with drug dependence, person with problematic drug use, person with substance use disorder; person who uses drugs (when use is not problematic)	Addict; drug/substance abuser; junkie; dope head, pothead, smack head, crackhead etc.; druggie; stoner
Substance use disorder; problematic drug use	Drug habit
Has a X use disorder	Addicted to X
Abstinent; person who has stopped using drugs	Clean
Actively uses drugs; positive for substance use	Dirty (as in "dirty screen")
Respond, program, address, manage	Fight, counter, combat drugs and other combatant language
Safe consumption facility	Fix rooms
Person in recovery, person in long-term recovery	Former addicts; reformed addict
Person who injects drugs	Injecting drug user
Opioid substitution therapy	Opioid replacement therapy

Appendix C: States With the Most Opioid Prescriptions



SOURCE: IMS, National Prescription Audit (NPA™), 2012.

(National Prescription Audit 2012)

Glossary

Addiction- See 'substance use disorder'

Black tar- Black, tar-like version of heroin. Usually from Mexico; popularized by Xalisco crews

Buprenorphine- A semisynthetic opioid used as substitution therapy for opiate dependence

Contains both a semisynthetic opioid and naloxone.

CARA- Comprehensive Addiction and Recovery Act

China white- White powder form of heroin

Drug misuse- Drug use that is inconsistent with medical guidelines

Medication-assisted treatment (MAT)- Treatment for opiate dependence using a synthetic opioid such as buprenorphine or methadone

Methadone- A synthetic analgesic drug that is similar to an opiate in its effects but longer acting, used as a substitute drug in the treatment of opiate dependence

Opiate- A non-synthetic derivative of opium, similar to morphine in its effects

Opioid- Refers to the entire family of opium-derived drugs including natural, semisynthetic, and synthetic varieties.

Outreach- Providing direct, mobile services populations which might not otherwise be able to access those services

OxyContin- Opioid painkiller, developed by Purdue Pharmaceuticals

Painkiller- A drug which reduces pain

Physical dependency- State where the body adapts to a drug and reacts negatively when drug use is ceased

Problematic substance use- Substance use that persists despite negative consequences

Shooting up- Slang for injecting drugs

Substance use disorder- “When the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home” (SAMHSA 2015)

Substitution therapy- See ‘medication-assisted treatment’

Works Cited

- Anon. 2016. *13th*. United States: Kandoo Films.
- Anon. n.d. "A Brief History of the Drug War." *Drug Policy Alliance*. Retrieved October 10, 2017 (<http://www.drugpolicy.org/issues/brief-history-drug-war>).
- Anon. 2016. "A History of Opiate Laws in the United States." *National Alliance of Advocates for Buprenorphine Treatment*. Retrieved October 12, 2017 (<https://www.naabt.org/laws.cfm>).
- Drug Policy Alliance. 2017. *A Public Health and Safety Approach to Problematic Opioid Use and Overdose*. Retrieved March 28, 2018 (https://www.drugpolicy.org/sites/default/files/Opioid_Response_Plan_041817.pdf).
- Anon. 2017. "A State by State Look at the Opioid Crisis." *American Physical Therapy Association*. Retrieved February 5, 2018 (<https://www.moveforwardpt.com/Resources/Detail/opioid-abuse-statistics-of-50-states-2>).
- Anon. n.d. "About the U.S. Opioid Epidemic." *U.S. Department of Health and Human Services*. Retrieved November 5, 2017 (<https://www.hhs.gov/opioids/about-the-epidemic/index.html>).
- Adams, Letizia. 2017. "Heroin Has Never Discriminated." *Tonic*. Retrieved February 11, 2018 (https://tonic.vice.com/en_us/article/newqjm/heroin-has-never-discriminated).
- Adamy, Janet and Paul Overberg. 2017. "Rural America Is the New 'Inner City'." *The Wall Street Journal*. Retrieved March 5, 2018 (<https://www.wsj.com/articles/rural-america-is-the-new-inner-city-1495817008>).
- Alexander, Michelle. 2010. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York, NY: The New Press.

Allen, Greg and Amita Kelly. 2017. "Trump Administration Declares Opioid Crisis A Public Health Emergency." *NPR*. Retrieved April 8, 2018

(<https://www.npr.org/2017/10/26/560083795/president-trump-may-declare-opioid-epidemic-national-emergency>).

