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Policy Commentary: Drug Wars, What Are They Good For?

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ABSTRACT: The United States has a history of systematic racism towards BIPOC (Black, Indigenous, and people of color) and a negative stigma towards individuals who use drugs. Those two intersecting facts leave us in the turbulence of U.S. drug policy, policies which sustain an arguably racist culture. This article details the history of how and why the United States has continued down this path and considers where we go from here.

KEYWORDS: American Drug Policy, Systematic Racism in Drug Policy, Substance Misuse Policy, Drug related Stigma.

INTRODUCTION

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If you live in the United States of America, you are directly impacted by its policies and laws. Moreover, if you identify as a minority, BIPOC (Black, Indigenous, and people of color), or "other" in our society, it is likely that U.S. policies and laws have oppressed or stigmatized you in some significant way. This article addresses how the United States drug laws have perpetuated systematic racism towards BIPOC individuals and supported negative stigma towards individuals who use drugs. In turn, these stigmas have changed how society views and reacts to drug users. Though substance use disorders do not discriminate based on race, gender, or creed, the BIPOC communities have been impacted in unique and damaging ways (Chatterjee et al., 2022).

This article will focus on individuals who use drugs, with specific attention paid to African Americans, and the impact that United States drug policies have had on oppression and stigmatization. However, it cannot go without mentioning the extensive systematic racism that other minority cultures have experienced. The U.S. has a long-standing history of using specific substances to stigmatize and alienate BIPOC communities (Chatterjee et al., 2022). In the early 1850s the U.S. saw an increase in Chinese immigrants and the Anti-Chinese movement that appeared thereafter relied heavily on their association with opium (Mark, 1975). The Opium Exclusion Act of 1909 was created based on racially motivated stigmas, which banned the import of opium to the United States (Hudak, 2020). Contrary to government and media portrayal, the United States was one of the countries who originally exported opium to China, causing widespread drug problems; drug problems that were grossly exaggerated to cause fear and to aid the government in passing multiple opium restriction policies (Mark, 1975).

Likewise, after the Spanish-American War (in 1898), Mexican immigrants were the target of negative stigma and slander through media portrayal and government rhetoric (Hudak, 2020), so much so that within the U.S., the use of the term "cannabis" changed to the vilified "marijuana," which held racist undertones of a violent drug being brought to our country by Mexican immigrants (Hudak, 2020). Still true today, cannabis is a key element of the hippie counterculture that exists in our society, thus creating and sustaining the government's conflict with the drug and those who use it (Hudak, 2020).

Additionally, some Native Americans were negatively branded by a plant used by some tribes for religious purposes, peyote. The U.S. government inappropriately lumped this plant under the umbrella of hallucinogens which caused turmoil for Native American tribes using peyote (Terry & Trout, 2017).

Even after the passing of the 1994 amendments to the American Indian Religious Freedom Act of 1978 (AIRFAA), only federally recognized tribes are permitted to use peyote in their religious ceremonies (Terry & Trout, 2017). Many U.S. drug laws have had both implicit and explicit negative consequences that ripple through today's culture and may continue to affect future policies, interfere with innovative drug treatment options, and influence society's attitudes towards

individuals who use drugs.

Breaking the Stigma down – A Framework

A framework of moral panic is useful to outline how society‘s response to substance use may be more damaging than the actual problem of substance misuse. The framework of moral panic explains how inflated concerns about social deviance are intertwined with public opinion and social policy (Eversman & Bird, 2016). This framework provides a comprehensive understanding of how public opinion, racism, and misinformation have polluted the discussion of substance use. Moral panic conventionally has four components: an enemy, which in this context consists of individuals using substances; a victim, which is mainstream society; a perceived threat stemming from the actions of the enemy, that is, the image that individuals using substances are dangerous and violent; and a societal consensus to act, in this case, policies and laws created to stop substance use and misuse (Eversman & Bird, 2016). This framework uncovers how society oppresses individuals who are using or misusing substances by symbolically, and often physically, removing them from mainstream society.

When an ‘us versus them' standard is introduced, it can be further enflamed by the media, news outlets, and even government. The United States government shapes how our country operates, defining and enforcing the rules and guidelines for how systems and individuals must function within society. When a system as powerful as the government is used to perpetuate and maintain a stigma, such as the stigma of individuals who use substances, there is cause for great concern.

