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ESSAYS

THE INFLUENCE OF WHITE EXCEPTIONALISM ON DRUG WAR DISCOURSE

*Taleed El-Sabawi & Jennifer Oliva**

INTRODUCTION

For much of its history, the United States has adopted a punitive approach to escalating overdose rates and addiction through the prohibition or stringent regulation of drugs deemed dangerous or habit forming.¹ The policy tools used to support this approach rely on criminal punishment for the possession and sale of such substances and are based on the theory that harsh criminal penalties will deter drug use.² Dominant drug narratives associate the most vilified substances with minoritized populations, who have been caricatured as moral deviants hijacked by an uncontrollable urge to give in to sinful pleasures of a “high,” no matter the cost.³ Authorities have secured public acceptance for the country’s predominantly punitive approach to drug policy through the use of heuristics, recycled narratives othering persons who use drugs,⁴ stereotypes,⁵ and racist

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1. See generally David T. Courtwright, *A Century of American Narcotic Policy*, in 2 TREATING DRUG PROBLEMS 1 (Dean R. Gerstein & Henrick J. Harwood eds., 1992), <http://www.ncbi.nlm.nih.gov/books/NBK234755> [http://perma.cc/PZD5-JYU3]; Mona Lynch, *Theorizing the Role of the “War on Drugs” in US Punishment*, 162 THEORETICAL CRIM. 175 (2012).

2. While deterrence theory has evolved since its inception, the primary theory is based on the premise that the threat of swift, certain, and severe punishment will deter undesirable behavior. Anthony A. Braga & David L. Weisburd, *The Effects of Focused Deterrence Strategies on Crime: A Systematic Review and Meta-Analysis of the Empirical Evidence*, 49 J. RSCH. CRIME & DELINQ. 323, 324 (2011).

3. Craig Reinerman, *The Social Construction of Drug Scares in Constructions of Deviance*, in SOCIAL POWER, CONTEXT, AND INTERACTION 155, 156–58, 161 (Patricia Adler & Peter Adler eds., 1994); DAVID T. COURTWRIGHT, DARK PARADISE 7–10 (2d ed. 2001) [hereinafter COURTWRIGHT, DARK PARADISE]. See generally CAROLINE ACKER, CREATING THE AMERICAN JUNKIE: ADDICTION RESEARCH IN THE CLASSIC ERA OF NARCOTIC CONTROL (2001).

4. Taleed El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*, 48 U. MEM. L. REV. 1357, 1388–92 (2018) [hereinafter El-Sabawi (2018)]; Taleed El-Sabawi, *Carrots, Sticks, and Problem Drug Use: Law Enforcement’s Contribution to the Policy Discourse on Drug Use and the Opioid Crisis*, 80 OHIO STATE L. J. 765, 772–75 (2019).

5. Sarah Tosh, *Drug Prohibition and the Criminalization of Immigrants: The Compounding of Drug War Disparities in the United States Deportation Regime*, 87 INT’L J. DRUG POL’Y 102846, 102847 (2021) (noting that “[n]ewly punitive laws implemented throughout the 1980s and 1990s were supported by unfounded

beliefs about minoritized populations.⁶ The popularity of this strategy persists despite ample evidence that punitive responses are not associated with a decrease in drug use or overdose.⁷

This punitive U.S. drug policy approach and its attendant symbolic moral crusade⁸ are commonly referred to as the “War on Drugs.” While frequently attributed to President Nixon, the inception of the War on Drugs can be traced back to the nation’s first opiate crisis in the late 1800s.⁹ Because the War on Drugs has been used as a strategy to further subordinate Black persons and other persons of color, it has disparately impacted these minoritized and subordinated communities.¹⁰ While white Americans use and sell drugs at similar or higher rates than people of color, Black people are 6.5 times more likely than their white counterparts to be incarcerated for drug-related crimes.¹¹ Consequently, almost eighty percent of people in federal prison and nearly sixty percent of people in state prison for drug offenses are racialized as Black or Latino.¹²

The War on Drugs is as much a collection of rhetorical tactics used to other and subordinate minoritized members of society as it is a set of punitive policy tools. These rhetorical policy tactics include the use of simple, causal narratives that define addiction

stereotypes scapegoating immigrants, as well as native-born racial minorities, for the societal problems of drugs and crime—and their outcomes only served to further ‘other’ and vilify existing ‘folk devils’”).

6. Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn’t: Wasted Whiteness, “Dirty Doctors,” and Race in Media Coverage of Prescription Opioid Misuse*, 40 *CULTURE, MED. & PSYCHIATRY* 664, 674 (2016).

7. As research makes clear, there is “no statistically significant relationship between state drug offender imprisonment rates and . . . drug use, drug overdose deaths, and drug arrests.” PEW, *MORE IMPRISONMENT DOES NOT REDUCE STATE DRUG PROBLEMS: DATA SHOW NO RELATIONSHIP BETWEEN PRISON TERMS AND DRUG MISUSE* 1 (2018), http://www.pewtrusts.org/-/media/assets/2018/03/pspp_more_imprisonment_does_not_reduce_state_drug_problems.pdf [<http://perma.cc/G8Y6-U3X8>]. Until recently, this well-evidenced observation had little impact on American policymakers, who repeatedly responded to drug use with “law and order” rhetoric and the enactment of increasingly harsh yet entirely ineffective criminal sanctions that were primarily enforced against poor people, immigrants, and persons of color. Katharine A. Neill, *Tough on Drugs: Law and Order Dominance and the Neglect of Public Health in U.S. Drug Policy*, 6 *WORLD MED. & HEALTH POL’Y* 375, 375–77 (2015), <http://onlinelibrary.wiley.com/doi/epdf/10.1002/wmh3.123> [<http://perma.cc/7R5Y-9ESU>].

