American Psychological Association
Society for the Psychological Study of Culture, Ethnicity, and Race
Cultural Diversity and Ethnic Minority Psychology

1099-9809/19/$12.00

2019, Vol. 25, No. 1, 6–11
http://dx.doi.org/10.1037/cdp0000260

Opioid Crisis: Another Mechanism Used to Perpetuate American Racism

Carl L. Hart
Columbia University and New York State Psychiatric Institute

Malakai Z. Hart
Columbia University

Objectives: Recently, driven largely by opioid-related deaths, President Donald Trump proclaimed that the opioid problem was now a national emergency. What looks like a radical shift to a more compassionate drug policy—one that favors treatment over incarceration—has encouraged many to hope that there will be far fewer drug-related arrests and deaths than there were in previous decades. ***Methods and Results:*** We present evidence showing that large numbers of drug-related arrests persist and that racial discrimination is evident in opioid-related arrests. In addition, conventional strategies implemented to address opioid-related deaths have proven inadequate. ***Conclusions:*** We propose solutions grounded in reason and evidence rather than moralism.

Keywords: opioid, racial discrimination, racism, overdose, incarceration

Every Friday evening, with sadness and pride, I (Carl L. Hart) make the hour and a half journey from Columbia University to Sing Sing Correctional Facility to teach a Drugs and Behavior course. It saddens me that my incarcerated students are predominately black. But I deeply admire their enthusiasm and the intellectually aggressive manner with which they engage the subject matter, not least because some of them have a personal stake in the subject. Several are serving time for a drug-related offense, as are hundreds of thousands of other Americans.

Is it possible that the current opioid crisis will help change this situation for the better? "You never let a serious crisis go to waste," Rahm Emanuel, then Obama White House Chief of Staff, once remarked, "and what I mean by that it's an opportunity to do things you think you could not do before." Or will the current crisis make the situation even worse by providing yet another reason to arrest specific Americans at high rates without solving drug-related problems?

The Gentler War on Drugs Isn't New

Recently, driven largely by public perception that many white Americans are experiencing difficulties and even dying from opioid use, Donald Trump proclaimed the opioid problem a national emergency. The president's announcement appeared to consolidate a shift in the way we view certain drug users. They are now patients in need of our help and understanding, rather than criminals deserving scorn and incarceration.

In 2014, the governor of Vermont, Peter Shumlin, devoted his entire State of the State address to the "heroin crisis" and urged his overwhelmingly white electorate to deal with addiction "as a public health crisis, providing treatment and support, rather than simply doling out punishment, claiming victory and moving on to our next conviction" (Shumlin, 2014). Politicians from both parties have echoed these sentiments, which ultimately spurred Congress to pass a multibillion-dollar bipartisan bill aimed at curbing opioid-related problems (H.R.6).

What looks like a radical shift to a more compassionate drug policy—one that favors treatment over incarceration—has encouraged many to hope that there will be far fewer drug-related arrests and deaths than there were in previous decades. We are not to be counted among the optimists.

Do not get us wrong, we support an approach that favors treatment over incarceration, although these are not the only options. Still, it's what we should do, certainly as it relates to dealing with individuals who are struggling with drug addiction.[1] But it is not, historically, what we have done for *all* of our citizens.

Recall the so-called crack cocaine epidemic of the late 1980s. Can you imagine Gov. George Wallace of Alabama urging his voters to view crack use as a health crisis? We think not. Back then, even northern liberals—both black and white—were calling for draconian measures to deal with perceived users and sellers of crack. New York governor. Mario Cuomo lobbied for life sentences for anyone caught selling crack, amounts as little as $50 worth (Schmalz, 1986), while Harlem Congressman Charles Rangel advocated for the deployment of military personnel and equipment to rid cities of the drug (Rangel, 1988). With this as a backdrop, in 1986 and 1988, Congress passed and extended the infamous Anti-Drug Abuse Act (aka crack-powder laws), setting penalties that were 100 times harsher for crack than for powder cocaine convictions.

The perceived user and seller of crack was black, young, and menacing, and public contempt expressed toward this group was

Carl L. Hart, Department of Psychology, Columbia University, and Division on Substance Abuse, New York State Psychiatric Institute; Malakai Z. Hart, Department of Psychology, Columbia University.

