Criminalization and Drug "Wars" or Medicalization and Health "Epidemics": How Race, Class, and Neoliberal Politics Influence Drug Laws

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Dollar, C.B. (2018). Criminalization and Drug 'Wars' or Medicalization and Health 'Epidemics': How Race, Class, and Neoliberal Politics Influence Drug Laws. *Critical Criminology*. doi: 10.1007/s10612-018-9398-7

Abstract:

This essay argues that race and class influence drug laws through politicized means. Crack-cocaine and methamphetamine production, sales, and use were met with criminalizing efforts because of their respective association with African Americans and poor Whites, two groups that have been differentially identified as threatening to hegemonic power. Despite some similarities in criminalizing outcomes, specific reactions differed. Crack-cocaine's publicized connection to violence resulted in extensive surveillance, arrest, and imprisonment. Attention surrounding methamphetamine, however, often linked the drug to safety hazards, including property explosions, physical distortions of users, and the pathology of un(der)employment. As a result, policing the methamphetamine problem increased detentions but not to the same extent as crack-cocaine. I contend that the current opioid "epidemic" has received more medicalized reactions due to opiate's association to middle- and upper-class Whites—social groups that are traditionally protected. I conclude by proposing that despite nuanced and unique consequences of criminalizing and medicalizing responses, each reflects a neoliberalist agenda that seeks to diffuse social threat and reinforce prevailing inequalities.

Keywords: Drug laws | Criminalization | Class | Politics | Race | Inequalities | Crack-cocaine | Methamphetamine | Opioids

Article:

Introduction

Despite the rhetoric of equal justice, the American justice system operates with persistent and pervasive inequalities. Research clearly concludes that persons who are economically disadvantaged are more likely to be scrutinized, arrested, prosecuted, and incarcerated as compared to those with greater socio-economic advantage. Much of this research examines the relative reactions to racial-ethnic minorities by criminal control institutions and concludes that minorities, especially African-Americans, receive more punitive treatment than Whites throughout criminal "justice" processes (e.g., Crutchfield et al. 2009; Chiricos and

Crawford 1995; Crawford et al. 1998; Morris 1988; Mauer 1999; Petersilia 1983; Ray and Dollar 2015; Spohn et al. 1982; Steffensmeier et al. 1998).

It can be difficult to disentangle race-class relationships. The legacy of slavery and other forms of race-based exclusionary practices has severely limited the amount of intergenerational wealth and social power of African Americans and other racial-ethnic minorities (Hamilton and Darity 2009; Massey and Denton 1993; Taylor et al. 2011). Yet, historically speaking, Whites living in relatively poor economic conditions also have been considered economically and politically threatening to hegemonic power (e.g., Cox 1959; Parkin 1979; Domhoff 1967; Wright 2009). Structural economic trends, including the advent of wage labor, the subsequent deindustrialization of the U.S. economy, and the growth in and mobility of specialized, technological jobs has resulted in increased proportions of people struggling with un(der)employment, poverty, and socio-political isolation across all races and ethnicities (e.g., Massey 2008; Massey and Denton 1993; McCall 2001; Morris et al. 1994; Wilson 1978, 1999). As such, the potential for productive hostility rises (Zweig 2000), encouraging elites to (re)create boundary maintenance strategies.

Discrepancies in the power to legislate certain behaviors as "criminal," "pathological," or "diseased" explain sanctioned responses to drug (mis)use. Indeed, some of the most well-documented instances of discriminatory law making and enforcement surround drug-related issues. Studies consistently reveal that Whites with relatively low education and income are more likely to be arrested, imprisoned, or otherwise punished than their wealthier counterparts for drug-using behavior (e.g., Chambliss 1975; Cole 1999; Pettit and Western 2004; Reiman 1995; Western and Pettit 2010) even though they often receive more lenient treatment than African Americans (Pettit and Western 2004; Welch et al. 1985; Tittle and Curran 1988; Zaw et al. 2016).

Criminalizing drug use is a common way for lawmakers to control and exclude persons who are defined as threatening to an existing social order; however, it is not the only response to drug use that American lawmakers have utilized. Medicalizing "problematic" drug use also has been employed. Identifying which response is used and when reveals significant socio-political decisions about drug use "concerns," including various ways in which drug laws are used to systematically regulate, control or disaffect certain groups of people.

In this essay, I follow the work of prior scholars (e.g., Chitwood et al. 2009; Reinarman 2004; Reinarman and Levine 1997) to argue that socio-political reactions to drug "concerns" largely depend on the social group that is associated with the drug's production, sales and use. Using this framework and employing the intersectional criminological approach advocated by Potter (2015), I review the criminalization efforts related to crack-cocaine and methamphetamine, noting areas of convergence and divergence between the two. Although prior work demonstrates how some drug-related policies limit physical, social, and political mobility of already disenfranchised groups (e.g., Alexander 2012; Beckett 1997; Gusfield 1967; Gottschalk 2016; Helmer 1975; Tonry 1995), the recent opioid "epidemic" provides a largely unexplored contemporary example by which to investigate systemic reactions to drug (mis)use. Stressing the drug-social group association, I discuss existing ties between corporate interests, politics, and the

media to examine current reactions to the opioid "epidemic." While arguing that medicalized responses to this "crisis" are heavily associated with state-sanctioned economic and financial incentives, I also point out the ways in which race, class, and gender underscore national attention on the opioid drug scare. I conclude by arguing that criminalization *and* medicalization processes occur in a broader socio-political context of pervasive hegemonic hierarchies. Specifically, I submit that both political strategies represent a unified neoliberalist agenda. Thus, while criminalization may be more common when drugs are associated with disenfranchised groups, including racial-ethnic minorities and poor whites, and medicalization may be more common when drugs are associated with relatively advantaged whites, each response regulates drug-using behavior and functions to reinforce group polarization to maintain prevailing social arrangement.

