THE CONVERSATION CONTINUES: THE JUDICIARY'S EVOLVING ROLE IN PERPETUATING RACIAL DISPARITIES IN ADDICTION TREATMENT

*Sydney Crute**

Language is a powerful means of social control, an idea that resonates deeply with court rhetoric as it relates to race. This Note examines the language courts use when discussing cases related to drug use and addiction. During the crack epidemic, when Black individuals represented the race of the primary drug user and drug dealer, courts relied on racially coded language related to crime and fear. Alternatively, during the opioid epidemic, when White individuals represented the race of the primary drug user, courts relied on more neutral language related to the health and well-being of society. Finally, the language courts recently used in decisions broadly related to drug use and addiction evinces similar patterns as seen in the decisions issued during the crack epidemic. This Note therefore proposes a solution grounded in racial realism and interest convergence to ensure that subsequent court decisions pertaining to addiction will have a less deleterious effect on Black individuals.

* J.D. Candidate, 2026, Fordham University School of Law; B.S. 2019, Boston University. I am immensely grateful to Professor Doni Bloomfield and Alexandra Wildman for their constant guidance and their thoughtful and valuable feedback. I would also like to thank the editors and staff of the *Fordham Law Review* for their insights and diligent editing assistance. Lastly, I would like to thank my parents, Jackie and Joe, my aunt, Sheree, and my friends for their unwavering support and encouragement.

INTRODUCTION

> Whitepeople believed that whatever the manners, under every dark skin was a jungle . . . . The more coloredpeople spent their strength trying to convince them how gentle they were, how clever and loving, how human, the more they used themselves up to persuade whites of something Negroes believed could not be questioned, the deeper and more tangled the jungle grew inside. But it wasn't the jungle blacks brought with them to this place from the other (livable) place. It was the jungle whitefolks planted in them. And it grew. It spread. In, through and after life, it spread until it invaded the whites who had made it . . . . The screaming baboon lived under their own white skin.[1]

Toni Morrison first wrote these words in 1987, embedding them in a fictional story saturated with racism, love, and loss.[2] Although the quote does not pertain to addiction, it is an eerily accurate reflection of America's racialized history of drug use and addiction. And courts and the language used in their decisions represent powerful forces in sustaining this history.[3] During the crack epidemic of the 1980s and 1990s, when Black individuals predominated as the typical crack user, court rhetoric reflected the criminalization of the crack epidemic.[4] However, in the late 1990s and mid-2000s, when White individuals predominated as the typical opioid user, the courts' language paralleled the medicalization of the opioid epidemic.[5] Recently, court decisions related to addiction appear to use language similar to that of the crack cases in the 1980s and 1990s.[6]

In the 1600s, White European settlers "believed that . . . under every dark skin was a jungle."[7] In other words, they believed that individuals with Black skin were uncivilized and inferior to White individuals.[8] This idea first began as a byproduct of colonialism and developed, with striking complexity, in the context of chattel slavery.[9] The understanding that Whites were superior to Blacks progressed to a more discrete hierarchy, vastly exceeding its origins,[10] and insidiously seeping into the cracks and crevices of the American

---

1. TONI MORRISON, BELOVED 234 (1987).
2. *See id.*
3. *See generally* Charles J. Ogletree Jr., *The Burdens of Race in America*, 25 HASTINGS CONST. L.Q. 219 (1998)*; see infra* Part III.A.
4. *See infra* Part III.A.
5. *See infra* Part III.A.
6. *See generally* Carmen Paun, *Everyone's Tough on Drugs Again*, POLITICO (Oct. 27, 2024, 4:00 PM), https://www.politico.com/news/2024/10/27/fentanyl-drugs-elections-00185576 [https://perma.cc/DN94-TQZM]*; see infra* Part III.A.
7. MORRISON, *supra* note 1, at 234; *see infra* Part III.A.
8. *See generally* D. Marvin Jones, *Darkness Made Visible: Law, Metaphor, and the Racial Self*, 82 GEO. L.J. 437 (1993).
9. *See generally Origin of Everything: The Racist Origins of U.S. Law*, PBS (Aug. 6, 2020), https://www.pbs.org/video/the-racist-origins-of-us-law-cn1fni/ [https://perma.cc/9B5E-LJZQ]; *1619, The Economy Slavery Built*, N.Y. TIMES (Aug. 30, 2019), https://www.nytimes.com/2020/01/23/podcasts/1619-podcast.html [https://perma.cc/7A6V-Y7GP].
10. *See Origin of Everything: The Racist Origins of U.S. Law*, *supra* note 9.

infrastructure.[11] One area where these ideologies heavily pooled was the American healthcare system, where such sentiments remain prevalent.[12] One notable example includes addiction.[13]

In the 1980s and 1990s, crack use disproportionately afflicted Black communities.[14] Although medical remedies to treat addiction existed, legislators opted for a more punitive approach.[15] Congress and several presidential administrations waged a "War on Drugs," enacting several tough-on-crime, antidrug laws, and increasing funding to the military and narcotics divisions of the United States government.[16] Courts and prosecutors also provided front line assistance in eradicating drug use, particularly in Black communities.[17] They engaged in an aggressive campaign of convicting and sentencing hundreds of thousands of Black individuals for minor drug use and drug possession charges.[18] Similarly, at this time, a majority of government and medical professionals did not perceive addiction treatment as a necessary or even a useful tool in combating the "War on Drugs."[19]

The opioid epidemic then spread "until it invaded the whites who had made it."[20] In the early 2000s, White individuals began getting sick and dying from drug use at rates higher than those of Black individuals.[21] This time, however, medical professionals spoke up.[22] Addiction was no longer a moral shortcoming; it was a legitimate medical diagnosis otherwise referred

11. *See* MICHELLE ALEXANDER, THE NEW JIM CROW 26 (2010) ("After the death of slavery, the idea of race lived on."); *see also* Deborah Kenn, *Institutionalized, Legal Racism: Housing Segregation and Beyond*, 11 B.U. PUB. INT. L.J. 35, 39–41, 66–70 (2001) (discussing housing and wealth); Alicia R. Jackson, *Inherently Unequal: The Effect of Structural Racism and Bias on K-12 School Discipline*, 88 BROOK. L. REV. 459, 474 (2023) (discussing education); Barbara A. Schwabauer, *The Emmett Till Unsolved Civil Rights Crime Act: The Cold Case of Racism in the Criminal Justice System*, 71 OHIO ST. L.J. 653, 684–88 (2010) (discussing the criminal justice system).

12. *See* HARRIET A. WASHINGTON, MEDICAL APARTHEID 2–7 (2006).

13. *See* Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 J.L. MED. ETHICS 404, 404 (2019); *see also* Jennifer D. Olivia & Taleed El-Sabawi, *The "New" Drug War*, 110 VA. L. REV. 1103, 1119–20 (2024).

14. *See* James & Jordan, *supra* note 13, at 410–11.

15. *See* JOHANN HARI, CHASING THE SCREAM 39–41 (2015).

16. *See* ALEXANDER, *supra* note 11, at 37–58.

17. *See* David E. Smith, *Medicalizing the Opioid Epidemic in the U.S. in the Era of Health Care Reform*, 49 J. PSYCHOACTIVE DRUGS 95, 95–101 (2017), https://psycnet.apa.org/record/2017-24931-002 [https://perma.cc/BJR4-MBHP].

18. *See* ALEXANDER, *supra* note 11, at 47–58.

19. *See* James & Jordan, *supra* note 13, at 416.

20. MORRISON, *supra* note 1, at 234.

21. *See* James & Jordan, *supra* note 13, at 408.

22. *See* Julie Netherland & Helena B. Hansen, *The War on Drugs That Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, CULTURE MED. SOC'Y, Dec. 1, 2017, at 1–6, https://pmc.ncbi.nlm.nih.gov/articles/PMC5121004/ [https://perma.cc/N823-7U4Y]; *see also* German Lopez, *Why Are Black Americans Less Affected by the Opioid Epidemic?: Racism, Probably.*, VOX (Jan. 25, 2016, 11:10 AM), https://www.vox.com/2016/1/25/10826560/opioid-epidemic-race-black [https://perma.cc/EY9D-DAKZ].

to as opioid use disorder.[23] Legislators acted in parallel with medical professionals, straying from criminalizing addiction and leaning toward laws and policies focused on treating opioid use disorder.[24] The focus of court opinions related to drug use shifted from sentencing users and dealers of illicit drugs to punishing the doctors and pharmaceutical companies allegedly responsible for White opioid use and related deaths.[25] Despite this reassignment of fault, Black individuals continued to receive disparate treatment for their opioid use disorders resulting in a higher prevalence of substance use and addiction-related stigma, illness, and death.[26]

In light of rising opioid use and opioid-related death rates among Black individuals, this Note examines how the medicalization of the opioid epidemic was used by courts to shift blame from party to party, detracting from the racist origins of the disease and its continued impact.[27] Part I examines the relevant history of drug use and addiction in America. Part II examines how courts have acted in response to the medicalization of the opioid epidemic over discrete periods of time. Part III proposes that courts and legislators adopt a critical race theory (CRT) framework to better address racial disparities related to addiction. Absent such a solution, America's courts and medical systems risk reigniting a racially disparate epidemic fueled by racism, love, and loss.

I. IS IT A MORAL DILEMMA OR A MEDICAL PROBLEM?: BACKGROUND AND LEGAL HISTORY OF DRUG USE AND ADDICTION IN AMERICA

This part addresses the history of racism and addiction[28] in America. Part I.A discusses different responses to addiction in America and how each response relates to race. Part I.B provides background information on

23. *See* Erin M. Kerrison, *White Claims to Illness and the Race-Based Medicalization of Addiction for Drug-Involved Former Prisoners*, 31 HARV. J. RACIAL & ETHNIC JUST. 105, 113–16 (2015).

24. *See id.*

25. *See infra* Part II.A.

26. *See* James & Jordan, *supra* note 13, at 405–08.

27. *See* Maria R. Khan, Lee Hoff, Luther Elliott, Joy D. Scheidell, John R. Pamplin II, Tarlise N. Townsend, Natalia M. Irvine & Alex S. Bennett, *Racial/Ethnic Disparities in Opioid Overdose Prevention: Comparison of the Naloxone Care Cascade in White, Latinx, and Black People Who Use Opioids in New York City*, 20 HARM REDUCTION J., Feb. 24, 2023, at 1, https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-023-00736-7 [https://perma.cc/L6WC-WDMZ] (explaining that "[d]rug overdose mortality is rising precipitously among Black people who use drugs").

28. To minimize stigma regarding addiction, the National Institute on Drug Abuse (NIDA) recommends the use of person-first language. *See Words Matter—Terms to Use and Avoid When Talking About Addiction*, NIDA (Nov. 29, 2021), https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction [https://perma.cc/F2EK-Z3AB] (defining person-first language as language that separates the individual from the disease by using language such as "person with a substance use disorder," rather than a phrase like "addict"); *see also* Daniel Z. Buchman, Pamela Leece & Aaron Orkin, *The Epidemic as Stigma: The Bioethics of Opioids*, 45 J.L. MED. & ETHICS 607, 608 (2017). The use of any words to the contrary in this Note should be assumed to reflect the language specific to the historical period being discussed.

Critical Race Theory, a doctrine created in response to ongoing racial tensions.

A. Tracking Government, Medical, and Societal Responses to Addiction

Broadly, the unequal treatment of Black individuals is likely attributed to, in part, "enduring racist cultural beliefs and practices."[29] Starting in the 1600s, when White Europeans forced the first enslaved individual onto American soil, race and medicine have operated in tandem to sustain the subordination of Black individuals.[30] And, nearly four hundred years later, medicine continues to act as a vehicle for White Americans to explicitly or implicitly satisfy a nearly impenetrable racial hierarchy.[31] Parts I.A.1, I.A.2, and I.A.3 examine the response of courts and legislators to racialized medical interpretations of addiction from the 1800s to present day.

1. Drugs and Addiction in the 1800s and the Early 1900s

During the 1800s, medical providers commonly used cocaine[32] as a "general tonic" to treat minor ailments and to manage opium, morphine, and alcohol dependence.[33] However, in the 1900s, Congress began regulating narcotics production.[34] In 1906, Congress passed the Pure Food and Drug Act[35] which "required the listing of narcotics . . . on the labels of patent medicines shipped in interstate commerce."[36]

Shortly after the passage of the Pure Food and Drug Act, and at the onset of prohibition, White Southerners noted an increase in crime.[37] In attempts

29. Zinzi D. Bailey, Justin M. Feldman & Mary T. Bassett, *How Structural Racism Works—Racist Policies As a Root Cause of U.S. Racial Health Inequities*, 384 NEW ENG. J. MED. 768, 770 (2020), https://www.nejm.org/doi/full/10.1056/NEJMms2025396 [https://perma.cc/7FX7-GVTD]. For more information on the medical mistreatment of Black individuals, see generally WASHINGTON, *supra* note 12; Ayah Nuriddin, Graham Mooney & Alexandre I. R. White, *Reckoning with Histories of Medical Racism and Violence in the USA*, 396 LANCET 949 (2020).

30. *See* Nuriddin et al., *supra* note 29.

31. W. Michael Byrd & Linda A. Clayton, *Race, Medicine, and Health Care in the United States: A Historical Survey*, J. NAT'L MED. ASS'N, March 2002, at 24S, https://pmc.ncbi.nlm.nih.gov/articles/PMC2593958/pdf/jnma00341-0013.pdf [https://perma.cc/49Y3-QZEJ].