Correspondence concerning this article should be addressed to Carl L. Hart, New York State Psychiatric Institute, 1051 Riverside Drive, Unit 120, New York, NY 10032. E-mail: clh42@columbia.edu

[1] The terms "addiction" and "abuse." as they are used throughout this article, conform to the *Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5)* definition of substance use disorder.

intense and visceral. But, in reality the majority of crack users were white (U.S. Department of Health & Human Services, Public Health Service, 1995), and most drug users buy their drugs from dealers within their own racial group (Riley, 1997). By 1992, though, more than 90% of those sentenced under the harsh crack-powder laws were black (United States Sentencing Commission, 2002). They were required to serve a minimum prison sentence of at least five years for small amounts of crack, even if they were first-time offenders.

To the extent that the use of crack among Whites was acknowledged, media reports sympathetically detailed the plight of white middle-class crack users. It was seen as an understandable tool for stressful professional lifestyles. According to this scenario, the users—Wall Street executives, computer programmers and the like—had initially snorted cocaine recreationally after hours but had gradually moved on to smoking the drug during work time. And some developed problematic use.

For Whites who were afflicted with crack addiction, medical experts were quoted extolling the effectiveness of treatment. Any law enforcement perspective was conspicuous by its absence. Public service announcements, geared toward middle-class crack users, encouraged sympathy and not judgment. Sound familiar?

This pattern of racial differentiation—one drug policy for white users and another for black users—followed the format of the heroin crisis beginning in the late 1960s. The face of the heroin addict then in the media was black, destitute and engaged in repetitive petty crimes to feed his or her habit. A popular solution was to lock up these users. New York State's infamous 1973 Rockefeller drug laws exemplified this perspective. This legislation created mandatory minimum prison sentences of 15 years to life for possession of small amounts of heroin or other drugs. More than 90% of those convicted under the Rockefeller laws were black or Latino, even though they represented a minority of drug users (Drucker, 2002).

This punitive approach to black heroin users coincided with a massive expansion of methadone maintenance programs that benefited large number of white "patients," including addicted soldiers returning from the Vietnam War (Schatz, 1971). Even President Richard Nixon praised methadone "as a useful tool in the work of rehabilitating heroin addicts," one that "ought to be available to those who must do this work" (Nixon, 1971).

One key feature of methadone programs that was viewed as a drawback was the requirement that the drug be administered through health clinics or hospitals. This meant that patients had to attend the clinic daily in order to receive the medication. This presented an inconvenience for some patients, especially those with jobs and demanding schedules. Also, the fact that patients were required to stand on line outside the clinic in order to receive the medication was viewed as a form of social shaming, which was stigmatizing. So, in 1971, New York City Mayor John Lindsay picked up their cause pushing for the use of private physicians to distribute methadone to a select group of middle-class and insured patients (Ranzal, 1971).

This characteristically American pattern of cognitive flexibility on drug policy, with harsh penalties for some and sympathetic treatment for others, thus has a long history—one that continues to this day. For psychologists, one particularly troubling aspect of these observations is that this type of differential treatment under drug laws can lead to racial disparities in health outcomes. For example, individuals who are sentenced to prison for violating drug laws experience stressful conditions, poor nutrition, inadequate health care, among other unfavorable circumstances. Once released, these individuals are subjected to restricted socioeconomic opportunities and mobility, which increases the likelihood that they will reside in resourced-poor neighborhoods. Undoubtedly, this situation can have detrimental mental and physical health consequences (Williams, 1999).

Defining Racism

In the United States, the differential response to drug users based on race did not begin with heroin policies in the 1960s. This type of racial discrimination (used here interchangeably with the term "racism") is as American as drug use itself. Before going any further, though, it is important to define racism because so many people have misused and diluted the term that its perniciousness gets lost when communicating, although the impact on its victims can continue to fester for a lifetime. When we use the term here, we simply mean an action(s) that results in disproportionate unjust or unfair treatment of persons from a specific racial group. Intent of the perpetrator is not required. What is required is that the treatment must be unjust or unfair, and that such injustice is disproportionately experienced by at least one racial group. Finally, individuals in positions of authority who fail to take actions to abolish or limit racism after being presented with evidence of its existence can be labeled racists in that specific domain. In other words, one can have black friends and/or loved ones but still be a racist as a result of her knowingly enforcing drug laws in a racially discriminatory manner. "My best friend is black," or "I don't see color" are not antidotes against being a racist.