ASAM Staff. 2016. "American Society of Addiction Medicine." *Congress Passes CARA! ASAM Applauds Passage of Historic Addiction Legislation*. Retrieved April 5, 2018

(<https://www.asam.org/resources/publications/magazine/read/article/2016/07/13/congress-passes-cara!-asam-applauds-passage-of-historic-addiction-legislation>).

Drug Policy Alliance. 2017. *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*. Retrieved April 9, 2018

(http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf).

Apuzzo, Matt. 2018. "Sessions and Kushner Square Off, and Prisoners Hang in the Balance." *The New York Times*. Retrieved April 5, 2018

(<https://www.nytimes.com/2018/03/28/us/politics/jeff-sessions-jared-kushner-prisons.html>).

Aronczyk, Amanda. 2014. "The Revolutionaries Who Rescued a Hospital." *WNYC*. Retrieved February 1, 2018 (<https://www.wnyc.org/story/lab-coat-afro-and-shades-taking-lincoln-hospital/>).

Baker, David W. 2017. *The Joint Commission's Pain Standards: Origins and Evolution*. The Joint Commission. Retrieved April 11, 2018

(https://www.jointcommission.org/assets/1/6/Pain_Std_History_Web_Version_05122017.pdf).

- Battelle, John. 2017. "Capitalism at Its Worst: The Opioid Crisis." *NewCo Shift*. Retrieved April 4, 2018 (<https://shift.newco.co/capitalism-at-its-worst-the-opioid-crisis-443cb0da91f9>).
- Bayoumi, Ahmed M. and Gregory S. Zaric. 2008. "The Cost-Effectiveness of Vancouver's Supervised Injection Facility." *CMAJ* 179(11):1143–51. Retrieved March 28, 2018 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582765/>).
- Beekman, Daniel. 2010. "Lincoln Recovery Move Questioned." *New York Post*. Retrieved April 9, 2018 (<https://nypost.com/2010/01/28/lincoln-recovery-move-questioned/>).
- Bondi, Mason. n.d. "The Lincoln Story." *The Lincoln Story*. Retrieved February 1, 2018 (<https://www.acudetox.com/the-lincoln-story-2>).
- Anon. n.d. "BOOM! Health: Issues." *Issues - BOOM!Health*. Retrieved April 2, 2018 (<https://www.boomhealth.org/issues>).
- Boullosa, Carmen and Mike Wallace. 2016. *A Narco History: How the United States and Mexico Jointly Created the "Mexican Drug War"*. New York, NY: OR Books in partnership with Counterpoint Press.
- Bourgois, Philippe et al. 2006. "Reinterpreting Ethnic Patterns among White and African American Men Who Inject Heroin: A Social Science of Medicine Approach." *PLoS Medicine* 3(10). Retrieved January 17, 2018 (<http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.0030452>).
- Bracy, Emma. 2015. "Here's the Surprising Difference Between Crack and Cocaine." *ATTN*: Retrieved January 25, 2018 (<https://www.attn.com/stories/2643/crack-vs-cocaine>).
- Carter, Jimmy. 1977. "Drug Abuse Message to the Congress." *The American President Project*. Retrieved April 8, 2018 (<http://www.presidency.ucsb.edu/ws/?pid=7908>).
- Drug Policy Alliance. 2017. *Centering Black Voices in Drug Policy*. Retrieved December 10,

2017

(<https://www.youtube.com/watch?v=9jrfNrH8t38&index=2&list=PLf6y9tNpg8wPyfykudkYtPYa8bpZ9rTfI>).

Cicero, Theodore J., Matthew S. Ellis, and Zachary A. Kasper. 2017. "Increased Use of Heroin as an Initiating Opioid of Abuse." *Addictive Behaviors* 74:63–66. Retrieved February 15, 2018 ([https://www.dropbox.com/s/sdsil7tIm9vgdp6/Cicero et al Heroin Initiation Add Beh 2017.pdf?dl=0](https://www.dropbox.com/s/sdsil7tIm9vgdp6/Cicero%20et%20al%20Heroin%20Initiation%20Add%20Beh%202017.pdf?dl=0)).

Crenshaw, Kimberlé Williams. 1995. "Race, Reform, and Retrenchment: Transformation and Legitimation in Anti-Discrimination Law." Pp. 103–26 in *Critical Race Theory: The Key Writings That Formed the Movement*. New York, NY: The New Press.