8. For additional information on moral drug crusades, see, e.g., Mike Vuolo, Joy Kadowaki & Brian C. Kelly, *Marijuana’s Moral Entrepreneurs, Then and Now*, 16 *CONTEXTS* 20 (2017).

9. See El-Sabawi (2018), *supra* note 4, at 1387–92.

10. See MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* 20–22 (2010).

11. *Rates of Drug Use and Sales, by Race; Rates of Drug Related Criminal Justice Measures, by Race*, HAMILTON PROJECT (Oct. 21, 2016), http://www.hamiltonproject.org/charts/rates_of_drug_use_and_sales_by_race_rates_of_drug_related_criminal_justice [<http://perma.cc/3KUK-62E3>]; Christopher Ingraham, *White People Are More Likely To Deal Drugs, but Black People Are More Likely To Get Arrested for It*, WASH. POST (Sept. 30, 2014), <http://www.washingtonpost.com/news/wonk/wp/2014/09/30/white-people-are-more-likely-to-deal-drugs-but-black-people-are-more-likely-to-get-arrested-for-it> [<http://perma.cc/74A5-5BKG>] (“Blacks are far more likely to be arrested for selling or possessing drugs than whites, even though whites use drugs at the same rate. And whites are actually *more* likely to sell drugs” (emphasis in original)).

12. See Tara O’Neill Hayes & Margaret Barnhorst, *Incarceration and Poverty in the United States*, AM. ACTION F. (June 30, 2020), http://www.americanactionforum.org/research/incarceration-and-poverty-in-the-united-states/#_ednref60 [<http://perma.cc/V9JN-4LWA>].

and overdose in ways that limit the availability of the full array of evidence-based solutions.¹³ These causal narratives also determine which populations are blamed for the policy problem and who should benefit (or be burdened by) policy solutions.¹⁴ These narratives are of particular importance because their underlying constructs lie at the heart of the policymaking process.¹⁵ Their construction of target populations also contributes to the othering of subordinated groups and hampers the ability of those groups to fully participate in the democratic process.¹⁶

The War on Drugs relied on typified political responses to spikes in substance use or overdoses from the 1800s¹⁷ until “the [current] white drug war that wasn’t.”¹⁸ In an *apparent* departure from previous War on Drugs rhetoric—which blamed drug use on flawed moral character—popular media coverage of the overdose crisis spanning from the 2010s to the present day has attributed the rise in overdose deaths to a “blameless disorder that [did] not discriminate”¹⁹ and for which medication as treatment is normalized.²⁰ While past media caricatures of persons who use drugs were dominated by stigmatizing portrayals of racial and ethnic minorities²¹ or poor, rural whites,²² the 2010s saw a rebranding of people who use drugs as “white, suburban youth and the middle-aged white housewife next door.”²³ Experts argue that such “sympathetic” media depictions are driven by “underlying notions of white exceptionalism, in which white nonmedical opioid users are described as community members, legitimate patients deserving of care, and victims of unscrupulous prescribers and pharmaceutical companies rather than as criminals or flawed individuals.”²⁴

These media portrayals depict middle-class white persons as a population deserving of policy benefits in policy-studies speak. They weave a causal narrative that frames addiction as a disease and blames the crisis on individual “bad apples” (doctor dealers,

13. See El-Sabawi (2018), *supra* note 4, at 1375–87.

14. See *id.*

15. See DEBORAH STONE, POLICY PARADOX 148–54 (3d ed. 2012).

16. Anne Schneider & Helen Ingram, *Social Construction of Target Populations: Implications for Politics and Policy*, 87 AM. POL. SCI. REV. 334, 334 (1993).

17. El-Sabawi (2018), *supra* note 4, at 1388; Jennifer D. Oliva, *Dosing Discrimination: Regulating PDMP Risk Scores*, 110 CAL. L. REV. 47, 52–58 (2022) [hereinafter Oliva, *Dosing Discrimination*].

18. Netherland & Hansen, *supra* note 6, at 677.

19. *Id.* at 665.

20. See Sonia Mendoza, Allyssa Stephanie Rivera & Helena Bjerring Hansen, *Re-Racialization of Addiction and the Redistribution of Blame in the White Opioid Epidemic: Re-Racialized Addiction and Redistributed Blame*, 33 MED. ANTHROPOLOGY Q. 242, 245 (2019).

21. See Stuart Taylor, *Outside the Outsiders: Media Representation of Drug Use*, 55 PROB. J. 369, 369 (2008).

22. Methamphetamines have “been constructed as a white drug used in poor rural communities, one that denotes declining white status and cultural anxieties about white social position.” Netherland & Hasen, *supra* note 6, at 667.

23. *Id.* at 664; see also *id.* at 667 (“Although the race and ethnicity of the protagonists in these stories was rarely explicitly mentioned, it was clear from the photos, the surnames, and the locales (Vermont, Maine, Newton Massachusetts, West Los Angeles) that the novelty was their whiteness and the shock that (presumed white and middle class) readers would experience stemming from that fact that ‘they are just like us!’”).

24. Mendoza et al., *supra* note 20, at 244.

unethical pharmacists, profit-driven pharmaceutical manufacturers, etc.)²⁵ and nefarious prescription drugs.²⁶ These causal narratives thereby limit policy solutions to those that are framed in health-oriented rhetoric.