32. Cocaine is not an opioid; it is a "powerfully addictive stimulant." *Commonly Used Drugs Charts*, NIDA (Sept. 19, 2023), https://nida.nih.gov/research-topics/commonly-used-drugs-charts#Heroin [https://perma.cc/4DXZ-989A].

33. Kathleen R. Sandy, *The Discrimination Inherent in America's Drug War: Hidden Racism Revealed by Examining the Hysteria over Crack*, 54 ALA. L. REV. 665, 678 (2003).

34. *See id.*

35. Ch. 3915, 34 Stat. 768 (1906) (repealed 1938).

36. The Pure Food and Drug Act did not make cocaine use illegal, rather it served as the government's attempt to regulate cocaine distribution. *See* Sandy, *supra* note 33, at 678.

37. *See* Edward Huntington Williams, *Negro Cocaine "Fiends" Are a New Southern Menace: Murder and Insanity Increasing Among Lower Class Blacks Because They Have Taken to "Sniffing" Since Deprived of Whisky by Prohibition*, N.Y. TIMES, Feb. 8, 1914, at M12, https://www.nytimes.com/1914/02/08/archives/negro-cocaine-fiends-are-a-new-south

to ease their concerns, White America, particularly White Southerners, blamed these problems on the cocaine use of free Black slaves.[38] White Southerners thus began associating cocaine use with the alleged violent behavior of Black individuals, or as described by the media, "Negro cocaine fiends."[39] They feared that cocaine would cause Black individuals to disregard their purported position in the racial caste and incite a rebellion against White people.[40] As a solution, medical professionals advised imprisoning Black drug users to prevent them from consuming the drug and endangering society.[41]

Building on their new crusade in drug regulation, the U.S. government passed the Harrison Narcotics Act[42] (the "Harrison Act") in 1914.[43] At first, the Harrison Act merely intended to better monitor and restrict cocaine prescriptions.[44] However, in 1918, as fears regarding Black cocaine use grew, Congress repeatedly amended the Harrison Act, creating strict criminal punishments for drug use and possession.[45] Of note, during the passage of the Harrison Act, Congress relied on medical expertise illustrating cocaine as "a potent incentive in driving humbler negroes all over the country to abnormal crimes."[46]

In the 1930s and 1940s, these tough-on-crime, antidrug efforts intensified as the public remained fearful of Black cocaine use.[47] Around the same time,

---

ern-menace-murder-and-insanity.html [https://perma.cc/SVJ8-5WJW] (noting a likely correlation between increased crime rates and cocaine use).

38. *See* Courtney Lauren Anderson, *Opioids Are the New Black*, 69 DEPAUL L. REV. 55, 65–66 (2019).

39. *Id.*; *see* Kimani Paul-Emile, *Making Sense of Drug Regulation: A Theory of Law for Drug Control Policy*, 19 CORNELL J.L. & PUB. POL'Y 691, 713–14 (2010) ("Southern whites, during the early twentieth century, successfully characterized cocaine as a drug that incited criminality, sexual deviance, and defiant behavior in African-Americans.").

40. These ideas were unsubstantiated and pure speculation. *See* Sandy, *supra* note 33, at 687–89. White individuals also believed that cocaine caused Black individuals to develop abnormal physical and intellectual abilities and incentivized them to sexually assault White women. *See id.*; *see also* Shima Baradaran, *Drugs and Violence*, 88 S. CAL. L. REV. 227, 238 (2015).

41. Huntington Williams, *supra* note 37, at M12.

42. Ch. 1, 38 Stat. 785 (1914) (repealed).

43. *See* Richard C. Boldt, *Drug Policy in Context: Rhetoric and Practice in the United States and United Kingdom*, 63 S.C. L. REV. 261, 274 (2010); *see also* Baradaran, *supra* note 40, at 240–41 (explaining that the Harrison Act "became the first piece of legislation validating the fears of violence caused by drugs"); *see also* Richard Dvorak, *Cracking the Code: "De-coding" Colorblind Slurs During the Congressional Crack Cocaine Debates*, 5 MICH. J. RACE & L. 611, 647 (2000) (noting that the "association of cocaine and heroin with Blacks . . . fueled the passage of the Act").

44. *See* Baradaran, *supra* note 40, at 241–42 (explaining that drug convictions increased significantly following the passage of the Harrison Act).

45. *See* Sandy, *supra* note 33, at 680.

46. The same doctor that Congress relied on in the passage of the Harrison Act also warned that "the use of cocaine by the negroes of the South is one of the most elusive and troublesome questions which confront the enforcement of the law." William Spade, Jr., *Beyond the 100:1 Ratio: Towards a Rational Cocaine Sentencing Policy*, 38 ARIZ. L. REV. 1233, 1246–47 (1997).

47. *See* David Herzberg, *Entitled to Addiction?: Pharmaceuticals, Race, and America's First Drug War*, 91 BULL. HIST. MED., no. 3, 2017, at 6; Laura I. Appleman, *Opioids,*

federal officials also came to a perplexing conclusion—"if you arrest a large number of drug dealers, drug dealing [and corresponding use do not] go down."[48] However, they simply glossed over this finding and continued on in the early stages of what was to become a decades-long war.[49]

2. The Criminalization of Crack and Black Bodies

In the 1940s, congressional and societal concern regarding drug sales and use grew.[50] The federal government advertised an assumed link between drugs and violence and pushed states to enact strict drug laws.[51] In particular, during the 1940s, the commissioner of the Federal Bureau of Narcotics, Harry J. Anslinger, initiated public awareness campaigns to warn the public of the dangers associated with drug use.[52] Commissioner Anslinger first targeted Black individuals who used cannabis.[53] He then employed similar tactics to curb cocaine use among Black individuals,[54] contending that "the increase in drug addiction [was] practically 100 percent among Negro people."[55]

In 1951, Congress passed the Boggs Act of 1951,[56] which "increased penalties for drug use by four times and included mandatory penalties."[57] In 1956, President Dwight D. Eisenhower signed the Narcotic Control Act of

Addiction Treatment, and the Long Tail of Eugenics, 80 OHIO ST. L.J. 841, 847–48 (2019); *see also* Ruth Delaney, Ram Subramanian, Alison Shames & Nicholas Turner, *American History, Race and Prison*, VERA, https://www.vera.org/reimagining-prison-web-report/american-history-race-and-prison [https://perma.cc/QE6G-SPC2] (last visited Apr. 2, 2025). In the 1930s, the government also established the Federal Bureau of Narcotics (FBN). *See* Kasey C. Phillips, Note, *Drug War Madness: A Call for Consistency Amidst the Conflict*, 13 CHAP. L. REV. 645, 654–55 (2010). The FBN oversaw the enforcement of federal anti-opiate and anti-cocaine laws. *See id.*; Jennifer E. Cobbina, *Race and Class Differences in Print Media Portrayals of Crack Cocaine and Methamphetamine*, 15 J. CRIM. JUST. & POPULAR CULTURE, no. 2, 2008, at 146–47 (explaining that White individuals' panic over cocaine primarily stemmed from "anticipation of [an] African American rebellion").

48. HARI, *supra* note 15, at 90.

49. At this time, there existed a small minority of doctors that understood opioid dependence strictly as a medical condition. *Id.* at 38–39. However, federal narcotics officials silenced such theories. *Id.*

50. *See* Jennifer D. Oliva, *Dosing Discrimination: Regulating PDMP Risk Scores*, 110 CALIF. L. REV. 27, 58 & n.50 (2022).

51. Baradaran, *supra* note 40, at 243–44.

52. *See* HARI, *supra* note 15, at 26–28.

53. Similar to White Southerners in the 1900s, Anslinger believed that cannabis made Black individuals forget the racial hierarchy and that Black men, specifically, used the drug and developed a "lust for white women." *Id.* at 16–17.

54. *See id.* at 26.

55. *Id.* at 26–27.

56. Pub. L. No. 82-255, 65 Stat. 767.

57. Anderson, *supra* note 38, at 67. Several states also passed Little Boggs Laws that instated mandatory minimums equal to or greater than those at federal levels. *See* David T. Courtwright, *A Century of American Narcotics*, *in* 2 TREATING DRUG PROBLEMS 1, 22 (Dean R. Gerstein & Henrick J. Harwood, eds., 1992), https://www.ncbi.nlm.nih.gov/books/NBK234755/ [https://perma.cc/4MWN-ZJY4].

1956[58] as high rates of minority drug use came to light.[59] The Narcotic Control Act increased penalties for narcotics violations by: (1) limiting a judge's ability to reduce a sentence for a narcotics conviction, (2) increasing the authority of narcotics agents and officers, and (3) requiring all "drug offenders, addicts, and users," to register for a special certificate to leave the United States.[60]

During the 1950s and 1960s, the understanding that cocaine use also ravaged White communities became less discreet.[61] In near parallel with the timing of this realization, the U.S. Supreme Court decided *Robinson v. California*[62] in 1962.[63] In *Robinson*, the appellant challenged a California statute that made it a criminal offense for a person to be addicted to narcotics, arguing that it violated the Eighth Amendment of the U.S. Constitution.[64] The Court reasoned that the statute criminalized a person's status as an individual with a narcotics addiction and held that a state law "which imprisons a person [based on their status of using narcotics]" inflicts a cruel and unusual punishment in violation of the Fourteenth Amendment.[65] Otherwise stated, *Robinson* established that incarcerating an individual on status alone violated the Fourteenth Amendment.[66] Perhaps this holding was enough to detract the public eye from White cocaine use, but public fears regarding Black individuals using and selling drugs lingered.[67]

---

58. Pub. L. No. 84-728, 70 Stat. 567.

59. *See* Phillips, *supra* note 47, at 655; *see also* Courtwright, *supra* note 57, at 17 ("[T]here is no reason to doubt that minorities were using drugs in the 1940s and 1950s in a way they had not been before. Black narcotic arrests . . . were increasing. . . ."); Baradaran, *supra* note 40, at 245–46 ("[G]overnment reports of drugs leading to violent crime and increases in other crime supported harsher drug legislation.").

60. Phillips, *supra* note 47, at 655. As for point three, the individual faced up to three years of imprisonment if they returned without the certificate. *See id.*

61. "After World War II, however, punitive measures aimed at deterring racially marginalized drug-involved men and women decreased as a greater prevalence of white, middle-class Americans began to more frequently partake in illicit drug use." Kerrison, *supra* note 23, at 110; *see* Cobbina, *supra* note 47, at 147 (explaining that during the 1960s and 1970s, cocaine use was "[most] prevalent among middle- and upper-class users").

62. 370 U.S. 660 (1962).

63. *Id.* at 660–62.

64. *See id.*

65. *Id.* at 667 (noting that addiction is an illness that may be contracted innocently or involuntarily, thus "[e]ven one day in prison would be a cruel and unusual punishment for the 'crime' of having a common cold"). *But see* Powell v. Texas, 392 U.S. 514, 533 (1968) (reasoning that *Robinson* does not "deal with the question of whether certain conduct cannot constitutionally be punished because it is, in some sense, 'involuntary' or 'occasioned by compulsion.'")

66. *See Robinson*, 370 U.S. at 667–68. Indeed, the defendant in *Robinson* was Black. *See* Nathan Lewin, *How an Accidental Ruling Led to Homeless Encampments*, WALL ST. J. (Aug. 9, 2024, 2:20 PM), https://www.wsj.com/opinion/how-an-accidental-ruling-led-to-homeless-encampments-law-courts-history-022a7ad6 [https://perma.cc/3Q5A-2KNH]. However, neither Justice John Marshall Harlan nor his law clerks were aware of the defendant's race. *See id.*

67. Specifically, after World War II, some middle-class White individuals believed that Black men were mugging Whites for money to purchase illicit drugs. *See* Courtwright, *supra* note 57, at 17.

In 1966, the United States experienced a brief repose in tough-on-crime laws under President Lyndon B. Johnson's administration.[68] Leaning away from criminalization, Congress enacted the Narcotic Addict Rehabilitation Act of 1966,[69] although the more punitive pieces of legislation from previous administrations remained.[70] Unlike prior narcotics legislation, the Narcotic Addict Rehabilitation Act prioritized treating, rather than punishing, addiction.[71] However, the public continued to fear Black individuals using drugs.[72] For example, in 1968, "81% of those responding to a Gallup Poll agreed with the statement blaming the breakdown of law and order in America on Negros who start riots and Communists."[73]

The punitive sentiments of prior administrations resumed, and the rehabilitative efforts of President Johnson's administration came to a halt when President Richard M. Nixon entered office.[74] In a public statement, President Nixon asserted: "America's public enemy number one in the United States is drug abuse. In order to fight and defeat this enemy, it is necessary to wage a new, all-out offensive."[75] And wage an "all-out offensive" he did.[76] In 1970,[77] Congress enacted the Drug Abuse Prevention

68. The rationale for this shift away from punitive drug policy is not clear. Potential explanations that coincide with the enactment of treatment-centered legislation include: (1) President Johnson's progressive agenda, as opposed to prior and subsequent conservative agendas, (2) an increase in popularity of marijuana among the middle class, (3) a growing movement of liberal support for addiction treatment, and (4) the media's portrayal of drugs. *See Lyndon B. Johnson*, OBAMA WHITE HOUSE, https://obamawhitehouse.archives.gov/1600/presidents/lyndonbjohnson [https://perma.cc/7BPY-HM8Y] (last visited Apr. 2, 2025); Baradaran, *supra* note 40, at 246 (explaining that Americans viewed drugs more favorably in the 1960s because of widespread marijuana use by the middle class); Courtwright, *supra* note 57, at 24 (noting that some liberal commentators "began to question the very moral and political bases of American narcotic policies"); Spade, *supra* note 46, at 1248 (explaining the "Youth" and "Baby Boom" generations' interest in experimenting with drugs and the media's favorable portrayal of drug use).

