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The Opioid Crisis: The War on Drugs Is Over. Long Live the War on Drugs

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Abstract

A closer examination of media coverage, the response of law enforcement and policy makers, the legislative record, and the availability of proven, high-quality treatments for substance abuse casts doubt on claims that the country pivoted toward public health and harm-reduction strategies to address the opioid crisis because its victims were disproportionately white people. Law enforcement solutions directed at people who use and sell street drugs continue to far outpace public health and harm-reduction strategies. Government support for expanding access to proven treatments for opioid use disorder that save and rebuild lives remains paltry given the scale of this public health catastrophe. And although the rhetoric has been somewhat more sympathetic, at times it rivals the excesses of the crack era. The article examines the various phases of the opioid crisis as they have unfolded over the past 25 years; related geographic and racial shifts in overdose fatalities with each new phase; media coverage of the crisis; the federal government's response, including by the US Congress and presidents from George H.W. Bush to Joe Biden; punitive developments at the state and local levels; and the country's poor record on prevention and making effective treatment widely available for people with substance use disorder.

1. INTRODUCTION

The United States is in the midst of an unprecedented drug crisis that kills tens of thousands of people each year and ravages many more lives, families, and communities. Leading public officials and commentators have fostered the view that the country has deployed a racialized double standard in the opioid crisis.[1] In a keynote address to the Drug Policy Alliance in 2017, Michelle Alexander, author of the best-selling *The New Jim Crow*, suggested that the United States has entered an era of "newfound tolerance and compassion" in drug policy because the public face of the opioid crisis is predominantly white (Singh 2017). Around that time, then-Senator Kamala Harris (D-CA) decried how people with opioid problems have been treated with empathy, in contrast to the stigmatization and demonization years ago of Black people and Latinos who used crack (King 2017).

Depictions of the opioid epidemic have been somewhat kinder and gentler compared to how the media, politicians, and other public figures waged earlier drug wars against opium, marijuana, heroin, crack, and methamphetamine—and against the people who used these substances.[2] Nonetheless, tough law enforcement rhetoric has predominated, even if it has not always been at full blast, during the opioid crisis, which began more than two decades ago. And at times, rhetoric about the opioid crisis has rivaled the excesses of the crack era.

This moderation in rhetoric has not punctured the remarkable quiescence given the enormity of the crisis. Compared to the so-called crack epidemic, the opioid epidemic has been "*under*- rather than overstated" (Laugesen & Patashnik 2020, p. 366, italics in original). Until the COVID-19 epidemic struck in 2020, the opioid crisis was the country's greatest public health catastrophe since the Spanish flu a century ago. At the height of the war on crack, the total number of overdose deaths for all drugs in the United States numbered approximately 8,000 per year (Katz & Sanger-Katz 2018). By comparison, nearly 108,000 people in the United States died of a drug overdose in 2021 (Weiland & Sanger-Katz 2022). This figure is nearly twice the total number of US casualties during the decade-long American war in Vietnam and more than twice the 1995 peak in annual deaths from HIV/AIDS before antiretroviral drugs stemmed that epidemic (Katz & Sanger-Katz 2018). Synthetic opioids—primarily fentanyl—were implicated in nearly two-thirds of those overdose deaths (Weiland & Sanger-Katz 2022).

Unlike in the first stages of the HIV/AIDS crisis in the 1980s and 1990s, we know what works to treat opioid use disorder and stem its dangerous and lethal consequences for individuals and communities, as elaborated below. Yet there has been a massive public health failure in the United States to ameliorate the pervasive harms caused by opioid dependency and a massive political and public policy failure to address the epidemic's underlying political and socioeconomic causes. Hundreds of thousands of people have died prematurely of opioid overdoses since the turn of the twenty-first century, and millions more have been unable to access high-quality substance abuse treatment to stabilize their lives. As of 2017, the overdose death rate in the United States was ten times greater than the European Union's rate (Eur. Monit. Cent. Drugs Drug Addict. 2019).

A common refrain is that the opioid crisis is being treated primarily as a public health problem rather than a law enforcement problem—unlike in the case of crack—because its main victims are white people. But this view is not well supported by the facts on the ground. As opioids have cut a widening swath of destruction across the United States, the government and public policy

[1] See, for example, Glanton (2017), Peterson & Armour (2018), and Yankah (2016).

[2] I use the term opioid crisis and opioid epidemic throughout because these are the terms policy makers, politicians, journalists, and researchers generally use to refer to the problematic use of both opiates, such as heroin, which are derived from opium poppies, and drugs synthesized largely from chemicals, such as oxycodone (OxyContin), hydrocodone (Vicodin), and fentanyl, that perform in ways similar to opiates.

response has been at best inadequate and misguided, and, at worst, cruel and lethal (Laugesen & Patashnik 2020). The federal government, states, cities, and towns have engaged in another punitive and unwarranted war on drugs, this time against opioids and the people who use them. They have redeployed punitive tools from previous wars on drugs and created some new ones, which have bolstered the carceral state and exacerbated the opioid crisis. Even though the proportion of people serving time in prison for drug crimes has fallen, US drug policy remains exceptionally punitive and lethal.

In the latest war on drugs, the harshest words and most punitive policies have been aimed primarily at people who use opioids and other drugs, not at the pharmaceutical companies, medical providers, and government regulators who triggered the crisis. The individuals and companies that opened the floodgates for tens of billions of legally prescribed, high-dosage opioid pills to course through the United States despite compelling evidence about their toxic effects—including high rates of addiction and fatal overdoses—have largely escaped punishment.

A closer examination of media coverage, the response of law enforcement and policy makers, the legislative record, and the availability of proven, high-quality treatments for substance abuse casts doubt on claims that the country pivoted toward public health and harm-reduction strategies to address the opioid catastrophe because its victims were disproportionately white people. Law enforcement solutions directed at people who use and sell street drugs continued to far outpace public health and harm-reduction strategies. Government support for expanding access to proven treatments for opioid use disorder that save and rebuild lives remained paltry given the scale of this public health catastrophe. And although the rhetoric has been somewhat sympathetic, at times it rivals the excesses of the crack era. In 2016, for example, Senator Kelly Ayotte (R-NH), whose state has been hit hard by the opioid epidemic, excoriated people who sell fentanyl as "agents of death" and likened the drug to serial killers (Ayotte 2016). That same year, Republican governor Paul LePage implored Maine to bring back the guillotine and called for public executions of drug traffickers (Kopan 2016).

The next section briefly examines the three phases of the opioid crisis, which began more than two decades ago, and related geographic and racial shifts in overdose fatalities with each new phase. Section 3 surveys media coverage of the crisis. Sections 4 and 5 focus on the federal response to the opioid crisis, including by the US Congress and presidents from George H.W. Bush to Joe Biden. Section 6 examines punitive developments at the state and local levels, and Section 7 looks at demographic shifts in arrests and incarceration. Sections 8–11 survey the country's poor record on prevention and making effective treatments widely available for people with substance use disorder.

2. THE CHANGING PHASES AND DEMOGRAPHICS OF THE OPIOID CRISIS

The initial causes of the opioid epidemic are markedly different from those that propelled earlier wars on drugs. Most of these earlier drug scares were not real public health crises or epidemics, even though they were portrayed as such. Due to fear, political opportunism, ignorance, and prejudice, historically disadvantaged groups were overwhelmingly singled out for blame, shame, and punishment during these prior drug scares (Davis et al. 2017). In the early twentieth century, the target was Chinese immigrants who used opium. In the 1930s, the target was Mexican Americans who smoked marijuana. In the 1990s, the target was poor white people in struggling rural and Rust Belt communities who used methamphetamine. And, most notoriously, the war on crack in the late 1980s and 1990s targeted African Americans and Latinos living in poverty-stricken urban neighborhoods.

The crack scare was precipitated by a highly racialized moral panic fueled by fears that were greatly out of proportion to the actual problem. With the introduction of crack, "crackheads" became the most prominent target in the war on drugs beginning in the mid-1980s. A moral panic ensued as politicians, with the help of a willing media, promulgated exaggerated and racialized accounts of crack as a "devil's drug" that was "instantly and inevitably addictive" and that inculcated extremely violent and antisocial behavior in users (Reinarman & Levine 2004, p. 185). Sensationalist media accounts and early scientific reports stoked fears of a new generation of severely disabled "crack babies" in need of costly medical care for the rest of their lives. These apocalyptic claims turned out to be unfounded (Okie 2009). Crack and crackheads became the scapegoats onto which politicians, other public figures, and even some residents of poor African American neighborhoods heaped much of the blame for rising rates of violence, crime, and social decay in urban areas, much as they had blamed heroin and heroin addicts in the 1960s and 1970s (Forman 2017). This justified greater investment in law enforcement, including militarized policing, and cracking down on poor, urban neighborhoods and their residents, especially young Black men. It legitimized casting a massive dragnet over these neighborhoods while the real culprits—disinvestment in public housing and education, the assault on organized labor and public-sector jobs, a failing health-care system, residential segregation, a shredded social safety net, and a regressive tax system—remained invisible. The crack crisis was a moral panic that created a law enforcement crisis for poor, urban communities as police officers behaved like an occupying army, emboldened by a slew of new federal and state drug laws, legal decisions, and public policies that fostered dangerous and intrusive policing tactics.

The opioid crisis, which unfolded in three phases over the past 25 years or so in the United States, has been a public health crisis in ways that the crack crisis and earlier drug scares were not. The obsequiousness of government regulators and public officials toward the powerful pharmaceutical industry triggered the first phase. Against the recommendations of their own experts, government regulators greenlighted the sale and marketing of dangerous new opioid pain prescription pills beginning in 1995 with the Food and Drug Administration's approval of OxyContin, a semisynthetic opioid manufactured by Purdue Pharma that "is basically heroin made in a lab" (Curr. TV 2009). Despite Purdue's and the FDA's claims to the contrary, OxyContin and other new formulations of oxycodone were actually highly addictive and subject to misuse. Pharmaceutical companies and distributors, including well-known companies like Johnson & Johnson, CVS, Walgreens, and Walmart, flooded the market with these pills, aided by doctors and other medical providers who promiscuously prescribed them. In their aggressive marketing campaigns, drug companies explicitly targeted white people and certain rural and suburban communities (Murch 2019).