The "Crack Attack" and the "Meth Crisis:" Criminalizing Illicit Drug Use

Criminalizing Crack-Cocaine

Socio-historical examinations reveal that the 1909 Opium Exclusion Act, the Harrison Narcotic Tax Act of 1914, and the Marihuana Tax Act of 1937 were largely enacted to minimize White perceptions of racial-ethnic threat (Alexander 2012; Baumohl 1992; Becker 1963; Chambers 2008; Duster 1970; Gusfield 1986; Lusane 1991; Morgan 1978; Musto 1999). Yet laws criminalizing particular drugs or forms of drug use are not isolated to early American history. From 1968 to 1996, Congress passed six major "anti-crime" bills, which were subsequently signed into law (Donziger 1996). Perhaps the most widely discussed drug law of this time is The Anti-Drug Abuse Act of 1986. This law established different imprisonment terms for possession of crack cocaine and powder cocaine. Largely identified as the "100 to 1 Rule," the law, for example, established a 5-year prison sentence for the possession of 5 g of crack-cocaine and the same prison sentence for 500 g of powder cocaine.

Even though crack-cocaine is simply a derivative of powder cocaine, the two were often touted as entirely unique (e.g., Danielian and Reese 1989; Reinarman and Levine 2004; Reeves and Campbell 1994; Reinarman 2006). What is more, laws regulating crack-cocaine use were not passed when use was most prominent. In fact, in the 1970s, emergency room and police documentation reveal that crack-cocaine was commonly used among White middle and upper-class Americans, including investment brokers, professional athletes, and Hollywood stars (Reinarman and Levine 2004, p. 182). In response, Congress passed laws that extended health insurance coverage to drug-related treatment.

During the 1980 "crack attack," however, crack-cocaine use, production, and sales were predominantly associated with poor, minority neighborhoods and residents within those neighborhoods (Boggess and Bound 1997). Political dialogue, disseminated through various media outlets, depicted crack-cocaine as highly addictive and linked to extensive violent crime (Coyle 2002; Stuart 2008). Although scholarly attention largely focuses on the class-race differences in laws criminalizing cocaine use, politicized dangerousness of crack-cocaine was simultaneously gendered. While [poor] men of color were often deemed vicious, weapon-carrying threats to social order and convention, women of color, especially poor Black women,

were depicted as irresponsible, hypersexual, and reliant on on social welfare. Stories of "crack mothers" and "crack babies" proliferated, which resulted in cooperative efforts between medical and legal actors who criminally prosecuted women of color using or assumed to be using drugs (i.e., Humphries 1999; also see Maher 1997). These campaigns renewed public attention to long-held, White-informed anxieties about Black criminality but is also systemically extended subjugation to other marginalized minorities, including Latinas, who had begun immigrating at relatively high rates in recent years prior. Such attention bolstered public support for Congress's proposal to pass laws drastically reducing public aid to poor families and increasing raids and policing in poor, minority neighborhoods (e.g., Hartman and Golub 1999; Reinarman 2006; Reinarman and Levine 2004).[1]

Although the U. S. Sentencing Commission warned of potential disparities due to the discrepant depictions and proposed punishments, Congress refused to reevaluate the Anti-Drug Abuse Act. This marked the first time that Congress ever rejected a Sentencing Commission recommendation (Chambers 2008, p. 1). In the years following, the Sentencing Commission's supposition was realized. Taxy, Samuels, and Adams (2015) report that 76% of persons incarcerated for federal drug offenses are Black or Latino. At the state-level, Carson and Golinelli (2013) estimate that Blacks and Latinos convicted of state-level drug crimes make up about 77% of the state prison population. Although the overall racial composition of state prisons has undergone some change (e.g., Mauer 2009), these disproportions are quite stable over time. Indeed, research consistently finds African-Americans are arrested and convicted more often and imprisoned for longer periods for cocaine use and sales (Alexander 2012; Beckett et al. 2006; Blumstein 1995; Duster 1997; Flanagan and Maguire 1990; Haney and Zimbardo 1998; McDonald and Carlson 1993; Tonry 1995) even though their drug use is comparable to or lower than Whites (Beckett et al. 2005; Blumstein 1993; DeFleur 1975; Hartman and Golub 1999; Tonry 1995). Mauer (2011) estimates that one in three African American men and one in six Latinos will be imprisoned at some point in his life. Similar disparities among women, while not as substantial, also are expected (also see Pettit and Western 2004; The Sentencing Project 2013).

Criminalizing Methamphetamines

Amphetamines were available without a prescription until the early 1950s (Maxwell and Brecht 2011; Miller 1997). By 1969, amphetamine use reached a peak, owing largely to the increased prescriptions physicians were dispersing to White middle-class adults for weight loss and psychiatric purposes (Rasmussen 2008a). Drug companies successfully urged Congress to forgo enforcement of pharmaceutical distribution (Smith 1965); thus, legal attention focused on problematic amphetamine diversion and counterfeiting name-brand pharmaceuticals (Graham 1972; King 1972).

Methamphetamine is a synthetically produced derivative of amphetamine (Zorick et al. 2008). Although methamphetamines were originally synthetized in 1965 (Lavigne 1996), combining over-the-counter cold medicines with other chemicals to create methamphetamines became more prominent in the 1980s (Bianchi et al. 2005; Maxwell and Rutkowski 2008). Over the next several years, methamphetamine use increased as did political and public attention about the

drug's dangerousness (Ling et al. 2006; Weisheit and White 2009). Throughout mid-late 1990s, however, national survey data indicate only slight fluctuations in methamphetamine use, yet media accounts often exaggerated and sensationalized methamphetamine use (Tunnell 2006; Weidner 2009; Weisheit and White 2009).

