Brigham Young University Prelaw Review

Volume 34 Article 7

4-2020

Underlying Racism within the Opioid Epidemic

Hannah L.A.S. Wilson
hannahlaswilson@gmail.com

Underlying Racism within the Opioid Epidemic

Written by Hannah Wilson[1] edited by Natallia Dummar[2]

Within the past century, the United States attempted different legal avenues to address drug abuse. Some of these efforts made access to drugs punishable and illegal. Others encouraged research to look at underlying issues of drug abuse and implement those findings. Within the past fifty years, these laws tended to treat drug addicts as criminals instead of as persons suffering from a health crisis. According to the FBI and Uniform Crime Reports, from the 1980's to the 2000's, drug arrests rose by 1.5 million per year, while drug usage rates stayed the same.[3] The severe increase in the criminalization and incarceration surrounding drug exploited underprivileged minorities, specifically persons of color. Lawsuits and lobbying brought attention to these injustices. However, a heavy bias in drug-related crime still persists. The penalization of drug crime historically has been a vehicle for implicit and explicit racism.

In the past three years, significant attention has been given to opioid abuse branding it as the "Opioid Crisis" or "Opioid Epidemic". To address the opioid crisis, an Executive Order 13784 was implemented by the Trump Administration.[4] This order brought the Department of Justice, the Office of National Drug Control

---

1 Hannah Wilson is a Senior at Brigham Young University studying Biostatistics with a minor in International Diplomacy. She is preparing to attend law school fall of 2021.

2 Natallia Dummar is a senior at Brigham Young University majoring in family studies with a minor in gerontology. She is preparing to attend law school in the fall of 2020.

3 Uniform Crime Reports FBI, Drugs and Crime Facts Bureau of Justice Statistics (BJS), https://www.bjs.gov/content/dcf/tables/arrtot.cfm.

4 Exec. Order No. 13784, C. F. R. (2017)

Policy, and the Department of Health and Human Services together to address the opioid epidemic.[5] Executive Order 13784 increased penalties against illicit-drug users, and measures to provide rehabilitative support to the opioid user, but failed to provide the same resources for all drug users. The order does not address the same protection nor medical support that is long overdue for all illicit drug abuse. As opioid prevalence increased significantly in white communities, usage stayed at low levels within communities of color; therefore, Order 13784 had a predominantly white audience. The order provides funding, legislation, and protections for opioid users. In contrast, a criminalizing approach in addressing marijuana, crack/cocaine, and other drug-related crimes has been largely associated with communities of color. Emphasizing healthy opioid recovery has led to an institutionalized bias, and implicit racism. I request an expansion of the public health approach including research, rehabilitative services, and furthered legislation to support the aforementioned order and include all illicit drugs, not just opioids.

This article establishes the history and relevance of the relationship between racism and drug crime, and explores this recent association in relation to Executive Order 13784 and the opioid epidemic. Then, it will walk through suggested legislative expansions to approach all drug addictions as a public health issue, instead of a criminal justice issue.

I. Background

A. Racial Implications of the War on Drugs

President Nixon declared the War on Drugs in the 1970's. With this movement, incarceration rates have grown over 500%.[6] Different approaches to address illegal drugs included drug courts

5 Tracking Federal Funding to Combat the Opioid Crisis Bipartisan Policy Center (2019) [hereinafter , *Tracking Federal Funds*] https://bipartisanpolicy.org/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf.

6 Lauren Carrol, How the war on drugs affected incarceration rates (Politifact, 2016)

and rehabilitation treatment. Despite these efforts, alternatives to incarceration were, and continue to be, limited and when available, weak. As a result, mass incarceration spurred other social problems such as latent discrimination against those of lower socioeconomic status, racial minorities, and other societal minorities, particularly blacks. This article will look solely at the racism resulting from this mass incarceration in relation to non-violent drug crimes.