The companies targeted their aggressive marketing campaigns at rural and suburban white people to avoid the racialized stigmas associated with street drugs sold in urban markets that the police and politicians had been waging war against for decades (Herzberg 2020, Murch 2019, Netherland & Hansen 2017). Focusing on "deserving" white patients in need of pain relief was a way to neutralize the historic hostility of the Drug Enforcement Administration (DEA), other law enforcement groups, and government regulators to the expansion of opioid use (Murch 2019). Thanks to this racial and geographic targeting—as well as the structural advantage that white people have in health-care access and the medical profession's long-standing pattern of undertreating pain in African Americans—the new opioids were disproportionately prescribed and made available to white people complaining of or at risk of pain (Boggs 2019, Dasgupta et al. 2018).

OxyContin, the brand name of oxycodone, rapidly became a blockbuster drug with more than $1 billion in annual sales. Purdue Pharma and other manufacturers and distributors of natural and semisynthetic opioids, most notably oxycodone and hydrocodone, saturated rural communities

with high dosage prescription pain pills. They created "a virtual opioid belt" of more than 90 counties stretching from West Virginia to Kentucky (Horwitz et al. 2019b).

The opioid industry's marketing strategies that targeted white people in states with laxer regulations on prescribing opioids do not entirely explain why certain rural and Rust Belt communities were the initial epicenters of the opioid crisis. The hollowing out of the social safety net and public services in these areas was also a key catalyst, as were the spate of trade agreements, which shuttered factories, and the Great Recession, which battered their already enfeebled economies (Dean & Kimmel 2019, Nagelhout et al. 2017, Natl. Acad. Sci. Eng. Med. 2017, Peters et al. 2020, Rigg et al. 2018, Venkataramani et al. 2020).

As the wreckage of the opioid crisis mounted, with tens of thousands of people dying each year from drug overdoses, the government belatedly spurred into action, launching the second phase of the epidemic. Around 2010, it sought to abruptly choke off the supply of OxyContin and other semisynthetic opioids by cracking down on pill mills, instituting prescription monitoring programs, and imposing restrictions on how many pain pills doctors were permitted to prescribe and to whom (Davis & Lieberman 2021). In a public policy failure of epic proportions, it made this move without radically expanding access to proven treatments for substance use disorder and alternative means of pain management for people dependent on these pills. Many people were forced to turn to illegal street drugs, notably heroin, to stave off withdrawal symptoms and cravings and manage their pain, which put them at great risk for fatal drug overdoses and needle-borne diseases, notably HIV/AIDS and hepatitis C.

The third phase of the opioid crisis began around 2015 as suppliers of street drugs began lacing fentanyl—which is 50 times more potent than heroin—into heroin and other street drugs, turning drug use into a game of Russian roulette (Caulkins et al. 2021). Doses as small as two milligrams of fentanyl—equivalent to a few grains of table salt—can be fatal. In the latest phase, cheap and deadly fentanyl and fentanyl-like analogs pervade the illegal drug market, laced into everything from heroin to Ecstasy to pain pills.

In each of these three phases, a changing mixture of racial, ideological, political, and institutional factors has propelled the crisis and recast some of its consequences. As a result, the demographics and geographical sweep of the opioid epidemic have shifted over time. In its early phases, the overdose rates of white people outpaced those of African Americans by wide margins. The gap has been narrowing in recent years as more drugs have been adulterated with fentanyl and fentanyl analogs. Initially centered in certain rural and Rust Belt communities, the opioid epidemic has spread to a growing number of urban areas.[3]

The first phase of the opioid epidemic generated a reversal in geographic and racial disparities in fatal overdoses. In 1999, drug overdose rates for urban areas exceeded those in rural areas. By 2004, they had converged. Two years later, the rural rate surpassed the urban rate.[4] The first phase also generated racial shifts in opioid deaths. In 1999, the rate of opioid overdose deaths for African Americans slightly exceeded the rate for white people and equaled the rate for Hispanic people. Two years later, the rate for white people began charging ahead. Over the next decade, the overdose death rate for African American and Hispanic people remained reasonably constant but continued to surge for white people (Furr-Holden et al. 2021, Hoopsick et al. 2021). By 2010, white people

[3]There is enormous geographic heterogeneity in the opioid crisis. Opioid-related deaths have soared to epidemic levels in certain rural areas, notably in Appalachia, New England, and the Mountain West, while remaining relatively low in some other rural areas in the Delta South and Great Plains (Rigg et al. 2018).

[4]In 2015, the rural rate was 17 per 100,000 and the urban rate was 16.2 per 100,000. The respective rates for 1999 were 4 and 6.4 (CDC 2017).

were dying of overdoses at about three times the rate of African American and Hispanic people (Furr-Holden et al. 2021).[5]

Overdose deaths involving fentanyl and other synthetic opioids (other than methadone), which had been gradually climbing between 2000 and 2013, have since soared. Around 2016, fentanyl became the leading cause of overdose deaths in the United States, far surpassing deaths from heroin and prescription drugs (Gramlich 2022; Hedegaard et al. 2021, figure 4).

With the rapid spread of fentanyl and fentanyl-laced heroin and other drugs in urban areas, the third wave of the opioid crisis has been rapidly closing the rural–urban and white–Black disparities in overdose deaths.[6] Around 2010, the overdose death rate for Black and Hispanic people began to climb significantly after being largely flat since the start of the opioid crisis. By 2013, the rate of increase in opioid fatalities among African Americans began outpacing that of white people by wide margins as the rate of increase slowed or leveled off for white people (Furr-Holden et al. 2021). In 2019, the overdose death rate for Black men surpassed that of white men for the first time in decades and is now the highest of any demographic group. The overdose fatality rate for Black women—which was just half the rate of white women five years ago—is now just slightly lower than that of white women (Gramlich 2022). In 2016, urban overdose rates overtook those of rural counties for the first time in about a decade (Hedegaard et al. 2019, Keyes et al. 2014).

3. THE OPIOID CRISIS AND MEDIA COVERAGE

Many op-eds and other articles in the popular media contend that a racialized double standard has prevailed in news coverage of the opioid crisis (Krisai 2016, Newkirk 2017, Seelye 2015, Shaw 2017, Shihipar 2019). These commentaries typically make their case by singling out anecdotes or news stories that sympathetically feature the struggles of white individuals with opioid problems who are trying to turn their lives around. These commentaries contrast this sympathetic coverage with the sensationalistic reporting in the 1980s and 1990s that demonized African American people who used crack.

Academic research on media coverage of the opioid epidemic reveals a more complicated picture on the question of a racialized double standard. Journalists have tended to portray white users of prescription opioids more favorably than people of color who use heroin, according to some researchers (Johnston 2020, Netherland & Hansen 2016, Stone 2018). Nonetheless, the use of stigmatizing language, such as "addict" or "substance abuser," to refer to people with opioid use disorder has been pervasive in the news media and has actually increased slightly as the epidemic has persisted (Kavanaugh & Schally 2021, McGinty et al. 2019, Perry et al. 2020, Webster et al. 2020). As stigmatizing references to so-called addicts increased in the news media, the complicity of the pharmaceutical industry in fostering the crisis largely disappeared from view for a long period (McGinty et al. 2018).

The high level of public stigma toward people who use drugs is a major obstacle to implementing harm-reduction policies to address the opioid crisis (Kennedy-Hendricks 2017, US Dep. Health Hum. Serv. 2016). When certain groups are framed in highly stigmatized ways, the public is more likely to endorse targeted interventions that punish rather than benefit these groups (Schneider & Ingram 1993).

In the face of the country's deadliest drug crisis, journalists persisted in portraying opioid abuse as primarily a criminal matter rather than as a treatable medical condition. Harm-reduction approaches, the shortage of substance abuse treatment, and the effectiveness of medication-assisted

[5] Figures in this paragraph calculated using data from the Kaiser Family Foundation (1999–2017).
[6] Calculated using data from the Kaiser Family Foundation (1999–2017).

treatment (MAT) received much less media coverage (McGinty et al. 2016). Frames that emphasize prevention and harm reduction to deal with the opioid epidemic have only recently been gaining ground on ones that stress illegal drug dealing, police, arrests, and prosecution (McGinty et al. 2016). Beginning around 2015, news reports about MAT with buprenorphine and methadone increased substantially (Kennedy-Hendricks et al. 2019). But in states with high opioid overdose rates, local news coverage emphasized the negative rather than the positive aspects of MAT for opioid use disorder (Kennedy-Hendricks et al. 2019).

One comprehensive study comparing media coverage of crack (1988–1989), methamphetamines (1992–1993), heroin (1988–1989, 1992–1993, and 2016–2017), and opioids (2016–17) at key moments spanning the past three decades concluded that a strong criminalization focus prevailed in news coverage of crack, whereas a medical model prevailed in reporting on the opioid crisis (Shachar et al. 2020). Notably, this study categorizes drug courts and prescription monitoring programs as treatment and prevention interventions rather than punitive acts of social control and law enforcement. But as discussed below, drug courts are actually quite punitive. As for prescription monitoring programs, their main aim is not treatment but rather to clamp down on the supply of opioids by punishing providers and people with opioid use disorder, as discussed above.

In analyzing reporting in the 2016–2017 period, Shachar et al.'s (2020) study separates out media coverage of heroin from that of prescribed opioids, even though the turn to heroin was a key feature of the third phase of the opioid crisis. This may explain why the researchers found that the law enforcement frame remained prominent in news coverage of heroin in 2016–2017 but not in reporting on opioids.[7] The authors of this study say their findings appear to lend "credence to the popular hypothesis that the opioid epidemic is perceived and framed differently because of the demographic groups it impacts" (Shachar et al. 2020, p. 234). But they caution that "it is difficult to conclusively state whether the difference in narratives between the opioid epidemic and other substance use epidemics stems from the perception that the opioid epidemic is uniquely white" (Shachar et al. 2020, p. 233). They note that a "heavy criminal justice narrative" drove reporting of the 1992–1993 meth scare, which was primarily associated with white people (Shachar et al. 2020, p. 233). Furthermore, although crack was framed primarily as a law enforcement issue in the 1988–1989 period, news coverage of heroin—which at the time was primarily associated with African Americans—deployed both public health and law enforcement frames (Shachar et al. 2020).