Davidson, W., D. W. Molloy, and M. Bédard. 1995. "Physician Characteristics and Prescribing for Elderly People in New Brunswick: Relation to Patient Outcomes." *CMAJ* 152(8):1227–34. Retrieved 3AD (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1337810/>).

Del Real, Jose A. 2017. "The Bronx's Quiet, Brutal War With Opioids." *The New York Times*. Retrieved January 17, 2018 (https://www.nytimes.com/2017/10/12/nyregion/bronx-heroin-fentanyl-opioid-overdoses.html?hp&action=click&pgtype=Homepage&clickSource=story-heading&module=photo-spot-region®ion=top-news&WT.nav=top-news&_r=0).

Diamond, Dan and Brianna Ehley. 2018. "Trump Talks Up Death Penalty, Border Wall in Opioid Speech." *POLITICO*. Retrieved April 8, 2018 (<https://www.politico.com/story/2018/03/19/donald-trump-plan-for-opioid-epidemic-424325>).

- Diamond, Dan. 2018. "Exclusive: Trump Finalizing Opioid Plan That Includes Death Penalty for Dealers." *POLITICO*. Retrieved April 10, 2018 (<https://www.politico.com/story/2018/03/15/exclusive-trump-finalizing-opioid-plan-death-penalty-418488>).
- Anon. 2015. "Dr. Carl Hart on Crack Vs. Cocaine." *YouTube*. Retrieved April 8, 2018 (<https://www.youtube.com/watch?v=iED6XLT6Yos>).
- Anon. 2008. "Drug Facts: Heroin." *National Institute on Drug Abuse*. Retrieved March 28, 2018 (<https://www.drugabuse.gov/publications/drugfacts/heroin>).
- Anon. 2010. *Drugs, Inc: Heroin*. Retrieved September 9, 2017 (<http://www.sawbuckproductions.org/drugsinc>).
- Dvorak, Petula. 2018. "We Scorned Addicts When They Were Black. It Is Different Now That They Are White." *The Washington Post*. Retrieved April 2, 2018 (https://www.washingtonpost.com/local/we-hated-addicts-when-they-were-black-it-is-different-now-that-they-are-white/2018/04/12/cd845f20-3e5b-11e8-974f-aacd97698cef_story.html?utm_term=.56d8e12537ac).
- Dwyer, Dialynn. 2016. "Gloucester 'Angel' Heroin Program Overwhelmed by Out-of-Town Addicts." *Boston.com*. Retrieved March 1, 2018 (<https://www.boston.com/news/local-news/2016/10/15/gloucester-angel-heroin-program-overwhelmed-by-out-of-town-addicts>).
- Farabee, David, Michael Prendergast, and M. Douglass Anglin. 1998. "The Effectiveness of Coerced Treatment for Drug-Abusing Offenders." *Uscourts.gov*. Retrieved April 10, 2018 (http://www.uscourts.gov/sites/default/files/62_1_1_0.pdf).
- Frederique, Kassandra. 2016. "The Role Race Plays in the War On Drugs." *EBONY*. Retrieved

- January 17, 2018 (<http://www.ebony.com/news-views/race-war-on-drugs#ixzz3zb5QDUNI>).
- Gordon, Elana. 2018. "What's Next For 'Safe Injection' Sites In Philadelphia?" *NPR*. Retrieved March 4, 2018 (<https://www.npr.org/sections/health-shots/2018/01/24/580255140/whats-next-for-safe-injection-sites-in-philadelphia>).
- Anon. n.d. "Governor's Cabinet Opiate Action Team." *Governor's Cabinet Opiate Action Team*. Retrieved February 12, 2018 (<http://fightingopiateabuse.ohio.gov/About>).
- Grol, R. et al. 1985. "Work Satisfaction of General Practitioners and the Quality of Patient Care ." *Family Practitioners* 2(3):128–35. Retrieved March 10, 2018 (<https://www.ncbi.nlm.nih.gov/pubmed/4043602>).
- Hansen, Helena and Samuel K. Roberts. 2012. "Two Tiers of Biomedicalization: Methadone, Buprenorphine, and the Racial Politics of Addiction Treatment." *Critical Perspectives on Addiction Advances in Medical Sociology* 79–102. Retrieved November 5, 2017 ([https://www.emeraldinsight.com/doi/abs/10.1108/S1057-6290\(2012\)0000014008](https://www.emeraldinsight.com/doi/abs/10.1108/S1057-6290(2012)0000014008)).
- Hansen, Helena. 2015. "Pharmaceutical Prosthesis and White Racial Rescue in the Prescription Opioid 'Epidemic.'" *Somatosphere*. Retrieved November 5, 2017 (<http://somasphere.net/2015/12/pharmaceutical-prosthesis-and-white-racial-rescue-in-the-prescription-opioid-epidemic.html>).
- Hart, Carl L. 2013. *High Price: Drugs, Neuroscience and Discovering Myself*. London: Penguin Books.
- Hart, Carl and Chris Hayes. 2015. "Meth and Adderall Are the Same Drug and Other Drug Facts." *Youtube*. Retrieved April 2, 2018 (<https://www.youtube.com/watch?v=zhdqhIIm4cQ>).