During the war on drugs, the nature of the Rockefeller Laws in New York City revealed existing racism within the criminal justice system. These laws included minimum sentencing starting at 15 years in prison for two ounces of marijuana.[7] Shortly after New York passed this legislation, Michigan followed and mandatory minimum sentences became widespread for non-violent drug crime throughout the US.[8] After these laws were passed, 90% of drug felons in prison were black and Hispanic.[9] These laws were initiated by politicians who wanted to appear hard on crime, and may not have been intentionally mandated with a racist agenda. However, they heavily/disproportionately impacted minorities who were the main users of these drugs. In 2009 this implicit racism in the Rockefeller laws was exploited. The laws became recognized as "new Jim Crow laws" and were changed.

Meanwhile, significant racial biases surfaced in the sentence incongruencies between crimes involving cocaine vs coke. Starting in 1986, the sentences for five grams of crack and for 500 grams of powder cocaine were the same. This came to be known as the 100:1 crack/powder cocaine disparity. Chemically, the two drugs are almost identical. The largest difference comes as a result of the

7 See Annual Message from Gov. Nelson Rockefeller to the Legislature of the State of New
York (Jan. 3, 1973), in 1973 N.Y. Laws 2309, 2317

8 William H. Pryor Jr. et al., Mandatory Minimum Penalties for Drug Offenses in the Federal Criminal Justice 19-22 (U. S. Sentencing Comm'n, 2017). https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171025_Drug-Mand-Min.pdf#page=19

9 Gabriel Sayegh, Background on New York's Draconian Rockefeller Drug Laws (Drug Policy Alliance NY)

production of the drugs; crack cocaine is significantly cheaper than powder cocaine. As a result, socioeconomic and racial disparities exist amongst users of the two drugs. Black communities commonly used crack cocaine and white upper class communities to use powder cocaine. The steep difference in usage did not decrease until 2010 when the disparity of reduced from 100:1 to 18:1. A study done by Drug Alcohol Depend, found that blacks were at an increased risk for being users of crack, and for being arrested for drug use when compared with whites using either crack or powder cocaine.[10] In the study they found that high socioeconomic status and being white were inversely correlated with prison time.[11] Whites tended to be users of powder cocaine, not crack cocaine, and were significantly less likely to be arrested for their drug use. As almost 25% of blacks within the US live under the poverty line, socioeconomic differences are inseparable from racial differences. Given this history, racism has deep roots in the relationship of incarceration and drug laws during the War on Drugs.

B. Brief History of the Opioid Epidemic

Physicians began prescribing opioids as pain medication in the early twentieth century. It wasn't until the late 1990s and early 2000s when prescribing opioids for pain became the norm. Hospitals and pharmaceutical companies heavily backed this movement. The addictive nature of the drugs was often masked and health care providers and patients alike were misled in their understanding of the drugs. Opioid addiction grew rampantly, sparking growth of illicit opioid distribution. Quickly, the US realized the vast spread of this epidemic which has continued through today. A recent study revealed as many

10 Joseph J. Palamar, Shelby Davies, and Michael Weitzman Powder Cocaine and Crack Use in the United States: An Examination of Risk for Arrest and Socioeconomic Disparities in Use (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4533860/)

11 *Id.* p 16

as two million Americans are patients of opioid dependency.[12] In 2017, opioids accounted for over half of the deaths due to drug overdoses.[13] This issue plagued both the Obama and the Trump presidential administrations.

In recent years, the opioid epidemic worsened and brought attention to the futile efforts of the war on drugs. In 2017, the Trump Administration issued the Executive Order 13784 declaring a public health emergency to address "the scourge of drug abuse, addiction, and overdose".[14] In this order, the opioid crisis was declared and a commission was established to research and make recommendations to lighten the societal burden of "drug addiction, and the opioid crisis."[15] In the two years after this order was made, recommendations regarding the opioid epidemic were implemented and funding was provided. Public health initiatives to assist opioid users in recovery continue to grow, resulting in a lessened criminalization of opioid user abuse.