This and many other studies of news coverage of the opioid crisis invoke media coverage of crack as a standard of comparison. This is useful but only up to a point. Many commentators and researchers slip into talking about the crack scare as an "epidemic," which fosters at times misleading apples-to-oranges comparisons between these two crises.[8] As discussed earlier, the crack crisis was a moral panic, not an epidemic or public health crisis. Hyperbolic claims about the threat crack purportedly posed to public health and safety unleashed a massive overreaction by police, prosecutors, politicians, and segments of the public that targeted poor, urban communities and people of color. Crack propelled a law enforcement crisis as residents of these communities increasingly viewed the police as an illegitimate occupying army and the United States as a semi-authoritarian state, not a democracy (Lerman & Weaver 2014).

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[7]The researchers acknowledge in a footnote and appendix that when they conducted a combined analysis of news coverage of opioid and heroin articles for 2016–2017, the law enforcement narrative became stronger, but the medical model, as they define it, continued to dominate (Shachar et al. 2020).

[8]See, for example, Kim et al. (2020), Netherland & Hansen (2017), and Shachar et al. (2020).

By contrast, the opioid crisis is the deadliest drug crisis in US history.[9] It is a real epidemic, not just a rhetorical one. Given the tens of thousands of lives lost each year to overdoses and the millions more upended because of opioid use disorder, a starting point for discussion of media coverage of the opioid epidemic needs to be an acknowledgment that this public health catastrophe has received comparatively little media and public attention, even though white people have been disproportionately at risk by wide margins until recently. As one public health expert observed, "The scale of death here is really unprecedented, and so you have to judge the response against the scale of the problem" (Joshua Sharfstein, quoted in Horwitz et al. 2019a). In short, given the enormous impact of the opioid crisis in lives lost and scarred, public attention has been relatively slight and intermittent compared to the public focus on the so-called crack epidemic (Kim et al. 2020).

4. THE OPIOID CRISIS AND THE WHITE HOUSE

Despite some modest gestures toward public health and harm-reduction approaches, the predominant response to the opioid crisis has been punitive and carceral. The drug warrior mentality of previous drug scares has persisted and, in some instances, intensified. As in past drug scares, politicians, policy makers, and police officers have engaged in "policy theater," pursuing actions that are "visible and noteworthy, regardless of their ultimate impact" (Beletsky 2019, pp. 883–84). This time around, these theatrics have had far deadlier consequences because the opioid crisis is a public health emergency, not just a moral panic.

The evidence is overwhelming that tougher sentences and other punitive measures do not reduce the harms associated with substance use disorder and may actually increase them (see, for example, Pew Charit. Trusts 2018). But after declining over the previous decade, the number of drug arrests in the United States increased each year from 2015 to 2018, before dipping down slightly in 2019 and again in 2020. The overwhelming majority of these arrests were for possession, not sale or manufacturing, and most involved small amounts (FBI 2020a,b; Stellin 2019).

Since Richard Nixon launched the war on drugs nearly 50 years ago, federal expenditures on law enforcement and interdiction have dwarfed spending for treatment by wide margins in most administrations. As the opioid crisis unfolded over the past 25 years, the executive branch, assisted by the US Congress, continued to wage the war on drugs in the United States and abroad (Drug Policy Alliance 2015, Reuter 2013). Even as the opioid crisis began to emerge in pockets of the United States in the late 1990s, drug policy remained largely unchanged during the Clinton administration, despite some softening of rhetoric. Toward the end of his administration, federal officials sought to crack down on prescription drug abuse by bolstering drug monitoring programs and shuttering pill mills to choke off the supply.

George W. Bush intensified the crackdown despite widespread warnings from in and outside the government that doing so would fuel a heroin epidemic as the black-market price of pain pills skyrocketed (Markon & Crites 2014). Those projections did not prod Bush or his successor Barack Obama to treat the emerging opioid epidemic as a public health emergency. Neither did the growing number of government reports, testimony in Congress, and warnings from top government scientists—including the directors of the National Institute on Drug Abuse and the National Institutes of Health in 2006—that the United States was in the throes of an opioid crisis (Ehley 2019). As the opioid epidemic escalated during the aughts, the reputed dangers of marijuana were

[9]This is true, of course, only if we do not categorize cigarettes and alcohol, which cause many more deaths each year than opioids do, as drugs.

the main focus of drug policy for the Bush administration. Federal drug dollars continued to be highly skewed to favor law enforcement and interdiction, even though Bush would periodically talk about the need for more treatment slots.

For the Obama administration, the war on drugs amounted to a series of low-profile but significant guerilla actions at home that scaled up punishment in key areas while softening some of the drug warrior rhetoric. Faced with a near doubling of overdose deaths during his administration, Obama did not declare a national emergency and did not speak out about the opioid epidemic until his final 16 months in office (Higham et al. 2019, Mitchell 2018). His silence brings to mind President Ronald Reagan's long public silence on the AIDS crisis, which he finally broke in 1988 during his last year in office. Obama sought only moderate increases in federal money for treatment and prevention, as detailed below.

In his second term, Obama and Attorney General Eric Holder haltingly promoted their Smart on Crime initiative to reduce time served for federal drug offenses. But many of the US attorneys who served under Obama continued to pursue harsh penalties for fentanyl and other drug-related offenses (Swan 2017). In late 2013, federal prosecutors openly revolted against Holder's support of the Smarter Sentencing Act, a modest sentencing reform bill (Gottschalk 2016).

Toward the end of his time in office, Obama sought to burnish his legacy with respect to the opioid epidemic. His administration issued a Surgeon General's report on substance abuse in 2016 that emphasized the need for a public health approach to stem the opioid epidemic. The Surgeon General's report included recommendations to rapidly scale up state-of-the-art treatment, curtail stigmas surrounding addiction, and expand access to naloxone (Narcan), the opioid overdose reversal drug. During Obama's final year in office, the White House proposed to spend, for the first time in decades, more money on treatment and research than enforcement and interdiction (Ingraham 2016, Maurer 2016).

In July 2016, Obama signed the Comprehensive Addiction and Recovery Act (CARA), which was hyped as "the first major federal addiction legislation in 40 years" (Pub. L. No. 114-198). In reality, this was a modest bill with some admirable provisions, including measures to expand access to MAT with methadone and buprenorphine, the most proven and effective treatments for opioid use disorder. CARA was ultimately enacted with strong bipartisan support but only after numerous amendments were added, including "stripping it of much of its funding" (Beletsky 2018, p. 372).

Months later, legislation to address the opioid crisis got a second chance on Capitol Hill. The unlikely vehicle was the 21st Century Cures Act, whose original focus was regulation—or, more aptly, deregulation—of the drug and medical device industries. This bill had been at a standstill (Kaiser Health News 2016). With public outrage mounting over Big Pharma's and the FDA's complicity in triggering the opioid crisis, it was not a politically auspicious moment to seek a radical deregulation of the drug industry.

The solution was to rebrand the 21st Century Cures Act as a landmark piece of legislation to address the opioid epidemic even though it was not. The original legislation did not include any provisions related to the opioid crisis. These were added subsequently to secure additional support in Congress (Beletsky 2018). In his final months in office, Obama embraced the Cures Act as a means to burnish his legacy on the opioid crisis, which gave the bill critical momentum (Beletsky 2018).

The sprawling Cures Act was one of the most lobbied health-care bills in recent history (Kaiser Health News 2016). The measure included controversial provisions to radically relax federal requirements for drug approval and marketing that industry lobbyists had been seeking for years and that would save pharmaceutical companies billions of dollars (Avorn & Kesselheim 2015). Knowledgeable critics of the bill, including scientific researchers and consumer advocates, argued that it dramatically watered down the rigorous scientific standards of evidence used to evaluate the

efficacy and safety of new drugs, new medical devices, and new uses for existing drugs (Kassierer 2018). They warned that doing so would open the market to more drugs and devices that were ineffective or dangerous (Kassierer 2018, Kinney 2018). The Cures Act also enfeebled restrictions on marketing drugs for off-label uses that have not been evaluated and sanctioned by regulators (Halabi 2018). The measure also shielded a wide swath of medical and health-care devices from government oversight and from requirements to protect patient and consumer privacy (Orlando & Rosoff 2018).

The Cures Act included a "grab bag of goodies" that helped to overwhelm or disarm its opponents, including new money for research on cancer and brain disease (Kaiser Health News 2016, Lupkin & Findlay 2016). To help pay for these new initiatives, funding for public health was cut.[10] Sen. Elizabeth Warren (D-MA) railed against the bill, charging that it had been "hijacked" by the pharmaceutical industry (Kaplan 2016). But Senate Majority Leader Mitch McConnell (R-KY) identified the Cures Act as a priority for the lame duck Congress following the 2016 election, and the measure ended up sailing through the House and Senate by landslides.

Days before signing the legislation, Obama singled out the $1 billion in new funding over the next two years to treat the opioid epidemic as the legislation's crowning achievement (White House Off. Press Secr. 2016). In reality, this was a trivial amount given the scope of the crisis. It was a far cry from the plan introduced three years later by Warren and Rep. Elijah Cummings (D-MD). They called for $100 billion in new spending over the next 10 years to battle the opioid crisis in a proposal that was modeled after the Ryan White Comprehensive AIDS Resources Emergency Act, which helped staunch the AIDS epidemic (Lopez 2019). Furthermore, numerous states sought to use Cures money not for treatment but to establish opioid task forces, which were dominated by police, prosecutors, and judges (Beletsky 2018).

In Obama's last year in office, his administration, with the help of the drug industry's champions in Congress, successfully curtailed the powers of the DEA to rein in opioid manufacturers and distributors. In April 2016, Obama signed legislation that made it virtually impossible for the DEA to freeze dangerous and suspicious shipments by drug manufacturers and distributors, upending four decades of practice. The "Marino bill," nicknamed in honor of Rep. Tom Marino (R-PA), whose district included many predominantly white communities in Pennsylvania hit hard by the opioid crisis and who was a leading defender of the opioid industry, sailed through Congress (Higham & Bernstein 2017a,b).

The opioid crisis was a key pillar of Donald Trump's 2016 campaign for the White House (Alemany 2016, Lopez 2015). The war on drugs was a linchpin of his nativist, anti-immigrant stance as he promoted the fiction that undocumented migrants crossing the US border with Mexico were the main couriers of the illegal drug trade. But that was only one leg of his stance on drugs. Trump also vowed that, if elected, he would declare a "national emergency" to address the opioid crisis, which would rapidly release federal disaster relief funding for states and municipalities (Davis 2017). Trump's focus on the opioid crisis helped secure him an important primary victory in New Hampshire, a state hit hard by the epidemic. In counties with higher drug, alcohol, and suicide mortality rates, Trump's vote totals in the 2016 election exceeded Republican nominee Mitt Romney's in the 2012 election (Horwitz et al. 2019a, Monnat 2016).