- Hawkins, Derek. 2017. "How a Short Letter in a Prestigious Journal Contributed to the Opioid Crisis." *The Washington Post*. Retrieved April 3, 2018
(https://www.washingtonpost.com/news/morning-mix/wp/2017/06/02/how-the-opioid-crisis-traces-back-to-a-five-sentence-scholarly-letter-from-1980/?noredirect=on&utm_term=.ae76d31e1751).
- Anon. n.d. "Heroin Facts." *Drug Policy Alliance*. Retrieved March 28, 2018
(<http://www.drugpolicy.org/drug-facts/heroin-facts>).
- Hunter, Charlayne. 1970. "Community Dispute Cuts Service at City Hospital." *The New York Times*. Retrieved April 8, 2018
(<https://www.nytimes.com/1970/08/26/archives/community-dispute-cuts-service-at-city-hospital-dispute-cripples.html>).
- Anon. 2018. "Interest in Drug-Induced Homicide Laws Grows." *American Bar Association: Health Law Section*. Retrieved April 10, 2018
(https://www.americanbar.org/groups/health_law/news/2018/02/interest_in_drug-ind.html).
- Jellinek, E. M. 1960. *The Disease Concept of Alcoholism*. New Haven, CT: Hillhouse Press.
- Katz, Josh. 2017. "Drug Deaths in America Are Rising Faster Than Ever." *The New York Times*. Retrieved March 19, 2018
(<https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html?mtrref=www.google.com>).
- Keefe, Patrick Radden. 2017. "The Family That Built an Empire of Pain." *The New Yorker*. Retrieved October 30, 2017 (<https://www.newyorker.com/magazine/2017/10/30/the-family-that-built-an-empire-of-pain>).

- Kolker, Robert. 2014. "The Rise and Fall of New York City's Biggest Pill Mill." *Daily Intelligencer*. Retrieved January 17, 2018 (<http://nymag.com/daily/intelligencer/2014/02/rise-and-fall-of-nycs-biggest-pill-mill.html>).
- Kral, Alex H. and Peter J. Davidson. 2017. "Addressing the Nation's Opioid Epidemic: Lessons from an Unsanctioned Supervised Injection Site in the U.S." *American Journal of Preventive Medicine* 53(6):919–22. Retrieved March 26, 2018 ([http://www.ajpmonline.org/article/S0749-3797\(17\)30316-1/pdf](http://www.ajpmonline.org/article/S0749-3797(17)30316-1/pdf)).
- Lopez, German. 2014. "Marijuana Has Been Legalized in Nine States and Washington, DC." *Vox*. Retrieved April 8, 2018 (<https://www.vox.com/cards/marijuana-legalization/where-is-marijuana-legal>).
- Lurie, Julia. 2017. "Ohio's New Overdose Rates Are Truly Insane." *Mother Jones*. Retrieved February 15, 2018 (<https://www.motherjones.com/politics/2017/08/ohios-new-overdose-rates-are-truly-insane/>).
- Lurie, Julia. 2018. "Philadelphia Could Become the First US City With a Safe Injection Site. Finally." *Mother Jones*. Retrieved February 15, 2018 (<https://www.motherjones.com/politics/2018/01/philadelphia-could-become-the-first-us-city-with-a-safe-injection-site-finally/>).
- Anon. 1987. *McCleskey v. Kemp*. Retrieved April 8, 2018 (<https://www.oyez.org/cases/1986/84-6811>).
- McGreal, Chris. 2016. "How Cracking Down on America's Painkiller Capital Led to a Heroin Crisis." *The Guardian*. Retrieved April 1, 2018 (<https://www.theguardian.com/science/2016/may/25/opioid-epidemic-prescription->

painkillers-heroin-addiction).