C. The Executive Order 1378—Shifting the Lens

On March 29, 2017, the Trump Administration published Executive Order 13784,[16] The order created a commission to research drug addiction and the opioid crisis with regards to healthcare, education, addiction prevention and treatment, overdose prevention, and overdose reversal.[17] It was also established in the order that the committee make recommendations for improving all these areas.[18] Funding was also granted for the research and implementation of the research

12 *See* Genetics Home Reference: Opioids Addiction (U. S. National Library of Medicine 2017).

13 *Id.*

14 Exec. Order No. 13784, C. F. R. (2017).

15 *Id.*

16 Exec. Order No. 13784, C. F. R. (2017).

17 Exec. Order No. 13784, C. F. R. § 2, 3, 4 (2017).

18 Exec. Order No. 13784, C. F. R. § 4. (2017).

findings.[19] The order established preliminary research to be completed in six months after the publishing of the order. In October 2017, President Trump declared the opioid crisis a "public health emergency".[20]

As established, drug offenses were historically painted as a criminal offense and directly treated in an aggressive manner as evident in the branding of the "War on Drugs". This legislation rebrands the formerly called "War on Drugs", to an "epidemic" when pertaining to opioid specific drugs. Now, instead of a criminal crisis, opioid overuse is a public health crisis. Addressing drug problems through a health lens is a more appropriate way to handle the situation. While black drug crime continues to exceed white drug crime, white drug related offenses resulting in incarceration grew 27% between the years of 2009 to 2016.[21] However, the time and way this new approach has been implemented holds elements of racism. Political motive sparked from the public investment to assist addicted individuals to recover, rather than treating them as an enemy of war. Implicit racism exists within the very inspiration behind this call to action; when the majority of the affected community was white, public health efforts were introduced for the first time.

D. Addressing the Issue

When compared to the response to other drug epidemics, the public health response to the opioid crisis betrays incongruencies pertaining to racial bias. To combat this, I suggest additional legislation should be written to accompany Executive Order 13784 that (i) promotes research opportunities for all drugs, and (ii) provides healthcare for drug addiction recovery and rehabilitate for all addicts of illicit drugs.

19 Exec. Order No. 13784, C. F. R. § 5, 6 (2017).

20 On Thursday October 26, 2017 President Trump officially declared the opioid crisis a "public health emergency." President Trump said from the White House that "This epidemic is a national health emergency."

21 National Research Council, The Growth of Incarceration in the United States Exploring Causes and Consequences (2014) at 33.

II. Presence of Public Health vs. Incarceration

A. Opioids and all Illicit Drugs Alike

Order 13784 explicitly stipulates resources are needed to fight all drugs, not just the opioid epidemic. The executive order consistently uses the phrase "drug addiction and the opioid crisis", implying that actions should not be limited to the opioid epidemic and should address all drug addictions. Efforts in response to the law should be consistent in making room for research, education, and other public health measures relating to drug addictions and the opioid crisis. Thus far, efforts to decriminalize drugs have mainly focused on the opioid epidemic.[22] The Department of Justice addressed other illicit drugs with increased criminal penalties.[23]

Different legal ramifications for different drugs are expected. For example, within the past decade states have explored varying approaches for recreational marijuana usage. Marijuana has a history of being used equally in communities of color and white communities, but only criminalized in communities of color. States are responding to this incongruency by decriminalizing recreational use of marijuana. We do not expect to see the same approach with drugs such as hypnotic depressants, heavy hallucinogens, or instantly addictive substances. Not all drugs have equal effects on the user, and reciprocally should not all bare the exact same legal ramifications. However, the attitude in which we approach all illegal drugs ought to be the same. The wording in this order however, consistently includes all drug addictions and does not specify action to be only applied to a certain type of drug.[24] As the order calls, effort to

22 Julie Netherland, White opioids: Pharmaceutical Race and the War on Drugs That Wasn't (2017) at 4, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5501419/#!po=3.26087.

23 White House, President Donald J. Trump's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand (2018), https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand-2/.

24 Exec. Order No. 13784, C. F. R. (2017).

increase funding and rehabilitative treatment for all drug addictions should increase, not opioids alone.