Indeed, as policymakers embraced media narratives that portrayed people who use drugs as persons suffering from a chronic medical disease,²⁷ the policy proposals enacted to address the overdose crisis were characterized by a health focus. The first federal legislative response to the ongoing overdose crisis, the Comprehensive Addiction and Recovery Act of 2016²⁸ (CARA), included an explicit statement that the current crisis is a public health problem.²⁹ In addition, the U.S. Department of Health and Human Services took the unprecedented step of declaring the current drug overdose crisis a national public health emergency in 2017.³⁰ Most recently, the Biden-Harris administration announced a nearly \$4 billion appropriation “to expand access to vital behavioral health services” for individuals who use drugs.³¹ The administration publicly asserted that “people should not be incarcerated for drug use but should be offered treatment instead.”³² Even efforts to increase surveillance and control the supply of prescription opioids were framed in the language of healthcare quality control instead of attempts to identify and root out deviancy. Perhaps most surprisingly, various high-profile politicians and law enforcement officials have publicly acknowledged that “we can’t arrest our way out of” the current crisis.³³

25. Taleed El-Sabawi, *The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis*, 11 NE. U. L. REV. 372, 383–90 (2019) [hereinafter El-Sabawi (2019)].

26. See Helena Hansen, *Assisted Technologies of Social Reproduction: Pharmaceutical Prosthesis for Gender, Race, and Class in the White Opioid “Crisis”*, 44 CONTEMP. DRUG PROBS. 321–38 (2017).

27. See, e.g., Press Release, Senator Robert Portman, *Portman, Whitehouse, Ayotte, Klobuchar Cheer Final Passage of Comprehensive Addiction and Recovery Act* (July 30, 2016), <http://www.portman.senate.gov/newsroom/press-releases/portman-whitehouse-ayotte-klobuchar-cheer-final-passage-comprehensive> [<http://perma.cc/8E9A-9JZJ>] (“This is also the first time we’ve treated addiction like the disease that it is, which will help put an end to the stigma that has surrounded addiction for too long.”).

28. Pub. L. No. 114-198, 130 Stat. 695.

29. *Id.* § 708, 130 Stat. at 754–55 (“It is the sense of the Congress that decades of experience and research have demonstrated that a fiscally responsible approach to addressing the opioid abuse epidemic and other substance abuse epidemics requires treating such epidemics as a public health emergency emphasizing prevention, treatment, and recovery.”).

30. *What Is the U.S. Opioid Epidemic?*, U.S. DEP’T HEALTH & HUM. SERVS. (Oct. 27, 2021), <http://www.hhs.gov/opioids/about-the-epidemic/index.html> [<http://perma.cc/B5B8-B7UD>].

31. *The Biden-Harris Administration’s Statement of Drug Policy Priorities for Year One*, EXEC. OFF. PRESIDENT, OFF. NAT’L DRUG CONTROL POL’Y 1 (Apr. 1, 2021), <http://www.whitehouse.gov/wp-content/uploads/2021/03/BidenHarris-Statement-of-Drug-Policy-Priorities-April-1.pdf> [<http://perma.cc/7527-FALJ>].

32. *Id.*

33. See, e.g., Press Release, Senator Dick Durbin, *Durbin, Duckworth Announce \$1.2 Million for Kane County Diversion Program* (Dec. 22, 2021), <http://www.durbin.senate.gov/newsroom/press-releases/durbin-duckworth-announce-12-million-for-kane-county-diversion-program> [<http://perma.cc/C4HN-64K4>] (recognizing that “we can’t arrest our way out of” the drug overdose crisis); see also Andrea Cipriano, *Rural Sheriffs: ‘We Can’t Arrest Our Way Out of the Opioid Crisis’*, CRIME REP. 20, (Jan. 20, 2021), <http://thecrimereport.org/2021/01/20/rural-sheriffs-we-cant-arrest-our-way-out-of-the-opioid-crisis> [<http://perma.cc/44JN-52F8>]; Pennsylvania Attorney General Josh Shapiro (@PAAttorneyGen), TWITTER (Feb. 14, 2019), <http://mobile.twitter.com/paattorneygen/status/1096168681325953024>

At first glance, the dominant policy discourse regarding the current overdose crisis suggests that the War on Drugs may be coming to an end. We are not so optimistic. We caution policymakers and scholars against drawing that conclusion. Instead, we argue that such health rhetoric is more appropriately viewed as a case of middle-class white exceptionalism, a key feature of the War on Drugs. Addiction is defined as a medical problem when the impacted population is primarily white and middle-class.³⁴ According to Netherland and Hansen, this “White Drug War” “has carved out a less punitive, clinical realm for [white people] where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern the drug use of people of color.”³⁵

Middle-class white exceptionalism treats addiction in middle-class white communities as the exception to the deviancy narrative. It also purposefully excludes ongoing addiction and overdose crises in communities of color from the policy discourse. For example, while indigenous communities experienced overdose death rates comparable to that of white communities,³⁶ indigenous people were excluded as victims in media portrayals of the overdose crisis.³⁷ Black communities also have experienced dramatic increases in the rates of overdose deaths involving illicit synthetic fentanyl and cocaine.³⁸ Yet media portrayals continue to brand the current crisis as an “opioid epidemic” primarily impacting white persons.³⁹ Branding the current crisis as a middle-class white opioid crisis has resulted in the exclusion of discourse on increases in methamphetamine-related overdoses in predominantly poor, rural, white communities.