Once in office, Trump did not make good on his promise to declare a national emergency to address the opioid crisis. Instead, in October 2017, he declared that the opioid epidemic was a

[10]The Cures Act cut $3.5 billion from the Prevention and Public Health Fund established under the Affordable Care Act to invest in public health and disease prevention, including infectious diseases that could spark pandemics (Kassierer 2018).

"public health emergency" and made available an additional $57,000—less than a dollar for each overdose death in the United States that year (US House Represent. Judic. Comm. 2018). As a result, according to a report by the US Government Accountability Office, very little changed in terms of funding and resources (Davis 2017, Lopez 2018a).

The Trump administration's President's Commission on Combating Drug Addiction and the Opioid Crisis made many of the same recommendations as the Obama administration's Surgeon General's report, including improving access to MAT and removing the policy and health insurance barriers to accessing treatment (Christie et al. 2017, US Dep. Health Hum. Serv. 2016). Released in November 2017, it was an amalgamation of public health and law enforcement proposals that were not pioneering and that did not add up to a new, coherent strategy to combat the opioid epidemic. Although the commission acknowledged that substance use disorder is a disease and recommended the expansion of treatment, it also called for enhanced law enforcement, including stepped-up penalties for trafficking fentanyl and its analogs (Christie et al. 2017). The administration did not use the report to press Congress for major guaranteed long-term funding to fight the opioid epidemic (Horwitz et al. 2019a).

The Trump administration leaned heavily toward framing the opioid crisis as a law-and-order problem. His two attorneys general—Jeff Sessions and William Barr—were seasoned drug warriors who remained committed to law enforcement and military solutions to the country's drug problems. Sessions, his first attorney general, had been a federal prosecutor in Alabama during the crack hysteria of the 1980s and 1990s. As a US senator for 20 years, he was a leading opponent of reforms to roll back harsh drug laws and other hardline policies. In one of his first official acts as attorney general in 2017, Sessions reversed the so-called 2013 "Holder memo," in which then–Attorney General Eric Holder had directed federal prosecutors to stop charging people accused of low-level drug offenses with charges that triggered long mandatory sentences. Sessions also pushed for ramping up federal prosecutions for fentanyl offenses and dispatched additional prosecutors to places with the highest number of overdoses (Horwitz et al. 2019a).

In a March 2018 speech in Manchester, New Hampshire, Trump, with Sessions by his side, vowed once again to build a border wall to stem the flow of illegal drugs into the United States. Several times during that speech, Trump enthusiastically called for sentencing drug traffickers to death. Shortly after the speech, Sessions told federal prosecutors to seek the death penalty against major drug traffickers (Horwitz et al. 2019a, Meese 2018, Merica 2018).

The Trump administration was slow to appoint someone as head of the White House Office of National Drug Control Policy (ONDCP), the country's so-called drug czar. Staffed with political operatives who had little or no experience in drug policy or substance abuse treatment, the ONDCP was adrift. The Trump administration finally nominated Rep. Tom Marino (R-PA), a leading defender of the opioid industry in Congress, to head the office. A political firestorm broke out and his name was withdrawn (Baker 2017).

In October 2018, Trump signed the SUPPORT Act, which the House and Senate had overwhelmingly approved. A hodgepodge of dozens of bills introduced by Democrats and Republicans, the legislation included modest measures to expand access to trained health-care providers permitted to administer MAT; allowed Medicare for the first time to cover some costs of opioid treatment; and permitted state Medicaid programs to cover opioid treatment in mental health residential facilities without a federal waiver (Wynne & Joyce 2018). It also required state Medicaid programs to cover a full range of MAT services but not if they had a shortage of qualified providers or treatment facilities, which was a giant loophole. It also included provisions to bolster prescription drug monitoring programs, beef up law enforcement at the border, and enhance penalties for overprescribing opioids.

The SUPPORT Act authorized $3.3 billion over the next decade to stem the opioid crisis, which was a paltry sum. It pales in comparison to the massive injections years earlier of guaranteed long-term federal funding to fight HIV/AIDS, including the 1990 Ryan White CARE Act and the President's Emergency Plan for AIDS Relief launched under President George W. Bush in 2003 (Lopez 2018b, Wynne & Joyce 2018). This sum also needs to be measured against the Trump administration's attacks on Medicaid and the Affordable Care Act (ACA), the two most critical pieces of the country's efforts to stem the opioid crisis. In March 2019, just months after signing the SUPPORT Act, Trump proposed $1.5 trillion in cuts to Medicaid over the next decade. That same month, the Justice Department joined 20 Republican-led states seeking to have the ACA declared unconstitutional (Horwitz et al. 2019a).

In January 2019, the Senate finally confirmed James Carroll to be the administration's first permanent drug czar. A former counsel to the Ford Motor Company, Carroll had served as acting director of the ONDCP and as Trump's deputy chief of staff. Once he formally became the director, the ONDCP released a 20-page sketch of drug policy that was largely a throwback to the Reagan administration's "Just Say No" to drugs campaign and that identified the border wall and increased interdiction overseas as critical to staunching the opioid epidemic (Gressier 2019).

William Barr, who succeeded Sessions as attorney general in early 2019, had served as President George H.W. Bush's attorney general. Bush's administration was bookended by the 1988 campaign's infamous Willie Horton ad and, four years later, by "The Case for More Incarceration," a US Department of Justice (DOJ) report released with Barr's blessing. Robert Mueller's investigation of possible Russian interference in the 2016 election was the central preoccupation during Barr's Senate confirmation hearings in early 2019 and his first year in office. The focus on the Mueller investigation overshadowed the fact that Barr presented himself at the hearings as an unapologetic drug warrior. During his Senate testimony, it was back to the law-and-order 1990s, as Barr, egged on by some Republican and Democratic senators, invoked images of marauding gangs, predatory repeat offenders, and blood "running on the streets all over the United States" to justify mass incarceration (US Senate Judic. Comm. 2019, p. 112). Barr likened the "crack epidemic" to "nuclear weapons going off in the inner city" and testified that fentanyl was the "new crack" (US Senate Judic. Comm. 2019, pp. 45–46). He credited escalating incarceration rates with the historic drop in the US crime rate. Barr ignored a mountain of research—some of it funded by the DOJ—that locking up people at record levels did not significantly decrease the US crime rate but did have enormous social and economic costs.[11]

5. PUNITIVE LEGISLATION AND SENTENCING GUIDELINES

The hardline drug policies that Trump and his appointees championed had considerable bipartisan support in Congress and elsewhere. A closer examination of the legislative record over the course of the opioid crisis casts doubt on claims that lawmakers embraced a harm-reduction approach to the opioid epidemic and dialed back the war on drugs because of a racialized double standard.

A 2020 comprehensive analysis of drug-related legislation sponsored in Congress concluded that lawmakers introduced more punitive bills during the crack scare and more treatment-oriented measures during the opioid crisis (Kim et al. 2020). The researchers also claimed there were strong race-of-victim effects, with legislators responding more sympathetically if the victims were white people and if the drug involved was an opioid. A closer look at that study, which examined all drug-related legislation sponsored in the US House of Representatives in several pivotal years between 1983 and 2016, casts some doubt on its central conclusions.

[11] See, for example, Travis et al. (2014).

The claim that the number of treatment bills began to rise rapidly at the start of the opioid crisis only holds up by dating the start of the crisis to 2009, as the researchers do (Kim et al. 2020, figure 2). But by 2009, the opioid crisis had been well underway for a decade, as discussed earlier, with tens of thousands of fatal overdoses each year and with white people dying at a rate that significantly exceeded that of African Americans and Latinos.

As their own graphs show, after peaking in 1988–89 at the height of the crack scare, the number of both punitive and treatment-oriented bills sponsored in Congress plummeted over the next decade and a half. Around 2005, the number of treatment bills began to rise again. About two years later, so did the number of punitive drug bills. But it was not until the mid-2010s—as the country was well into the second phase of the opioid crisis and at the cusp of the fentanyl-fueled third wave (as elaborated above in Section 2)—that treatment bills began to outpace punitive ones (Kim et al. 2020, figure 2). And this occurred during the period in which the racial gap in drug overdose deaths had actually started to narrow as the number of African American people dying from overdoses began to escalate, which further complicates claims about race-of-victim effects that disproportionately advantaged white people. The number of treatment-oriented drug bills sponsored in 2016 was only slightly above the number sponsored at the height of the crack era. As for the number of punitive bills, in 2016, it was somewhat lower than at the peak of the crack era, but it was considerably higher than a decade earlier when the opioid crisis was already well underway.

As fentanyl has infiltrated the illicit drug market, a broad range of federal and state legislators and policy makers from both parties have treated this synthetic opioid and its analogs as the new crack. They have demonized fentanyl and the people who use and sell it. Many lawmakers who say they favor scaling back mass incarceration have nonetheless been "supporting extremely harsh measures for fentanyl, undercutting the effectiveness of criminal justice reforms" (Collins & Vakharia 2020, p. 8). Fentanyl, like crack decades ago, is rapidly becoming a radical game-changer in drug policy. At all levels of government, lawmakers, prosecutors, and other policy makers have supported ramping up penalties for fentanyl-related offenses (Collins & Vakharia 2020). Since so much of the illegal drug market is now adulterated or contaminated with fentanyl and its analogs, the potential reach of these new measures is enormous. As in previous drug wars, these tougher sanctions have ended up ensnaring primarily users and small-time dealers—not the promised drug kingpins (Collins & Vakharia 2020).