The steep increase in opioid usage and overdoes warranted political attention and legislation that was specific to opioid related drugs. Although this order is reactionary to the opioid crisis and could have been opioid specific legislation, it is not. Instead, the order makes broad statements consistently referring to, "drug addiction and the opioid crisis".[25] This is acceptable because the order is not about punishment or sentencing of drug abusers. It attempts to preemptively avoiding other drug crises by making available the public health resources that would be allocated to the opioid epidemic. This long overdue approach to drug addictions is a step in the right direction. It does not, however, address the historic drug problem in association with race, or provide the necessary explicit allocation of resources to do so. Additionally, there still exists a bias of resources towards opioids in funding regarding treatment, recovery, and prevention. In the table adjacent, programs that are funded as a result of this order are categorized.

25 *Id.*

Category of Program	Funding for Opioids Only (in dollars)	Funding for Opioids and Other Drugs (in dollars)
Treatment and Recovery	1,259,224,930	932,542,000
Prevention	1,990,130,600	470,998,000
Criminal Justice and Law Enforcement	93,839,383	1,249,800,000
Research (2018 only)	—	500,000,000
Mixed Efforts	130,000,000	2,881,206,400

Table 1.
Federal Opioid and Drug Appropriation in 2017 and 2018.[25]
All costs recorded in USD.

As observed, significantly more money was allocated for only opioids in treatment and recovery programs, and less for other drugs. On the other hand, more finances are allocated to other drugs for Criminal Justice and Law enforcement, fueling the criminalization of these drugs. 41.6% of the Criminal Justice and Law Enforcement funds allocated for opioids and other drugs are for the Office of National Drug Control Policy—High Intensity Drug Trafficking Areas (HIDTA).[26] HIDTA's first area of focus for drug trafficking is the southern border.[27] Most opioids sold in the United States are produced by American Companies and are not being trafficked across any national borders.[28] This furthers racial implications encouraging the incarceration of nonwhites for non-opioid drug crimes. The funds designated to treatment and recovery favor opioids, while the efforts that further the incarceration of drug crimes are focused on non-opioid drugs, (and are accompanied with an additional association of racial bias.) Again, this synchronizes with the consistent trend of

26 *Id*.

27 High Intensity Drug Trafficking Areas (HIDTA) Program White House at 4 (2017) https://www.whitehouse.gov/wp-content/uploads/2017/11/ONDCP_High-Intensity-Drug-Trafficking-Areas.pdf.

28 Drilling Into the DEA's Pain Pill Database The Washington Post (2020). washingtonpost.com/graphics/2019/investigations/dea-pain-pill-database/.

racial association that has existed since the 1970's; decriminalizing white drug use while further criminalizing colored drug use.

B. Nature of Executive Orders

Although the nature of the legitimate legal authority of executive orders has been disputed, the practice has existed since George Washington. Throughout the history of the country, these executive orders have been canonized as law if they are deemed constitutional and unrevoked. If the order is not constitutional, the Supreme Court, Congress, and future presidents have the authority to revoke the order. This happened five times during Harry Truman's presidency, more than any president. The most famous of which occurred during the steel strike of 1952 when Truman issued executive order 10340 seizing control of the American steel industry.[29] In the Youngstown Sheet and Tube Co. v. Sawyer, the Supreme Court overruled Truman's order and reprivatized the steel industry.[30] The opportunity to revoke a presidential executive order still exists today. The Supreme Court overrode President Trump's executive order that banned citizens of seven Muslim countries from entering the United States on January 28, 2017.

Speaking in general terms, presuming the order is constitutional, it becomes the President's responsibility to oversee the implementation of the order. This is rarely an issue as written by the presidential cabinet, it is in his or her best interest to carry out the order. In 1948, Truman's executive order 9981 states that "there shall be equality of treatment and opportunity for all persons in the armed services without regard to race, color, religion or national origin."[31] This order has been executed and enforced by the executive branch and treated as law since. Article II of the Constitution establishes the executive branch to bear the responsibility to "take Care that the Laws

29 Exec. Order No. 10,340 3 C. F. R. (1952)

30 Youngstown Sheet & Tube Co. v. Sawyer (The Steel Seizure Case), 343 U.S. 579 (1952).

31 Exec. Order No. 9,981, 3 C. F. R. (1948).

be faithfully executed."[32] Truman's executive order 9981 is a prime example of this responsibility because it has been cited and upheld by the executive branch up through today.