It's important that the reader understands, too, that we have intentionally avoided use of the term "implicit bias" because it refers to unconscious attitudes that may or may not play a role in the act of racial discrimination. Simply having an implicit bias does not mean that a person will inevitably act on this bias in a racially discriminatory manner; nor does it mean a specific act of racial discrimination was due to implicit bias. Thus, the focus on implicit bias rather than racial discrimination tends to obfuscate the issue and to function as a tool to avoid addressing directly the observable egregious act, especially with regards to drug arrests.

A Brief History of How the United States Responds to "Drug Crises"

In the early years of the twentieth century, cocaine use by white Americans was promoted and celebrated. A range of over-the-counter and pharmaceutical products contained the drug and many prominent individuals openly used it, praised it, and recommended it. Sigmund Freud, perhaps the best-known proponent, endorsed cocaine as a general feel-good tonic and addiction cure. Cocaine use by Blacks, on the other hand, was increasingly condemned. Some of the most egregious myths about cocaine use by black men were that it made them better marksmen, homicidal—even when unprovoked, and rendered them unaffected by .32 caliber bullets. Some southern police forces, as a result, switched to the .38 caliber weapon in order to deal with this mythical, irrational superhuman (Williams, 1914). Between 1898 and 1914, numerous articles appeared exaggerating the association of heinous crimes and co-

caine use by Blacks. In some cases, suspicion of cocaine intoxication by Blacks was reason enough to justify lynchings (New York Times, 1913). Mischaracterizations about black cocaine users coincided with the peak period of lynching and restriction of Black people's civil liberties and rights.

Around this time, the U.S. Congress was debating whether to pass the Harrison Narcotics Tax Act, one of the country's first forays into national drug legislation. This unprecedented law sought to tax and regulate the production, importation and distribution of opium and coca products. Proponents of the law saw it as a strategy to improve strained trade relations with China by demonstrating a commitment to controlling the opium trade. Opponents, mostly from Southern states, viewed it as an intrusion into states' rights and had prevented passage of previous versions.

By 1914, however, the law's proponents had found an important scapegoat in their quest to get it passed: the mythical "negro cocaine fiend," which prominent newspapers, physicians and politicians readily exploited. Indeed, at congressional hearings, "experts" testified that "most of the attacks upon white women of the South are the direct result of a cocaine-crazed Negro brain." When the Harrison Act became law, proponents could thank the South's fear of Blacks for easing its passage. Noted drug-control policy historian David Musto observed that fabrications about Blacks and cocaine served as an important tool to preserve white supremacy (Musto, 1987).

Exploitation of white racial fears also played a crucial role in the de facto criminalization of marijuana in 1937, through the Marijuana Tax Act. Law enforcement types like Harry J. Anslinger, commissioner of the Federal Bureau of Narcotics, routinely connected use of the drug with Blacks and Mexicans while recounting gruesome stories: "[P]olice found a youth . . . With an ax he had killed his father, mother, two brothers, and a sister . . . he had become crazed from smoking marijuana" (Anslinger & Cooper, 1937). These fabrications were widely disseminated, facilitating draconian policies, racial discrimination, and incalculable human misery.

The Current U.S. Response to Opioids: What Works and Doesn't

With this as background, contemporary U.S. drug policy and its enforcement take on a sharper focus. Most opioid users are white. Not only do policymakers recognize this fact, but so too does law enforcement. That is one reason why public officials from those states with the largest numbers of opioid-related deaths have pushed for greater increased amounts of funding for opioid addiction treatment. Some law enforcement agencies now advocate moving beyond the arrest-first approach and are connecting users to treatment and other resources. But this humane approach is only part of the picture.