69. Pub. L. No. 89-793, 80 Stat. 1438.

70. *See id.*

71. *See id.*; *see also* Spade, *supra* note 46, at 1274.

72. *See* Olivia & El-Sabawi, *supra* note 13, at 1118–19. Ultimately the "treatment revolution of the late 1960s and early 1970s has proved to be something of a disappointment." *See* Courtwright, *supra* note 57, at 33.

73. ALEXANDER, *supra* note 11, at 46 (citing THOMES BYRNE EDSALL & MARY D. EDSALL, CHAIN REACTION: THE IMPACT OF RACE, RIGHTS, AND TAXES ON AMERICAN POLITICS 38 (1992)).

74. *Id.*

75. President Richard Nixon, Remarks About an Intensified Program for Drug Abuse Prevention and Control (June 17, 1971), https://prhome.defense.gov/Portals/52/Documents/RFM/Readiness/DDRP/docs/41%20Nixon%20Remarks%20Intensified%20Program%20for%20Drug%20Abuse.pdf [https://perma.cc/K6TB-EFY6]. In 1994, President Nixon's former domestic policy advisor revealed that Nixon's 1968 campaign targeted two demographics: the antiwar left and Black people. *See* Jelani Jefferson Exum, *From Warfare to Welfare: Reconceptualizing Drug Sentencing During the Opioid Crisis*, 67 KAN. L. REV. 941, 945 (2019).

76. Nixon, Remarks About an Intensified Program for Drug Abuse Prevention and Control, *supra* note 75.

77. Also noting that, at this time, illicit drug economies experienced exponential increases. *See* Eloise Dunlap & Bruce D. Johnson, *The Setting for the Crack Era: Macro Forces, Micro Consequences (1960-1992)*, 24 J. PSYCHOACTIVE DRUGS, no. 4, 1992, at 6,

and Control Act.[78] This Act included what is now known as the Controlled Substances Act.[79] The Controlled Substances Act classified all controlled substances, prescription and illicit drugs, "into one of five established Schedules based on a drug's potential for abuse, its recognized medical benefits, and the level of dependency that could result from its abuse."[80] Broadly, the schedule set forth in the Controlled Substances Act detailed: (1) Schedule I drugs[81] as those that have a high potential for abuse and addiction, and are unsafe and are not used in medical treatment; (2) Schedule II drugs[82] as those that have a high potential for abuse and dependence and may be prescribed but pose a significant risk to patient safety; (3) Schedule III drugs[83] as those that have a moderate potential for abuse and are accepted as medical treatment; (4) Schedule IV drugs[84] as those that have a low potential for abuse and are widely accepted as medical treatment; and (5) Schedule V drugs[85] as those that have the lowest potential for abuse (as compared to Schedule I–IV drugs) and are used for medical treatment.[86]

In the 1980s, crack replaced cocaine as the disciplinary focus of the federal government.[87] Crack is a low-cost version of cocaine that can be easily

---

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761228/ [https://perma.cc/M88X-QRXJ]. Individuals were lured by the quick cash of selling illicit street drugs, a financial benefit not as easily attainable from minimum wage jobs. *See id.* at 14.

78. Pub. L. No. 91-513, 84 Stat. 1236 (1970); *see* Phillips, *supra* note 47, at 657–58.

79. 21 U.S.C. §§ 802(34)–802(35), 812, 813; Phillips, *supra* note 47, at 657.

80. Emily J. Yang, *The Opioid Crisis and the Wrongful Conduct Rule: Does It Matter Who's to Blame?*, 75 FOOD & DRUG L.J. 574, 576–77 (2020); *see also* Mariano-Florentino Cuéllar & Keith Humphreys, *The Political Economy of the Opioid Epidemic*, 38 YALE L. & POL'Y REV. 1, 20 (2019) (noting that the U.S. Food and Drug Administration (FDA) and U.S. Drug Enforcement Administration (DEA) were responsible for making pharmacological determinations related to the Controlled Substances Act).

81. Examples include heroin and psychedelic drugs. *See* Nicole R. Ortiz & Charles V. Preuss, *Controlled Substances Act*, STATPEARLS (Feb. 9, 2024), https://www.ncbi.nlm.nih.gov/books/NBK574544/ [https://perma.cc/SN9Y-KY2C].

82. Examples include cocaine, crack, and opioids (e.g., fentanyl, hydromorphone, morphine, oxycodone). *See id*; *see also* DRUG ENF'T AGENCY, COCAINE (Dec. 2019), https://www.deadiversion.usdoj.gov/drug_chem_info/cocaine.pdf [https://perma.cc/TUL6-2NYA].

83. Examples include ketamine and steroids. *See* Ortiz & Preuss, *supra* note 81.

84. Examples include benzodiazepines (e.g., alprazolam, diazepam, clonazepam). *See id.*

85. Examples include cough suppressants containing codeine. *See id.*

86. *See id.*; *see also* ALEXANDER, *supra* note 11, at 54 (emphasizing that racial attitudes heavily governed the public's shared concern surrounding drug use).

87. Previously, cocaine use was highest among affluent White individuals. *See* Sandy, *supra* note 33, at 681; *see also* Eloise Dunlap, Andrew Golub & Bruce D. Johnson, *The Severely-Distressed African American Family in the Crack Era: Empowerment Is Not Enough*, J. SOCIO. & SOC. WELFARE, Oct. 9, 2008, at 5. Crack is effectively the same pharmacological substance as cocaine. Madeline Hodgman-Korth, *Crack vs. Cocaine: What's the Difference Between Crack and Cocaine?*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/stimulants/cocaine/differences-with-crack [https://perma.cc/RM8L-KMCD] (Nov. 10, 2024). Both are highly addictive and may result in overdose or death. *Id.* However, crack is a solid form of cocaine that is often cheaper and smoked rather than inhaled or rubbed on the gums. Caroline Jean Acker, *How Crack Found a Niche in the American Ghetto: The Historical Epidemiology of Drug-Related Harm*, BIOSOCIETIES, April 6, 2010, at 78–79, https://link.springer.com/article/10.1057/biosoc.2009.1 [https://perma.cc/75RQ-DP6Z].

smoked.[88] And because crack was a new drug at the time, as compared to cocaine which had been in circulation for more than two centuries, unsubstantiated theories of its potency, effects, and likely users flourished[89] —a reality resembling prior White Southern fear of Black cocaine use.[90]

President Ronald Reagan amplified the concerns of President Nixon's administration and, in 1982, announced that his administration would engage in another iteration of the "War on Drugs."[91] From 1980 to 1984, President Reagan increased antidrug funding from $8 million to $95 million, while funding for agencies responsible for drug treatment, prevention, and education decreased significantly.[92] In 1986, Congress passed the Anti-Drug Abuse Act of 1986[93] (the "1986 Act") which created mandatory minimum sentences for cocaine offenses (common among White individuals) and penalties that were 100 times harsher for crack charges (common among Black individuals) (the "100:1 ratio")[94]—a differential "deemed excessive" by medical researchers in the mid-1990s given the minimal differences between cocaine and crack.[95] Additionally, the 1986 Act allocated a majority of funds to law enforcement and prisons rather than treatment and prevention efforts.[96]

Legislative history related to the 1986 Act speaks minimally to Congress's rationale in establishing the 100:1 ratio and related sentencing guidelines.[97]

88. *See* Dunlap et al., *supra* note 87, at 5; *see also* ALEXANDER, *supra* note 11, at 51.

89. Sandy, *supra* note 33, at 681.

90. *Id.*; *see* Paul-Emile, *supra* note 39, at 713–14.

91. An effort that "had little to do with public concern about drugs and much to do with public concern about race." ALEXANDER, *supra* note 11, at 49.

92. *Id.*

93. Pub. L. No. 99-570, 100 Stat. 3207 (codified as amended in scattered sections of the U.S. Code).

94. *See* Paul-Emile, *supra* note 39, at 734–36 (2010); *see also* Kenneth B. Nunn, *Race, Crime and the Pool of Surplus Criminality: Or Why the "War on Drugs" Was a "War on Blacks"*, 6 J. GENDER RACE & JUST. 381, 396–98 (2002); David A. Sklansky, *Cocaine, Race, and Equal Protection*, 47 STAN. L. REV. 1283, 1288 (1995) (explaining the difference in crack and cocaine sentencing as the "100:1" ratio). The 1986 Act "created the basic framework of mandatory minimum penalties that currently apply to federal drug trafficking offenses." Spade, *supra* note 46, at 1251. Additionally, the 1986 Act established five-year and ten-year minimum sentences, triggered by "the quantity and type of drug involved in the offense." *Id.*

95. The "physiological and psychoactive effects of cocaine are similar regardless of whether it is in the form of [cocaine] or [crack]." Dorothy K. Hatsukami & Marian W. Fischman, *Crack Cocaine and Cocaine Hydrochloride. Are the Differences Myth or Reality?*, 276 JAMA 1580, 1580 (1996), https://pubmed.ncbi.nlm.nih.gov/8918856/ [https://perma.cc/4E35-R65E]. Accordingly, "the federal sentencing guidelines allowing possession of 100 times more [cocaine] than [crack] to trigger mandatory minimum penalties is . . . excessive." *Id.*

96. *See* Lauren-Brooke Eisen, *The Federal Funding That Fuels Mass Incarceration*, BRENNAN CTR. FOR JUST. (June 7, 2021), https://www.brennancenter.org/our-work/analysis-opinion/federal-funding-fuels-mass-incarceration [https://perma.cc/9W8Z-2PGY]; Charles Rangel, *Our National Drug Policy*, 1 STAN. L. & POL'Y REV. 43, 46 (1989).

97. *See* Spade, *supra* note 46, at 1253; *see also* DEBORAH J. VAGINS & JESSELYN MCCURDY, ACLU, CRACKS IN THE SYSTEM: TWENTY YEARS OF THE UNJUST FEDERAL CRACK COCAINE LAW 2 (2006), https://assets.aclu.org/live/uploads/document/cracksinsystem_20061025.pdf [https://perma.cc/SV6H-4KG9] (explaining that the Senate conducted a single hearing on the 100:1 ratio which only lasted a few hours).

Some records suggest that legislators believed that crack was more potent and thus more addictive and dangerous than powder cocaine, that crack was more likely to result in crime than powder cocaine, and that crack's lower price tag would make it more widely available.[98] Meanwhile, other legislators supported their decisions with racially coded reasoning.[99] For example, legislators explicitly identified crack dealers as Black gang members, while others used more covert language that "aggravated white fears that the crack problem would spread out of the ghettos."[100] Further, there exists no legislative history explaining the particular reason for the 100:1 ratio.[101]

Importantly, crack and cocaine do not exhibit any notable differences.[102] The "physiological and psychoactive effects of cocaine are similar regardless of whether it is in the form of powder or crack."[103] Furthermore, crack does not psychotically cause more violence than cocaine, rather a majority of crack-related violence results from an illegal drug market.[104]

The media and public outcry are more instructive in understanding the rationale for antidrug legislation.[105] First, in the 1980s, the media routinely depicted crack use and related crime as actions specifically consigned to Black communities, resulting in crack's portrayal as a "'Black' Drug."[106] The media led the public to believe that crack was "lethal and addictive" and substantially contributed to violent crime.[107] Second, the deadly overdose of a high-profile athlete agitated public fears.[108] In 1986, University of Maryland basketball star and National Basketball Association draftee, Len

98. *See* Spade, *supra* note 46, at 1252–53.

99. *See id.* at 1252–54 (explaining that the legislative history demonstrates that Congress considered, but ultimately rejected, alternative ratios, such as "50:1" and "20:1"); *see also* Sklansky, *supra* note 94, at 1303–04 (explaining that some of the known rhetoric surrounding the passage of the 1986 Act expressed a concern for "big-shouldered Trinidadians," and "bands of young black men" selling crack near "unsuspecting white retirees"); Dvorak, *supra* note 43, at 633–36 (examining the use of racial code words in enacting the sentencing guidelines).

100. *See* Spade, *supra* note 46, at 1255–56.

101. *Id.*

102. For more information on the differences between crack and cocaine, see *id.* at 1256–63.

103. VAGINS & MCCURDY, *supra* note 97, at 4–5.

104. *Id.*

105. *See* Spade, *supra* note 46, at 1233, 1254–55 ("[T]here is evidence that Congress was simply pandering to the anti-crime attitude of the nation.").

106. Cobbina, *supra* note 47, at 150, 154, 158 (noting that these conclusions originated from a study examining the content of news media produced during the 1980s and 1990s); *see also* Spade, *supra* note 46, at 1255 (explaining that "[t]hese stereotypical images" molded racial perceptions associated with crack).

107. Cobbina, *supra* note 47, at 147, 161 (explaining that news articles covering crack were more likely to express a need for a tough-on-crime response); *see also* Andrew Goulian, Marie Jauffret-Roustide, Sayon Dambélé, Rajvir Singh & Robert E. Fullilove III, *A Cultural and Political Difference: Comparing the Racial and Social Framing of Population Crack Cocaine Use Between the United States and France*, HARM REDUCTION J., May 12, 2022, at 2, https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-022-00625-5 [https://perma.cc/2CPN-VCR6].

108. *See* Goulin et al., *supra* note 107, at 2; *see also* Cobbina, *supra* note 47, at 161.