Stories about exploding home-based laboratories used to manufacture methamphetamine were widespread (Chitwood et al. 2009). In addition, photographic images were widely disseminated to reveal the physical injuries of methamphetamine users (i.e., open flesh wounds, disintegrating teeth), most of whom were portrayed as White young adults (Murakawa 2011; Stern 2006).[2] As with crack-cocaine depictions, these racialized images were also classed and gendered. Pictures were used to symbolize the "instability" of white hegemony by illustrating unemployed Whites as menacing and disrupting peaceful, productive rural communities. They also demonstrated a "pollution" of white bodies, which are highly valued in systems of white privilege. The photographs became wildly popular. In fact, Linnemann and Wall (2013, p. 7) point out

> the pain and humiliation of drug use and imprisonment…[became]… commodities…where confinement, human suffering and public humiliation conjures the…amusement of penal spectators… exploiting several intertwined bourgeois anxieties, namely binaries of cleanliness and filth, attractiveness and ugliness, productive and unproductive labor—inclusion and exclusion.

Although women and men were represented in these dramatic photographs, women have been historically held to different standards of beauty than men (e.g., Wolf 1991). Reflecting these differences, billboards titled "extreme meth makeover" more commonly presented images of women, parodies suggesting that methamphetamine could aid in weight control of young, [White] women were disseminated, and commercials about methamphetamine's link to "unwanted sex" featured young, White women being coerced into drug-induced sexual practices. Still, while gender featured prominently in some of these campaigns, media attention of methamphetamine emphasized the determinantal physical attributes of users and producers across sex-gender. It also hyped the destructive effects of surrounding, law-abiding neighbors. As such, this narrative was quite different from the politicized campaigning of crack-cocaine, which centered on drug-related aggression and interpersonal violence in criminogenic neighborhoods.

Like the 1986 Anti-Crime Act, however, the Comprehensive Methamphetamine Control Act (CMCA) of in 1996 was passed at a time when methamphetamine use was slightly fluctuating rather than significantly increasing. Also echoing the disparate conceptualization of crack-cocaine and powder cocaine as two distinct substances, the CMCA focused on limiting illicit methamphetamine production rather than restricting pharmaceutical amphetamines, which were base ingredients for methamphetamine production.[3] Reports reveal that prescribed amphetamine use, such as Adderall, quintupled from 1995 to 2005. In fact, by 2005 the medically-prescribed consumption of amphetamine had exceeded its earlier 1969 peak (Rasmussen 2008b; also see DEA Report 2006). Some raised questions about potential links between the dual pathways of growing (meth)amphetamine use. Police representatives, for example, argued for a need to

regulate pharmaceutical amphetamines, citing that most methamphetamine production relied on access to prescription or over-the-counter drugs (e.g., Engle 2013).

Evidence suggests that pharmaceutical companies were well-aware that their prescribed and over-the-counter cold and allergy products were being used in manufacturing methamphetamine in the 1980s, but not wanting to compromise their profit, drug companies aggressively lobbied against legal regulation of their products (Mehling 2007). In this way, their resistance mirrored the response in the 1960s when amphetamine use peaked. Bills calling for regulation were introduced to Congress but did not make it out of committee, owing largely to the multi-million-dollar contributions to politicians by pharmaceutical companies. Lawsuits filed against drug companies were often settled and met with strict confidentiality agreements that protected the companies from public attention.

Although national surveys indicate that methamphetamine prevalence remained relatively stable between 1999 and 2005 (Johnston et al. 2006; also see annual NSDUH reports), methamphetamine's dangerousness continued to be widely publicized. In 2005, the Combat Methamphetamine Epidemic Act was passed to institute limitations on accessing over-the-counter ephedrine products. Still, law enforcement efforts curtailing methamphetamine manufacturing primarily focused on surveilling poor, rural Whites who were socially marginalized in areas with high un(der)employment rates (Linnemann 2013; Pennell et al. 1999; Reding 2009; Riley 2000). As a result, the number of arrests for methamphetamine production increased. Interestingly, while methamphetamines were portrayed as a rural, poor White issue and some reports support that many arrested for methamphetamine-related issues were poor and White (Mauer 2009), federal data indicate that less than half of those arrested for methamphetamine drugs were White (Taxy et al. 2015).

Comparing Criminalizing Efforts

Crack-cocaine and methamphetamine provide a compelling comparison because of their similar psychopharmacological effects, largely domestic manufacturing, and emphasis on small group or single individual producers. These drug scares occurred about a decade apart, and although the cases of crack-cocaine and methamphetamine both illustrate criminalizing consequences of drug scares, they rely on differential techniques of criminalization to incite political and public panic.

Compared to crack-cocaine, accounts of methamphetamines less commonly indicated users as violent threats to civilians even though methamphetamines may be more robustly associated with violent outcomes (Homer et al. 2008). As mentioned above, publicized discourse on methamphetamine use tended to highlight somatic concerns of the users and "cooks" as well as the safety and well-being of those living in nearby areas. These differences plausibly replicate stereotypes whereby persons of color are often labeled as inherently criminal and in need of direct monitoring and control while Whites are assumed to be fundamentally law-abiding and generally esteemed, although gender differences certainly exist (e.g., Du Bois 1899; Visher 1983). Inciting fears about violent threats illustrates this presumed dangerousness and promotes isolation of racial-ethnic minorities through residential segregation, neighborhood

exclusion, and/or imprisonment (Wacquant 2002). The acceptance of these segregationist practices is apparent in White support of residential homophily and punitive legal strategies.

In contrast, rather than being labeled as inherently threatening or dangerous, poor Whites are often labeled as unconventional and languid, and these characteristics are often inseparable from their drug-using behavior (e.g., Linnemann and Kurtz 2013). As such, poor Whites are viewed as an exception to "normative," economically efficacious Whites. By publicizing bodily damages and geo-social remoteness, socio-political campaigns focused on poor, White drug users as unproductive or unemployable agents, thus designating them as economically threatening. Indeed, the commonly invoked label of "poor, white trash" reflects notions of their presumed uselessness and disposability. Criminalization of drugs associated with this group results in some arrests and imprisonment but not as extensively as the punitive laws targeting racial minorities. In fact, sentences for methamphetamine-related drug crime are significantly less than that of crack-cocaine (Taxy et al. 2015). Perhaps relatedly, Stoops et al. (2005) found that drug court participants who used methamphetamine had less serious criminal records than other drug court participants even though they reported extensive criminal histories. In fact, diversion programs actively sought to enroll methamphetamine users, suggesting that they could be effective in communities with problematic methamphetamine issues (e.g., Huddleston 2005; Marinelli-Casey et al. 2008). These findings suggest that disparaging comments about the methamphetamine users are followed by calls to reinforce the need for industrious participation in conventional labor activities. Such diversion advocacy was not systematically offered to crack-cocaine arrestees.