The federal First Step Act, signed into law by President Trump in December 2018 with much fanfare from leaders of both parties and support from a wide range of groups stretching from the ACLU to the Koch brothers, reduced penalties for several drug offenses. But it excluded people convicted of certain crimes, including fentanyl-related charges and sex offenses, from earning good time credits that could reduce their prison time. The First Step Act also included a sentencing enhancement for selling fentanyl (Fam. Against Mandat. Minim. 2018).[12]

Senators Dianne Feinstein (D-CA) and Charles Grassley (R-IA), who have alternately chaired the Senate Judiciary Committee, have been strong supporters of toughening the already harsh sanctions for the sale or trafficking of fentanyl and fentanyl analogs (C. Johnson 2017). In August 2020, they introduced legislation that would declare methamphetamine an emerging drug threat (US Senate Judic. Comm. 2020). The drug policy reform movement was forced to mount a major effort that finally succeeded in getting Feinstein in September 2018 to withdraw her support from an extremely punitive measure that ceded enormous new powers to the DOJ to dictate drug policy. The proposed legislation called for expanding penalties on fentanyl analogs

[12] See also Gottschalk (2019).

and granting permanent new powers to the attorney general—and by extension the DEA—to schedule drugs and thus determine penalties.[13] This victory for the drug reform movement was short-lived. In early 2020, it was unable to block a new measure that would temporarily extend the DEA's authority to classify many fentanyl analogs as Schedule I substances until May 2021. This legislation, which sailed through Congress, temporarily abrogated a federal statute dating back to 1986 that requires the Department of Health and Human Services to study the chemical makeup of a substance, determine its potential harms and benefits, and recommend whether it should be a scheduled drug, and, if so, in what category (Butler 2020). This measure temporarily suspended the government's obligation to demonstrate that a substance is chemically similar to fentanyl and harmful. The DOJ's successful push on behalf of this radical change in drug policy rested on misinformation and scare tactics, including claims by Barr that, without class-wide rescheduling, the United States would be "hit by a tsunami of newly legalized fentanyl analogues" (Barr 2020).

A coalition of dozens of advocacy groups warned that granting the DEA this power "will exacerbate already disturbing trends in federal drug prosecutions and incarceration levels and excise public health authorities from their critical role in promulgating drug policy" (New Path et al. 2020). Some drug experts warned that this premature move would render fentanyl analogs illegal before much is known about their potential medical benefits. It would also make it harder to get approval for research on these synthetic analogs, including the development of better drugs to reverse fentanyl overdoses (Lynch 2019a). Although Biden's campaign platform called for an end to mandatory minimums and dialing back the war on drugs, his administration—with broad bipartisan support in Congress—has backed reauthorizing the temporary extension several times since taking office. Biden has also called for making the extension permanent (DNC 2020, Firth 2021, Rayasam 2022).

Republicans have been leading the charge for even more extreme sanctions, including a proposal to impose a five-year mandatory minimum for possession of just two grams of any substance that contains detectable amounts of fentanyl (Hum. Rights Watch 2018).[14] In 2016, Rep. Tom Reed (R-NY) sponsored a bill that would make defendants convicted of selling fentanyl to someone who later died of an overdose eligible for the death penalty, and other Republican legislators indicated they might support making some fentanyl crimes punishable by death (Collins & Vakharia 2020).

Although sentencing has generally become less severe for federal drug crimes, opioid and methamphetamine cases have been treated with less leniency compared to offenses involving other drugs (Testa & Lee 2021). In 2018, fentanyl was cause for the US Sentencing Commission (USSC) to backpedal on reducing penalties for drug crimes. In a major shift, the USSC had agreed in 2014 to make some changes in the sentencing guidelines retroactive, rendering nearly 50,000 people serving time for drug offenses in federal prisons eligible to seek reduced sentences (Markon & Weiner 2014). But four years later, it voted unanimously to ratchet up penalties for fentanyl-related offenses (Collins & Vakharia 2020). Between 2014 and 2018, the number of people convicted of fentanyl offenses under federal drug trafficking laws increased nearly 5,000% (US Sentencing Comm. 2018b). A USSC study found that tougher sanctions for fentanyl violations disproportionately ensnared African Americans and Latinos and that these defendants were overwhelmingly street-level dealers or mules, not major traffickers (US Sentencing Comm. 2018a,b).

[13] Months earlier, the DEA, which is overseen by the DOJ, had temporarily designated certain fentanyl-related substances as Schedule I controlled substances, but that designation was due to expire in February 2020. Schedule I drugs, including heroin, are considered illegal under all circumstances and are subject to harsh mandatory minimum penalties (Collins 2020).

[14] This provision was part of the Ending the Fentanyl Crisis Act of 2018.

6. THE WAR ON OPIOIDS AT THE STATE AND LOCAL LEVELS

At the state and local levels, the successful string of ballot initiatives and legislation to decriminalize or legalize marijuana has prompted many commentators to prematurely declare that the beginning of the end of the war on drugs is in sight. But even as many states and municipalities have been reducing or eliminating penalties for marijuana, they have been ramping up the already harsh penalties for the use and sale of opioids, notably heroin, fentanyl, and fentanyl analogs, and excluding these drugs from reform measures to lessen the penalties for drug offenses (Ghandnoosh & Anderson 2017). For example, in 2014, Louisiana lawmakers approved a 10-year mandatory minimum sentence for the sale of any amount of heroin (Krisai 2016).[15] Paralleling developments at the national level, so-called reformers at the state level have sought to toughen up penalties for fentanyl offenses and explicitly exclude fentanyl from proposals to reduce penalties for violations involving other drugs (Collins & Vakharia 2020). Between 2011 and 2020, 39 states and the District of Columbia enacted legislation to stiffen penalties for fentanyl-related offenses (Collins & Vakharia 2020).

A comprehensive review of state-level drug sentencing provisions enacted from 2010 to 2016 found that legislators did not single out opioid offenses for especially lenient treatment (Beckett & Brydolf-Horwitz 2020). Indeed, if provisions related to marijuana are set aside, punitive measures have outnumbered lenient ones by wide margins, most notably for opioid crimes (Beckett & Brydolf-Horwitz 2020).[16] And although state lawmakers relaxed penalties for possession of nearly all types of drugs, they stiffened them for drug distribution (Beckett & Brydolf-Horwitz 2020). Because many drug users are petty dealers to support their habit, enhancing penalties for distribution renders wide swaths of users vulnerable to stiffer punishments.

A provision in the 1986 Anti-Drug Abuse Act (21 USC § 801), one of the signature pieces of legislation from President Ronald Reagan's war on drugs, has recently become a new weapon in the war on people who use opioids. The 1986 act, which Congress swiftly enacted after NBA recruit Len Bias died of a cocaine overdose, is best known for its infamous 100-to-1 disparity in punishment for possession of powder and crack cocaine. But it also included a tough provision that carries a mandatory minimum sentence of 20 years in prison for distribution "if death or serious bodily injury results from the use of such substance." During the 1980s, many states copied the federal government and enacted so-called drug-induced homicide laws of their own. But for a quarter-century, these federal and state measures lay largely moribund, with no or just a handful of such prosecutions each year in the 1980s and 1990s. After the turn of the twenty-first century, homicide prosecutions in the case of unintentional overdose deaths began rising, totaling a dozen or two most years from 2000 to 2009 (Health Justice Action Lab 2021). Over the past decade, the number of such prosecutions has skyrocketed, as have new and expanded laws to prosecute overdoses as homicide or manslaughter (Health Justice Action Lab 2021).

Local, state, and federal law enforcement officers have become champions of lodging homicide charges against people who gave or sold drugs to someone who then died of an accidental overdose (Nichanian 2019, Roebuck & Whelan 2019). Under these statutes, prosecutors generally do not need to prove that the defendant intended to kill someone with the drug or even that the defendant knew about the drug overdose or was present when it occurred.

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[15] One notable exception is Oregon, which recently became the first state to decriminalize possession of small amounts of drugs besides marijuana for personal use, including heroin, cocaine, and certain methamphetamines. In November 2020, Oregon voters overwhelmingly supported the decriminalization ballot initiative, which the Drug Policy Alliance spent more than $4 million campaigning for in the state (Whelan 2020).

[16] Of the 19 sentencing provisions related to opioids, 18 shifted penalties in a more punitive direction (Beckett & Brydolf-Horwitz 2020).

After the US Supreme Court upheld the conviction of Marcus Burrage in a drug-induced homicide case in 2014, Obama's DOJ pointedly recommended pursuing more such prosecutions (US Dep. Justice 2015). Between 2010 and 2017, drug-induced homicide cases surged at least tenfold at the state and federal levels, numbering over 700 in 2017 alone (Health Justice Action Lab 2021). Some of the states hit hardest by the opioid crisis, notably Pennsylvania and Ohio, have led the nation in such prosecutions (Health Justice Action Lab 2021, Prescr. Drug Abuse Policy Syst. 2019).

Police officers and prosecutors are increasingly treating overdoses as crime scenes and participating in workshops on how to successfully investigate and convict people of homicide in unintentional overdose cases (Daugherty & Stachula 2017). Drug-induced homicide charges typically sweep up friends, relatives, or partners of the deceased—not big-time drug dealers (Beletsky 2019, figure 5; Siegel 2017). These measures have exacerbated the opioid crisis (Drug Policy Alliance 2017). Pursuing homicide charges in drug overdose cases is resource intensive. As police, prosecutors, and the courts devote more personnel and other resources to these cases, public health agencies, nonprofit organizations, and medical personnel tasked with providing treatment and other services, including distributing the overdose reversal drug naloxone, are operating "in an environment of extreme scarcity" (Beletsky 2019, p. 882). Drug-induced homicide prosecutions also undermine Good Samaritan laws that provide limited criminal immunity for people who seek emergency assistance for overdose victims.

As in previous wars on drugs, pregnant women with substance abuse problems are once again widely viewed as criminals deserving severe sanctions (Kennedy-Hendricks et al. 2016). The practice of prosecuting women for substance use during pregnancy began in earnest during the moral panic over crack in the late 1980s and disproportionately affected Black women. District attorneys have deployed child abuse and "chemical endangerment" laws to step up prosecutions of pregnant women who use drugs. Their efforts have discouraged pregnant women from seeking treatment "even in the 19 states where a publicly funded drug-treatment program specifically for pregnant women exists" (Egan 2018; Kennedy-Hendricks et al. 2016, pp. 875–76). The rate of pregnant women using opioids has increased significantly, with the rise much higher in rural areas (Villapiano et al. 2017). Given the racial disparities of opioid use disorder, white women are now more likely to be arrested and prosecuted for substance abuse during pregnancy than are Black and Hispanic women (Bridges 2020).

Prosecutors and policy makers have also been intensifying their efforts to forcibly institutionalize pregnant women and other people with substance use problems to compel them into treatment under civil commitment statutes, which are highly punitive measures. The ethical code of the Association of Addiction Personnel opposes involuntary commitment for people with substance use disorder (Horn 2019, Møllmann & Mehta 2017).