Bias allegedly died from crack use.[109] In combination with existing media reports discussing crack, politicians were highly incentivized to act because crack "encompassed several hot-button issues . . . that made it a politically attractive focus."[110]

In 1988, Congress continued President Reagan's crusade against crack by enacting the Anti-Drug Abuse Act of 1988[111] (the "1988 Act"), amending the 1986 Act.[112] The 1988 Act allocated 70 percent of an $8 billion budget to law enforcement.[113] Additionally, the 1988 Act imposed mandatory minimums for drug trafficking conspiracies and attempts (charges previously only applied to completed offenses) and made crack the only drug with a mandatory minimum sentence for a first-time offense of simple possession.[114] Lastly, it allowed public housing authorities to evict tenants involved with any sort of drug use, eliminated benefits for those convicted of a drug offense, and expanded the use of the death penalty for serious drug-related offenses.[115] Although this policy was framed as race neutral, it provided "police, prosecutors, and judges [with] weapons [that] disproportionately imprison[ed] Black offenders," exacerbating existing racial disparities.[116]

President William ("Bill") J. Clinton's administration continued the antidrug efforts of prior administrations.[117] In 1994, President Clinton enacted the "Three Strikes, You're Out" law.[118] The law mandated life

109. Medical reports suggest that Bias actually died from cocaine use. *See* Spade, *supra* note 46, at 1249–50. However, the media distorted the facts and made it seem as if Bias died from crack. *See id.*

110. Christopher J. Tyson, *At the Intersection of Race and History: The Unique Relationship Between the* Davis *Intent Requirement and the Crack Laws*, 50 HOW. L.J. 345, 373 (2007); *see also* Goulian et al., *supra* note 107, at 2 (explaining that "Bias unwittingly became a public symbol of the dangers of [crack]" and that his "death and surrounding media coverage" catalyzed the enactment of legislation, including the 1986 Act); VAGINS & MCCURDY, *supra* note 97, at 1 (explaining the connection between crack-related media attention, midterm elections, and congressional action).

111. Pub. L. No. 100-690, 102 Stat. 4181 (codified as amended in scattered sections of the U.S. Code).

112. *Id.*; Spade, *supra* note 46, at 1254–55.

113. Phillips, *supra* note 47, at 664. The remaining 30 percent went to prevention, education, and treatment. *Id.*

114. *See* Spade, *supra* note 46, at 1256 (explaining that the 1988 Act assigned mandatory minimums for possession of more than three grams of crack (if the defendant had a prior conviction), or more than five grams of crack (if the defendant was a first time offender), versus a simple possession of cocaine which garnered a misdemeanor charge, punishable by at maximum, one year of incarceration).

115. *See* ALEXANDER, *supra* note 11, at 53.

116. Jefferson Exum, *supra* note 75, at 949; *see* Spade, *supra* note 46, at 1266–67 (explaining that following the implementation of the sentencing guidelines, "[s]entences received by black and Hispanic federal offenders in guideline cases were harsher, on average, than those imposed on whites.").

117. *See* Lauren-Brooke Eisen, *The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System*, BRENNAN CTR. FOR JUST. (Sept. 9, 2019), https://www.brennancenter.org/our-work/analysis-opinion/1994-crime-bill-and-beyond-how-federal-funding-shapes-criminal-justice [https://perma.cc/PQ6L-3GJJ].

118. Violent Crime Control and Law Enforcement Act of 1994, Pub. L. No. 103-322, 188 Stat. 1796. This law targeted violent repeat offenders. *See* U.S. DEP'T OF JUST., CRIMINAL

sentences for third-time offenders and created several new federal capital crimes.[119] President Clinton also made it so that federally assisted public housing projects could exclude all individuals with a criminal history.[120]

Ultimately, the administrations of Presidents Nixon, Reagan, George H. W. Bush, and Clinton continued to ascribe social ills or urban ills to the crack use of minority individuals residing in metropolitan cities.[121] As stated by Keturah James and Professor Ayana Jordan in their article examining the opioid epidemic in Black communities: "African-Americans were cast as pathological. Their plight was evidence of collective moral failure, of welfare mothers and rock-slinging thugs and a reason to cut off all help. . . . [T]he only answer lay in cordoning off the wreckage with militarized policing."[122] By the mid-1990s, 90 percent of those admitted to prison for drug offenses in many states were Black or Latino. Yet, the mass incarceration of communities of color was explained in race-neutral terms, an adaptation of the needs and demands of the then-political climate.[123]

3. "[I]t's a white problem now":[124] Medicalizing Addiction

In the mid- to late 1990s, a new drug emerged—prescription opioids.[125] Around the same time, research revealed that medical professionals were undertreating acute and chronic pain reported by patients.[126] Pharmaceutical companies capitalized on this information and began pushing opioids (e.g., synthetic opiates such as OxyContin) on medical providers, who then

---

RESOURCE MANUAL § 1032 (2019), https://www.justice.gov/archives/jm/criminal-resource-manual-1032-sentencing-enhancement-three-strikes-law [https://perma.cc/5ZSS-S2KX]. Specifically, legislators intended "to take the most dangerous offenders out of the community and keep them out." *Id.*

119. *See* ALEXANDER, *supra* note 11, at 56.

120. *See id.* at 57.

121. *Id.*

122. James & Jordan, *supra* note 13, at 411 (quoting *There Was No Wave of Compassion When Addicts Were Hooked on Crack*, PBS NEWS HOUR (Mar. 29, 2016, 8:06 PM), https://www.pbs.org/newshour/show/there-was-no-wave-of-compassion-when-addicts-were-hooked-on-crack#transcript [https://perma.cc/L252-H9R4]).

123. *See* ALEXANDER, *supra* note 11, at 58.

124. Netherland & Hansen, *supra* note 22, at 8.

125. *What Led to the Opioid Crisis–and How to Fix It*, HSPH (Feb. 9, 2022), https://www.hsph.harvard.edu/news/features/what-led-to-the-opioid-crisis-and-how-to-fix-it/# [https://perma.cc/CV5J-V4R6]. Prescription opioids are opioids used by medical professionals to treat moderate and severe pain. *See Prescription Opioids DrugFacts*, NIDA (June 2021), https://nida.nih.gov/publications/drugfacts/prescription-opioids [https://perma.cc/N3RM-HW6U].

126. *See* Mark R. Jones, Omar Viswanath, Jacquelin Peck, Alan D. Kaye, Jatinder S. Gill & Thomas T. Simopoulos, *A Brief History of the Opioid Epidemic and Strategies for Pain Medicine*, 7 PAIN THERAPY, Apr. 24, 2018, at 14–16, https://pmc.ncbi.nlm.nih.gov/articles/PMC5993682/pdf/40122_2018_Article_97.pdf [https://perma.cc/UXP3-D8KJ]; *see also* Stephen A. Bernard, Paul R. Chelminski, Timothy J. Ives & Shabbar I. Ranapurwala, *Management of Pain in the United States—A Brief History and Implications for the Opioid Epidemic*, 11 HEALTH SERVS. INSIGHTS, Dec. 26, 2018, at 2–4, https://pmc.ncbi.nlm.nih.gov/articles/PMC6311547/pdf/10.1177_1178632918819440.pdf [https://perma.cc/GNL6-MTTY].

prescribed the drugs, en masse, to patients complaining of mild to severe pain.[127] Concurrently, distributors heavily promoted opioids as nonaddictive.[128] As a result, OxyContin became the most prescribed Schedule II narcotic in America,[129] and from the mid-1990s to 2010, White opioid use became more pronounced[130] as it increased exponentially in White communities.[131]

In 1997, the director of the National Institute on Drug Abuse (NIDA), Alan I. Leshner, published an article titled, "Addiction Is a Brain Disease, and It Matters."[132] The article explained addiction as a biological phenomenon rather than a consequence of moral deviance.[133] Specifically, Leshner wrote:

> That addiction is tied to changes in brain structure and function is what makes it fundamentally, a brain disease. A metaphorical switch in the brain seems to be thrown as a result of prolonged drug use. Initially, drug use is a voluntary behavior, but when that switch is thrown, the individual moves into the state of addiction.[134]

Leshner's statement encompassed a new medicalization framework used to better understand addiction as a disease or opioid use as opioid use disorder

127. *See* Nora Freeman Engstrom & Robert L. Rabin, *Pursuing Public Health Through Litigation: Lessons from Tobacco and Opioids*, 73 STAN. L. REV. 285, 307–10 (2021); *see also* Julie Netherland & Helena Hansen, *White Opioids: Pharmaceutical Race and the War on Drugs That Wasn't*, 12 BIOSOCIETIES, June 28, 2017, at 16–17, https://link.springer.com/article/10.1057/biosoc.2015.46 [https://perma.cc/ZLN9-4GTT].

128. Bernard et al., *supra* note 126, at 2.

129. Freeman Engstrom & Rabin, *supra* note 127, at 309.

130. *See* James & Jordan, *supra* note 13, at 412–13 (noting that the opioid epidemic has affected many White, middle-class Americans). Researchers attribute this disparity, in part, to the underprescription of opioids in Black patient populations. *See* Monica J. Alexander, Mathew V. Kiang & Magali Barbieri, *Trends in Black and White Opioid Mortality in the United States, 1979–2015*, 29 EPIDEMIOLOGY 707, 707 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC6072374/pdf/ede-29-707.pdf [https://perma.cc/4ZD9-KSTG]. Such an understanding is partially explained by the false assumption that Black people were more likely to abuse drugs and were less likely to experience severe pain (as compared to White individuals). *See* Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4296–97 (2016).

131. *See* Alexander et al., *supra* note 130, at 712 ("[T]he acceleration in the mortality increase for whites since 1990 has been closely tied to an increase in the number of prescription drugs and the use of opioid pain medication."); *see also* Freeman Engstrom & Rabin, *supra* note 127, at 307–10; Christine Minhee & Steve Calandrillo, *The Cure for America's Opioid Crisis?: End the War on Drugs*, 42 HARV. J.L. PUB. POL'Y 547, 570 (2019) (quoting T.J. Cicero, H.L. Surratt & S.P. Kurtz, *The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years*, 71 JAMA PSYCHIATRY 821, 821–26 (2014)) ("[W]hat was once considered 'an inner-city, minority-centered problem' has rapidly transformed into one with greater geographical distribution, with outsized, fatal impact on white Americans residing far outside of 'large urban areas.'").

132. *See* Richard J. Bonnie, *The Virtues of Pragmatism in Drug Policy*, 13 J. HEALTH CARE L. & POL'Y 7, 19–20 (2010).

133. *Id.*

134. *Id.* (quoting Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCIENCE 45, 45 (1997)).

(OUD).[135] Ultimately, courts, the media, and politicians relied on this narrative to discourage moralizing addiction and encourage treating addiction as a disease.[136]

This sentiment was particularly evident in news articles.[137] Unlike media reports during the 1980s and 1990s regarding crack, the media portrayed the opioid epidemic as a problem primarily afflicting White individuals residing in suburban communities.[138] For example, the media promoted the idea of White victims as "innocent, suffering OxyContin abusers" and blamed "doctors and big pharma."[139] Dealers were no longer portrayed as Black gang members but as doctors, the U.S. Food and Drug Administration (FDA), and pharmaceutical companies.[140] Simply put, drug use in White communities represented an "unmarked norm," leading the media to humanize, rather than criminalize, White individuals using drugs.[141]

Additionally, similar to the prior response to crack, the opioid epidemic exhibited the use of a sociological construct as a means of social control.[142] However, rather than criminalizing drug use, medicalization[143] operated in the alternative by treating and empathizing with individuals, particularly

135. *Id.*; *see also* Katherine Pettus, *Whiteness, Scapegoating and Scarcity: Medicalizing 'the US Opioid Crisis*,' 2 J. ILLICIT ECONS. & DEV. 29, 33 (2021) (discussing the medicalization of the opioid epidemic). OUD is the "chronic use of opioids that causes clinically significant distress or impairment." Alexander M. Dydyk, Nitesh K. Jain & Mohit Gupta, *Opioid Use Disorder*, STATPEARLS (Jan. 17, 2024), https://www.ncbi.nlm.nih.gov/books/NBK553166/ [https://perma.cc/X7DS-P43V]; *see also* Bikash Sharma, Ann Bruner, Gabrielle Barnett & Marc Fishman, *Opioid Use Disorders*, CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM., July 2017, at 2–4, https://pmc.ncbi.nlm.nih.gov/articles/PMC4920977/pdf/nihms-776910.pdf [https://perma.cc/RZ8U-BK6Q]. For additional information explaining the underlying biology of addiction, see generally Danielle M. Dick & Arpana Agrawal, *The Genetics of Alcohol and Other Drug Dependence*, 31 ALCOHOL RSCH. & HEALTH 111 (2008).

136. Bonnie, *supra* note 132, at 19–20.

137. *See* Xinyan Wu, *Parallel Development: Medicalization and Decriminalization in the Changing Media Framing of the Opioid Overdose Crisis*, SOCIUS, July 2023, at 1–2.

138. *See* Cobbina, *supra* note 47, at 160–62; James & Jordan, *supra* note 13, at 410–11; *see also* STEPHANIE SCHMITZ BECHTELER & KATHLEEN KANE-WILLIS, CHI. URB. LEAGUE, WHITEWASHED: THE AFRICAN AMERICAN OPIOID EPIDEMIC 8, 10 (2017), https://chiul.org/wp-content/uploads/2019/01/Whitewashed-AA-Opioid-Crisis-11-15-17_EMBARGOED_-FINAL.pdf [https://perma.cc/FVN4-BVCU].

139. Wu, *supra* note 137, at 6.

140. *See id.* at 7

141. Netherland & Hansen, *supra* note 22, at 8–9. Rather than blaming opioid use on poor morals, government and medical professionals attributed it to either: (1) youths using medications prescribed to older family members, (2) individuals falling in "with a bad crowd," or (3) individuals becoming addicted to opioids initially prescribed to treat an injury or illness. *Id.*

142. *See* Wu, *supra* note 137, at 13.