The Opioid "Epidemic:" Medicalizing Illicit Drug Use

The United States Center of Disease Control (CDC) recently declared an "opioid epidemic." According to the CDC, the number of opioid prescriptions and deaths related to opioid overdose has almost quadrupled since 2000. Opioids, also known as opiates or narcotics, encompass a variety of substances, including illegal drugs like heroin, and legal, prescription-based drugs such as oxycodone, hydrocodone, morphine, fentanyl, codeine, and methadone. Through depressing the central nervous system, opiates are effective pain relievers and are commonly used to reduce tension, anxiety, and aggression (Kuhn et al. 2008). These effects explain both their therapeutic use and misuse potential.

The National Survey of Drug Use and Health (NSDUH), the primary source of drug prevalence in America, consistently finds that prescription opiates are more frequently misused than illegal opiates. Misuse of prescription opioids has increased in the past several years. For example, a comparison of annual NSDUH data reveals that about 600,000 respondents reported misuse of prescription-based opioids in 1990, but by 2010, well over 2 million respondents reported such misuse. Overdoses have increased alongside increases in misuse. Meldrum (2016) notes that between 2000 and 2014, opioid-related overdoses doubled.

Within the last year, calls to investigate prescription drug abuse and establish preventative and educational efforts proliferate. Opioid misuse was at the center of this attention. In 2016, former President Obama signed The Comprehensive Addiction and Recovery Act into law. This bill

addressed opioid addiction by providing funds to establish health-related support to persons seeking treatment. Immediately after signing the Act, former President Obama (2016) stated

> I have heard from too many families across the country whose lives have been shattered by this [opioid] epidemic… My Administration has been doing everything we can to increase access to treatment, and I'm going to continue fighting to secure the funding families desperately need… to deal with this public health crisis…That's what the American people deserve.

As a result of this national attention, the public's awareness and concern about opioid misuse markedly increased.

Below, I argue that the current opioid scare provides a contemporary example of how drug law enactment and enforcement continue to be socially and politically informed. Consistent with the preceding sections, I submit that the race and class of the drug users and suppliers (i.e., producers and sellers) explain the more medicalized response of the opioid "crisis," especially as compared to the crack-cocaine and methamphetamine "problems" discussed earlier.[4] In addition, I suggest that the collusive, coaligned motives between corporate elites, political leaders, and their joint use of media coverage on drug-related issues elucidate this selected medicalized response.[5] In constructing these arguments, I continue to rely on the work of Reinarman and Levine (1997) and Reinarman (2004, 2006) who argue that repressive drug laws are often endorsed when those with relative power, including corporate and political elites, direct public fear and attention toward social groups or behaviors deemed as threatening.

The Race and Class of Opioid Users

Opioid misuse is largely associated with White, middle-class users. Although it is not uncommon for drugs to be associated with groups who are not the most prevalent users (e.g., see earlier discussions above regarding cocaine), this is not the case with opiates. Opioids are more commonly prescribed to Whites than other racial-ethnic groups (Hausmann et al. 2013; Pletcher et al. 2008). This prescription-based disparity arguably provides Whites with greater access to the drugs, which may explain racialized patterns of misuse. Indeed, survey research consistently reveals that non-Hispanic Whites misuse narcotics more frequently than any other race-ethnicity (Dollar and Ray 2013; Dollar and Hendrix 2015; Harrel and Broman 2009; Simoni-Wastila et al. 2004; also see annual NSDUH reports). Data examining trends in mortality rates further suggest that the unusual increase in mortality rates among middle-life Whites may be attributed to substance misuse deaths (Case and Deaton 2015).

The current opioid "epidemic" is widely framed as a White, middle-class public health issue. McLean (2017), for instance, concludes that this most recent opioid crisis centers on stories depicting opioid misusers as largely White, female, and in need of sympathetic responses, including addiction-related treatments, harm reduction strategies, and public education. Netherland and Hansen (2016) find similar patterns in their analysis of popular press articles on opioid misusers. They reveal that media coverage of prescription opioid misusers centralizes

stories of rural or suburban White victims in need of empathy and treatment and note the use of backstories that humanize misusers as a family and community member. Interestingly, they also expose stories of non-prescription opioids, such as heroin, that often feature urban, non-White illicit drug users deserving of criminal punishment. In other words, racial divides in media presentations of the opioid problem are apparent. While not surprising given the historic legacy of racialization, the media coverage is consequential in encouraging different policy responses for White and non-White opioid users. A divestment of law enforcement is often encouraged when stories depict economically privileged Whites, especially White women, as users; hence, the criminal control system rarely appears as an important deterrent to opioid misuse (McLean 2017). But in stories illustrating non-White heroin users, adherence to punitive efforts is evident (Netherland and Hansen 2016; 2017). Notwithstanding these variations, the contemporary opioid "epidemic" is largely flaunted as a White, middle class issue. Indeed, national reports of opiate misuse substantially focus on relatively prestigious Whites (e.g., CNN 2003; Cohen 2015; Kounang 2017; Schwartz 2012; Seelye 2015; Silverman and Voas 2001; Tough 2001; Ung 2001).