At the same time, these same officials seem to be ignorant about the fact that most drug sellers are also white. We speculate that this is one reason why many politicians still adroitly make the distinction between drug users and sellers. Consider the remarks of former Maine Governor Paul LePage at Town Hall Form in 2016. LePage was careful to reassure the audience that he was not suggesting stiffer penalties for "people that take drugs" [the White people of Maine]. Instead, he told the large and overwhelmingly white audience that the problem laid with drug traffickers: "These are guys with the name D-Money, Smoothie, Shifty—these types of guys—they come from Connecticut and New York, they come up here, they sell their heroin, they go back home." LePage was not done, "Incidentally, half the time they impregnate a young white girl before they leave, which is a real sad thing because then we have another issue we have to deal with down the road." https://www.cnn.com/videos/us/2016/01/08/maine-governor-paul-lepage-shifty-d-money-drugs-sot.wmtw.

Despite today's political rhetoric attesting to a gentler war on drugs, 1.5 million Americans are arrested for drug-law violations each year; this number has not appreciably changed in nearly 25 years (Federal Bureau of Investigation, 2017). Furthermore, multiple states have passed legislation that enhances penalties for opioid possession and trafficking. In some states, prosecutors have begun leveling murder charges against drug dealers, friends, acquaintances, or anyone suspected of facilitating the acquisition of drugs to someone who died from an overdose. Since 2015, the number of such "murder by overdose" cases has dramatically increased to well over 1,000 (Goldensohn, 2018). Deaths related to fentanyl, a potent synthetic opioid, have been a major driver for these prosecutions.

If past drug law enforcement action is predictive of future behavior, most of those convicted of opioid-related crimes will be black and brown. For example, despite the fact that we now know that the crack-powder laws greatly exaggerated the effects of crack—that is, crack is no more harmful than powder cocaine—and, in 2010, President Obama signed legislation that reduced the sentencing disparity between crack and powder cocaine from 100:1 to 18:1, Blacks still represent more than 80% of those convicted under these laws (United States Sentencing Commission, 2018). Moreover, at the state level, Black people are four times more likely to be arrested for cannabis possession than their white counterparts (Edwards, Bunting, & Garcia, 2013). At the federal level, Latinos represent two thirds of the individuals arrested for cannabis violations. This is despite the fact that Blacks, Latinos, and Whites all use the drug at similar rates and they all tend to purchase the drug from individuals within their racial group.

Recent federal arrest data for opioids are consistent with the above. More than 80% of those convicted of heroin trafficking are black or Latino (United States Sentencing Commission, 2018). As was observed with crack use decades earlier, most heroin users are white (Martins et al., 2017) and they most likely purchase the drug from someone within their own racial group (Riley, 1997). The discretionary nature of drug law enforcement, which continues to focus mostly on black and Latino communities, is basis for racial discrimination in heroin arrests. To put it in blunt terms, this means that the current opioid crisis is but one more mechanism to perpetuate racism.

Perhaps what's even worse is that most "official" proposed solutions to deal with the so-called opioid crisis completely misses the mark, mainly because such approaches are not data driven. For example, the overwhelming majority of opioid users do not become addicts. Less than a third of heroin users (Santiago Rivera, Havens, Parker, & Anthony, 2018) and less one percent of people prescribed opioids for pain will become addicted (Noble et al., 2010). We know that one's chances of becoming addicted increase if s/he is young, unemployed and/or has co-occurring psychiatric disorders. That is why it is critically important for policies to

ensure that people have jobs, affordable housing and access to effective mental health services, rather than exclusively focusing on eliminating drugs from society. If we took this approach the number of people addicted to drugs would be substantially reduced.

The public also seems to be unaware of this fact: for nearly 20 years, the number of Americans who tried heroin for the first time in a particular year has remained between 100,000–200,000 (Substance Abuse and Mental Health Services Administration, 2018). This number translates to about 0.1% of Americans aged 12 and older, which is relatively low compared with cannabis and cocaine, for which the numbers are 2.6 million (1%) and 1 million (0.4%), respectively. Still, the number of new heroin users has not appreciably changed in several years, despite the fact that heroin was banned in 1914. In other words, heroin use specifically, and opioid use in general, isn't going anywhere, whether we, as a society, like it or not. This isn't an endorsement of drug use but rather a realistic appraisal of the empirical evidence with which we, the authors, deal in our continuing efforts to help keep people safe. We urge society to allow data to dictate its actions, not moral or racist impulses.