143. Medicalization is defined as the "process by which nonmedical problems become defined and treated as medical problems." Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOCIO. 209, 209 (1992). Medicalization treats a perceived social problem through scientific means, by allowing those who deviate socially through illness to assume a sick role. *See id.* at 223. Regarding illicit drug use, medical and federal authorities defined the act of drug misuse as the medical condition of addiction. *See id.* at 213, 219.

White individuals, with OUD.[144] Therefore, when drug use prevailed in White communities, White individuals using drugs may have been othered as a victim or as an individual with a disease, but they were not made subservient to the rest of society.[145]

The medicalization of the opioid epidemic also resulted in key changes related to: (1) medical treatment for OUD, (2) punishing medical professionals responsible for encouraging excessive prescription opioid use, and (3) addiction treatment legislation.[146] First, from 2000 to 2006, Congress and the FDA passed several pieces of legislation that allowed for the distribution of full or partial opioid agonists.[147] Additionally, the Patient Protection and Affordable Care Act[148] (ACA) and Mental Health Parity and Addiction Equity Act[149] provided individuals with OUD access to rehabilitative services.[150] Understanding addiction as a medical condition also allowed for individuals to better advocate for harm reduction programs, such as needle exchange programs and naloxone therapy.[151] Therefore, treatment mechanisms became more accessible by acknowledging addiction as a disease and not a crime.[152]

However, the accessibility of treatment had its limits.[153] Proper treatment and education were mainly accessible to middle-to-high income White individuals,[154] whereas poor Black and White individuals often lacked access.[155] Even so, there existed a dichotomy between Black and White individuals with a substance use disorder,[156] one where society acknowledged White individuals as victims of an epidemic and Black

144. *See* Wu, *supra* note 137, at 3 ("[M]edicalization is simply one process of power dynamics in a network of power relations containing many modes of social control.").

145. *See id.*

146. *See* Barbara Fedders, *Opioid Policing*, 94 IND. L.J. 389, 392 (2019); Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. ONLINE 1165, 1235 (2020). A shift in public sentiment accompanied this realization. *See* Frank O. Bowman, III, *The Geology of Drug Policy in 2002*, 14 FED. SENT'G REP. 123, 123–24 (2002) (explaining that, by 2001, only 1 percent of Americans felt that illegal drugs were the nation's most important problem, as opposed to 1989, when roughly 70 percent of Americans felt that illegal drugs were the nation's most important problem).

147. Opioid agonists are medications that help suppress cravings experienced by individuals with OUD. *See* Suzanne Nielsen, Wai Chung Tse & Briony Larance, *Opioid Agonist Treatment for People Who Are Dependent on Pharmaceutical Opioids*, COCHRANE DATABASE SYS. REV., Sept. 5, 2022, at 4; *see also* Netherland & Hansen, *supra* note 127.

148. 42 U.S.C §§ 18001–18122.

149. Pub. L. No. 110-343, 122 Stat. 5213 (2008).

150. *See id.*; §§ 18001–18122.

151. *See* Katherine M. Rich, Joshua Bia, Frederick L. Altice & Judith Feinberg, *Integrated Models of Care for Individuals with Opioid Use Disorder: How Do We Prevent HIV and HCV?*, 15 CURRENT HIV/AIDS REPOSITORY 266, 266–67 (2018).

152. *See* Wu, *supra* note 137, at 2.

153. *See* Riley Shearer, Hildi Hagedorn, Honora Englander, Tracy Siegler & Roxanne Kibben, *Barriers and Facilitators to Implementing Treatment for Opioid Use Disorder in Community Hospitals*, 167 J. SUBSTANCE USE & ADDICTION TREATMENT, Dec. 2024, at 2–5 (describing barriers to accessing OUD treatment).

154. *See* James & Jordan, *supra* note 13, at 414.

155. *See id.* at 412.

156. *See id.*

individuals as lazy or criminals.[157] Accordingly, White individuals of varying classes further marginalized Black individuals who continued to use drugs because, whether due to lack of knowledge or resources, they failed to seek treatment that was otherwise available.[158]

Second, from 2000 to 2010, the U.S. Drug Enforcement Administration (DEA), the FDA, the U.S. Centers for Disease Control and Prevention (CDC), and other regulatory agencies prosecuted wholesale distributors for the excessive dissemination of prescription opioids.[159] Similarly, state governments enacted a series of regulatory measures that required physicians to receive formal training in pain management and limited the quantity of opioids that clinics could distribute in a set period of time.[160]

Third, in 2016, President Barack Obama passed the Comprehensive Addiction and Recovery Act of 2016[161] (CARA), which allocated $181 million to prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal.[162] In 2017, President Donald J. Trump's administration declared the opioid epidemic not a war, but a public health emergency.[163] However, despite some funding increases for mental health resources, this declaration still placed immense focus on the criminal justice system.[164] Most recently, President Joseph R. Biden Jr.'s administration announced the 2024 State Opioid Response (SOR) and Tribal Opioid Response (TOR) Notices of Funding Opportunity.[165] These initiatives provide states with up to $1.48 billion to address the opioid epidemic.[166] Ideally, this funding addresses "prevention, harm reduction, treatment . . . and recovery supports."[167] Further, there have been recent discussions regarding the decriminalization[168] of Schedule II substances (e.g., opioids,

157. *See* ALEXANDER, *supra* note 11, at 40.

158. *See generally* Netherland & Hansen, *supra* note 127.

159. *See* Edgar Aliferov, Note, *The Role of Direct-Injury Government-Entity Lawsuits in the Opioid Litigation*, 87 FORDHAM L. REV. 1141, 1151–52 (2018); *see also infra* Part II.B.

160. *See* Laxmaiah Manchikanti, *National Drug Control Policy and Prescription Drug Abuse: Facts and Fallacies*, 10 PAIN PHYSICIAN, May 2007, at 420–21; *see also* Jacob Gross & Debra B. Gordon, *The Strengths and Weaknesses of Current US Policy to Address Pain*, 109 AM. J. PUB. HEALTH 66, 67–68 (2019).

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

162. *See* Gross & Gordon, *supra* note 160, at 70.

163. *See id.*

164. *See* Cuéllar & Humphreys, *supra* note 80, at 29 (explaining that President Trump's approach to addiction "advocated a 1980s-style enforcement approach, including longer sentences and expansive use of capital punishment"); *see* Minhee & Calandrillo, *supra* note 131, at 597.

165. Press Release, HHS, *Biden-Harris Administration Announces Critical More Than $1.5 Billion State and Tribal Opioid Response Funding Opportunities* (May 2, 2024), https://www.hhs.gov/about/news/2024/05/02/biden-harris-administration-announces-critical-more-than-1.5-billion-state-tribal-opioid-response-funding-opportunities.html [https://perma.cc/H8HG-6NHT].

166. *Id.*

167. *Id.*

168. "Decriminalization" in this context means permitting a person to possesses a small quantity of a given drug, either lawfully or for a reduced penalty. *See* Mason Marks, *State Drug Laws*, 93 FORDHAM L. REV. 439, 445–46 (2024).

cocaine, and crack)[169] as a potential solution to crime,[170] disease,[171] and economic problems related to substance use.[172]

Despite these efforts, opioid related deaths and illnesses continue to increase.[173] In the mid-2000s, deaths related to heroin began to increase.[174] More recently, from 2019 to 2020, non-Hispanic Black persons and Hispanic persons experienced "the greatest burden of drug overdose deaths in communities with high income inequalities."[175] And, starting in 2013, the use of fentanyl and synthetic fentanyl analogues increased.[176]

---

169. Some countries have already decriminalized drug possession and use. *See* Brian Mann, *How Portugal Eased Its Opioid Epidemic, While U.S. Drug Deaths Skyrocketed*, NPR (Feb. 24, 2024, 8:13 AM), https://www.npr.org/2024/02/24/1230188789/portugal-drug-overdose-opioid-treatment [https://perma.cc/C8RK-KXVE]; O'NEILL INST. FOR NAT'L & GLOB. HEALTH L., PORTUGAL'S PIONEERING APPROACH TO DRUG POLICY: LESSONS LEARNED 1 (2023), https://oneill.law.georgetown.edu/wp-content/uploads/2023/07/ONL_QT_Drug_Policy_P5.pdf [https://perma.cc/XU7N-XNGB]; Carmen Paun & Aitor Hernández-Morales, *Why Portland Failed Where Portugal Succeeded in Decriminalizing Drugs*, POLITICO (March 28, 2024, 8:13 AM), https://www.politico.com/news/2024/03/28/oregon-drug-criminalization-portugal-00148872 [https://perma.cc/LEW7-ZWY7].

170. *See generally* Miki Saito, *Decriminalize Drugs Now: A Dire Situation Becomes Much More Urgent*, 20 SEATTLE J. SOC. JUST. 357, 371 (2022) (explaining the beneficial impact of decriminalizing drugs on crime rates); Corey S. Davis, Spruha Joshi, Bianca D. Rivera & Magdalena Cerdá, *Changes in Arrests Following Decriminalization of Low-Level Drug Possession in Oregon and Washington*, INT'L J. DRUG POL'Y., Aug. 9, 2023 (same).

171. Nick Werle & Ernesto Zedillo, *We Can't Go Cold Turkey: Why Suppressing Drug Markets Endangers Society*, 46 J.L. MED. & ETHICS 325, 337–38 (2018) (explaining the potential health benefits of decriminalizing drug use); *Decriminalization Works, but Too Few Countries Are Taking the Bold Step*, UNAIDS (Mar. 3, 2020), https://www.unaids.org/en/resources/presscentre/featurestories/2020/march/20200303_drugs [https://perma.cc/9W84-29ER] (same); NYU LANGONE HEALTH, *Decriminalizing Drug Possession Not Linked to Higher Overdose Death Rates in Oregon or Washington* (Sept. 27, 2023), https://nyulangone.org/news/decriminalizing-drug-possession-not-linked-higher-overdose-death-rates-oregon-or-washington [https://perma.cc/FY4N-WHD6] (same); Tessa Ptucha, *Re-directing the 50-Year-Long War on Drugs in the United States: Safe Injection Sites As the Necessary Weapons*, 50 HOFSTRA L. REV. 929, 942 (2022) (same); *see also* Sarah E. Wakeman & Josiah D. Rich, *Barriers to Post-acute Care for Patients on Opioid Agonist Therapy: An Example of Systematic Stigmatization of Addiction*, 32 J. GEN. INTERNAL MED. 17, 17–18 (2022) (explaining the benefits of increased access to OUD treatment).

172. *See* Curtis Florence, Feijun Luo & Ketra Rice, *The Economic Burden of Opioid Use Disorder and Fatal Opioid Overdose in the United States, 2017*, DRUG ALCOHOL DEPEND., Jan. 1, 2022, at 7–9 (discussing the economics of OUD); Jeri D. Ropero-Miller & Paul J. Speaker, *The Hidden Costs of the Opioid Crisis and the Implications for Financial Management in the Public Sector*, FORENSIC SCI. INT'L: SYNERGY, Sept. 21, 2019, at 227–28 (same); Steven B. Duke & Albert C. Gross, *Legalizing Drugs Would Benefit the United States*, *in* LEGALIZING DRUGS 32, 32–40 (Karin L. Swisher ed., 1996); Richard J. Dennis, *The Economics of Legalizing Drugs*, ATLANTIC, Nov. 1990, at 129–30, https://www.theatlantic.com/magazine/archive/1990/11/the-economics-of-legalizing-drugs/668320/ [https://perma.cc/7W7T-N7TF] (same).

173. Henry Rosen & Chinazo O. Cunningham, *Time to End Racial Disparities in Buprenorphine Access*, 113 AM. J. PUB. HEALTH 1083, 1083 (2023).

174. Alexander et al., *supra* note 130, at 707–08. Heroin is a potent and highly addictive opioid. *See* NAT'L INST. ON DRUG ABUSE, *Heroin Research Report: Overview* (2011), https://nida.nih.gov/publications/research-reports/heroin/overview [https://perma.cc/9CRE-YKER].

175. Rosen & Cunningham, *supra* note 173, at 1083.

176. *See* Nora D. Volkow & Carlos Blanco, *The Changing Opioid Crisis: Development, Challenges and Opportunities*, MOLECULAR PSYCH., Jan. 2021, at 1–2. Fentanyl is a highly

In sum, White individuals with OUD are "portrayed as largely blameless victims of their own biology, and deserving of help."[177] Accordingly, legislators are more empathetic toward a treatment-centered approach now than they were in the 1980s and 1990s when crack use predominated.[178]

B. Racism and the Role of Critical Race Theory

As a means of combating racial tension during the 1970s and 1980s, legal scholars adopted the doctrine of Critical Race Theory.[179] CRT is "an intellectual movement" acknowledging racism as a force that operates within all American institutions, rather than as an individual bias.[180] Despite disparate interpretations of CRT, the doctrine advances two common interests: (1) understanding how the subordination of people of color began and how it has persisted and (2) the desire to change society's understanding of the relationship between the law and racial power.[181] Professor Derrick Bell, a CRT scholar, advocated for two slightly more restrictive doctrines.[182] First, Professor Bell proposed the theory of interest convergence, a critique of conventional civil rights discourse.[183] In his article titled "*Brown v. Board of Education* and the Interest Convergence Dilemma," Professor Bell established a connection between the advancement of White interests and the

addictive and potent synthetic opioid. *Fentanyl*, NAT'L INST. ON DRUG ABUSE, https://nida.nih.gov/research-topics/fentanyl [https://perma.cc/HG4N-CEEC] (last visited Apr. 2, 2025).