The Race and Class of Opioid Producers and Sellers

The social group that drug (mis)use is associated with is not the only important feature of determining whether a drug will be defined as dangerous, crime-inducing, and in need of legal regulation. The drug *supplier* is an important determinant. Indeed, previous laws criminalizing drug behavior often focus on street-level sellers (Beckett 1997; Beckett et al. 2006; Beckett et al. 2005; Duster 1997; Nunn 2002; Tonry 1995). In explaining the medicalization of opiate misuse, the social characteristics of the supplier are an important consideration. As mentioned earlier, most opiates misused are prescription-based pills. In fact, about 75% of people who report being dependent on opioids began opiate use by taking prescription drugs (Cicero et al. 2014; also see annual NSDUH Reports). Federal and state agencies often imply that those persons who misuse prescription drugs obtain the drugs through forgery, misrepresentation, or illegally buying diverted drugs on the street; however, the NSDUH consistently finds that the large majority—often over 90%—of individuals who report misusing prescriptions obtained the drugs from a physician or from a friend or relative who received the prescription from a physician. Even among persons using illicit opiates, such as heroin, evidence suggests that their dependence frequently started from taking prescription drugs (Cicero et al. 2014; Lankenau et al. 2012). In fact, nearly 80% of heroin users reported using prescription opioids prior to heroin (Jones 2013; Muhuri et al. 2013).

The vast majority of physicians in the United States are White and male. Women comprise far less than half of U.S. physicians and surgeons (Castillo-Page 2010), and African Americans, Latinxs, and Native Americans collectively comprise only 6.4% of all physicians who graduated from traditional U.S. medical schools (Castillo-Page 2006). Research suggests that medical schools are dominated by students from affluent areas and families (e.g., Steven et al. 2016). The lack of professional diversity is likely related to the cost of attendance as well as the assessments required to enter medical school, which involve a review of scholastic achievement and aptitude tests. Research has long-shown that these outcomes are positively associated with financial

resources (e.g., Lareau 2003; Rist 1970; Tilly 1999), and selection interviews likely reveal the same cultural bias shown to favor White males in other industries (e.g., Acker 2006; Kanter 1977; Kirschenmann and Neckerman 1991; Moss and Tilly 2001; Wilson 2010). Once practicing, physicians must maintain costly associations, which provide prestige, but also are a necessary for licensing credentials (Becker et al. 2009). Although some variations by social groups exist, physicians are widely considered trustworthy authorities of our health.[6] In short, then, the primary suppliers of the opioids being misused are White, male, financially wealthy, highly educated, and prestigious. Interestingly, however, scholarship revealing physicians as being publicly culpable for the current opioid crisis are often identified as foreign born and/or physicians of color (Netherland and Hansen 2016).

Institutional Coalignment

Physician's access to prescription drugs is maintained by pharmaceutical companies. The pharmaceutical industry is one of the most profitable industries, and thus has great wealth and power (Washington 2011). Pharmaceutical companies entice physicians to supply drugs to their patients through "kickback" incentives, which include massive cash bonuses, paid vacations, and money for research (see Van Zee 2009 for further discussion on pharmaceutical promotion to physicians). In addition, pharmaceutical corporations spend billions of dollars on public advertising each year to market their drugs as safe, helpful, and/or necessary for "normal" functionality. Although the extensiveness of demands is debatable, direct pharmaceutical marketing to the consumer encourages patients to visit their physicians with explicit requests for specific medications (Britten 1995).

Connections between corporate interests, politics, and the media are extensive and multifaceted, resulting in an intricate relationship between profit-motive, electoral politics, and publicly disseminated information. For example, political action groups lobby for certain officials who will benefit them in defining and legislating various elements of social life, including those related to drug use and supply. Physicians are backed by one of the largest and most powerful lobbies in the United States—The American Medical Association's Political Action Committee (AMPAC). The AMPAC contributed $4.2 million in the 2007–2008 election year to support pro-medicine political candidates, and AMPAC claims that 95% of the candidates they supported were elected (see AMPAC 2010). Although the reliability of the percentage of electoral wins is questionable, the money contributed to elected officials plausibly gives the medical industry significant power in lobbying for laws that benefit their interests.[7]

In addition to the AMPAC, pharmaceutical companies, health insurance companies, and medical facilities contribute a great deal of resources to "regulatory" agencies and political candidates who support pro-medicine interests. For instance, Makinson (1992) reports that within a single year approximately $3 million was contributed from pharmaceutical companies, $2 million was given by medical facilities, and approximately $11 million dollars was contributed by health insurance companies. More recently, Steinbrook (2009) estimates that the "health sector," including pharmaceutical, healthcare product, and insurance companies, spent about a half-billion dollars in annual lobbying contributions to Congress and federal agencies. There is little reason to suspect these contributions have since lessened. Although contributions to political

campaigns are given to encourage elected politicians to represent contributors' interests, contributions likely prevent criminalizing legislation. Indeed, these contributors argue that "by virtue of their specialized forms of knowledge," they can provide guidance to lawmakers about which drugs are most threatening and dangerous to society (Reinarman 2006: 144). Moreover, Abraham (2008) describes how "regulatory" agencies' have become financially dependent on pharmaceutical companies as the agencies rely heavily on fees paid to them by the pharmaceutical industry.

Medicalizing drug use benefits the medical industry. For example, drug maintenance programs supply users with pharmaceuticals (i.e., other drugs) to stave off cravings and withdrawal symptoms from other "illicitly" used drugs. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), over 1400 opiate treatment program centers (OTPs) operate in the United States. The majority of participants in OTPs are White (Netherland and Hansen 2017). Opiate treatment programs must employ physicians and a medical director with state regulated credentials (see CFR 2001), and as mentioned above, physicians are disproportionately socio-economically privileged White males. It is probable that some of the institutions seeking to treat substance use or addiction and the medically trained personnel that manage and operate them include the campaign contributors mentioned earlier. Even if particular facilities or persons are not contributors, they vicariously benefit from pro-medicine special interest groups.