The major concern with illicit opioid use is the potential for overdose and death. It is certainly possible to die from an overdose of an opioid alone, but this accounts for only about a quarter of the thousands of opioid-related deaths (Substance Abuse and Mental Health Services Administration, 2014). Combining an opioid with another sedative such as alcohol, an antihistamine (like promethazine), or a benzodiazepine (like Xanax or Klonopin) causes many of these deaths. Put another way, people are not dying because of opioids, they are dying because of ignorance. The solution? Public service announcement campaigns warning users about the real potential dangers of these drug combinations need to be clear and greatly expanded.

Now there is an additional opioid that we have been made to fear—fentanyl. Fentanyl produces a heroin-like high but is considerably more potent, meaning that less of the drug is required to produce an effect, including overdose. To make matters worse, according to some media reports, illicit heroin is sometimes adulterated with fentanyl. This, of course, can be problematic, and even fatal, for unsuspecting heroin users who ingest too much of the substance thinking that it's heroin alone.

One simple solution to this problem is to make available free, anonymous drug-purity testing services. It works like this: drug samples can be submitted for testing in order to determine what they actually contain. This information can be given to the user so they can decide whether or not to take a particular drug and how much of it to take. These services already exist in places such as Belgium, Portugal, Spain, and Switzerland, where the first goal is to keep users safe. Sadly, no such options are available in the United States.

In addition, the opioid overdose antidote naloxone should be made more affordable and readily available to opioid users, and their family and friends. Naloxone now comes in multiple forms, including nasal spray, making it easier for family members, friends and caregivers to administer in emergencies, such as an overdose.

The availability of Supervised Drug Consumption Facilities has also been shown to reduce drug-related harms (EMCDDA, 2004; Kerr, Mitra, Kennedy, & McNeil, 2017). These are sanctioned facilities where people who use drugs can take illicitly obtained drugs under medical supervision. From these facilities, clients can obtain sterile drug-using equipment, drug educational materials that help to reduce drug-related harms, health care and related information, treatment referrals, and access to medical staff, among other services. These facilities now exist in multiple countries including Australia, Canada, Denmark, Germany, Luxembourg, Norway, the Netherlands, Spain, and Switzerland. Again, in the United States, they are conspicuously absent.

Another life-saving piece of information that has been absent from discussions of the opioid problem is acetaminophen toxicity. The most recent data from the National Survey on Drug Use and Health shows that just under 500,000 people reported using heroin at least once in the past 30 days (SAMHSA, 2018). This number is substantially lower than the number of individuals who reported use of marijuana, which came to about 26 million, prescription opioids, over 3 million, and cocaine, 2 million, over the same period. Most individuals seeking a heroin-like high use prescription opioids recreationally. On the one hand this is a good thing, because the purity of street heroin is often poor due to adulterants added to increase the quantity of the product. Prescription opioids are usually a higher quality, as they are pharmaceutical-grade. But: Popular prescription medications like Percocet, Vicodin and Tylenol 3 contain a relatively low dose of an opioid in combination with a considerably larger dose of acetaminophen—and excessive acetaminophen exposure is the number one cause of liver damage in the United States. Some users may unwittingly risk liver damage by taking too many of these pills. It seems that a responsible society would inform people not to overdo it on opioids containing acetaminophen because it can be more fatal than the low doses of opioids contained in these formulations.

Patients Are Paying the Price

Negative unintended consequences that stem from our approach to dealing with drugs abound. But the fact that many physicians are unwilling or reluctant to prescribe opioid medications for fear of appearing to run "pill mills" has received insufficient discussion, especially in relation to its impact on racism in medical practice. The barrage of media stories attesting to an epidemic of opioid use has left many with the belief that physicians are too quick to distribute opioid medications to patients. Indeed, occasionally media headlines blare with stories about rogue physicians arrested for "pushing pills," that is, dispensing pain medications indiscriminately for quick cash. There are also periodic stories of cunning patients who "doctor shop," deceiving physicians in order to obtain large amounts of opioid medications. The fact that most physicians want to do the right thing and are judicious in their prescribing of pain medications is frequently omitted from sensational accounts of the "drug pusher doctor." These developments, ultimately, make it more difficult for patients to obtain opioids when medically indicated. Importantly, it has been well documented that physicians are even less likely to prescribe opioids to Blacks than to Whites (Singhal, Tien, & Hsia, 2016). This type of racism contributes to health disparities, which will be further exacerbated by the current alarmist approach in dealing with opioids.