177. James & Jordan, *supra* note 13, at 412.

178. *See id.*

179. *See* Derrick A. Bell, *Who's Afraid of Critical Race Theory?*, 1995 UNIV. ILL. L. REV. 893, 898–900; *see* Caroline Mala Corbin, *A Critical Race Theory Analysis of Critical Race Theory Bans*, 14 U.C. IRVINE L. REV. 57, 61–70 (2024) ("Critical race theory focuses on how the law itself perpetuates these inequalities.").

180. Cornel West, *Foreword* to CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, at xi, xi (Kimberleé Crenshaw, Neil Gotanda, Gary Peller & Kendall Thomas eds., 1995); *see also* Leah M. Watson, *The Anti-"Critical Race Theory" Campaign—Classroom Censorship and Racial Backlash by Another Name*, 58 HARV. C.R.-C.L. L. REV. 487, 499 (2023) ("Critical race theory is more than a passing reference to race, racism, or even systemic racism. It focuses on the ways that legal rules facilitate the social construction of race by using whiteness as a normative baseline for colorblind analysis.").

181. *See* CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, *supra* note 180, at xii–xv.

182. *See id.* at 20, 302.

183. Derrick A. Bell, Jr., Brown v. Board of Education *and the Interest Convergence Dilemma*, *in* CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, *supra* note 180, at 20, 22.

passage of substantive civil rights reform.[184] In relevant part, the application of interest convergence extends beyond education.[185]

Professor Bell later proposed the more cynical doctrine of racial realism.[186] Racial realism asserts that "[r]acial equality is, in fact, not a realistic goal."[187] Instead, it acknowledges that the subordinated state of Black individuals is perpetual.[188] However, in accounting for this reality, Black individuals "may open the gateway to attaining a more meaningful status."[189]

As seen by the different approaches to defining and discussing racism, CRT is not a monolith but rather a spectrum. In conclusion, CRT helps in theorizing different mechanisms of achieving racial equity.[190]

184. *See id.* at 22. Professor Bell asserted that, under the principle of interest convergence, "the interest of blacks in achieving racial equality will be accommodated only when it converges with the interests of whites." *Id.* Professor Bell illustrated this theory by applying it to *Brown v. Board of Education*, 347 U.S. 483 (1954). Bell, *supra* note 183, at 22. Specifically, Professor Bell contended that the Court's decision in *Brown* did more than desegregate public schools in pursuit of racial equality. *Id.* Rather, the decision emphasized White people's understanding that abandoning school segregation came with economic and political advantages for Whites. *Id.* Professor Justin Driver served as a prominent critic of Bell's interest convergence theory. *See* Justin Driver, *Rethinking the Interest-Convergence Thesis*, 105 NW. L. REV. 149, 164–97 (2011) (describing four primary analytical flaws of Bell's interest convergence theory and their consequences).

185. *See* Philip Lee, *A Wall of Hate: Eminent Domain and Interest-Convergence*, 84 BROOK. L. REV. 421, 422–25 (2019) (applying interest convergence to eminent domain); SpearIt, *Economic Interest Convergence in Downsizing Imprisonment*, 75 UNIV. PITT. L. REV. 475, 475–76 (2014) (applying interest convergence to incarceration). Professor Mary Crossley applies interest convergence to the opioid epidemic. *See* Mary Crossley, *Opioids and Converging Interests*, 49 SETON HALL L. REV. 1019, 1030–35 (2019). Professor Crossley asserts that expanding Medicaid satisfies the interests of Black and White individuals and would represent a feasible solution to racial disparities related to addiction. *Id.* at 1030–36. This Note also finds that interest convergence proposes a tenable framework for addressing racial disparities in addiction. *See infra* Part III.B.2. However, it offers an alternative legislative solution, incorporates the doctrine of racial realism, and examines the problem as one stemming, in part, from language used by the courts. *See infra* Part III.

186. *See* Derrick A. Bell, Jr., *Racial Realism*, *in* CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, *supra* note 180, at 302; *see also* Willie Abrams, *A Reply to Derrick Bell's Racial Realism*, 24 CONN. L. REV. 517, 517 (1992) ("*Racial Realism* is a weary despair about the efficacy of traditional civil rights litigation, legislative advocacy, and politics as strategies in the struggle for freedom, justice, and dignity for black Americans."); Richard Delgado, *Derrick Bell's Racial Realism: A Comment on White Optimism and Black Despair*, 24 CONN. L. REV. 527, 527 (1992) ("The message of Racial Realism may have been appropriate in the past, but [Professor Bell], by continuing in this vein, has made a large mistake.").

187. Bell, *supra* note 186, at 302.

188. *See id.*

189. *Id.* at 308. Professor Bell understands that racial realism will not invoke transcendent change and may even elevate the system at fault more than the victims of the system. *See id.*

190. *See* CRITICAL RACE THEORY: THE KEY WRITINGS THAT FORMED THE MOVEMENT, *supra* note 180, at xiii–xv.

II. JUDICIAL RHETORIC: EXAMINING DISPARITIES IN THE LANGUAGE USED BY COURTS IN RESPONSE TO THE CRIMINALIZATION AND MEDICALIZATION OF ADDICTION

This part analyzes how perceived demographics of individuals using drugs, as defined by medical and legislative institutions, influenced courts' use of language and reasoning in the assignment of fault for the crack and opioid epidemics.[191] Part II.A discusses the language courts employed during the 1980s and 1990s when deciding cases related to crack sentences. Part II.B examines the language courts used when deciding cases related to providers and pharmaceutical corporations with a known involvement in the opioid epidemic. Part II.C reviews recent court actions regarding addiction.

A. Government Prosecution of Individuals Dealing Crack

In the 1980s and 1990s, courts adopted language government officials put forth regarding crack use and its alleged danger to society.[192] Specifically, courts relied on such language to perpetuate the sentencing guidelines related to crack offenses.[193] As a result, the criminal legal system arrested, convicted, and sentenced a disproportionate number of Black individuals for crack offenses.[194] By the 1990s, 85 percent to 90 percent of all crack defendants convicted and sentenced in the federal system were Black.[195]

United States v. Buckner[196] serves as a prime example of concerns surrounding the effects of the crack and cocaine sentencing guidelines. In 1988, Reginald S. Buckner was indicted for possession with intent to distribute cocaine and crack.[197] Before receiving his sentence, Buckner filed a motion challenging the constitutionality of the sentencing guidelines,

191. This Note acknowledges that courts, barring the Supreme Court, do not choose the cases brought before them.

192. *See, e.g.*, United States v. Reece, 994 F.2d 277 (6th Cir. 1993); United States v. Williams, 982 F.2d 1209 (8th Cir. 1992); United States v. Buckner, 894 F.2d 975 (8th Cir. 1990).

193. *See* Bowman, *supra* note 146, at 129 ("[There is] no dispute that drug enforcement had a statistically disproportionate impact on minority groups," one notable example being "the quantity-based sentence differential between crack and powder cocaine.").

194. *See* LaJuana Davis, *Rock, Powder, Sentencing—Making Disparate Impact Evidence Relevant in Crack Cocaine Sentencing*, 14 J. GENDER RACE & JUST. 375, 389 (2011) (explaining that Black individuals have shouldered the severe burden imposed by crack cocaine sentences); *see also* Sklansky, *supra* note 94, at 1308 ("The Federal crack penalties provide a paradigmatic case of unconscious racism.").

195. *See* Davis, *supra* note 194, at 388; *see also* David Cole, *As Freedom Advances: The Paradox of Severity in American Criminal Justice*, 3 U. PA. J. CONST. L. 455, 466 (2001) ("From 1986 to 1991, the number of white drug offenders in state prisons increased by 110%, but the number of imprisoned black drug offenders grew by 465% . . . [r]acial disparities in the area of drug crimes . . . increased exponentially during the war on drugs.").

196. 894 F.2d 975 (8th Cir. 1990).

197. *See id.* at 977. Buckner was also indicted for possession of a firearm by a convicted felon. *See id.* In the opinion, the court referred to crack as cocaine base. *See id.*; *see also Cocaine*, DRUG ENF'T AGENCY, https://www.dea.gov/factsheets/cocaine [https://perma.cc/J5ZQ-N3UX] (last visited Apr. 2, 2025) (describing cocaine base and crack cocaine as other common terms for crack).

claiming that they violated the substantive due process element of the Fifth Amendment and the Cruel and Unusual Punishment Clause of the Eighth Amendment.[198]

First, regarding the due process claim, Buckner alleged that Congress's decision to treat one gram of crack the same as one hundred grams of cocaine was unconstitutional.[199] The U.S. Court of Appeals for the Eighth Circuit, affirming the district court's decision, held that Congress's decision to apply a 100:1 ratio to cocaine and crack sentencing was constitutional.[200] The court reasoned that Congress enacted the sentencing guidelines with the understanding that crack was inherently more dangerous than cocaine.[201] Specifically, as compared to cocaine, the court observed that Congress deemed crack to be more "dangerous to society . . . because of [its] highly addictive nature," affordability, and increasing prevalence.[202] In its analysis, the court relied on statements made during the enactment of the sentencing guidelines, which described crack as far more potent than cocaine and clarified that those carrying crack deserve the "maximum penalty possible."[203] Therefore, the court affirmed the 100:1 ratio because it was rationally related to Congress's goal of "protecting the public welfare."[204]

Second, regarding the Eighth Amendment claim, Buckner again based his argument on the sentencing disparity between cocaine and crack.[205] He asserted that a "250 month prison sentence is so grossly disproportionate to an offense of possessing 53 grams of [crack] as to constitute cruel and unusual punishment."[206] The court also rejected this argument, again relying on the language of Congress.[207] The court understood Congress's intent as setting "stiff" crack penalties to alert society of the true danger posed by crack.[208] Moreover, the court interpreted Congress's language as justifiably tough on crime and perceived the enactment of the sentencing guidelines as a means of reshaping society's conceptualization of crack.[209] As such, the court stated that crack "posed a threat to individuals and to the very fabric of our society," and to ensure that individuals understood this very threat, Congress needed to enact a greater penalty for crimes related to crack.[210] In

198. *Id.* at 977; *see supra* Part I.A.2. (discussing the 100:1 ratio).

199. Specifically, Buckner argued that Congress lacked a rational basis in establishing vastly disparate sentencing guidelines for crack and cocaine given their similarities. *Id.* at 977; *see supra* Part I.A.2. (discussing the 100:1 ratio).

200. *Buckner*, 894 F.2d at 978.

201. *Id.*

202. *Id.*

203. *Id.* at 979.

204. *Id.* at 980.

205. *Id.* at 977.

206. *Id.* at 978.

207. *Id.* at 980 ("[P]erceptions of crimes, their heinousness, and the dangers they pose to society dictate the punishment [the court] impose[s].").

208. *Id.* at 980–81.

209. *See id.*

210. *Id.* at 980.

sum, the court held that "sentences for crimes involving [crack] do not contravene [the Eighth Amendment]."[211]

The Eighth Circuit held similarly in *United States v. Williams*.[212] Trent L. Williams was convicted of possession with intent to distribute crack and for use of a firearm during and in relation to drug trafficking.[213] Following his conviction, Williams brought a due process claim and an equal protection claim.[214] Regarding the due process claim, Williams argued that the disparity in sentencing for crack versus cocaine offenses was not supported under a rational basis review and violated the due process clause of the Fourteenth Amendment.[215] However, the court found the statute constitutional because Congress derived the statute from the alleged fact of crack being "more dangerous to society than [powder] cocaine" because of its "potency, its highly addictive nature, its affordability, and its increasing prevalence."[216] Williams also argued that the 100:1 ratio violated the equal protection clause because it resulted in the imprisonment of a greater percentage of Black individuals than White individuals.[217] Specifically, Williams cited a survey conducted by a local public defender's office which found that "of all persons charged with possession of [crack] in 1988, 96.6% were Black, and of all persons charged with possession of powder cocaine, 79.6% were White."[218] The court rejected the survey's findings, upholding the validity of the 100:1 ratio.[219] The court relied on *United States v. House*,[220] reasoning that the 100:1 "ratio does not impermissibly differentiate on the basis of race."[221] Thus, the court found the guidelines constitutional because they promoted Congress's facially nondiscriminatory goals of protecting society from the dangers of crack.[222]

The Eighth Circuit did not stand alone in these decisions. The U.S. Courts of Appeals for the Second, Fourth, and Sixth Circuits followed the Eighth Circuit, also finding the disparate impact of the crack sentencing guidelines permissible.[223] For example, in *United States v. Stevens*,[224] the defendants were convicted of conspiracy to distribute and possess with the intent to

211. *Id.* at 981.
212. 982 F.2d 1209 (8th Cir. 1992).
213. *See id.* at 1209.
214. *Id.*
215. *See id.* at 1213.
216. *Id.* (quoting *Buckner*, 894 F.2d at 978).
217. *Id.*
218. *Id.*
219. *Id.*
220. 939 F.2d 659 (8th Cir. 1991). In *House*, the court held that the 100:1 ratio did not discriminate on the basis of race because the more severe penalties for crack were "rationally related to Congress's objective of protecting the public welfare." *Id.* at 664.
221. *Williams*, 982 F.2d at 1213 (citing *House*, 939 F.2d at 664).
222. *See id.*
223. *See, e.g.*, United States v. Stevens, 19 F.3d 93 (2d Cir. 1994); United States v. Reece, 994 F.2d 277 (6th Cir. 1993); United States v. Robinson, Nos. 91-5414, 91-5415, 1992 WL 172672 (4th Cir. July 22), *cert denied*, 560 U.S. 925 (1992).
224. 19 F.3d 93 (2d Cir. 1994).