Criminalization and Medicalization as Regulating Threat: An Apparatus of Neoliberal Politics

Criminalization and medicalization have been differentially employed to be sure, but both legislative responses reflect neoliberalist agendas. Criminalizing problems narrows attention to punishing and deterring pathological behavior, and medicalizing problems narrows attention to symptom management and therapeutics. Thus, neither encourage an examination of underlying societal issues. Indeed, drug "wars" and drug "epidemics" distract public attention away from systemic inequalities by scapegoating social problems onto discreet groups of people who manifest certain attributes, behaviors, or conditions.

Neoliberalism is an economic approach that seeks to privatize the economy and limit oversight of corporate behavior. Policies reflecting neoliberalist ideals generally (1) advocate market deregulation, thus increasing private interests and reducing social welfare, and (2) emphasize individual responsibility. Below I review these points in more detail to illustrate the wide-reaching arm of neoliberalism while also revealing their inextricable ties to punitive drug control measures. In fact, criminalizing and medicalizing drug use behaviors have occurred alongside demands for economic deregulation (Beckett 1997; Beckett and Western 2001). To this end, [conservative] politics significantly influence law-based practices.

Market Deregulation and Private Interests

Since the 1970s, a variety of neoliberal policies have been passed but market deregulation has markedly increased since the late 1980s. Since this time, we have witnessed a great transformation of law and policy that seeks to reflect business interests over public interests. Tort reform and sentencing reform are two examples. Arguing that most civil suits filed were

frivolous or unnecessary, politicians began passing tort reform in the 1970s to reduce civil litigation. Tort reform encompasses a variety of civil litigation limitations but most commonly seeks to restrict the ability to file claims and places caps on compensation. As a result of tort reform, for example, cases involving medical malpractice require a signed certification from a medical agent practicing in the same specialty of the defendant before suit can be filed (e.g., see Rule 702 Federal Rules of Evidence). In addition, many states have instituted caps for medical negligence claims. Tort reform limiting the prosecution of medically-related companies and providers for improper care is important given the social context of profit-driven, institutional coalignment (i.e., the medical-industrial complex) discussed in the preceding section.

While tort reform reflected a redefinition of civil responsibility, sentencing reform was simultaneously underway, thus coupling repressive turns in both civil and criminal law. Sentencing reform not only exacerbated punitive responses to existing criminal activity but extended the criminal control system's involvement into new activities considered disruptive. As an example of the former, the 1980s saw an elimination of federal parole and established mandatory minimum sentences. The 1990s also saw a proliferation of tough-on-crime policy implementation, including monetary sanctions, pretrial detention, and habitual offender laws. Examples of the latter most relevant herein include aggressively pursuing private substance use and small-ring distribution as criminal targets. Federal, state, and local funds were significantly increased to implement "street-level" anti-drug enforcement. The result of criminal law reformation was a substantial increase in the imprisonment of persons with "low-level" (i.e., nonviolent, drug-related) offenses who were characterized as troublesome to the existing power structure (Alexander 2012; Beckett 1997; Garland 1990). In fact, in response to overcrowding in Immigration and Naturalization Service (INS) facilities, private prisons grew tremendously throughout the 1980s and 1990s and have since been used to house many persons being held for low-level violations of drug-related state crimes (Davis 2003; Sinden 2003).

Emphasizing Individual Responsibility

The cultural emphasis on individual responsibility is another component of neoliberalism that helps to explain the proliferation of formalized control measures related to drug use (as well as other activities deemed "dangerous"). Individual responsibility is the cornerstone of criminalization, and thus criminalization-or-medicalization models. The significance of individual responsibility in explaining criminal behavior, including drug use, is often invoked to argue that punishment leniency results in the promotion of inadequate familial control, a "criminal" lifestyle, and welfare dependency (Ismaili 2006). Links between political conservativism, rational individualism, and drug-related punitiveness is widely evident in the drug scares reviewed in this paper. For instance, the "Just Say No" campaign, launched in 1986 and arguable responsible for significant increases in imprisonment, encouraged young persons to simply decline drugs offered to them, thus implicating drug consumption as an individual failure and effectively ignoring socio-cultural pressure and other contextual factors related to use. The public ridicule exhibited towards methamphetamine users similarly relied on depictions of users as morally inferior (e.g., Linnemann and Wall 2013), and a recent investigation by Keller and Pearce (2016) highlights how prosecutors, police, and judges in small, predominately-White,

politically conservative counties rely on notions of individualism to explain the unusual imprisonment of persons charged with unlawful opioid sales. They cite one of the elected prosecutors as stating, "I am proud of the fact that we send more people to jail than other counties…That's how we keep it safe here." In short, accentuating individual responsibility means accentuating punitiveness and attenuating social assistance.

Although medicalization efforts may not involve the same degree of culpability for one's drug-using behavior, individual responsibility is nonetheless central to the identification and treatment of illness. Medicalization is often promoted as a "suitable" response once drug misuse reaches "epidemic proportions." As a result, politicized calls to regulate behaviors, including illicit and licit drug use, is exacerbated. Chitwood et al. (2009), in fact, argue that designations of drug epidemics purposefully enhance restrictive penalties. Because epidemics denote widespread prevalence, such calls intend to regulate behaviors among relatively large populations of people *in the name of public health*. The current opioid "crisis" is illustrative of this point. Publicized reports repeatedly emphasize the extensiveness of patient manipulation and overprescribing, and masses of people are urged to seek treatment for their problematic drug use. As a part their treatment regime, individuals are expected to request, adhere to, and comply with certain practices deemed necessary for health promotion. These practices are developed and implemented by legitimated authority figures who are often considered state-sanctioned "experts" (Foucault 1972, 1980). As such, individuals remain controlled by the corporate-driven state's oversight (Wright 2009). Of relevance, the previous "meth problem" saw a similar framing of the wanton consumer. Specifically, attention focused on the unlawful accumulation of chemicals used to manufacture methamphetamine. What is missing from political and public accounts is a consideration to how macro-structural inequalities may promote self-medication as a means of coping with strain well as discussions of instrumental efforts to equalize widespread distribution of resources. As such, existing hierarchies and dominant ideology are left unquestioned. If anything, governance is highlighted as necessary for public health and safety, thus financially benefiting various sectors of control apparatus (i.e. the prison-industrial complex).