These cases are unrelated to the Executive Order 13784, rather, they prove the power of an executive order. This form of legislation is one of the strongest manifestations of executive power. Order 13784 went without opposition from the Supreme Court or Congress. The Trump Administration is therefore bound by this unrevoked executive order. Because the of the inclusion of all drug addictions with the opioid crisis in the wording of the law, the Trump Administration is expected to see the fulfillment of both parts of the order. Meaning, it is the President's responsibility to establish policies supporting those addicted to opioids and other drugs alike.

C. Opioids: the White Drug

Opioid addictions often start as a medically prescribed pain killer. Painkillers are shown to be more commonly prescribed to white patients than to people of color for a variety of reasons.[33] While these reasons provide insight to underlying implicit racial bias, for the scope of this paper, it is only required to establish that opioids are in fact more common among white low-income areas. Overdose

32 U. S. Const. art. II.

33 Joseph Friedmen, Assessment of Racial/Ethnic and Income Disparities in the Prescription of Opioids and Other Controlled Medications in California, April 2019 at 473 "One foundational study showed that Hispanic patients were 2 times less likely to receive analgesics following long bone fractures than white patients, after accounting for other factors. Similar discrepancies in pain medication prescribing were found for black patients relative to white patients. Recent studies have found that health care professionals often underestimate the pain of black patients when compared with white patients and that such racial/ethnic biases in the detection of pain are seen among health care professionals who report no explicit racial/ethnic biases."

deaths in 2017 grew to 47600 making up 67.8% of all drug overdose the deaths.[34] Eighty percent of those opioid users were white.[35]

Leading up to 2017, there were three times more white opioid users than black opioid users in prison (24% of white prisoners are opioid users while only 7.9% of blacks are opioid users).[36] However, blacks are still convicted for drug charges six times more than whites.[37] The opioid users are in the minority of those in prison for drug use. Rehabilitative and decriminalization efforts associated with this order are primarily helping the minority. Focusing the implementation of the order on decriminalizing opioid abuse continued the racist tendencies within drug law. Criminalizing the broader drug use has been an easy way to allow implicit racism to seep into the US Justice system. Implicit racism has come as a result of increased attention to opioid recovery, but a limited health approach to addressing marijuana, crack/cocaine, and other drug crimes.

Between the overdoses and the increase in white drug incarceration rates, the epidemic was a political wakeup call. The Trump Administration's response is inseparably connected with the political demographics of his supporters at the time. Many voters who most supported Trump were hit by the opioid epidemic the hardest. For example, in West Virginia in 2017 there were over 81 opioid prescriptions for every 100 people.[38] In the 2016 election, West Virginia had the highest support for Trump with 67.9% of the vote in his

34 Opioid Overdose Deaths by Race/Ethnicity, Kaiser Fam. Found., https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/?currentTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

35 *Id*

36 Bureau of Justice Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates 2007-2009 at 6 (U.S. Dept. Just. 2007-2009), [hereinafter, *BJS Drug Use*] https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf.

37 *Id.*

38 Opioid Summaries by State National Institute of Drug Abuse (2019) https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state

favor.[39] This state is particularly white with a 92.1% non-Hispanic white population as recorded in the 2019 census.[40] West Virginia and other predominantly white states who were hit hard by the opioid crisis became the face of the epidemic. The Trump Administration had significant political incentive to please these white low-income communities by providing this legislation.