The white-exceptionalism narrative not only deprives minoritized and subordinated populations from benefitting as the intended targets of evidenced-based policy solutions but further subordinates those populations by repeatedly framing persons of color as drug dealers—that is, as deviants driving the crisis and deserving of punishment.⁴⁰ In fact, analysis of the current overdose-crisis framing demonstrates the sustained othering of racial minorities as drug traffickers responsible for importing heroin into white communities.⁴¹

Immediately after the enactment of CARA in 2016, Senator Robert Portman (R-OH) boldly proclaimed, “[t]his is . . . the first time that we’ve treated addiction like the disease that it is, which will help put an end to the stigma that has surrounded

[<http://perma.cc/ZU2A-REV3>] (declaring that “[w]e can’t arrest our way out of the #OpioidEpidemic” and that “[d]rug addiction is a disease, not a crime”).

34. See El-Sabawi (2018), *supra* note 4, at 1390–92.

35. Julie Netherland & Helena Hansen, *White Opioids: Pharmaceutical Race and the War on Drugs that Wasn’t*, 12 *BIOsocieties* 217, 218 (2017).

36. Robin T. Tipps, Gregory T. Buzzard & John A. McDougall, *The Opioid Epidemic in Indian Country*, 46 *J. LAW., MED., & ETHICS* 422, 422 (2018).

37. Mendoza et al., *supra* note 20, at 243.

38. Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 *J. LAW., MED., & ETHICS* 404, 404 (2018).

39. *Id.*

40. See Mendoza et al., *supra* note 20, at 244.

41. *Id.* at 244.

addiction for too long.”⁴² We disagree. In this Essay, we contend that the use of causal narratives that (1) characterize addiction as a health issue for middle-class white persons and (2) blame prescribers, pharmaceutical dispensers, and drug manufacturers for drug use disorder dates back at least one hundred years. We also demonstrate that this exceptional narrative has historically been deployed alongside parallel causal narratives of deviance, which define addiction and recreational drug use among persons of color as evidence of flawed moral character and not symptomatic of a medical condition. In sum, the middle-class white exceptionalism that others have highlighted as framing the current overdose crisis’s causal stories serves not as evidence of the end of the Old Drug War but as one of the ongoing Drug War’s key defining features.

CAUSAL NARRATIVES AND THE WAR ON DRUGS

The War on Drugs has historically targeted immigrants, Black people, people of color, and the economically disadvantaged,⁴³ framing those people as criminals⁴⁴ and the drugs that they are associated with as prohibitively dangerous.⁴⁵ The Drug War rhetoric accomplishes this while simultaneously advancing the causal narrative that white middle-class addiction is a health problem.⁴⁶ Such narrative distinction has existed for nearly a century and is evidenced in the country’s very first documented opiate crisis in the mid-1800s to early 1900s.

By the mid-1800s, the use of opiates to treat common ailments was widespread among white Americans,⁴⁷ including white women, physicians, pharmacists, and Civil

42. Press Release, Senator Robert Portman, *supra* note 27.

43. See Marc Mauer, *The Changing Racial Dynamics of the War on Drugs*, SENT’G PROJECT 1–2 (Apr. 2009), <http://www.sentencingproject.org/wp-content/uploads/2016/01/The-Changing-Racial-Dynamics-of-the-War-on-Drugs.pdf> [<http://perma.cc/7GD6-FSZL>] (reporting that “[t]he increase in incarceration for drug offenses has been fueled by sharply escalated law enforcement targeting of drug law violations, often accompanied by enhanced penalties for such offenses” and “police agencies have frequently targeted drug law violations in low-income communities of color for enforcement operations, while substance abuse in communities with substantial resources is more likely to be addressed as a family or public health problem”).

44. See Cigdem V. Sirin, *From Nixon’s War on Drugs to Obama’s Drug Policies Today: Presidential Progress in Addressing Racial Injustices and Disparities*, 18 RACE, GENDER & CLASS 82, 84 (2011) (“Since the launch of the campaign for the war on drugs, public opinion in the U.S. has been largely shaped by news stories from popular media and reports from law enforcement agencies that depict certain minority groups as being associated with the use, transportation, distribution, and sale of illicit drugs and thus responsible for the country’s ‘drug problem.’”).

45. There is a long history in the United States of criminalizing drugs based on their association with minoritized or economically disadvantaged populations rather than on those substances’ chemical profiles or addictive properties. El-Sabawi (2018), *supra* note 4, at 1388–92.

46. See *id.* at 1390–92; see also Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL’Y REV. 257, 261 (2009) (“Race has been and remains inextricably involved in drug law enforcement, shaping the public perception of and response to the drug problem.”).

47. See James Nevius, *The Strange History of Opiates in America: From Morphine for Kids to Heroin for Soldiers*, GUARDIAN (Mar. 15, 2016), <http://www.theguardian.com/commentisfree/2016/mar/15/long-opiate-use-history-america-latest-epidemic> [<http://perma.cc/MBQ2-5VWY>] (“America’s burgeoning opiate problem is a tragedy, but it shouldn’t come as a surprise: it stretches back to the arrival of the Mayflower in 1620.”).