In terms of treating individuals with opioid addiction, well-run agonist maintenance programs (i.e., methadone or buprenorphine), with appropriate adjunctive therapies that address other medical or psychosocial needs of patients with heroin addiction, work to

lessen debilitating symptoms associated with the disorder. Moreover, in a growing number of countries, including Switzerland, The Netherlands, Germany and Denmark, effective opioid treatment may include daily injections of heroin, just as the diabetic may receive daily insulin injections (Khan, Khazaal, Thorens, Zullino, & Uchtenhagen, 2014). Also, like diabetes treatment, heroin administration is only one aspect of the treatment, which includes also addressing the medical and psychosocial issues of the patient. Some of these programs have been running successfully for more than 20 years. Notably these patients hold jobs, pay taxes, and live long, healthy, productive lives. Yet, in the United States, these programs are not even discussed as an academic exercise, let alone as another tool in our armamentarium used to treat opioid addiction. This situation has got to change if we actually care about our citizens and if we take seriously our responsibility to let the evidence dictate our course of action.

Time to Dispense With Anachronistic and Racist Approaches

History has repeatedly shown that enhancing penalties for opioid possession and trafficking is a less than effective strategy to deal with opioid-related deaths (Musto, 1987). In addition, the reimposition by former Attorney General Jeff Sessions of more mandatory minimum prison sentences for drug offenses will result in more black and brown people being locked away. This is not only anachronistic, mean and racist, but it does not address the real concerns associated with opioid misuse as noted above. Nor does this approach help those afflicted with opioid addiction.

Psychologists, as well as other health care professionals, concerned with solving problems associated with opioid use—or any other drug use for that matter—should place greater emphasis on creating more hospitable environments for all of our citizens. They should also call out those who peddle the unrealistic goal of eliminating recreational drugs from society. This goal has proven impossible, is not even desired by most, and invariably leads to rampant racial discrimination and bulging prison populations. Racist enforcement of drug laws should have no place in contemporary society—which means that those who engage in this practice in the guise of dealing with drug crises do not, either.

References

Anslinger, H. J., & C. R. Cooper. (1937). Marijuana: Assassin of youth. *The American Magazine, 124,* 19, 153.

Drucker, E. (2002). Population impact of mass incarceration under New York's Rockefeller drug laws: An analysis of years of life lost. *Journal of Urban Health, 79,* 434–435. http://dx.doi.org/10.1093/jurban/79.3.434

Edwards, E., Bunting, W., & Garcia, L. (2013). The war on marijuana in black and white. American Civil Liberties Union report, June 2013. *National Survey on Drug Use and Health: Summary of National Findings*. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf

EMCDDA (European Monitoring Centre for Drugs and Drug Addiction). (2004). *European report on drug consumption rooms,* EMCDDA thematic paper. Office for Official Publications of the European Communities, Luxembourg.

Federal Bureau of Investigation (FBI). (2017, September 25). Crime in the United States 2016, Uniform Crime Reports. *Uniform Crime Reporting (UCR) Program*. Retrieved from https://ucr.fbi.gov/

Goldensohn, R. (2018, May 25). They shared drugs. Someone died. Does that make them killers? *New York Times*. Retrieved from https://www.nytimes.com/2018/05/25/us/drug-overdose-prosecution-crime.html

Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: Past, present, and future. *Harm Reduction Journal, 14,* 28. http://dx.doi.org/10.1186/s12954-017-0154-1

Khan, R., Khazaal, Y., Thorens, G., Zullino, D., & Uchtenhagen, A. (2014). Understanding Swiss drug policy change and the introduction of heroin maintenance treatment. *European Addiction Research, 20,* 200–207. http://dx.doi.org/10.1159/000357234

Martins, S. S., Sarvet, A., Santaella-Tenorio, J., Saha, T., Grant, B. F., & Hasin, D. S. (2017). Changes in U.S. lifetime heroin use and heroin use disorder: Prevalence from the 2001–2002 to 2012–2013 National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of the American Medical Association Psychiatry, 74,* 445–455. http://dx.doi.org/10.1001/jamapsychiatry.2017.0113

Musto, D. (1987). *The American disease: Origins of narcotic control* (rev. ed.). New York, NY: Oxford University Press.