McGreal, Chris. 2017. "Don't Blame Addicts for America's Opioid Crisis. Here Are the Real Culprits." *The Guardian*. Retrieved March 2, 2018

(<https://www.theguardian.com/commentisfree/2017/aug/13/dont-blame-addicts-for-americas-opioid-crisis-real-culprits>).

Mendoza, Sonia, Allyssa S. Rivera-Cabrero, and Helena Hansen. 2016. "Shifting Blame: Buprenorphine Prescribers, Addiction Treatment, and Prescription Monitoring in Middle-Class America." *Transcultural Psychiatry* 53(4):465–87. Retrieved

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5540139/>).

Metzger, Scott. 2017. *Whitewashed: The African American Opioid Epidemic*. Chicago Urban League. Retrieved December 6, 2017

(https://www.thechicagourbanleague.org/cms/lib/IL07000264/Centricity/Domain/1/Whitewashed_AA_Opioid_Crisis_11-15-17_EMBARGOED_FINAL.pdf).

Miller, Leah. 2016. "Methadone Withdrawal." *Recovery.org*. Retrieved April 9, 2018

(<https://www.recovery.org/topics/methadone/>).

Mills, C. Wright. 1959. *The Sociological Imagination*. New York: Oxford University Press.

Mills, Charles W. 1997. *The Racial Contract*. Ithaca, NY: Cornell University Press.

Narvaez, Alfonso A. 1970. "Young Lords Seize Lincoln Hospital Building." *The New York*

Times. Retrieved April 8, 2018 (<https://www.nytimes.com/1970/07/15/archives/young-lords-seize-lincoln-hospital-building-offices-are-held-for-12.html>).

Netherland, Julie et al. 2009. "Factors Affecting Willingness to Provide Buprenorphine Treatment." *Journal of Substance Abuse Treatment* 36(3):244–51. Retrieved

(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2866292/>).

- Netherland, Julie and Helena B. Hansen. 2016. "The War on Drugs That Wasn't: Wasted Whiteness, 'Dirty Doctors,' and Race in Media Coverage of Prescription Article Misuse." *Cult Med Psychiatry*. Retrieved January 12, 2018 (file:///Users/anntartakoff/Downloads/NetherlandHansenCMP2016.pdf).
- Anon. 2018. "New York City Program Takes Controversial Approach to Opioid Crisis." *WNYC*. Retrieved February 15, 2018 (<https://www.wnyc.org/story/harm-reduction-how-one-new-york-city-program-tackles-opioids/>).
- New York State Department of Health. 2017. *New York State - Opioid Annual Report*. Retrieved February 18, 2018 (https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2017.pdf).
- More Perfect Podcast. 2016. *Object Anyway*. Retrieved October 12, 2017 (<https://www.wnycstudios.org/story/object-anyway>).
- Anon. 2017. "Opioid Overdose." *Centers for Disease Control and Prevention*. Retrieved April 12, 2018 (<https://www.cdc.gov/drugoverdose/data/prescribing.html>).
- Anon. 2017. "Opioid Overdose." *Centers for Disease Control and Prevention*. Retrieved November 5, 2017 (<https://www.cdc.gov/drugoverdose/epidemic/index.html>).
- Anon. 2018. "Opioid Overdose Crisis." *National Institute on Drug Abuse*. Retrieved April 5, 2018 (<https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis>).
- Anon. n.d. "Origins of the Disease View." Retrieved October 30, 2017 (http://faculty.uml.edu/rsiegel/47.272/documents/Wk2_DiseaseModels.pdf).
- Anon. 2007. *Outreach Competencies: Minimum Standards for Conducting Street Outreach for Hard-to-Reach Populations*. Addiction Technology Transfer Center. Retrieved April 10,