distribute crack.[225] On appeal, the defendants argued that "the Sentencing Guidelines arbitrarily treat one gram of [crack] as the equivalent of one hundred grams of powder cocaine, resulting in an unconstitutionally disparate impact on [African Americans]."[226] Unlike the previously discussed cases, the defendants did not allege that Congress acted with discriminatory intent; rather, the defendants only questioned whether the sentencing scheme had a rational basis related to a legitimate government purpose.[227] In support, the defendants relied on statistics from *State v. Russell*,[228] which showed that, in Minnesota, Black individuals constituted 96.6 percent of all persons charged with crack offenses, whereas White individuals constituted 79.6 percent of all persons charged with powder cocaine offenses.[229]

The Second Circuit held that the sentencing guidelines were "rationally related to the legitimate governmental purpose of protecting the public against the greater dangers of [crack]."[230] It reasoned that Congress's intent in passing the sentencing guidelines "is obvious—[crack] is the most addictive and destructive form of cocaine, and because it is also cheaper it is more widely available and has had . . . a corresponding increase in usage."[231] Therefore, the court held that such language validated Congress's enactment of the sentencing guidelines.[232] In the court's eyes, Congress understood the true dangers of crack, as compared to cocaine, and the need to protect society from its use.[233]

The Fourth Circuit took the same position in *United States v. Robinson*.[234] The defendants were convicted for several drug-related crimes.[235] On appeal, the defendants contested the validity of the sentencing guidelines.[236] They argued that the harsher sentences resulting from crack offenses imposed a significantly more severe punishment on Black individuals, "the primary distributors and users of crack."[237] The court did not find purposeful discrimination on the basis of race, and thus, subjected the guidelines to a

225. *Id.* at 94.
226. *Id.* at 96.
227. *Id.*
228. 477 N.W.2d 886 (Minn. 1991). In *Russell*, the Minnesota Supreme Court held that a Minnesota state law imposing harsher sentences for crack offenses failed a rational basis review. *Id.* at 887–88 (explaining that the trial court had applied Minnesota's three-factor rational basis test, which allowed the court to exercise less deference). The court reasoned that although the legislature did not demonstrate discriminatory intent in enacting the law, the law disparately impacted more Black individuals than White individuals. *Id.* The court also explained that the legislature failed to establish a legitimate reason for the differential treatment of crack and cocaine sentencing guidelines. *Id.* at 891.
229. *Stevens*, 19 F.3d at 96.
230. *Id.* at 97.
231. *Id.* (quoting United States v. Haynes, 985 F.2d 65, 70 (2d. Cir. 1993)).
232. *Id.*
233. *Id.*
234. Nos. 91-5414, 91-5415, 1992 WL 172672 (4th Cir. July 22), *cert denied*, 560 U.S. 102 (1992).
235. *Id.* at *1.
236. *Id.* at *4.
237. *Id.*

rational basis review.[238] In its analysis, the court described crack as a "menace to society" because it was "more addictive than cocaine powder and because it specifically targeted youth."[239] Ultimately, similar to the above and below discussed circuit courts, the Fourth Circuit held that the sentencing guidelines were rationally related to Congress's goal of protecting the public from the dangers of crack.[240]

Likewise, in *United States v. Reece*,[241] the Sixth Circuit held that the 100:1 ratio was not enacted on the basis of race and was therefore constitutional.[242] Reginald Reece pled guilty to distributing crack and, in line with the sentencing guidelines, faced a mandatory minimum sentence of ten years for the offense.[243] Reece challenged the constitutionality of the sentencing guidelines, arguing that Congress instituted the crack equivalency on the basis of race.[244] Reece presented two primary pieces of evidence in support of his challenge: (1) statistical evidence showing that the sentencing guidelines resulted in the imprisonment of a disproportionate number of Black individuals and (2) the legislative history of the sentencing guidelines which suggested that Congress acted on the basis of race.[245] The court ultimately rejected both pieces of evidence and held the sentencing guidelines constitutional.[246]

First, the court relied on the holding in *Washington v. Davis*,[247] reasoning that numbers alone cannot support a finding of disparate impact in relation to a facially neutral law.[248] Second, the court rejected the legislative history Reece introduced because it pertained to the 1988 Act and the provision at issue, the 100:1 ratio, first appeared in the 1986 Act.[249] Again, the court disregarded the potential disparate impact of the sentencing guidelines and found that Congress lacked a discriminatory intent.[250] Several other courts decided similar cases on similar grounds, each relying on Congress's language to overrule defendants' claims challenging the constitutionality of the sentencing guidelines.[251]

---

238. *Id.* at *5.
239. *Id.* (quoting United States v. Thomas, 900 F.2d 37, 39–40 (4th Cir. 1990)).
240. *Id.*
241. 994 F.2d 277 (6th Cir. 1993).
242. *Id.* at 278.
243. *Id.*
244. *Id.*
245. *Id.*
246. *Id.*
247. 426 U.S. 229 (1976) (holding that numerical evidence alone is insufficient to support a disparate impact claim).
248. *Reece*, 994 F.2d at 278.
249. *Id.* Otherwise stated, Reece needed to discuss the legislative history of the 1986 Act. *See id.*
250. *See id.*; *see generally* United States v. Stevens, 19 F.3d 93 (2d Cir. 1994); United States v. Williams, 982 F.2d 1209 (8th Cir. 1992); United States v. Robinson, Nos. 91-5414, 91-5415, 1992 WL 172672 (4th Cir. July 22), *cert denied*, 560 U.S. 925 (1992); United States v. Buckner, 894 F.2d 975 (8th Cir. 1990).
251. *See* United States v. Haynes, 985 F.2d 65, 70 (2d Cir. 1993) (reasoning that crack is "the most addictive and destructive form of cocaine"); United States v. Watson, 953 F.2d 895, 897–98 (5th Cir.) (reasoning that Congress had a rational basis in enacting the sentencing

B. Opioid Use Disorder and Related Litigation

In the early 2000s, opioid use predominated in White communities.[252] Similar to law enforcement's and Congress's shift in sentiment regarding drug use and drug sales, the type of litigation brought before courts also changed.[253] Government actors brought actions against those responsible for distributing opioids where, dissimilar to crack litigation, doctors, pharmacists, and pharmaceutical corporations composed a majority of defendants.[254] Individual plaintiffs also brought private actions against providers and pharmaceutical corporations.[255] Rather than referring to opioids as dangerous or a grave threat to society, as courts did with the crack epidemic, courts adopted alternative rhetoric that spoke more empathetically of addiction.[256] Thus, as the perceived user of the drug at issue changed from that of a Black individual to a White individual, courts modified the language of their decisions.[257]

1. Government Prosecution of Healthcare Providers

Drug-related litigation transformed starting in the early 2000s.[258] As the general understanding of the perceived user or seller changed, so did the type of individual held responsible.[259] In parallel with the newly adopted medicalization framework, courts altered their language pertaining to addiction and identified new actors in the lineup—medical providers, pharmacies, and pharmaceutical corporations.[260]

---

guidelines because "[crack] is more addictive [and] more dangerous" than cocaine), *cert. denied*, 504 U.S. 928 (1992); United States v. King, 972 F.2d 1259, 1260 (11th Cir. 1992) (same); United States v. Abrams, Nos. 90–3973, 90–3974, 1991 WL 164327, at *6 (6th Cir. Aug. 23, 1991) (asserting that "there is a sufficient difference of the opinion in the scientific community regarding the different likelihood of becoming addicted to crack or cocaine"), *cert. denied*, 502 U.S. 1044 (1992); *see also* United States v. Reyes, No. 89 Cr. 1006, 1989 WL 146786, at *3 (S.D.N.Y. Nov. 30, 1989) ("The quality of life in poor neighborhoods has been crippled by the influx of drugs. The violence associated with the drug trade has made it literally impossible for many people to leave their homes . . . . Addicts are forced to rob and steal to support their habits."), *cert. denied*, 904 F.2d 34 (2d Cir. 1990).

252. *See supra* Part I.A.3.

253. *See supra* Part I.A.3.

254. *See* Aliferov, *supra* note 159, at 1150–52.

255. *See supra* Part II.A; *see also infra* Parts II.B.1–2. By the early 2000s, lawmakers and courts understood that multiple actors—the "pharmaceutical companies that produce the drugs, the pharmacies that distribute prescription drugs, and the doctors who prescribe" opioids—all shared the blame for the opioid crisis. *See* Dallin Judd, Connor R. King & Curtis Galke, *The Opioid Epidemic: A Review of the Contributing Factors, Negative Consequences, and Best Practices*, CUREUS, July 10, 2023, at 2.

256. *See infra* Parts II.B.1–3.

257. *See infra* Parts II.B.1–3.

258. *See* Freeman Engstrom & Rabin, *supra* note 127, at 307–34 (explaining the different types of opioid litigation).

259. *See id.*

260. *See generally In re* Nat'l Prescription Opiate Litig., 589 F. Supp. 3d 790 (N.D. Ohio 2022) (manufactures and distributors); Koon v. Walden, 539 S.W.3d 752 (Mo. Ct. App. 2017) (medical providers).

For instance, in *Koon v. Walden*,[261] the plaintiff brought an action against their provider for overprescribing opioids.[262] This practice ultimately led to the development of the plaintiff's OUD.[263] The court held that the defendant acted negligently in prescribing an excessive quantity of opioids to the plaintiff.[264] The court set forth several reasons supporting its holding.[265] First, the court began its decision by discussing the dangers of using opioids.[266] Specifically, it adopted language disseminated by medical professionals and explained the science governing OUD.[267]

The court acknowledged that opioids were dangerous, however, they placed this concern with the individual using the substance, rather than the effect of the user or the seller on the well-being and safety of society.[268] During discovery and trial, the court permitted the use of expert testimony to explain the specifics of the opioid epidemic.[269] Additionally, the court allowed evidence demonstrating how an individual, such as a provider, may contribute to another individual's OUD.[270] Here, the court asserted that the plaintiff was not responsible for his substance use disorder, rather it resulted from the doctor's poor conduct.[271]

The U.S. Court of Appeals for the Seventh Circuit employed similar reasoning in *United States v. Kohli*[272] and *United States v. Chube II*.[273] In both *Kohli* and *Chube II*, the defendant-physicians dispensed opioids to patients, "outside the scope of medical practice and without a legitimate medical purpose."[274] Specifically, defendant-physicians used their authority as medical providers to distribute opioids in excess to individuals predisposed to or with OUD.[275] In both cases, the court affirmed the defendant-physicians' convictions, in part, out of concern for the addictive nature of prescribed opioids.[276]

Similar to *Koon*, *Kohli* and *Chube II* demonstrate courts' willingness to hold individual physicians accountable, not for the danger their conduct potentially imposed upon society, but for the danger their conduct imposed

261. 539 S.W.3d 752 (Mo. Ct. App. 2017).
262. *Id.* at 755. Per the defendant's advice, the plaintiff went from taking six pills a day to nearly forty pills a day. *See id.* at 759.
263. *See id.* at 763.
264. *See id.*
265. *See id.* at 755–56.
266. *Id.*
267. *See id.* (explaining how opioids interact with the brain and may, if consumed in excess, lead to a substance use disorder).
268. *See id. But see supra* Part II.A.
269. *See Koon*, 539 S.W.3d at 763.
270. *Id.* at 764.
271. *Id.*
272. 847 F.3d 483 (7th Cir.), *cert. denied*, 83 U.S. 869 (2017).
273. 538 F.3d 693 (7th Cir. 2008).
274. *See id.* at 706; *see also Kohli*, 847 F.3d at 486–87.
275. *See Kohli*, 847 F.3d at 486–87; *Chube II*, 538 F.3d at 696–97.
276. *See Kohli*, 847 F.3d at 486–87; *Chube II*, 538 F.3d at 706.

upon the afflicted patient—an individual with OUD.[277] Indeed, the government brought such actions, similar to crack litigation, in the 1980s and 1990s.[278] Here, however, the government was not acting under congressional instruction, where individuals suspected of dealing drugs required imprisonment to minimize crack's scope of danger to society.[279] Instead, the government acted pursuant to congressional and medical instruction that deemed opioids addictive and dangerous to the individual user.[280] Accordingly, courts reasoned that society's safety represented a lesser concern because individuals using and selling drugs faced opioid addiction, a harmful disease, rather than mere crack use, conduct that posed a "threat to individuals and to the very fabric of our society."[281]

2. Private Actions Against Manufacturers: Nuisance Claims

In addition to holding individual providers accountable via government prosecution, courts also considered nuisance claims as a means of assigning fault for the opioid epidemic.[282] The common nuisance claim often involves a small community bringing a nuisance claim against a large factory for its pollution and resulting interference with the community's well-being.[283] However, in the early to mid-2000s of the opioid epidemic, a less familiar nuisance claim emerged.[284] Individual plaintiffs, specifically state counties, brought a series of nuisance claims against large pharmaceutical distributors.[285] And though these claims differed from the "typical" nuisance case, courts permitted such actions.[286]

---

277. *Kohli*, 847 F.3d at 486–87, 494; *Chube II*, 538 F.3d at 696–97; Koon v. Walden, 539 S.W.3d 752, 763 (Mo. Ct. App. 2017).

278. *See supra* Part II.A.

279. *See supra* Part I.A.3.

280. *See supra* Part I.A.3.