War veterans.⁴⁸ Opium products were unregulated and readily available for purchase over the counter.⁴⁹ Moreover, morphine was used widely by physicians to treat various physical and mental conditions and was frequently prescribed to middle-class white women in the southern United States.⁵⁰ Early on, the addictive properties of opiate products were unknown, or at least not widely acknowledged.⁵¹ Iatrogenic opioid physical dependence or addiction in patients developed due to unawareness.⁵² While morphine was likely overprescribed and over-the-counter medications containing opium were likely overconsumed in the late nineteenth century, those opiate products certainly have medicinal value and provided much-needed pain relief during harsh times.⁵³

Because there were very few—if any—effective medications or medical interventions at the time,⁵⁴ morphine and opium elixirs continued to be popular among medical providers even after providers acknowledged they might be “habit-forming.”⁵⁵ Doctors argued that physical dependence and addiction were side effects of the medication and, therefore, should be medically managed by the prescribing physician.⁵⁶ Until the early 1900s, doctors prevailed on that position.⁵⁷ As the number of white

48. Oliva, *Dosing Discrimination*, *supra* note 17, at 55 (“The prototypical opioid aficionado in the middle-to-late 1800s was a middle-class, middle-aged, White woman. The men who tended to habitually indulge in opiates during that period were White physicians, dentists, pharmacists, and Civil War veterans. These White Americans, who usually obtained their opioids from physicians or pharmacists, preferred specific opioid delivery systems: they ingested their opium, usually as an ingredient in a medicinal tincture, and injected their morphine with a hypodermic syringe.” (footnotes omitted)); *see also* Editorial, *An Opioid Crisis Foretold*, N.Y. TIMES (Apr. 21, 2018) [hereinafter *An Opioid Crisis Foretold*], <http://www.nytimes.com/2018/04/21/opinion/an-opioid-crisis-foretold.html> [<http://perma.cc/BVH7-QUV8>] (“In the 19th century, like today, the medical community was largely responsible for the epidemic. . . . In addition to getting homemakers, Civil War veterans and others addicted, many doctors [developed opioid use disorder] themselves.”).

49. *See* Sarah Brady Siff, *Burn, Sell, or Drive: Forfeiture in the History of Drug Law Enforcement*, 80 OHIO STATE L. J. 859, 862 (2019) (explaining that “opium in various forms had been available in apothecaries’ shops and among general merchandise since colonial times”).

50. *See* David T. Courtwright, *The Hidden Epidemic: Opiate Addiction and Cocaine Use in the South, 1860-1920*, 49 J. S. HIST. 57–72 (1983) [hereinafter Courtwright, *Hidden Epidemic*].

51. *An Opioid Crisis Foretold*, *supra* note 48 (“In the 19th century, like today, the medical community was largely responsible for the epidemic. Doctors did not fully appreciate the risks [opioids] posed.”).

52. Physical dependence is a side effect of some drugs that causes patients to suffer physical symptoms when those drugs are withdrawn without proper tapering. *Is There a Difference Between Physical Dependence and Addiction?*, NAT’L INST. ON DRUG ABUSE, <http://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/there-difference-between-physical-dependence-addiction> [<http://perma.cc/99LF-R5BU>] (last visited May 1, 2022). This is different from addiction, which is a psychological phenomenon characterized by increased use of drugs despite escalating harmful consequences of drug use. *Id.* Moreover, addiction differs from “substance use disorder,” which is a medical diagnosis accompanied by specific criteria. *Substance-Related Disorders*, DREXEL UNIV. COLL. OF MED., http://webcampus.med.drexel.edu/nida/module_2/content/5_0_AbuseOrDependence.htm [<http://perma.cc/D9BK-GK58>] (last visited May 1, 2022).

53. *An Opioid Crisis Foretold*, *supra* note 48 (“In the 1800s, many doctors viewed morphine as a wonder drug for pain, diarrhea, nerves and alcoholism.”).

54. *See* COURTWRIGHT, DARK PARADISE, *supra* note 3, at 43–53.

55. El-Sabawi (2018), *supra* note 4, at 1388–97.

56. *See id.*

57. *See id.*

patients addicted to morphine escalated and as the fervor of the temperance movement gained steam, the policy discourse embraced white opiate addiction as a problem in need of a solution.

Policymakers were faced with deciding whom to blame for causing their opiate-use policy problem. American policy discourse has always favorably portrayed white middle-class women. Indeed, policy framing models predict that causal stories that define policy problems affecting white middle-class women will often shift the problem's causal blame to another population and be crafted in ways that allow for the proposal of policy solutions that benefit the white middle-class.⁵⁸ In line with this longstanding trend, the current overdose crisis was framed as an “opioid crisis” or “opioid epidemic,” characterized by a spike in opioid addiction and overdose deaths caused by the overprescription of addictive yet licit pharmaceutical drugs.⁵⁹ Despite the evidence that the crisis likely stemmed from socioeconomic factors, compounded by untreated pain and a poisoned illicit drug supply, the dominant framing of the opioid crisis as the fault of bad doctors and greedy pharmaceutical companies was so salient that it persists.⁶⁰ Accompanying the causal narratives that blamed prescribers, drug dispensers, and pharmaceutical manufacturers for addiction was the framing of drug misuse as a chronic medical disease that required treatment and not criminalization.⁶¹

Much like the popular policy narratives that define the current drug crisis, the morphine addiction narrative adopted by policymakers in the late 1800s framed middle-class white American morphine misuse as a health problem.⁶² And much like the current crisis, nineteenth-century policymakers blamed doctors, pharmacists, and drug manufacturers for the widespread addiction to medicinal drugs due to mass marketing and liberal prescribing.⁶³ In addition, the policy proposals accompanying those morphine-addiction narratives centered around the increased surveillance, policing, and arrest of prescribers—very much like the proposals in response to the modern-day opioid crisis.⁶⁴ In sum, the medicalization of addiction as a health problem for middle-class whites is an old and reliable causal story that dates back to the country's inaugural Drug War.

It is important to note that, while morphine became heavily regulated in response to the increasing rates of addiction in the early twentieth century, the drug remains

58. Helen Ingram, Ann Schneider & Peter deLeon, *Social Construction and Policy Design*, in THEORIES OF THE POLICY PROCESS 109 (Paul Sabatier ed., 2d ed. 2007).