Yet, there is an added layer that cannot be ignored in the stigmatizing of individuals who use substances, which is the racist undertones and discrimination that existed in the very creation of our country. Throughout U.S. history, there are countless examples of laws and policies that have discriminated against a wide range of minority populations. Where the issue of substance use gets complex is that not only are individuals who use substances subject to discrimination and stigma, but substance misuse is inaccurately said to affect minority populations at a higher rate than white populations (Corcoran & Walsh, 2019). This deadly cycle of stigma and discrimination is perpetuated by society's reaction to the individuals who are suffering and, in turn, directly affects the drug policies created in the United States.

Riding the Waves – The War on Drugs

Ongoing examples of our government maintaining and perpetuating the stigma imposed on individuals who use substances can be seen in the drug policies being created at specific points in time. Although the United States history with drugs and the individuals who use them is a complex and winding road, we must start our story with an individual who created the spark that set our country ablaze with drug bias, Harry J. Anslinger (Hari, 2015). Appointed by President Herbert Hoover as the first commissioner of the newly created ‗Bureau of Narcotics,‘ Harry Anslinger was no stranger to managing and perpetuating laws that criminalized substance use (Hari, 2015; Hudak, 2020). He started his life being affected in the most intimate way by drugs and alcohol, which was to have substance misuse ravage his family (Hari, 2015). Anslinger then dedicated his life to being a ‘drug warrior’ for the United States and, though he was not the first, he was passionate and filled with a hatred for drugs and minorities that helped shape drug policy in the twentieth century (Hari, 2015; Hudak, 2020). Harry Anslinger often used a framework of moral panic to wage his fight against drugs. He would manipulate data or create false narratives to help spin his stories regarding the dangers of drugs or the minorities upon whom he set in his crosshairs (Hari, 2015; Hudak, 2020). Though his reach was wide in the creation and passage of drug laws, two are particularly noteworthy. In 1951 Anslinger went before Congress to advocate for the passing of the Boggs Act, which set a mandatory minimum for prison sentencing for drug law violators (Hudak, 2020). In 1956, he returned to Congress for the Narcotics Control Act which increased the penalties set with the Boggs Act (Hudak, 2020). The actions of this one man set the stage for our country to engage in arguably its most violent war to date, the war on drugs.

Although presidents before him made efforts towards controlling drug use in the United States, Richard Nixon is said to have officially declared the war on drugs (Hudak, 2020). Nixon used the 'war on drugs' framework to rid the United States of drug use, along with discriminatory ulterior motives.

President Richard Nixon had favored the well-known southern strategy which meant he had a specific animosity towards people who were 'other' in our society including racial minorities and members of the counterculture (Hudak, 2020). Moreover, Nixon's policies and efforts in the war on drugs were racially motivated. His political efforts were a direct pushback on the 1960's social disturbances, particularly the civils rights movement, and the Johnson administration's progressive policies (Hudak, 2020). Nixon continued to use 'Americans' fear of an ever-changing society to target minority drug users. In 1969, he gave a speech to Congress that was filled with racist undertones and included a ten-point plan that empowered law enforcement agencies and expanded punishment of individuals using drugs (Hudak, 2020). This precedent of punishment over treatment or care for individuals using drugs can be seen throughout U.S. history up to the present. Although drug use and misuse exist all over the world, the United States is said to have an epidemic of drug misuse (Macy, 2018). The term epidemic can be understood in this context as a public health concern that is not well controlled and impacts the entire nation (Forge Health, n.d.). There have been two major waves of the 'war on drugs', the first being the crack cocaine crisis of the 1980's and the second being the current opioid epidemic. The main differences between these chapters of our story are the populations they were perceived to affect and the media coverage of these crises.