Comparatively, the crack cocaine epidemic was also addressed by appealing to the white population. The imbalance in sentencing cocaine and coke heavily biased wealthier white communities who at the time bore significant political power. The 1980 crack cocaine crisis primarily involved black communities and persons, while the opioid epidemic is identified as mostly affecting white communities.[41] Crack users of the 1980's, predominantly black, bore the weight of excessive incarceration, mandatory minimum sentencing, and outright racism.[42] Opioid users, predominantly white, are unmistakably being provided furthered care and attention from the state to protect and secure their health without the cost of incarceration.[43] The opioid epidemic is the first significant drug crisis that is aimed primarily to influence white communities in the U.S. Correlatedly, it is the first time the law has reflected protection for drug users, and yet it is rooted in white privilege.

Action to address the incarceration of opioid users came about because the opioid epidemic is associated with white populations. As

39 Presidential Election Results: Donald Trump wins N. Y. Times, (Aug 9, 2017) https://www.nytimes.com/elections/2016/results/president

40 U.S. Census Bureau (2019) https://www.census.gov/quickfacts/WV.

41 Khiara Bridges, Race, Pregnancy, and the Opioid Epidemic, 790 Har. L. Rev. 133 (2020), https://harvardlawreview.org/wp-content/uploads/2020/01/770-851_Online.pdf

42 Mandatory Minimum Sentencing Reform CRIMINAL JUSTICE POLICY FOUNDATION https://www.cjpf.org/mandatory-minimums

43 Hansen & Netherland Editorial, Is the Prescription Opioid Epidemic a White Problem?, 106 AM. J. PUB. HEALTH 2128 this order "institut[es] voluntary take-back programs for unused medication and disseminat[es] the opioid overdose reversal medication naloxone, while passing Good Samaritan laws to protect those calling for emergency assistance during an overdose from drug charges."

prevalence rates of drug addictions increase within black communities, similar legal ramifications do not occur. This begs the question, that had the opioid epidemic been branded as an issue in black communities, would it have received the same amount of productive attention, or would it have resulted in furthered incarceration?

D. Combatting Institutionalizing the Bias of Race

As shown in the *Table 1* above, Executive Order 13784 called for a large increase in funding towards addressing the opioid crisis and an future improvement in addressing non-opioid drug crises. However, because all non-opioid drugs are allocated finances in conjunction with opioid crisis budget, there is no ensured budget for any non-opioid drug within this order. Research, prevention, treatment and recovery, and criminal justice improvement measures are only explicitly provided for opioid related services. Additionally, these funds exacerbate the difference between races incarcerated for drug crimes due to the difference in drug use between races. The funding's heavy favor here adds an economic bias in addition to the legal bias already established. Together, this order institutionalizes racism.

Furthered legislation can help to address this. Because so many efforts have already been made for the opioid crisis, expanding the research, education, and other public health measures will require less funding than they initially did. This legislation needs to support research, rehabilitation and reassimilation. Secondly, room within Medicare should be created for those struggling with drug addictions to be able to get medical help to address the addiction. Looking through the lens of a public health crisis will allow a perspective shift to occur for all drugs, and one day the association between racist tendencies and drug law can be eradicated.

III. Conclusion

The opioid crisis is associated with a white demographic. I argue that because of this association, there has been more funding, legislation, and political power to provide aid to the epidemic. After a closer look at the Executive Order 13784, the inequality in treating different drug

types is correlated with the inequality in treating different races. To avoid furthered racist associations with this law, measures to combat this racism should be taken. I propose legislation to be written that establishes healthcare provisions and legal protections for all drug users without regard to the type of drug. Additionally, healthcare and addiction recovery for all drug users should be prioritized over incarceration. While previous drug epidemics in communities of color and low socioeconomic status, have resulted in furthered incarceration, stigma in the media, etc., this epidemic can set a standard of public health for all future drug addiction crises. By providing services and support to all suffering from drug abuse without reference to the drug or race of the users, the following three effects are expected to be seen on society. First, a legally supported priority on health, accounting for confounding differences in demographics, resulting in a healthier society. Secondly, those who are incarcerated will have more access to aid resulting in reduced recidivism and bettered reassimilation coming out of prison or jail. Third, there will be less implicit racism in the law, and potential future racist drug associations that have been rampant in the past can be avoided. We have the potential to create a society that encourages growth, change, and improvement rather than facilitating recidivism, racism and increased incarceration.