- 2018 ([http://attcnetwork.org/regcenters/productDocs/2/2009 updated Outreach Competencies.pdf](http://attcnetwork.org/regcenters/productDocs/2/2009%20updated%20Outreach%20Competencies.pdf)).
- Anon. 2017. "Overdose Death Rates." *National Institute on Drug Abuse*. Retrieved April 8, 2018 (<https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>).
- Parran, Theodore V. et al. 2017. "Access to and Payment for Office-Based Buprenorphine Treatment in Ohio." *Substance Abuse: Research and Treatment* 11. Retrieved April 10, 2018 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5473522/>).
- Anon. n.d. "People's Doctor Murdered! An Unsuccessful Attempt to Destroy the Lincoln Detox Program." Retrieved April 9, 2018 (https://www.freedomarchives.org/Documents/Finder/DOC58_scans/58.White.Lightening.RichardTaft.pdf).
- Portenoy, Russell K. and Kathleen M. Foley. 1986. "Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 Cases." *Pain* 25(2):171–86. Retrieved March 23, 2018 (<https://www.ncbi.nlm.nih.gov/pubmed/2873550>).
- Anon. n.d. "Portsmouth, OH Demographics." *AreaVibes*. Retrieved April 2, 2018 (<http://www.areavibes.com/portsmouth-oh/demographics/>).
- Porzig, Molly and Vicente Alba. 2015. "Lincoln Detox Center: The People's Drug Program." *The Abolitionist*. Retrieved February 15, 2018 (<https://abolitionistpaper.wordpress.com/2013/03/15/lincoln-detox-center-the-peoples-drug-program/>).
- Center for Disease Control. n.d. *Prescribing Data*. Retrieved April 2, 2018 (<https://www.cdc.gov/drugoverdose/data/prescribing.html>).
- Anon. n.d. "Principles of Harm Reduction." *Harm Reduction Coalition*. Retrieved March 5, 2018

(<http://harmreduction.org/about-us/principles-of-harm-reduction/>).

Quinones, Sam. 2015. *Dreamland: the True Tale of Americas Opiate Epidemic*. New York: Bloomsbury Press.

Anon. 2016. “Rates of Drug Use and Sales, by Race; Rates of Drug Related Criminal Justice Measures, by Race.” *The Hamilton Project*. Retrieved April 19, 2018 (http://www.hamiltonproject.org/charts/rates_of_drug_use_and_sales_by_race_rates_of_drug_related_criminal_justice).

Richey, Zoie. 2017. “New Syringe Exchange Law Causes Hope and Concern in Scott County.” *The Statehouse File*. Retrieved February 13, 2018 (<http://thestatehousefile.com/new-syringe-exchange-law-causes-hope-concern-scott-county/31437/>).

Roberts, Dorothy E. 1995. “Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy.” Pp. 384–425 in *Critical Race Theory: The Key Writings That Formed the Movement*. New York, NY: The New Press.

Ryan, Harriet, Lisa Girion, and Scott Glover. 2016. “‘You Want a Description of Hell?’ OxyContin’s 12-Hour Problem .” *Los Angeles Times*. Retrieved February 11, 2018 (<http://www.latimes.com/projects/oxycontin-part1/>).

Sable-Smith, Bram. 2017. “Missouri Finally Has Prescription Drug Monitoring, So Why Can’t Prescribers Use It?” *KBIA*. Retrieved April 12, 2018 (<http://kbia.org/post/missouri-finally-has-prescription-drug-monitoring-so-why-can-t-prescribers-use-it#stream/0>).

Seelye, Katharine Q. 2015. “In Heroin Crisis, White Families Seek Gentler War on Drugs.” *The New York Times*. Retrieved November 20, 2017 (<https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html?mtref=www.google.com&gwh=556DD3A1557B3B23C5F9EAD54FA82>

7BE&gwt=pay).

Sessions, Jeff. 2017. "Attorney General Jeff Sessions Delivers Remarks at National Law Enforcement Training on Child Exploitation." *The United States Department of Justice*. Retrieved April 8, 2018 (<https://www.justice.gov/opa/speech/attorney-general-jeff-sessions-delivers-remarks-national-law-enforcement-training-child>).

Shah, Arpeet S., Robert H. Blackwell, Paul C. Kuo, and Gopal N. Gupta. 2017. "Rates and Risk Factors for Opioid Dependence and Overdose after Urological Surgery." *The Journal of Urology* 198(5):1130–36. Retrieved (<https://www.sciencedirect.com/science/article/pii/S0022534717671878>).

Sherman, Melina. 2017. "How to Train Your Opioid Consumer: Branding Painkillers in the Opioid Epidemic." *Communication, Culture & Critique* 10(4):593–608. Retrieved November 5, 2017 (<https://onlinelibrary.wiley.com/doi/full/10.1111/cccr.12181>).

Anon. 2014. "Substance Use Disorders." *Substance Use Disorders*. Retrieved April 2, 2018 (<https://www.samhsa.gov/disorders/substance-use>).