59. Nabarun Dasgupta, Leo Beletsky & Daniel Ciccarone, *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 182–83 (2018).

60. *Id.* As the prescription opioid drug supply decreased and reports of illicit fentanyl overdoses increased, the narrative has shifted to include an acknowledgment that illicit fentanyl is the dominant factor in the continued rise in overdose deaths. But this narrative nonetheless makes clear that fentanyl had simply become the new drug of choice, refueling an overdose crisis that was caused by the overprescription of nefariously marketed pharmaceutical opioids.

61. Netherland & Hansen, *supra* note 35, at 422.

62. El-Sabawi (2018), *supra* note 4, at 1388–90; Oliva, *Dosing Discrimination*, *supra* note 17, at 53–55.

63. El-Sabawi (2018), *supra* note 4, at 1388–90 (illustrating how physicians were blamed historically for causing mass opiate addiction); El-Sabawi (2019), *supra* note 25, at 383–90 (discussing how current policy narratives blame the doctors for causing the opioid overdose crisis).

64. El-Sabawi (2018), *supra* note 4, at 1388–90; El-Sabawi (2019), *supra* note 25, at 383–90.

available for medicinal use and has never been outlawed.⁶⁵ In contrast, heroin—a medicinal opioid developed in the 1800s that is chemically similar to morphine—remains prohibited from use even in clinical settings in the United States.⁶⁶ In 1898, Bayer began manufacturing heroin, which the German pharmaceutical company marketed as a nonaddictive cure to morphine addiction and a children’s cough treatment.⁶⁷ Unlike morphine, which was associated with iatrogenic addiction and middle-class white persons, heroin use was associated with single, non-white, working-class men who had begun to populate urban areas⁶⁸—that is, a target population viewed as deviant and politically weak. Unsurprisingly, the federal government swiftly banned heroin as a dangerous substance with no medical value.⁶⁹ The mainstream narrative attributed heroin addiction to flawed character rather than viewing it as a health issue.⁷⁰ White exceptionalism did not extend to populations constructed as poor or racialized, even in the early 1900s.⁷¹

Addiction has always been viewed as a symptom of deviant recreational drug use—sinful behavior that demonstrates a lack of moral restraint—in the United States. The medicalization of morphine addiction serves as a case study in middle-class white exceptionalism because it instigated an exception from the dominant narrative that addiction was the natural consequence of flawed moral character for the white middle class. Middle-class white persons were exempted from this dominant causal narrative, whereas persons who were poor, not racialized as white, or immigrants were othered and labeled as deviants. This made it politically feasible to resort to prohibitionist and criminalizing policies as the only appropriate solutions for addressing the drug use of these subordinated groups.

For example, Chinese immigrants engaged in opioid drug use much like their white American counterparts.⁷² Consistent with their culture and unlike white Americans, however, Chinese immigrants preferred to smoke opium rather than ingest or inject the drug.⁷³ The nineteenth century witnessed an influx of Chinese immigrants to the United States due to the opportunities presented by the California gold rush and western railroad

65. 21 C.F.R. § 1308.12(b)(1)(ix) (listing morphine as Schedule II drug under the Federal Controlled Substances Act).

66. See 21 U.S.C. § 812(b)(1)(A).

67. Netherland & Hansen, *supra* note 35, at 223.

68. See David T. Courtwright, *The Roads to H: The Emergence of the American Heroin Complex, 1898–1956*, in ONE HUNDRED YEARS OF HEROIN 3, 7–11 (David F. Musto ed., 2002); see also Jill Jonnes, *Hip To Be High: Heroin and Popular Culture in the Twentieth Century*, in ONE HUNDRED YEARS OF HEROIN 227, 227–28 (David F. Musto ed., 2002).

69. See Act Prohibiting the Importation of Crude Opium for the Purpose of Manufacturing Heroin, Pub. L. No. 68-274, 43 Stat. 657 (1924) (repealed 1970).

70. See Courtwright, *supra* note 68; Jonnes, *supra* note 68.

71. *Id.*; see also Reinerman, *supra* note 3, at 158 (noting that “[a] nationwide scare focusing on opiates and cocaine began in the early 20th century” and, while “[t]hese drugs had been widely used for years, [they] were first criminalized when the addict population began to shift from predominantly white, middle-class, middle-aged women to young, working-class males, African-Americans in particular”).

72. See Siff, *supra* note 49, at 863.

73. See *id.*

expansion projects.⁷⁴ As anti-immigrant sentiment against the Chinese escalated, the western states—and ultimately the federal government—criminalized opium smoking, and the United States thereafter outlawed Chinese immigration.⁷⁵ Meanwhile, opiates in forms predominantly consumed by white Americans remained licit until the early twentieth century.⁷⁶ As sociologist Rebecca Tiger has explained, “[t]he first drug scares in the U.S., which were . . . about opiates, were reflections of thinly veiled anti-Chinese racism in the late 19th and early 20th centuries. Drug prohibition often relies on the image of a demonized racial other whose drug use threatens social stability.”⁷⁷

A late nineteenth-century case involving a Chinese immigrant’s challenge to his conviction for violating an Oregon law prohibiting the sale of opium illustrates the point.⁷⁸ In an 1886 decision upholding that conviction, the federal district court judge characterized the immigrant petitioner as “a subject of the emperor of China.”⁷⁹ He then went on to expressly distinguish Oregon’s treatment of opium (which was outlawed for nonmedicinal purposes) from that of tobacco and alcohol (which were and remain licit, recreational drugs under Oregon law) as follows:

True, we permit the indiscriminate use of alcohol and tobacco, both of which are classed by science as poisons, and doubtless destroy many lives annually. But the people of this country have been accustomed to the manufacture and use of these for many generations. . . . On the other hand, the use of opium, otherwise than as this act allows, as a medicine, has but little, if any, place in the experience or habits of the people of this country, save among a few aliens. Smoking opium is not our vice, and therefore it may be that this legislation proceeds more from a desire to vex and annoy the “Heathen Chinese” in this respect, than to protect the people from the evil habit.⁸⁰

Historically, causal narratives describing Black American drug use similarly attributed the policy problem to the deviant nature of the drug user and drug seller⁸¹ and

74. See generally Qian Guo, *Chinese Immigration During the 1800s in the United States*, 3 J. CONTEMP. ED. RES. 50 (2019).