7. SHIFTS IN PATTERNS OF ARRESTS AND INCARCERATION

A brief overview of racial and geographic shifts in arrests and incarceration for drug crimes since the onset of the opioid crisis at the turn of the twenty-first century calls into question claims that a more sympathetic frame has prevailed, resulting in more lenient drug policies, because white people are the poster children of the epidemic.[17] The racial disparities in incarceration rates have certainly not closed in the United States, but they have narrowed considerably since the turn of the twenty-first century. After reaching a high of about 7 to 1 in 2000, the Black:white ratio had

[17] I have chosen to use pre-pandemic figures in the discussion that follows because it is unclear what lasting effect, if any, COVID-19 will have on longer-term trends in incarceration.

fallen to about 4 to 1 in 2019 on the eve of the pandemic (calculated from data in Beck & Karberg 2001; Carson 2021, table 5; Minton & Zeng 2021, table 4). This is slightly lower than the 5 to 1 ratio that prevailed for much of the twentieth century before the US incarceration rate began its steep upward climb in the 1970s.[18]

After peaking in 2008, incarceration rates for African American people had fallen by 30% by the eve of the pandemic in late 2019. Rates for Hispanic people had fallen by 26% and for white people by less than 5%.[19] Declines in the number of incarcerated African American people have driven most of the recent modest drop in the total number of people incarcerated in US prisons and jails. The number of Black people in state and federal prisons fell by nearly 23%—or approximately 203,000 people—between 2008 and 2019. The drop for white people was approximately 76,000—or about 9%. After escalating sharply in the early 2000s, the number of people incarcerated in local jails has held steady at about three-quarters of a million people over the past decade. But this masks a huge divergence in who is going to jail. After a significant spike in the early 2000s, the Black jail population has fallen back to where it was in 2000—about one-quarter of a million people. The number of non-Hispanic whites in local jails climbed steadily between 2000 and the pandemic, hitting 363,000 people in 2019—an increase of 39%. The total number of Hispanic people in US prisons and local jails fell during this time by just 3%.

Although African American people are still much more likely than white people to be arrested, charged, convicted, and imprisoned for drug crimes, the racial gap has been narrowing. The emergence of powerful movements centered primarily in urban areas to slow or roll back the war on drugs has had some success. These movements include New York State's Drop the Rock in the 1990s, the emergence of Black Lives Matter a decade ago, and the recent push to elect more progressive prosecutors in large cities. The percentage of Black people among all drug arrests rose from 27% in 1980 to a peak of 42% in 1993 before falling back to 27% in 2017 (FBI 2018, table 43; Hum. Rights Watch 2009, table 1). After peaking in 2000, the number of Black people serving time in state prisons for drug offenses had plummeted by 66% as of late 2019. Over that same period, the number of Hispanic people serving time in state prisons for drug crimes fell by 28%, whereas the number of white people serving time for drug offenses rose by 10 percent (calculated from data in Carson 2021, table 15; Mauer 2009, table 1; Sabol et al. 2009, table 7). In 2000, there were about 2.5 times as many Black people incarcerated in state prisons for drug offenses compared to the number of white people serving time for drug crimes. As of 2019, the number of white people incarcerated for drug offenses in state prisons was 32% higher than the number of Black people serving time in state prisons for drug crimes (calculated from data in Carson 2021, table 15; and Sabol et al. 2009, table 7).

With the scaling back of the penalties for crack cocaine and the partial retreat of the war on drugs in major urban areas, the imprisonment rate for Black women in state prisons has plummeted.[20] The overall decline in women serving time for drug offenses in the United States between 2000 and 2016 was the result of a 600% drop in Black women sent to state prisons for drug crimes. This drop masked a 65% increase in the number of white women held in state prisons for drug crimes over the same period (Myers et al. 2018).[21]

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[18]For historic trends, see Muller (2012). On declining racial disparities in US jails, see Subramanian et al. (2018).

[19]The calculations in this paragraph are based on data from Beck & Karberg (2001), Carson (2021, tables 3 and 5), and Minton & Zeng (2021, tables 2 and 4).

[20]Between 2000 and 2009, it fell by about one-third (from 205 per 100,000 to 142 per 100,000) (Mauer 2009; see also Bush-Baskette 2010, Lenox 2011).

[21]See also Mauer (2009, table 4).

The imprisonment rates for Black and white women in state prisons have converged sharply. Between 2000 and 2016, the rate for Black women fell by more than half (from about 200 per 100,000 to about 100 per 100,000), whereas the rate for white women increased by almost 50% (from 34 per 100,000 to 49 per 100,000) (Myers et al. 2018). As a result, the racial gap plummeted from a peak of 7.5 to 1 in 1995 to 2 to 1 in 2016 (Myers et al. 2018). Black women made up about a quarter of all women in state prisons as of 2016, down from about half in 1995. Meanwhile, the proportion of white women in state prisons rose from 41% to 61% (Myers et al. 2018).

As for geographic disparities, in dozens of states (both blue and red), incarceration rates are slowing or declining in urban areas while rising in rural communities, even though rural areas tend to have much lower crime rates (Kang-Brown et al. 2018, appendix table 1).[22] Annual prison admissions for big cities have been plummeting, driving state-wide drops in incarceration rates in New York State, California, Texas, and elsewhere. Meanwhile, prison and jail admissions in many rural and smaller metro areas have been rising. A decade and a half ago, residents of rural, suburban, and urban areas had about an equal chance of being sent to prison. Today, people in small counties are about 50% more likely to be sent away than people residing in large counties with more than 100,000 residents (Keller & Pearce 2016).

After peaking in 2005, the incarceration rate for African American people in US jails has fallen back to about where it was 30 years ago. But this national trend masks important geographic differences. The incarceration rate for African American people in jail peaked in the West and Northeast in the mid-1990s but continued to grow for another decade in the South and Midwest before starting to decline. In rural areas, it continued to climb for much of this period, more than doubling between 1990 and 2013. As for white people, their rate of incarceration in local jails continued to grow steadily, nearly doubling over this same period. Jails in rural and small and medium-sized metro areas today hold more white people than the total number of white people held by urban and suburban jails (Subramanian et al. 2018).

8. A DEARTH OF QUALITY TREATMENT

The surge in law enforcement to stem the opioid crisis has not been matched by a surge in access to high-quality and proven treatments. Despite a marked rise in substance use treatment capacity over the past 20 years, opioid use disorder goes largely untreated in the United States. State and federal money for treatment actually decreased by nearly one-third in real dollars between 2008 and 2019 (Hoagland et al. 2019). Compared to Canada and Western Europe, the United States is legions behind in enthusiastically embracing harm-reduction strategies that save lives and help repair families and communities (Reuter 2013, Stanton 2016, Wallace et al. 2019). In the United States, opposition to clean needle exchanges, safe injection sites, MAT for opioid use disorder, and wide distribution of naloxone (the opioid overdose reversal drug) has been fierce.

In 1998, President Bill Clinton blocked federal funding for clean needle programs against the recommendation of Donna Shalala, his health secretary. The Biden administration's proposal to finally begin federal funding of sterile needle programs set off a political dustup in early 2022 as conservative groups falsely charged that Washington was preparing to distribute "crack pipes" paid for with tax dollars (Stolberg 2022). A bipartisan group of lawmakers introduced legislation that would bar federal funding of drug paraphernalia. If enacted, this legislation would likely doom needle exchange programs, a crucial tool widely deployed in peer countries to staunch the serious harms from drug use, including the spread of potentially fatal diseases, such as HIV/AIDS and hepatitis C.

[22] See also Kang-Brown & Subramanian (2017).

The DOJ, which for years has battled in federal court to prevent the opening of any supervised drug injection sites, appears to be reversing or at least softening its opposition under the Biden administration (Roebuck & Whelan 2022). In late 2021, New York City became the first jurisdiction in the United States to open an officially sanctioned injection site, where trained staff provide clean needles, administer naloxone to reverse overdoses, and provide drug users with information about treatment and other services.

An estimated 2.2 million people in the United States have an opioid use disorder, but barely one in five are receiving treatment for this problem (Subst. Abuse Ment. Health Serv. Adm. 2019a, figures 42, 53, and 65; Wu et al. 2016). Lack of health insurance is a formidable barrier to treatment despite passage of the Affordable Care Act in 2010 and the subsequent expansion of Medicaid (Grogan et al. 2016, Mark et al. 2015). Shortages of providers and programs keep timely and efficacious care out of reach (Andrilla & Patterson 2021). So do cumbersome insurance and government rules, such as preauthorization requirements and strict federal regulations regarding who is permitted to prescribe or administer MAT (Andraka-Christou 2020). Misinformation about and ideological opposition to treating opioid use disorder on an outpatient basis with methadone or buprenorphine are additional hurdles (Andraka-Christou 2020, Macy 2018, Sue 2019, Szalavitz 2018).

Only about one out of every three substance use treatment facilities offers MAT for opioid use disorder, and, as of 2016, only 6% of them offered all three FDA-approved medications—methadone, buprenorphine, and naltrexone (Mojtabai et al. 2019). Not only do most substance use treatment centers neglect to offer MAT, but they "often actively dissuade patients from accessing these medications" (Andraka-Christou 2020, p. 93). An estimated 30 million people—or 10% of the US population—live in counties without a single medical provider with a waiver to prescribe methadone and buprenorphine, and more than two-thirds of them reside in rural areas (Rosenblatt et al. 2015). People living in states outside the Northeast generally have far less access to MAT, as do low-income people and those who lack adequate health insurance (Jones et al. 2015, Rembert et al. 2017). The few clinics and doctors' offices that do prescribe these medications often have long waitlists. The Biden administration slightly relaxed restrictions on prescribing buprenorphine and dispensing methadone (Cirruzzo 2021, Off. Natl. Drug Control Policy 2022).

The pervasive and multiple stigmas associated with substance use disorder are also formidable obstacles that keep people from seeking out treatment, let alone proven and effective treatments such as MAT (Bearnot et al. 2019, Tsai et al. 2019). People residing in small rural communities are especially reluctant to seek treatment because patients and providers are more likely to know one another in other contexts (Tsai et al. 2019). Because of racialized stigmas about opioid use, African American people with opioid use disorder are more likely to be channeled into community methadone clinics that operate outside of the main health-care system rather than receive MAT prescribed by individual medical providers in private offices (Andraka-Christou 2021).