Neoliberal Mechanisms of Criminalization and Medicalization

Criminalization and medicalization each involve processes of systemic "othering," and such divisions benefit the reproduction of prevailing hierarchies. Following capitalism, neoliberalism encourages privatization and a lack of corporate accountability, thus the (re)creation of difference, often through distinguishing social groups, minimizes collective dissention or pushback. In fact, if persons or social groups are busy protecting their "own" interests, cohesion and realization of shared interests are less likely. Emphasizing difference, in fact, breeds suspicion and subsequently intensifies calls for more intrusive supervision and restraint of relatively subjugated people and groups (Hall et al. 1978; Marone 2003). Elites' "successful" implementation of systemic othering likely explains the pervasive patterns of fear and panic against certain social groups, especially racial-ethnic minorities and un(der)employed White young adults.

Contentious categorizations do not just occur across social-demographic groups. They also occur across the criminalization and medicalization classifications themselves. Indeed, these different categories allow multiple pathways by which to politicize substance (mis)use. While one pathway may involve deeming drug use as normative, healthy, or responsible as in the case of socially acceptable alcohol consumption or complying with a prescribed pharmaceutical regimen, another pathway involves deeming drug use as pathological, which may result in criminal punishment or being monitored by credentialed medical personnel. Despite these different characterizations, these responses fundamentally underline drug use as an individual-level behavior, not a socially-induced one.

Examining the way in which alcohol was identified as a sin, a crime, and a sickness helps further demonstrate the calculated nature of drug laws. Reflecting a struggle between "native" Protestants and non-native Catholics, consumption of alcohol was deemed a social problem in the late eighteenth century whereby the former believed that alcohol consumption violated temperance movement ideals, such as self-control (Gusfield 1986). Proponents of alcohol prohibition relied on images of immoral, non-Protestant Whites and drunken, violent African Americans to endorse bans of alcohol (Herd 1985, 1991; Reinarman 1994; Sinclair 1962). Capitalizing on an opportunity to expand, white supremacy groups, who traditionally focused their hostility on African Americans, redefined their antagonism towards all ethnic minorities and immigrants (Gordon 2017). Although Prohibition began in 1920, largely passed due to White evangelical American Protestants, the law was repealed in 1933.

During the Great Depression, alcohol misuse underwent a medicalization process. Gusfield (1986) argued that the expectation of alcohol abstinence largely lost favor due to socio-economic changes that promoted the ideals of teamwork and tolerance. However, alcohol was used to cope with social, economic, and psychic losses (Brenner 1973; Elder 1974), so it is not a coincidence that the growth of the "alcoholism as a disease" model started at the time of a national debt calamity. This medicalization process encouraged a strict, individualized focus on *problematic* alcohol use, distracting public attention from the economic structural strain that a majority of citizens were facing. Excessive drinking was no longer a moral dilemma; it was a legitimized, scientific, medical issue. Indeed, the Yale Center for Alcohol Studies and Alcoholics Anonymous were both established in 1935 and advocated alcoholism's disease status in hopes of reorienting local and state policy (e.g., Chafetz and Demone 1962; Norris 1976; Straus 1976).

The medicalization of alcoholism allowed for the concurrent expansion of recreational forms of alcohol consumption. In fact, following the repeal in 1933, cocktail lounges flourished, creating a profitable market place where it was acceptable for men and women to drink together publicly (Blocker 2006). Again, alcohol consumption was considered immoral and criminal when associated with lower status, stigmatized groups, but beginning during the economic depression of the 1930s, it became associated with a large proportion of the White population (many of who used it to cope with socio-economic stressors). Non-coincidentally, "normative" alcohol use became acceptable and even promoted as recreational while alcoholism was discretely developed as a valid, medical issue. The creation and allocation of distinct "types of people" across time periods are evident. Categorical distinctions enable groups to make resource claims against other

groups (Schwalbe et al. 2000), and doing so generally means macro-social arrangements go unchallenged. As such, distinctions and separateness are necessary conditions for distributing and legitimating inequalities.

Contemporary research demonstrates how media coverage and medical attention recursively produce political misappropriation. Socio-historical research indicates collusion between corporate agents, politicians, and media leaders, all of which reify dominant hierarchies of race, class, and gender. For example, Orcutt and Turner (1993) find that journalists exaggerate and falsify drug-related reports due to institutional and organizational pressures shaped by a competitive, profit-driven motive. Their results also indicate that news coverage of drug scares sought to over-emphasize problems among racial minorities in poor communities. Best (2012) reveals how political advocacy for particular diseases influences funding distributions for disease research. She discovers that diseases primarily associated with Blacks and women receive lower levels of advocacy, hence less support for etiological and treatment studies. Others explain how concentrated power interlocking corporate and political officials increases class divisions and inequalities (e.g., Light 2007; Portes and Roberts 2005; Sell 2003). Despite the apparent complicity, debates about how this immersion occurs arise. Some argue that corporate money corrupts elected officials who use existing prejudices to bolster corporate control (Etzioni 1984; Pettigrew 1922); others conclude that privatization hampers a publicly-informed government and encourages public corruption (Murphy 2007; Olson 1982), and still others find that it is lobbying attention itself rather than money that influence representative's voting decisions (Dahl 1967; Langbein 1986; Susman 2008; Wright 1990). In any case, a relatively small number of people profoundly influence voting, policy, and law enactment.