New York Times. (1913, September 29). 10 dead, 20 hurt in a race riot: Drug-crazed negroes start a reign of terror and defy whole Mississippi town. *New York Times*. Retrieved from https://www.nytimes.com/1913/09/29/archives/10-dead-20-hurt-in-a-race-riot-drugcrazed-negroes-start-a-reign-of.html

Nixon, R. M. (1971, June 17). *Special Message to the Congress on Drug Abuse Prevention and Control*. Retrieved from http://www.presidency.ucsb.edu/ws/?pid=3048

Noble, M., Treadwell, J. R., Tregear, S. J., Coates, V. H., Wiffen, P. J., Akafomo, C., & Schoelles, K. M. (2010). Long-term opioid management for chronic noncancer pain. *Cochrane Database of Systematic Reviews, 20,* CD006605.

Rangel, C. B. (1988, May 17). Legalize drugs? Not on your life. *New York Times*. Retrieved from https://www.nytimes.com/1988/05/17/opinion/legalize-drugs-not-on-your-life.html

Ranzal, E. (1971, March 5). Mayor seeks $9.2 million for methadone. *New York Times*. Retrieved from https://www.nytimes.com/1971/03/05/archives/mayor-seeks-92million-for-methadone.html

Riley, K. J. (1997). *Crack, powder cocaine, and heroin: Drug purchase and use patterns in six U.S. cities*. Report. Retrieved from https://www.ncjrs.gov/pdffiles/167265.pdf

Santiago Rivera, O. J., Havens, J. R., Parker, M. A., & Anthony, J. C. (2018). Risk of heroin dependence in newly incident heroin users. *Journal of the American Medical Association Psychiatry, 75,* 863–864. http://dx.doi.org/10.1001/jamapsychiatry.2018.1214

Schatz, A. (1971, July). The war within: Portraits of Vietnam veterans fighting heroin addiction. *Life Magazine*. Retrieved from http://time.com/3878718/vietnam-veterans-heroin-addiction-treatment-photos/

Schmalz, J. (1986, August 18). Cuomo plan fuels drug laws debate. *New York Times*. Retrieved from http://www.nytimes.com/1986/08/18/nyregion/cuomo-plan-fuels-drug-laws-debate.html?pagewanted=all

Shumlin, P. (2014). *State of the state speech*. Retrieved from http://www.governing.com/topics/politics/gov-vermont-peter-shumlin-state-address.html

Singhal, A., Tien, Y. Y., & Hsia, R. Y. (2016). Racial-ethnic disparities in opioid prescriptions at emergency department visits for conditions commonly associated with prescription drug abuse. *PLoS ONE, 11,* e0159224. http://dx.doi.org/10.1371/journal.pone.0159224.eCollection2016

Substance Abuse and Mental Health Services Administration. (2018). *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables*. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.htm#tab1-1A

Substance Abuse and Mental Health Services Administration. (2014). The DAWN Report. *Benzodiazepines in combination with opioid pain relievers or alcohol: Greater risk of more serious ED cisit outcomes*. Rockville, Maryland. Retrieved from https://www.samhsa.gov/data/sites/

default/files/DAWN-SR192-BenzoCombos-2014/DAWN-SR192-BenzoCombos-2014.pdf

United States Sentencing Commission. (2002, May). *Special Report to the Congress—Cocaine and Federal Sentencing Policy*. Retrieved from https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/200205-rtc-cocaine-sentencing-policy/200205_Cocaine_and_Federal_Sentencing_Policy.pdf

United States Sentencing Commission. (2018). 2013 through 2017 data files, USSCFY13-USSCFY17. Retrieved from https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Crack_Cocaine_FY17.pdf

U.S. Department of Health and Human Services, Public Health Service. (1995). *National household survey on drug abuse, main findings 1993*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Williams, D. R. (1999). Race, socioeconomic status, and health. The added effects of racism and discrimination. *Annals of the New York Academy of Sciences, 896,* 173–188. http://dx.doi.org/10.1111/j.1749-6632.1999.tb08114.x

Williams, E. H. (1914, February 8). Negro cocaine fiends are a new southern menace. *New York Times*. Retrieved from https://www.nytimes.com/1914/02/08/archives/negro-cocaine-fiends-are-a-new-southern-menace-murder-and-insanity.html