While the current opioid epidemic is portrayed as a white American problem, the crack-cocaine crisis was said to be ravaging African American communities (Kim et al., 2020). From 1999 to 2019 over 500,000 people died from an opioid overdose and within the same timeframe opioid overdose have quadrupled (Centers for Disease Control and Prevention, 2021). Nevertheless, the media coverage of the opioid crisis has been scarce and the policy development in its wake has focused on treatment and recovery, while the crack-cocaine crisis, perceived as a problem among Black people, resulted in public outrage, fear, and policy development that criminalized substances and penalized individuals (Kim et al., 2020; Kruis & Merlo, 2021). We saw this discrimination unfold in U.S. policies like 1986's Anti-Drug Abuse Act which made convictions for crack-cocaine, more often used by Black people, significantly harsher than convictions for powder cocaine, typically used by white people (Hart, 2022). The Anti-Drug Abuse Act was extended in 1988 and a few years later the data showed that over 90% of individuals convicted under this act were African American (Hart, 2022). This is only one of many examples of a racial differential in drug policies, where drug laws exist for whites and minorities in a quietly segregated fashion.

America's Drug Policies and the Consequences

Hari (2015) believes that Richard Nixon's 'war on drugs' was supported by the passing of the Harrison Act of 1914. The Harrison Act essentially imposed a tax on the sale of opium as well as created a register and report system for prescribing physicians and pharmacies (Hohenstein, 2001; Redford & Powell, 2016). This act led to many unintended consequences including stigma and a continuum of anti-drug policies, the most important being the Comprehensive Drug Abuse Prevention and Control Act of 1970. The most widely known components of this act are Titles II and III which contains the Controlled Substance Act (CSA). As noted, in the 1930s cannabis was criminalized under false racist pretenses due to widespread government propaganda (Nelson, 2019; Steiner, 2021). Yet what is more alarming is that the propaganda was so effective that it has survived for decades. This speaks to the racist nuances of American history that misinformation about a substance and the users of that substance can not only survive but prosper. This misinformation was immortalized by the passing of the Controlled Substance Act (CSA) of 1970.

The CSA is the basis for modern drug regulation and has helped federal administrations maintain authority over the United States drug supply (Courtwright, 2004; Hall, 2018; McAllister, 2004; Spillane, 2004). The policy was intended to maintain the federal government's control of the

production, manufacturing, sales, and possession of a range of substances. Beyond that control, the CSA also purports to establish the utility verses harm of substances, in the form of scheduling. Five drug schedules exist, ranging from those drugs perceived as having the highest potential for abuse (schedule I) to lowest (schedule V) (Spillane, 2004; Hall, 2018; McAllister, 2004). The two government agencies that oversee the review and scheduling process are the Food and Drug Administration (FDA) and what is now known as the Drug Enforcement Administration (DEA). However, instead of the FDA or a separate scientific/medical entity organizing the drugs into schedules, Congress did so itself (Hudak, 2020). These schedules are used as a tool for bureaucratic control and have perpetuated decades of stigma and bias for many drugs and their users (Spillane, 2004; Hall, 2018; McAllister, 2004). While organizing substances by which ones have the highest potential for abuse seems to make sense, we must ask who is making those decisions, for what reasons, and based on what research.

Created in 1970, the Controlled Substance Act has been amended over the decades and some analysts suggest this has made the policy less flexible than originally intended (Courtwright, 2004). As new substances are introduced additions were made, yet there has been no major overhaul of the initial controversial scheduling decisions. The proposed benefits of the CSA were to implement a reform law that integrated a law-enforcement and public-health approach to drug policy. In addition to supply control, the Comprehensive Drug Abuse Prevention and Control Act of 1970 also provided funds to the Department of Health, Education, and Welfare (HEW) to further education, rehabilitation, training, and research regarding addiction prevention and treatment (Courtwright, 2004). Additionally, the act was said to adjust sentencing reforms, remove implicit bias, and be more lenient for casual drug users and to impose heavier sentences on organized criminal traffickers. Ultimately, the CSA left the sentencing details up to the states (Lassiter, 2015). Then-President, Richard Nixon‘s rationale was that the drug laws of the time were ‗outdated and inadequate.‘ These observations by were largely because only drugs like opiates and cocaine were known to be widely misused in the early 1900s (Courtwright, 2004). Nixon saw a pressing need to create a comprehensive drug law to regulate drugs and help our nation manage the growing drug crisis which had negative effects on public health. Considering all the good intentions, how then has this modest reform law transformed into the punitive drug policy known today?