75. DAVID F. MUSTO, *THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL* 3 (3d ed. 1999) (“Weighing heavily against [opium smoking] was its symbolic association since mid-century with the Chinese, who were actively persecuted, especially on the West Coast. By then they were almost totally excluded from immigrating into the United States.”); Patrick McCaffrey, *Drug War Origins: How American Opium Politics Led to the Establishment of International Narcotics Prohibition* (May 2019) (Master’s Thesis, Harvard Extension School); Oliva, *Dosing Discrimination*, *supra* note 17, at 55–56 (“Motivated by anti-Chinese hysteria, San Francisco passed the country’s first anti-drug law, the Opium Den Ordinance, in 1875. Numerous other Western states enacted laws in the late 1800s prohibiting the sale and distribution of opium smoking. This ‘virulent anti-Chinese movement’ provoked Congress to pass the Chinese Exclusion Act of 1882, which barred Chinese laborers from entering the country.”).

76. See Oliva, *Dosing Discrimination*, *supra* note 17, at 56.

77. Rebecca Tiger, *Race, Class, and the Framing of Drug Epidemics*, 16 CONTEXTS 46, 48 (2017); see also Reinerman, *supra* note 3, at 157 (“Whatever the hazards of opium smoking, its initial criminalization in San Francisco [in 1875] had to do with both a general context of recession, class conflict, and racism, and with specific local interests in the control of vice and the prevention of miscegenation.”).

78. *Ex parte Yung Jon*, 28 F. 308, 309 (D. Or. 1886).

79. *Id.* at 309.

80. *Id.* at 311–12.

81. Kenneth B. Nunn, *Crime and the Pool of Surplus Criminality: Or Why the “War On Drugs” Was a “War on Blacks,”* 6 J. GENDER RACE & JUST. 381, 382 (2002) (“In the minds of the criminal justice system’s

were more likely to portray Black persons as villains who import poisonous drugs into white communities. Certain high-level political actors have purposefully deployed such causal narratives to subordinate and disenfranchise Black persons. One such politician was President Richard Nixon, who remains the American policymaker most associated with the War on Drugs.⁸²

In the early 1970s, President Nixon reinvigorated America's War on Drugs by declaring drugs "public enemy number one," enacting the Controlled Substances Act,⁸³ and creating the U.S. Drug Enforcement Administration.⁸⁴ It was ultimately revealed that the real targets of Nixon's drug war were his political enemies. As senior Nixon administration advisor (and Watergate coconspirator) John Ehrlichman publicly confessed in 1994:

The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course, we did.⁸⁵

In the 1980s, the Reagan administration similarly demonized Black Americans as responsible for the escalating use of "crack" cocaine. However, it was the use of powder cocaine by white Americans, and not "crack" cocaine by Black Americans, that was on the rise at the time.⁸⁶ Moreover, "the number of whites using crack has always exceeded the number of black [people]" who use the drug.⁸⁷ Despite this data, the dominant 1980s policy narrative blamed the crack cocaine crisis on young Black men who purportedly trafficked crack cocaine into the inner cities, resulting in a spillover supply into the white suburbs.⁸⁸ Media portrayals of such threatening, young Black men encouraged policy solutions that criminally targeted Black communities. The federal government enacted the harsh Anti-Drug Abuse Act of 1986,⁸⁹ which created an unjustifiable 100-to-1 incarceration disparity between crack and powder cocaine.⁹⁰ As a result, the possession

managers, planners and workers, drugs are frequently associated with African American citizens and their communities. The criminal justice system shapes its policies and practices according to this perception.").

82. See *id.* at 381 n.1.

83. 21 U.S.C. §§ 801–904.

84. See, e.g., Conor Friedersdorf, *The War on Drugs Turns 40*, ATLANTIC (June 15, 2011), <http://www.theatlantic.com/politics/archive/2011/06/the-war-on-drugs-turns-40/240472> [<http://perma.cc/MK9F-U2GJ>].

85. Dan Baum, *Legalize It All: How To Win the War on Drugs*, HARPER'S MAG. (Apr. 2016), <http://harpers.org/archive/2016/04/legalize-it-all> [<http://perma.cc/M7RT-TSKD>].

86. Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL'Y REV. 257, 262 (2009).

87. *Id.* at 263 n.31.

88. *Id.* at 264.