The contraction and erosion of the public health system in the United States, once the envy of the world, have also impeded addressing the opioid crisis. Public health in the United States has been starved for personnel and other resources for decades (Himmelstein & Woolhandler 2016, Weber et al. 2020). With the COVID-19 pandemic, public health workers have come under vicious political attacks, turning what had been a mass exit into a stampede to leave the profession (Leider et al. 2018, Weber et al. 2020). Between 2010 and 2019, the budget of the CDC, the country's leading public health agency, fell by 10%, after adjusting for inflation (McKillop & Ilakkuvan 2019, figure 2). The CDC is the main source of federal money to address the opioid epidemic, including funds for state and local public health agencies and departments (McKillop & Ilakkuvan 2019). CDC funding specifically aimed at addressing the opioid epidemic increased significantly in 2018 and 2019 compared to 2017, but the overall increase was trivial given the extent of the

crisis. Furthermore, much of that money was targeted at punitive supply-side interventions, such as prescription drug monitoring programs (McKillop & Ilakkuvan 2019).

9. PARTY POLITICS AND OPIOID TREATMENT

The opioid crisis has fostered a growing policy and political dilemma for the Republican Party. The rate of chronic opioid use is generally higher in states that supported Donald Trump in 2016, and people residing in states with high numbers of overdose deaths are more supportive of federal spending to address the crisis (Goodwin et al. 2018, T. Johnson 2017). Republican-led states at the epicenter of the opioid epidemic have faced growing pressures to expand Medicaid. At the same time, they have had to contend with strong political headwinds from national leaders of the Republican Party and the powerful network of conservative campaign donors and organized interests, including the billionaire Koch brothers, for whom opposition to the ACA and Medicaid expansion has been a signature issue. Since passage of the ACA a dozen years ago, the Republican Party has turned to the courts and Congress numerous times to repeal this legislation outright or, failing that, to dismember it through a war of attrition.

The opioid crisis has been a crucial driver for a dozen Republican-led states to break ranks and opt into Medicaid expansion under the ACA (Kaiser Health News 2022). States under Republican control have enacted comparatively more opioid-related legislation and appropriated more money for prevention and treatment initiatives than Democratic-led states (Grogan et al. 2020). Legislators and policy makers in Republican states hardest hit by the opioid crisis have sympathetically "emphasized the personal nature of the opioid epidemic" and the direct impact of overdose deaths on families and local communities (Grogan et al. 2020, p. 285).

On the surface, these actions suggest that the Republican Party is tending to its base, taking a more sympathetic stance toward the opioid epidemic because its white constituents are most at risk. But a closer look reveals that this is another case of policy theater in which there has been a lot of motion but no real movement to expand access to state-of-the-art treatment for opioid use disorder.

Republican states that opted in to Medicaid expansion under the ACA sought to put a conservative stamp on their actions. This included, for example, attempting to impose copays and work requirements on Medicaid recipients in the name of siphoning off "deserving" recipients from "undeserving" ones (Grogan et al. 2020). Republican states, including those that did not choose to expand Medicaid under the ACA, also jiggered their existing Medicaid programs to increase access and federal money for treatment of opioid use disorder—but again with a conservative imprimatur (Grogan et al. 2020). They channeled these extra federal dollars to drug treatment programs that were in sync with the dominant ideology of the Republican Party but that were not the most efficacious means to treat this disorder.

Although Republican-led states enacted more opioid-related legislation than did Democratic-led states between 2014 and 2018, these measures tended to be low-hanging fruit that was not politically or fiscally costly. Measures included legislation to raise public awareness of the opioid crisis, implement prescription drug monitoring programs, and increase access to naloxone, the opioid overdose reversal drug (Grogan et al. 2020). None of these initiatives substantially expanded access to treatment, let alone to the most effective and proven treatments (Grogan et al. 2020). Republican-controlled states did devote a higher proportion of their state spending to these opioid initiatives than did Democratic-controlled states, but the total amounts were infinitesimal (Grogan et al. 2020, tables 3, 5c). By comparison, in states that opted to expand Medicaid coverage, the increase in spending on treatment for opioid use disorder was gigantic (Clemans-Cope et al. 2019).

Republican-led Florida provides one of the most egregious examples of playing to your base of conservative voters and wealthy and corporate patrons at the cost of people desperate for good treatment for their substance use disorders. Republican lawmakers in Florida have successfully beaten back efforts to expand Medicaid under the ACA. But they have found other ways to channel billions of federal Medicaid dollars to the state for substance use disorder programs, not always to the benefit of people needing help with their alcohol or drug dependency.

In 2019, Florida succeeded in securing a federal waiver that permits the state to use federal dollars to cover residential treatment services for Medicaid recipients with substance use disorder (Dep. Health Hum. Serv. 2019, Grogan et al. 2020). The Medicaid waiver, together with the ACA's requirement that insurers include substance use disorder as a basic benefit and provide comparable coverage for behavioral health and physical ailments, turbo-charged the recovery industry in the Sunshine State. Florida is now home to a vast archipelago of drug treatment programs and facilities and "sober" homes generating billions of dollars a year that draw patients from around the country (Wooten 2019).

Treatment centers for substance use disorder and other behavioral health problems, such as eating disorders, are not federally licensed and are often only loosely regulated, if at all, by the states (Andraka-Christou 2020, Goode 2016). Their counselors tend to have minimal training and are usually not psychologists. Their medical directors may not even be onsite (Wooten 2019). "Sober" or "safe" homes (which are springing up in other states) are largely unregulated in Florida and elsewhere. The "Florida shuffle" churns people from detox centers to inpatient treatment to recovery centers or "sober" homes, often keeping them "in an endless pattern of relapse to siphon off their insurance benefits" (quoted in Wooten 2019, paragraph 51). The explosive growth of unregulated addiction centers and "sober" or "safe" homes has been wracked with rampant fraud in Florida (Wooten 2019).

10. OPIOID USE DISORDER IN PRISONS AND JAILS

The problem of lack of access to substance use treatment, let alone efficacious treatment, is especially acute for people who are incarcerated. Approximately four in ten people serving a jail or prison sentence reported having a drug use disorder in the year before they were admitted. Most incarcerated people do not receive good—or indeed any—treatment for their drug or alcohol problems (Bronson et al. 2017; Ghandnoosh & Anderson 2017, table 6). What passes for substance use treatment in prison can be shockingly punitive and unscientific.[23]

In 2009, the World Health Organization (WHO) declared that all incarcerated people with opioid use disorder should have access to methadone and buprenorphine to reduce their dependency on opioids, the risk of overdoses, and the harm caused by their drug use, as well as to stem the cycle of incarceration and addiction (Ghandnoosh & Anderson 2017, Horn 2019, UN World Health Org. 2009). Yet very few jails and prisons in the United States provide incarcerated people with access to these two medications. Of the country's approximately 5,100 prisons and jails, only 30 offered methadone or buprenorphine as of 2017 (Williams 2017). Most jails actually prohibit the use of methadone and buprenorphine. Even though jails have become de facto detox centers, many of them do not even provide methadone or buprenorphine for detox, let alone maintenance. People in jail must often endure the wrenching symptoms of opioid withdrawal with no or only minimal medical support (Horn 2019, Subst. Abuse Ment. Health Serv. Adm. 2019b).

[23] See, for example, the ethnographic study of a so-called "therapeutic community" for women (McCorkel 2013; see also Sue 2019, ch. 2–4).

Resource constraints, security concerns, the strong bias against harm-reduction approaches, and the deep stigma surrounding MAT help explain the lack of methadone or buprenorphine treatment in prisons and jails (Grella et al. 2020, Haider et al. 2020, Schwartzapfel 2019, Westervelt 2019). Incarcerated people have eked out a handful of legal victories that have forced some jails and prisons to provide methadone or buprenorphine in individual cases or limited class action lawsuits. But no general right of access to these medications for incarcerated people has been established (Goodnough 2019, Horn 2019, Lynch 2019b, Schwartzapfel 2019).

The majority of MAT programs in jails are limited to the controversial injectable drug naltrexone. Better known by its brand name Vivitrol, naltrexone is more attractive than methadone or buprenorphine to moralistic, hardline corrections officials, politicians, and law enforcement officers because it appears "more punitive in nature" (Csete 2020, MacGillis 2017). Vivitrol, which is available in an estimated 300 jails (A. Klein, personal communication), is typically administered to incarcerated people just as they are about to be released and is classified as an "opioid antagonist." Taken as a monthly shot, Vivitrol acts like a helmet, blocking the opioid receptors in users' brains so they do not experience feelings of euphoria associated with opioids, such as heroin, pain pills, and fentanyl (but not nonopioids like cocaine and methamphetamine). Prior to starting a Vivitrol regimen, people with opioid use disorder must undergo detoxification, thus forcing an abrupt exit rather than a more gradual one from drug dependency and addiction (MacGillis 2017). Vivitrol is not popular with people with opioid use disorder because it gives them the worst of both worlds. It blocks opioids from producing feelings of euphoria and yet does not stave withdrawal symptoms, which can be intense and even life threatening. It also does not alleviate the cravings that are obstacles to stabilization and recovery (Westervelt 2019). Critics charge that Vivitrol is more expensive than other treatments such as methadone and buprenorphine and yet is less effective and more harmful (Meagher 2018).

Alkermes, which manufactures Vivitrol, has aggressively marketed this drug. The company has focused its efforts on law enforcement and public officials rather than medical providers. Its sales representatives have targeted sheriffs managing jails and judges overseeing drug courts (Goodnough & Zernike 2017). Alkermes even provides free starter shots of Vivitrol for people leaving jail and for defendants in drug court, counting on Medicaid or insurance companies to later pick up the costs of the monthly shot (Goodnough & Zernike 2017, MacGillis 2017). The company's generous campaign contributions and aggressive marketing strategies have paid off. In May 2017, Health and Human Services Secretary Tom Price lauded Vivitrol as the future of addiction treatment. His remarks alarmed 700 experts in addiction, who signed a letter complaining that the company's marketing tactics and Price's remarks ignored widely accepted science. The evidence is scant, they charged, that Vivitrol is an effective treatment for opioid use disorder (Goodnough & Zernike 2017).