The Controlled Substances Act did have more punitive features than originally advertised, such as the creation of ‘no-knock’ search warrants. The law also provided funding for additional federal drug enforcement agents (Courtwright, 2004). The comprehensive policy seemed to have something to appease all parties and their constituents. For example, it allocated resources to expand law-enforcement agencies but also to further research; it imposed social control and regulation on drugs but did so for the good of public health. The Controlled Substances Act of 1970 was intended to contain the nation's drug problems but that is not what happened. We must consider the cultural factors for why this policy did more harm than good.

The CSA allowed each state to control sentencing; as youths continued to use and misuse drugs, anti-drug advocacy groups promoted an approach of ‗zero tolerance‘ that many states, including New York with its ‘Rockefeller laws’ confirmed (Courtwright, 2004; Quintero, 2012). The Rockefeller laws mandated prolonged prison sentences for individuals convicted of felony drug offences (Hart, 2022; Hudak, 2020). More than 90% of convictions under the Rockefeller laws were of African Americans or Latinos although that did not represent the demographic of drug users (Hart, 2022). These laws and the overall cultural understanding of drugs continued to perpetuate negative stereotypes of drug users. Then came the crack-cocaine epidemic, so in the 1980s the war on drugs was still in full swing. The results of the crack-cocaine epidemic and the increase in ‘zero tolerance’ drug laws, allowed the private prison industry to grow and law enforcement agencies to receive more and more funding to deal with ‗drug crimes‘ (Alexander, 2010; Courtwright, 2004). This shift supplanted the CSA‘s approach of improving public health, and instead focused on law-enforcement. The wave of drug use and misuse of the 70s and 80s sustained a culture of moral panic, as well as fear and intolerance of substances and the individuals who used them. This culture of fear

encouraged politicians to adopt a stricter outlook on drug policy, and like a snowball, the war on drugs continued, bigger and with more speed (Hudak, 2020).

Financial Motives

Dating back to as early as the Harrison Act of 1914, there have been ulterior motives for the United States federal government's involvement with substance use and regulation of drugs - predominantly for racial and financial reasons (Hohenstein, 2001; McAllister, 2004; Walker & Netherland, 2019). As a capitalist society our policies are often motivated by finances. Yet, this does not explain why only certain drugs, and in turn, certain individuals are targeted.

For example, pharmaceutical, tobacco, and alcohol industries are considered by most to be valid businesses, therefore are socially acceptable and not a cause for social outrage (Gregory, 2003). Nevertheless, we continue to criminalize individuals using certain substances, primarily people who are African American, Hispanic, or from a low socioeconomic background. The stigma and discrimination created by our government's drug policies over the past century have reverberated through many other financially motivated social problem areas today, such as our approaches to criminal justice, health care, and poverty. Parallel to the reaction of the crack-cocaine epidemic versus our current opioid epidemic, United States history has shown us how it discriminates and criminalizes drugs and the individuals using them. Moreover, the Controlled Substance Act of 1970 confirmed that cannabis was a Schedule I substance, which is considered the most dangerous. This scheduling indicates that cannabis has no accepted medical use and has a high potential for abuse (Nelson, 2019; Spillane, 2004; Steiner, 2021), thus was easier to criminalize.

The criminalization of cannabis was left largely unquestioned until 1996 when California passed Proposition 215, legalizing its medical use (Nelson, 2019). Yet the Department of Justice (DOJ) and Drug Enforcement Agency (DEA) continue to use cannabis as a tool to discriminate against BIPOC and people of low socioeconomic standing in the United States.

The Regan administration gave substantial cash grants to law enforcement agencies that were willing to prioritize drug crimes (Alexander, 2010). These cash grants paved the way for many law enforcement agencies to spread systematic racism, directly contributing to the negative perception of drugs and the individuals who use them. Power and racism are important nuances to consider in the criminalization of certain drugs. McAllister (2004) explains the economic and political factors that played a part in the passing of the Controlled Substance Act of 1970. The scheduling of substances had less to do with the actual danger of each substance, and more to do with which nations were producing them and who was making money from them. Substances that were listed as Schedule I, for example, were determined to be less profitable for the United States, therefore easier to stigmatize.