89. Pub. L. No. 99-570, 100 Stat. 3207 (1986) (codified as 21 U.S.C. § 841) (amended 2010).

90. DEBORAH J. VAGINS & JESSELYN MCCURDY, AM. CIV. LIBERTIES UNION, CRACKS IN THE SYSTEM: 20 YEARS OF THE UNJUST FEDERAL CRACK COCAINE LAW i (2006), <http://www.aclu.org/other/cracks-system-20-years-unjust-federal-crack-cocaine-law> [<http://perma.cc/6Z3Y-D7S9>].

of just 5 grams of crack cocaine triggered the same mandatory minimum sentence as 500 grams of powder cocaine.⁹¹ This is because “Reagan’s anti-drug rhetoric was skillfully designed to tap into deeply held cultural attitudes about people of color and their links to drug use and other illicit behavior.”⁹² And—despite the recent popularity of health-oriented rhetoric to describe the current opioid crisis—racial disparities (worsened by the 1980s crack cocaine campaign) continue to persist.⁹³

Much like the criminalization of opioids and cocaine, the rhetoric of the American war on cannabis stems directly from its propagandized and racialized association with Mexican immigrants and Black Americans.⁹⁴ Policymakers and the popular press blamed escalating deviant behaviors on cannabis consumption, including the “murder, rape, and mayhem among blacks in the South, Mexican Americans in the Southwest, and disfavored white immigrants from laboring classes.”⁹⁵ Cannabis use, for example, was “blamed for the seduction of white girls by black men and for violent crimes committed by these groups.”⁹⁶

Backed by these prejudicial causal stories, southern and western states with large Mexican and Black populations began to criminalize the sale and possession of cannabis—which was popularized as “marijuana” as a racist scare tactic—in 1913.⁹⁷ The federal government followed suit in 1937 on the heels of the release of the infamous drug propaganda film, *Reefer Madness*, which portrayed cannabis users as depraved and murderous.⁹⁸ Moreover, while cannabis was described as the “devil’s weed” and its possession was heavily criminalized when the dominant narrative associated its use with Black and Mexican Americans, the discourse shifted when the white youth became involved.⁹⁹ Due to the unpopular reality that young people faced severe criminal penalties for marijuana possession due to the federal war on Mexican immigrants and Black persons, some states decriminalized personal possession in the late 1970s, bolstered by the narrative that the white youth who used marijuana were the victims of the true perpetrators: “Mexican immigrants,” “gangsters,” and other “racialized pushers.”¹⁰⁰

Fueled by statistics that youth marijuana use had increased in the late 1970s, parent groups doubled down on the causal narratives that blamed Mexican immigrants and

91. *Id.*

92. Nunn, *supra* note 81, at 390–91.

93. EQUAL JUST. INITIATIVE, *Racial Double Standard in Drug Laws Persists Today* (Dec. 9, 2019), <http://eji.org/news/racial-double-standard-in-drug-laws-persists-today> [<http://perma.cc/8N22-CU73>].

94. Steven W. Bender, *The Colors of Cannabis: Race and Marijuana*, 50 U.C. DAVIS L. REV. 689, 690 (2016).

95. Steven W. Bender, *Joint Reform?: The Interplay of State, Federal, and Hemispheric Regulation of Recreational Marijuana and the Failed War on Drugs*, 6 ALB. GOV’T L. REV. 359, 362 (2013).

96. *Id.*

97. *Id.*

98. *Id.* at 363.

99. See Matthew D. Lassiter, *Impossible Criminals: The Suburban Imperatives of America’s War on Drugs*, 102 J. AM. HIST. 126, 126–40 (2015).

100. *Id.* at 128–30 (“In postwar Los Angeles, local media and law enforcement blamed ‘Mexican pushers’ for the narcotics trade and perpetuated exaggerated stories of Mexican American ‘juvenile gangsters’ invading white suburbs to provide marijuana and heroin to teenagers.”).

Black people for flooding their neighborhoods with the “devil’s weed.”¹⁰¹ Such narratives placed additional pressure on policymakers to enact policy solutions that targeted communities of color. In addition, the popularized portrayal of a white youth marijuana crisis persisted, notwithstanding the argument advanced by substance use treatment providers that the real drug crisis involved escalating heroin overdose deaths that primarily affected Black communities.¹⁰² Expert pleas for help for the Black victims of heroin misuse, in fact, fell on deaf ears. Just as the dominant, white-centric narratives of the current drug crisis have obfuscated overdoses in communities of color, the white exceptionalism propagated by the dominant 1970s and 1980s causal narratives provided cover for policymakers as they ignored a severe heroin overdose crisis that disparately impacted Black communities.

CONCLUSION

One longstanding and defining feature of the American War on Drugs is white middle-class exceptionalism. As one researcher explains:

From the Chinese Exclusion Act of 1882, which drew on societal attitudes linking Chinese immigrants with opium, to the prohibition of marijuana in the 1930s with the support of racist campaigns associating the drug with “dangerous” Mexican immigrants, the scapegoating of [people of color] for drug use and trafficking has long been a feature of U.S. policymaking.¹⁰³

This Essay contends that the shift in rhetoric associated with the modern overdose crisis represents a classic case of white middle-class exceptionalism: a longstanding staple of the War on Drugs that demonstrates the Drug War’s retrenchment rather than its demise. This exceptionalism defines addiction as a public health issue when middle-class white persons are perceived as the primarily impacted population. It simultaneously advocates for enhanced surveillance, punishment, and incarceration of Black persons, other racially and ethnically minoritized groups, and socioeconomically disadvantaged individuals, which it constructs as the culprits.

The War on Drugs has always been a classist and racist war that defines addiction as a sinful and deviant behavior when associated with racially minoritized and economically disadvantaged groups. While the effort to frame overdose deaths as a public health problem may indeed increase the likelihood that subordinated groups will experience improved access to lifesaving medications and treatments alongside their white counterparts, the War on Drugs continues as it has for more than a century. It remains unclear whether such health framing of substance use disorder and overdose will continue if the impacted population is no longer perceived as predominantly middle class and white.

101. See El-Sabawi (2018), *supra* note 4, at 1380–82, 1385.

102. See *id.*

103. Tosh, *supra* note 5, at 102847.