Anon. n.d. "Supervised Injection Facilities." *Drug Policy Alliance*. Retrieved April 10, 2018 (<http://www.drugpolicy.org/issues/supervised-injection-facilities>).

Svab, Petr. 2016. "Bronx Battles Opioid Addiction as Death Rate Soars." *The Epoch Times*. Retrieved April 9, 2018 (https://www.theepochtimes.com/bronx-battles-opioid-addiction-as-death-rate-soars_2168731.html).

Szalavitz, Maia. 2015. "A Brief History of New York City's Heroin Scene." *Vice*. Retrieved January 31, 2018 (https://www.vice.com/en_us/article/4wb93w/a-brief-history-of-the-heroin-scene-in-new-york-city).

Szalavitz, Maia. 2015. "White Parents Are Fighting Back Against the Drug War They Helped

- Create.” *Vice*. Retrieved February 1, 2018
(https://www.vice.com/en_us/article/3bjjw9/white-parents-helped-start-the-drug-war-could-they-end-it-as-well-120).
- Szalavitz, Maia. 2017. “Prescribed Painkillers Didn't Cause the Opioid Crisis.” *Tonic*. Retrieved February 11, 2018 (https://tonic.vice.com/en_us/article/a3z98b/big-pharma-didnt-cause-the-opioid-crisis-most-pain-patients-dont-get-addicted).
- Szalavitz, Maia. 2017. “There's Been a Secret Safe Injection Site in the US for Three Years.” *Tonic*. Retrieved February 18, 2018 (https://tonic.vice.com/en_us/article/433ynj/theres-been-a-secret-safe-drug-injection-site-in-the-us-for-three-years).
- Tabor, Michael Cetewayo. 2006. “Capitalism Plus Dope Equals Genocide.” *Capitalism Plus Dope Equals Genocide*. Retrieved October 15, 2018
(<https://www.marxists.org/history/usa/workers/black-panthers/1970/dope.htm>).
- Anon. 2013. *The Family at 1312*. Sawbuck Productions. Retrieved October 30, 2017
(<https://vimeo.com/76186407>).
- Anon. 2018. “The War on Drugs Is a War on People – It's Time to Change That.” *The Global Commission on Drug Policy*. Retrieved April 5, 2018
(<http://www.globalcommissionondrugs.org/the-war-on-drugs-is-a-war-on-people-its-time-to-change-that/>).
- Tiger, Rebecca. 2017. “Race, Class, and the Framing of Drug Epidemics.” *American Sociological Association*. Retrieved January 17, 2018 (<http://www.asanet.org/news-events/asa-news/race-class-and-framing-drug-epidemics>).
- CNN. 2017. *Trump Declares Opioids a National Emergency*. Retrieved October 30, 2017
(<https://www.youtube.com/watch?v=xcUOIZF5CRQ>).

- Urbanoski, Karen A. 2010. "Coerced Addiction Treatment: Client Perspectives and the Implications of Their Neglect." *Harm Reduction Journal* 7(1):13. Retrieved (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2906422/>).
- Drug Policy Alliance. 2017. *White Faces Black Lives 5/10: Differential Responses*. Retrieved December 20, 2018 (<https://www.youtube.com/watch?v=SEVUZPvyAkg&list=PLf6y9tNpg8wPyfykudkYtPYa8bpZ9rTfl&index=6>).
- Drug Policy Alliance. 2017. *White Faces Black Lives 6/10: Racism and Its Role in White Drug Exceptionalism*. Retrieved December 20, 2017 (<https://www.youtube.com/watch?v=ru062WLQeyw&list=PLf6y9tNpg8wPyfykudkYtPYa8bpZ9rTfl&index=7>).
- Anon. 1996. *Whren v. United States*. Retrieved April 8, 2018 (<https://www.oyez.org/cases/1995/95-5841>).
- Wood, Evan, Mark W. Tyndall, Ruth Zhang, Julio S. G. Montaner, and Thomas Kerr. 2007. "Rate of Detoxification Service Use and Its Impact among a Cohort of Supervised Injecting Facility Users." *Addiction* 102(6):916–19. Retrieved March 27, 2018 (<https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1360-0443.2007.01818.x>).
- Wormser, Richard. 2002. "The Rise and Fall of Jim Crow: Populist Party." *Thirteen - Media With Impact*. Retrieved April 8, 2018 (https://www.thirteen.org/wnet/jimcrow/stories_org_populist.html).