Summary and Conclusions

Fluctuations or rises in drug (mis)use do not necessarily reflect increases of epidemic proportions nor do they require a war. However, the political rhetoric of drug laws helps reveal why certain responses are instituted for certain forms of drug use. As part of this determination, we must examine the various forms and magnitudes by which drug (mis)use is identified and legislated. Previous scholarship concludes that [white] elites use their position of power to manufacture support for law and policy enactment, consequently maintaining a structure of dominance through the enactment of law and policies (Alexander 2012; Domhoff 1983, 1990; Feagin 2001; Massey and Denton 1993; Mills 1956; Persell 1977; Wacquant 2002; Wellman 1992). Drug laws are certainly one way to do that. Drug scares successfully exacerbate race, class, and gender tensions and create further divisions among distinctly identified groups. For instance, Whites report persistent fear and threat of racial-ethnic minorities. Whites across social classes are more likely to advocate harsher punishment for African Americans, and minorities are more likely to be harshly punished as compared to Whites (e.g., Bonilla-Silva 2006; King and Wheelock 2007; Quinney 1975; Tittle and Curran 1988; Ulmer and Johnson 2004).

The present paper discusses the legislative responses of crack-cocaine, methamphetamine, and opiate misuse. I pay particular attention to the generalized race and class of associated users, producers, and sellers to help explain variations across these three types of drug "problems;" however, I also note raced and classed gender differences within them. Despite variations in

magnitude and specific responses, both crack-cocaine and methamphetamine use are criminalized. In the more recent case of opioid misuse, political and public attention calls for widespread medicalized reactions even though some variations across racial categories of users are notable. Such medicalized responses promote their own form of surveillance and control even though the disciplinary quality is unique. Indeed, in the latter case, political and media campaigns often disseminate messages that, in spite of their conventional lifestyles, White, middle-class persons have fallen prey to addictive substances and need medical treatment from trained professional experts. This rhetoric reflects that espoused to promote the medicalization of alcoholism [see Schneider (1978) and Trice and Roman (1972)].

Corporate, political, criminal, and medical systems are intimately linked, resulting in a hegemonic defining of social problems. While some scholarship has discussed ways in which criminalizing racial minorities and/or [white] working-class populations is related to capitalism and conservative politics (e.g., Blalock 1967; Bonger 1969[1916]; Beckett 1997; Quinney 1970; Quinney and Wildeman 1977; Rusche and Kirchheimer 1939; Spitzer 1975; Turk 1976) and some research discusses the racialization, bureaucratization, and/or impersonalization of medicine (Mechanic 1976; Reiman 1980; Ritzer and Walczak 1988; Washington 2008), neoliberalist practices are common in each. The central components of neoliberalism—economic deregulation (and the related convergence of corporate and political interests) and an institutionalized focus on individual responsibility—assure a form of corporatized governing. This form of social organization provides a diversion from, and ultimately an ignorance of, the widespread injurious trends of neoliberalist agendas. Indeed, the drug scares reviewed in this paper occur at a time of massive macro-social change due to industrial transitions, economic recessions, social welfare reductions, or class-raising protests such as the Occupy movement.

Whether explicitly directed or coercively implied, coaligned institutions and their agents circulate patterned messages that demonize or victimize certain groups by naming them as "dangerous," "threatening," or "deserving." Because drug use is often tied to serious crime and other social disorders and it is a behavior that many people have (direct or vicarious) experience with, drugs are often invoked to rally support for "personal safety" and "public health." As such, drug laws become a primary vehicle by which to propagate politico-corporate interests. Once we recognize the subtext of these laws as being about domination, division, and complicity, not only is the meaning of them revealed but so is the consequence. As this becomes visible, we are primed to act towards interrupting our social incapacitation—to break the cycle of our preoccupation with the manufactured antipathy and pain that reifies self-injury. We have yet to appreciate the full potential of our societal well-being. It is time that we reimagine our social world as a place of diplomacy and harmony. In doing so, we not only participate in the praxis of intersectional criminology, but we may find ourselves rejecting the restrictive basis of neoliberalism in favor of the unlimited potential of humanitarianism.

Footnotes

1. The passage of the 100 to 1 Rule mirrors the earlier-passed Harrison Act, which linked cocaine use—then in its powder form—to African Americans and some poor Whites. Science and public media campaigns depicted African Americans as threatening white

society, especially through the rape and coercion of White women, after drinking cocaine-laced cola (Carstairs 2000). The consequence of the Harrison Act was increased lynchings of African Americans, greater voter restrictions, and the passage of laws designed to segregate African Americans from Whites.

2. These accounts were colloquially known as the "This is Your Face on Meth," which reclaimed "This is Your Brain on Drugs" scare tactic commercials used in the 1980s. Chambliss (2001) notes how this imagery equivocated working-class, rural Whites to poor, urban minorities. As such, both of these media campaigns were designed to incite anxiety and terror of illicit drug use among the public in an effort to mobilize support for punitive drug-related policies.
3. Ironically, the CMCA is cited as the reason that smaller, "kitchen" laboratories arose (Chitwood et al. 2009).
4. In the present paper I discuss the opioid crisis as generally encountering more medicalized responses than crack-cocaine and methamphetamine; however, I acknowledge that some areas, groups, and individuals still confront criminal punishment for opioid (mis)use. I discuss some of these patterns in subsequent sections of the paper.
5. Although recognizing similarities in the socio-political consequences of drug "wars" and drug "epidemics," the latter provoke a more medicalized, and thus legitimized and less culpable, response than drug wars. In other words, when drug epidemics are declared, medical monitoring occurs, which requires establishing programs and services designed to treat and resolve drug-related issues. Here, criminal control measures are not primary responses. Instead, treatment and symptom management are emphasized. While I acknowledge medicalization as promoting a form of surveillance and control, I posit it as a process unique to strict punitive, criminalized responses where the criminal control apparatus maintains authority over punishment.
6. For example, African Americans are less likely to consider physicians trustworthy due to historic racism in medical practices (Washington 2008).
7. In addition, individual medical personnel annually contribute approximately $5.5 million to candidates supporting pro-medicine policy (Makinson 1992).

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