The Controlled Substances Act did have some strength, such as the initial funding of research into drug treatment and harm reduction approaches. Without this initial push, likely much of the United States would not have had treatment programs integrated into our medical system. Furthermore, the CSA created a valuable scheduling system, as many drugs, such as opioids, need to be strictly regulated. The weakness of the CSA is implementation. While funding research was accepted, the systematic biases prioritized research that confirmed drug-related stigmas, and strictly focused on abstinence-only outcomes of treatment (Walker & Netherland, 2019). The focus on abstinence-only treatment is still prevalent in substance misuse treatment today which, in turn, discourages social or professional acceptance of harm reductions approaches such as medication-assisted treatment (MAT) (I.e., methadone, suboxone, or naltrexone) (Davis & Rosenberg, 2013).

While well-intentioned, the CSA's scheduling framework introduced financial incentives and rewards into the design. As explained by McAllister (2004, p. 5):

If, for example, a pharmaceutical company could arrange for its drug(s) to be scheduled in a less restrictive category than those of competitors, the potential rewards in sales and profits could be more substantial when compared to substances placed in a more restrictive category.

Our nation has seen this incentive misused by pharmaceutical companies like Purdue

Fredrick, which many credit for creating and fueling the current opioid epidemic with their promotion and aggressive sales of OxyContin (Keefe, 2021; Macy, 2018). Moreover, the scheduling system is coordinated by federal agencies such as the FDA and DEA, yet companies like Purdue can achieve their goals through financial mechanisms outside of public awareness (Macy, 2018). Purdue Pharma first developed MS Contin from morphine in 1984 as an end-of-life medication for the terminally ill and the drug did its job of liberating dying individuals from pain (Keefe, 2021; Macy, 2018). The profit margins for MS Contin were limited, due to the small demographic of end-of-life individuals. With their bottom line at stake, Purdue set out to have the FDA approve OxyContin as a new drug, the painkiller for 'everyday pain' (Keefe, 2021; Macy, 2018).

Approved in 1995, OxyContin was the first schedule II narcotic that the FDA labeled as 'less addictive' and this FDA label allowed sales representatives from Purdue to sway medical professionals around the country to prescribe this highly addictive drug to the masses (Keefe, 2021; Macy, 2018). Purdue has since been discovered to have fabricated their application to the FDA with false science regarding the time release component of the drug and how it would make addiction 'nearly impossible' (Keefe, 2021; Macy, 2018). Because of their socioeconomic power, Purdue was able to maneuver and manipulate U.S. policies to their benefit (Keefe, 2021; Macy, 2018). This story is an example of only one pharmaceutical company and their advertisement of one drug. These practices are unlikely to be limited to OxyContin because of substandard regulations and easily manipulated policies in the United States and in the world. It should be noted that without the financial influence and white power of the Sackler family, the family behind Purdue Pharmaceutical, these types of practices would likely not have escalated to the level they did. To gain a deeper understanding of Purdue Pharmaceutical and the Sackler family, see Keefe's 2021, Empire of Pain.

Mass Incarceration and Decriminalization

Beginning in the 1980s, the DEA created a training program for police officers called Operation Pipeline (Alexander, 2010; Glasser, 1999). This federally funded program taught law enforcement agencies how to use the pretext of a routine traffic stop to search for individuals possibly carrying drugs.

A drug-courier profile was created, which encouraged law enforcement officials to stop any individuals they deemed suspicious (Alexander, 2010). 'Suspicious' often translated to African American or other minorities. This means that who to stop could be based on officer's personal bias. This federally funded policy, therefore, taught law enforcement officers to racially profile. Furthermore, it perpetuated society's understanding that African Americans, and other minorities, were to blame for the ongoing war on drugs. The DEA's Operation Pipeline incentivized law-enforcement agencies to 'crack down' on individuals who might possibly have substances in their possession. Both the FDA and DEA have created a culture of stigmatizing drugs and the lower socioeconomic strata (particularly African American communities) while fueling the ongoing war on drugs.

Where Are We Now?

With the many problems identified here, we need some solutions. Recent policies such as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Affordable Care Act (ACA) of 2010, the U.S. attempt to correct some of the discrimination and stigma in healthcare against individuals who use and misuse drugs (Weber, 2013). Nevertheless, the U.S. does not have sufficient social safety nets to use a public health/treatment approach to drug policy. Therefore, as a nation, we need to restructure our current social welfare policies to be more inclusive and less restrictive so that the appropriate services (i.e., harm reduction, other treatment programs, MAT, etc.) could be available to all individuals who need them.