For people dependent on opioids, a stint in prison or jail can be a death sentence. Between 2001 and 2018, the number of people who died of drug overdoses or alcohol intoxication increased by more than 600% in state prisons and more than 200% in county jails (Schwartzapfel & Jenkins 2021). A brisk black market for drugs—some smuggled in by visitors, most brought in by staff and outside contractors—exists in most penal facilities. Yet sheriffs and guards in many jails and prisons do not have ready access to naloxone, the overdose reversal drug, and in some cases are actually prohibited from carrying it (Horn 2019). A delay of even a few minutes can be fatal for someone who is overdosing (Potter 2010). In the weeks after release from prison, formerly incarcerated people face an astronomical risk of a fatal overdose (Merrall et al. 2010, Ranapurwala et al. 2018). Studies have shown that providing buprenorphine to incarcerated people dramatically reduces their risk of overdose and death after they are released (Horn 2019, Sue 2019).

11. DRUG COURTS AND TREATMENT FOR OPIOID USE DISORDER

Many people have singled out the proliferation of drug courts as an indication that the country is finally turning away from the war on drugs to embrace public health and harm-reduction approaches. The Trump administration's report on the opioid crisis and Joe Biden's campaign platform called for expanding drug courts despite mounting concerns that such courts fuel the carceral state (Christie et al. 2017, DNC 2020).

Drug courts, which date back to the 1980s, were once a tiny part of the criminal legal system. Since then, they have mushroomed across the country, despite growing evidence that they do not significantly reduce problematic drug use, crime, or incarceration or that they save much money (Drake et al. 2009, Drug Policy Alliance 2011, Ettner et al. 2006, Lilley 2017, Lilley et al. 2020, Møllmann & Mehta 2017, Rossman et al. 2011, Sevigny et al. 2013). A vast network of at least 3,100 drug courts, which are governed by few regulations or standard procedures, operates in about half the counties in the United States (MacGillis 2017).

Specialists in addiction have raised serious concerns about drug courts and have cast doubt on claims that they represent a major turn toward public health and harm-reduction approaches to substance use (Kaye 2020, Tiger 2013). Drug courts are built on a fundamental contradiction: People are reportedly being "treated" through a medical model, but the symptoms common to substance use disorder—relapses and the struggle to maintain abstinence—are treated through a penal one (Drug Policy Alliance 2011). People who relapse while under the supervision of a drug court risk being sent to jail or prison, where they are not likely to receive adequate drug treatment or medical care (Abrahamson 2016). Drug courts are run by judges whose primary training and experience are in the law, not social work, medicine, or substance use. Many drug courts are not equipped to adequately assess people's needs and place them in appropriate treatment due to overcrowded dockets, high staff turnover, and inadequate training and expertise in substance use treatment and in dealing with diverse populations (Lutze & van Wormer 2007). Drug court staff are routinely called "treatment teams," even though they often lack qualified health providers with medical backgrounds (Andraka-Christou 2020). A survey of judges and other drug court personnel revealed widespread ignorance about buprenorphine and methadone treatment (Andraka-Christou & Atkins 2020, Matusow et al. 2013). As of 2014, barely 5% of drug court and diversion program participants were referred to MAT with methadone or buprenorphine (Krawczyk et al. 2017).

Many drug courts prohibit the gold standard in treating opioid use disorder—MAT with methadone or buprenorphine. Drug courts also run roughshod over norms and protections that are bedrocks of medical care, including privacy, confidentiality, and meaningful consent to treatment, which raises serious human rights concerns (Møllmann & Mehta 2017). The enthusiasm of drug court judges for mandatory injections of Vivitrol raises particularly troubling issues about consent (MacGillis 2017).

The extensive drug court system in the United States and the bipartisan enthusiasm for expanding it are not, as some claim, signals that the country is finally abandoning the war on drugs. Rather they are indicators of just how exceptional US drug policies remain (Csete 2020). Legal experts who testified before a special session of the United Nations to review global drug policy urged the international community to reject drug courts because most of them fail to follow the best practices in substance use disorder treatment (Møllmann & Mehta 2017, UN Hum. Rights Spec. Proced. 2019).

Although MAT with methadone and buprenorphine is slowly gaining wider acceptance in the United States, these critical medications remain out of reach for many people with opioid use disorder. But even if MAT were brought up to scale, this does not address what caused and perpetuated the opioid crisis in the first place. Widescale access to high-quality MAT is not a panacea

for the opioid crisis. MAT provides a vital opening for people with substance use disorder to stabilize their lives, but it is not a remedy for joblessness, poverty, lack of access to good health care, homelessness, and other socioeconomic and environmental factors that fuel despair and put some people at much higher risk for substance use disorder and relapse. It also does not address the fact that the opioid epidemic was iatrogenic—that is, induced by the pharmaceutical industry and medical providers, who were aided and abetted by lax and self-interested government regulators at the FDA and elsewhere.

12. CONCLUSION

Claims that the United States has embraced harm-reduction strategies and dialed back on the war on drugs because the main victims of the opioid crisis are white people do not bear up under closer scrutiny. Such claims need to reckon with the unprecedented 108,000 overdose deaths in 2021 (Weiland & Sanger-Katz 2022). If the United States had an overdose death rate comparable to that of Portugal, the figure would have been more like 800 (Drug Policy Alliance 2019). Although the rhetoric has been less harsh at times, the country continues to deploy many of the same punitive weapons and has added some new ones. These claims have deflected attention from how the real culprits in the opioid crisis have gone unpunished.

The pharmaceutical companies, drug distributors, and medical providers that instigated the crisis have emerged relatively unscathed, except for belatedly singling out a few bad apples, notably Purdue Pharma. They go on conducting business as usual, undeterred by the civil lawsuits or occasional criminal investigations that they resolve by shelling out for fines and settlements and by signing deferred prosecution agreements in which they admit no wrongdoing. They have been largely spared criminal charges in the opioid epidemic (Beletsky 2018).[24]

The White House and Congress failed miserably to tackle the decades-long opioid crisis. Faced with a public health catastrophe, they approved minuscule amounts of money to expand treatment and harm-reduction programs. The federal government did not deploy its fiscal and regulatory might to compel states and local governments to significantly improve access to the most proven and effective treatments for opioid use disorder. Nor did it rein in the pharmaceutical companies and conflicts of interests or strengthen the weak regulatory regime that triggered the opioid crisis.

Scaling up harm-reduction strategies is desperately needed to save lives. But harm-reduction strategies treat the symptoms, not the underlying causes of the growing socioeconomic and other factors that render more people in the United States vulnerable to substance use (Flores et al. 2020, Haider et al. 2020). As one of the shrewdest analysts of the opioid crisis commented, "the United States is a nation in pain" (Beletsky 2019, p. 844). US consumption of opioid painkillers as well as antidepressants, stimulants, and other behavioral drugs tops world rankings (Beletsky 2019, UN Int. Narc. Control Board 2010). People take opioids "as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness" (Dasgupta et al. 2018, p. 182).

For all the recent public outrage over the role that drugmakers like Purdue Pharma and drug distributors like CVS and Walgreens played in fomenting the opioid crisis, prescribing patterns for opioid pain pills have not changed radically. As one expert on drug policy testified before Congress in 2018, as "long as we continue putting countless Americans in 'heroin prep school' each year by overprescribing opioids, the next generation of users will soon replace those who exit the heroin market" (US House Represent. Judic. Comm. 2018, p. 4). It was not until 2016 that the CDC issued voluntary guidelines that physicians severely limit their use of opioids for chronic pain (Dowell et al. 2016). That year, the CDC made the chilling observation: "We know of no

[24]See also Macy (2018) and Meier (2018).

other medication that's routinely used for a nonfatal condition that kills patients so frequently" (quoted in McLean 2019).

Nearly two decades into the opioid crisis, the Trump commission on opioids acknowledged in 2017 that use of opioids for noncancer pain continues to be a problem. The commission noted that patients and their families were still "not often fully informed regarding whether their prescriptions are opioids, the risks of opioid addiction or overdose, control and diversion, dose escalation, or use with alcohol or benzodiazepines" (Christie et al. 2017, p. 22).

As fentanyl and its analogs have flowed through the illegal drug market, the opioid crisis has entered its third and most lethal phase. The racial gap in overdoses has rapidly narrowed, but this is a grim milestone. In this third phase, the national overdose death rate has been escalating fastest for African American people and has begun to exceed the overdose fatality rate for white people and other demographic groups. Promulgating claims that the United States has embraced harm-reduction strategies and pivoted from a war on drugs threatens to rob the crisis of its urgency at a time when fatal overdoses for African American people, Latinos, and other groups have skyrocketed as the epidemic has become even more deadly and destructive. The bipartisan demonization of fentanyl is reminiscent of the demonization of crack and people who use crack. But the impact is likely to be much greater because so much of the street drug market has been adulterated with fentanyl and its analogs. The stampede to indict fentanyl has spawned a slew of punitive measures that are already disproportionately punishing the large and growing number of marginalized people in the United States, including African American people.

The opioid crisis has contributed to a "reversal in fortunes" in life expectancy that is rapidly diffusing across the United States (Case & Deaton 2017, Ezzati et al. 2008). Although the overall mortality rate is still higher for African American people than for white people, that gap is closing quickly for people younger than 65 years of age and especially for women (Angell 2018). This is due to the escalating "deaths of despair" among middle-aged non-Hispanic white people—including drug and alcohol overdoses, suicide, and alcoholism (Angell 2018).

Case & Deaton (2020) argue against attributing the epidemic of opioid fatalities and other "deaths of despair" from alcohol, suicide, and chronic diseases such as diabetes to short-term economic fluctuations, such as the Great Recession and the unraveling unleashed by COVID-19. Opioid deaths were rising before the 2008–2009 financial crisis and continued to escalate even after the economy rebounded and unemployment plummeted to its lowest levels in decades. The underlying causes of the "deaths of despair" are structural problems that stretch back decades, including rising inequality, declining real wages, and disparate economic development, and have unhinged families and communities. The twin shocks of the Great Recession and the COVID-19 pandemic exacerbated these problems but did not create them. The pandemic revealed a health-care system that was already in critical condition and a public health system that was on life support.

Providing affordable state-of-the-art treatment for opioid use disorder on demand and enthusiastically embracing other harm-reduction strategies that are rare in the United States but commonplace in Canada and Western Europe are key to saving individuals with opioid use disorder. But they do not address why so many people in the United States are gripped with such lethal despair in the first place—and then turn to drugs, alcohol, or suicide for some relief because the economic system, the health-care system, and the social safety net have forsaken them.

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