In the words of Maté (2008), when helping individuals who misuse drugs, we must strive to change not them, but their environment. Current treatment of substance misuse silos drug treatment from other avenues of healthcare and therefore we are not seeing individuals holistically. Moreover, we must educate professionals in other areas of healthcare to prevent gaps in

assessment or treatment from occurring. If primary care providers are not properly screening individuals for substance misuse, we are less likely to engage them in treatment. Some call for a radical de-stigmatization movement to occur in our country (Lavin & Barnes, 2020). We must structure de-stigmatization in both the practice of medicalization and assimilation (Lavin & Barnes, 2020). Assimilation requires substance misuse treatment and standard healthcare to be integrated instead of drug use disorders being treated separately, outside of routine medical and mental health treatment.

Furthermore, the current movement towards decriminalization must be supported for us to move away from the continued mass incarceration of low socioeconomic status and BIPOC individuals. One major advancement in the movement of decriminalization is that, as of this writing, 36 states have laws allowing expungement of drug-related criminal records (Prescott & Starr, 2019). What expungement does for individuals is seal their past convictions from public view and databases, which allows people to find more job opportunities, earn more money, and data even suggests they re-offend at a lower rate (Prescott & Starr, 2019). The red tape, waiting time, and resources needed to expunge a record are daunting. Policymakers in these states must create more inclusive and easier to navigate protocols for individuals to expunge their records.

Some states, such as California, have already passed a bill that automatically expunges records after an individual has served their sentence (Prescott & Starr, 2019). Still, individuals in our society who have been incarcerated for drug-related crimes could be left out when implementing any changes to policies. The next step in research is to examine mechanisms to assist those already damaged by stigma surrounding substance use and misuse, addressing the intersection of systematic racism, social control, and public perception of drugs and drug users.

Another overarching issue highlighted in this article is the systematic and persistent racism that is intertwined with past and current laws in the United States. Some scholars implore our government to consider historical reparations for BIPOC individuals (Bassett & Galea, 2020). Though it is not explained in a tangible way, at its core these reparations would aim to acknowledge the wrong doings of our government and allow for BIPOC individuals to access resources that have long been out of reach due to power and equity discrepancies (Bassett & Galea, 2020). I believe the government can take this idea and find more practical ways to implement it into future polices, such as investing more in financial literacy and policy development literacy in our public education systems.

A specific policy that I mention throughout this article, the Controlled Substance Act (CSA), I believe requires the most attention when addressing where we go from here. This policy is not only outdated but has since contradicted itself when the FDA approved two different cannabinoids for medical use (Hill, 2015). As mentioned, ‘Schedule I’ substances are said to have a high potential for abuse and no current accepted medical use in treatment in the United States (Hudak, 2020). The mentioned cannabinoids that were granted FDA approval are forms of medical marijuana utilized for cancer treatment to help with nausea and vomiting (Hill, 2015).

This data does not stand alone as it is becoming more common place for states to legalize medical cannabis for a variety of physical ailments (Hill, 2015; Lucas & Walsh, 2017). Studies in the states that have legalized medical marijuana also found reductions in negative health outcomes for misuse of other substance, such as opioids (Lucas & Walsh, 2017). Additionally, there has been studies that are substantiating the effectiveness of LSD or psilocybin mushrooms for the treatment of depression, anxiety, and PTSD (Lavin & Barnes, 2020). With this noteworthy data becoming available regarding ‘Schedule I’ substances and their value in medical treatment, I beseech the federal government to amend the scheduling laid out in the CSA. This amendment would be the first step in correcting catastrophic mistakes made by our government and allow scientific studies and medical professionals to weigh in on this important scheduling process. I believe when we take the stigma out of the reasoning regarding scheduling drugs and how our government reacts to them, we can begin healing from our past inaccuracies.

Overall, if drug policies were created within a public health framework rather than taking a

criminal approach, we would see more research and action in harm-reduction policies. Harm-reduction approaches, such as needle exchange programs, safe injections sites, and a stronger focus on Medication-Assisted Treatment can address the actual social issue of substance misuse in the United States. The culture of drug use and the individuals who use them have been largely stigmatized, criminalized, and disenfranchised for far too long. Without a more meaningful understanding of the social and political context of this stigma, we cannot enact policies that will improve things. Rather we will continue down the path of discrimination and fail to solve our drug problems.

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