281. United States v. Buckner, 894 F.2d 975, 980 (8th Cir. 1990).

282. *See* Molly Grace Baldock, Note, *Sharing the Blame: Using Market Share to Allocate Liability in Opioid Public Nuisance Lawsuits*, 38 NOTRE DAME J.L. ETHICS & PUB. POL'Y 315, 324 (2024); *see also* Leslie Kendrick, *The Perils and Promise of Public Nuisance*, 132 YALE L.J. 702, 731–36 (2023).

283. *See generally* Boomer v. Atl. Cement Co., 26 N.Y.2d 219 (1970). Other examples include nuisance claims for noise and vibrations. *See generally* Morgan v. High Penn Oil Co., 77 S.E.2d 682 (N.C. 1953); Estancias Dallas Corp. v. Schultz, 500 S.W.2d 217 (Tex. Civ. App. 1973).

284. *See* Kendrick, *supra* note 282, at 731 ("For roughly twenty years, governmental entities have employed public-nuisance litigation to attempt to address the opioid epidemic.").

285. *See* Baldock, *supra* note 282, at 324 ("Since the political branches did not take necessary steps to abate the crisis, the opioid epidemic became the next social ill to seek relief via public nuisance."); *see also* Michael J. Purcell, Note, *Settling High: A Common Law Public Nuisance Response to the Opioid Epidemic*, 52 COLUM. J.L. & SOC. PROBS. 135, 160 (2018) (discussing several cases where communities sued opioid manufacturers and distributors for creating a public nuisance).

286. Not all courts were amenable to plaintiffs bringing nuisance claims against pharmaceutical corporations. *See In re* McKinsey & Co. v. Nat'l Prescription Opiate Litig., MDL No. 3084, 2024 WL 2261926, at *13 (N.D. Cal. May 16, 2024) (holding that the plaintiffs pled an insufficient nuisance claim against the opioid manufacturers and distributors); *see also* State *ex rel.* Hunter v. Johnson & Johnson, 499 P.3d 719, 722 (Okla.

In bringing a nuisance claim,[287] state actors alleged a series of harms suffered by their community because of the opioid epidemic.[288] In contrast to the fear-inducing rhetoric of the crack epidemic, counties described the following harms in bringing their claims: "the high rates of opioid use, the emotional and financial burdens of residents caring for addicted loved ones, lost companionship and wages, increased health care costs, lost productivity value . . . and the number of lives lost and addictions endured."[289]

The main actors held responsible for such harm were opioid manufacturers (i.e., pharmacies and pharmaceutical corporations) who knowingly and intentionally distributed a substance known to be highly addictive, absent sufficient warning or safety monitoring procedures.[290] For example, in *In re National Prescription Opiate Litigation*,[291] counties in the Northern District of Ohio brought nuisance claims against retail pharmacy stores including CVS, Walgreens, and Walmart for "substantially contribut[ing] to an oversupply of legal prescription opioids . . . outside appropriate medical channels, thereby endangering public health or safety and creating a public nuisance."[292] A jury decided in favor of the plaintiff-counties at trial, and the defendants responded by filing a motion for judgment as a matter of law pursuant to Federal Rule of Civil Procedure 50(b).[293] The U.S. District Court for the Northern District of Ohio held that the plaintiffs presented sufficient evidence to establish that the defendants' conduct in distributing opioid prescriptions in plaintiffs' counties constituted a public nuisance.[294] In affirming the jury's decision, the court considered whether the defendants "engaged in intentional and/or unlawful conduct that caused a significant and ongoing interference with a public right to health or safety."[295] The court examined whether CVS, Walgreens, and Walmart each independently satisfied the following factors: (1) unlawful conduct, (2) intentional conduct, and (3) causation.[296]

As for unlawful conduct, the court found that each defendant failed to take "adequate measures to avoid diversion of prescription opioids."[297]

2021) (reasoning that mitigating the effect of the opioid epidemic on communities is a public health and policy making power, solely intended for legislative and executive branches).

287. A nuisance is an "unreasonable interference with a right common to the general public." RESTATEMENT (SECOND) OF TORTS § 821B (1979). To recover under a nuisance claim, the plaintiff must "have suffered harm of a kind different from that suffered by other members of the public exercising the right common to the general public that was the subject of interference." *Id.* § 821C.

288. *See* Purcell, *supra* note 285, at 160. Notably, the plaintiffs drew from prior public nuisance litigation related to the tobacco industry. *See* Freeman Engstrom & Rabin, *supra* note 127, at 291.

289. Purcell, *supra* note 285, at 160.

290. *See id.*

291. 589 F. Supp. 3d 790 (N.D. Ohio 2022).

292. *Id.* at 795.

293. *Id.*

294. *See id.* at 831–32.

295. *Id.* at 796.

296. *See id.* at 796–811.

297. *Id.* at 797.

Specifically, the defendants knew of the ongoing opioid epidemic and of the addictive nature of the substances their pharmacies prescribed but failed to implement sufficient compliance policies.[298] Accordingly, the court held that each defendant "knowingly engaged in unlawful dispensing conduct."[299]

As for intentional conduct, the court found that plaintiffs presented sufficient evidence to establish that: (1) "prescription opioids were highly addictive," (2) prescription opioids "had a high potential for abuse," and (3) if improperly distributed, prescription opioids would lead to significant harm within the community.[300] According to the court, by continuing to distribute opioids upon learning of these facts, defendants intentionally acted "under circumstances which [they] knew or [were] substantially certain would interfere with public health or public safety."[301]

Lastly, as for causation, the court found that the defendants' distribution of opioids "corresponded with huge increases in addiction and other health and safety issues in their communities," which contributed to creating a nuisance.[302]

In conducting its analysis, the court found that defendants were aware of the "dangers associated with diversion of prescription opioids."[303] However, unlike the courts discussing crack use and distribution in the 1980s and 1990s, the court described the idea of "danger" as one of contributing to an ongoing epidemic of drug abuse[304] and not an epidemic "threat[ening] to individuals and to the very fabric of our society."[305] Additionally, in acknowledging these nuisance claims, courts evinced their newly adopted rhetoric by using other words such as "public health and safety" and "unlawful conduct," rather than words like "danger," "harm," and "destructive."[306]

In *City of Huntington v. AmerisourceBergen Drug Corp.*,[307] the Fourth Circuit certified the question of whether, under West Virginia law, opioid manufacturers could be held accountable for a public nuisance claim.[308] In

298. That is, taking measures to effectively resolve any red flags prior to dispensing a known addictive substance. *See id.* at 796–805.

299. *Id.* at 797.

300. *Id.* at 805–06.

301. The court relied on trial evidence explaining the specific health impacts of the opioid epidemic. *See id.* at 806. Admitted testimony stated that "prescription opioids would likely lead to significant harm in the community," that opioids have a "high potential for abuse and addiction," and that opioids pose a "risk to the public." *Id.* at 805–06 (noting that "the abuse of prescription drugs . . . is a serious social and health problem in the United States").

302. Specifically, the quantity of and rate at which defendants distributed opioids constituted substantial factors in creating a public nuisance. *Id.* at 808–11.

303. *Id.* at 807.

304. *Id.* Drug abuse, at this time, was not perceived as a social shortcoming, but a medical phenomenon. *See supra* Part I.A.3.

305. United States v. Abrams, Nos. 90–3973, 90–3974, 1991 WL 164327, at *6 (6th Cir. Aug. 23, 1991) (quoting United States v. Buckner, 894 F.2d 975, 980 (8th Cir. 1990)).

306. *See supra* Part II.A.

307. 96 F.4th 642 (4th Cir. 2024).

308. *See id.* at 644 (noting that the court opted to certify the instant question rather than affirm the district court's holding that the defendants' involvement in the distribution of opioids did not create a public nuisance).

explaining its decision to certify the question, the court acknowledged that the opioid epidemic enabled "an extraordinary public health crisis that . . . has accelerated over the past decade."[309] The court focused primarily on the health effects of the opioid epidemic in its analysis.[310] It spoke of pregnant women being admitted to hospitals for OUD, as well as infants suffering from neonatal abstinence syndrome, and an increase in the spread of infectious diseases, like HIV and Hepatitis B and C.[311] It also discussed the members of the community specifically impacted by the opioid epidemic and the number of deaths resulting from opioid overdoses.[312] Thus, in line with *In re National Prescription Opiate Litigation*, the court recognized the "health" impacts of the opioid epidemic and the "risk" created by irresponsibly manufacturing the drug.[313]

In conclusion, nuisance claims illustrate the willingness of courts to prioritize the health concerns associated with opioid use and addiction as compared to their prior classification of crack as threatening and requiring punitive response efforts.[314]

3. Miscellaneous Problems Related to Litigating the Opioid Epidemic

Despite some courts demonstrating increased empathy toward individuals with a substance use disorder, others are still willing to shield opioid manufacturers from accepting responsibility for their role in the opioid epidemic.[315] For example, appellate courts at the state and federal level concealed evidence evincing the extent of manufacturers' involvement in the

309. *Id.* at 647.
310. *See id.*
311. *See id.*
312. *See id.*
313. *See id.*; *In re* Nat'l Prescription Opiate Litig., 589 F. Supp. 3d 790, 831–32 (N.D. Ohio 2022). Similar to nuisance cases, bankruptcy litigation related to the opioid epidemic also demonstrates courts' willingness to recognize OUD as a medical condition affecting the well-being of society. *See* Baldock, *supra* note 282, at 325. For example, in *Harrington v. Purdue Pharma, L.P.*, 144 S. Ct. 2071 (2024), both the U.S. Supreme Court's majority and the dissent acknowledged the opioid epidemic as a public health matter and shared the goal of equitably redressing the claimants—communities and individuals affected by, or victims of, the opioid epidemic. *Harrington*, 144 S. Ct. at 2079 (reasoning that discharging the owners of Purdue Pharma, L.P., the Sackler family, of current and future claims without the approval of those affected would impede the Sackler family from remedying their mistakes related to advertising and manufacturing opioids); *see id.* at 2088 (Kavanaugh, J. dissenting) ("Today's decision is wrong on the law and devastating for more than 100,000 opioid victims and their families").
314. *See AmerisourceBergen Drug Corp.*, 96 F.4th at 647; *In re* Nat'l Prescription Opiate Litig., 589 F. Supp. 3d at 831–32. *But see supra* Part II.A.
315. *See* Benjamin Lesser, Dan Levine, Lisa Girion & Jaimi Dowdell, *How Judges Added to the Grim Toll of Opioids*, REUTERS (June 25, 2019, 1:00 PM), https://www.reuters.com/investigates/special-report/usa-courts-secrecy-judges/ [https://perma.cc/64BU-SU9V].

opioid epidemic.[316] Such a practice limited the liability of those most responsible for contributing to the opioid epidemic.[317]

Additionally, many parties opted to forgo litigation and simply settle claims related to the opioid epidemic.[318] However, some public health officials identified settlements as ineffective in combatting the opioid epidemic.[319] Further, pharmaceutical companies involved in opioid litigation settlements continue to engage in the practices that sparked the initial onslaught of litigation.[320]

C. The Problem Lingers: Present Day Language Pertaining to Addiction

Since the onset of the crack epidemic, there has been a change in court rhetoric, from criminalizing crack use and sales to medicalizing OUD.[321] However, disproportionate rates of drug use among Black individuals and White individuals persist.[322] And although there have been several advancements in the management and treatment of OUD at the local public health level, legislators and courts have been less successful.[323] Two recent court decisions highlight this challenge. First, in *United States v. Safehouse*,[324] the government sought a declaratory judgement against Safehouse,[325] alleging that Safehouse's intended consumption room violated

316. This includes courts opting to conceal and seal evidence related to the addictive nature of OxyCotin, the involvement of sales representatives in pushing OxyCotin sales despite providers' concerns, and the industry practices promoting sales and misleading consumers and providers. *See* Lesser et al., *supra* note 315.

317. *Id.*

318. *See* Aliferov, *supra* note 159, at 1152; *see also Statement from Public Health Experts on Announcement of Opioid Settlement*, JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH (July 21, 2021), https://publichealth.jhu.edu/2021/statement-from-public-health-experts-on-announcement-of-opioid-settlement [https://perma.cc/MN8R-Q6JY]; *Opioids*, NAT'L ASS'N OF ATT'YS GEN., https://www.naag.org/issues/opioids/ [https://perma.cc/8VUD-XFTQ] (last visited Apr. 2, 2025).

319. *See* Rebecca L. Haffajee & Michael R. Abrams, *Settling the Score: Maximizing the Public Health Impact of Opioid Litigation*, 80 OHIO ST. L.J. 701, 713–14 (2019); Abbe R. Gluck, Ashley Hall & Gregory Curfman, *Civil Litigation and the Opioid Epidemic: The Role of Courts in a National Health Crisis*, 46 J.L. MED. & ETHICS 351, 361 (2018).

320. *See* Haffajee & Abrams, *supra* note 319, at 713–14.

321. *Compare supra* Part II.A, *with supra* Parts II.B.1–2.

322. *See* James & Jordan, *supra* note 13, at 405–08; Marjorie C. Gondré-Lewis, Tomilowo Abijo & Timothy A. Gondré-Lewis, *The Opioid Epidemic: A Crisis Disproportionately Impacting Black Americans and Urban Communities*, J. RACIAL & ETHNIC HEALTH DISPARITIES, Sept. 6, 2022, at 8–12, https://pmc.ncbi.nlm.nih.gov/articles/PMC9447354/ [https://perma.cc/8U4A-PM63].

323. *See* Shearer et al., *supra* note 153, at 2–5 (describing barriers to existing treatments for OUD); Sarah E. Wakeman, Marc R. Larochelle & Omid Ameli, *Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder*, 3 JAMA OPEN NETWORK 1, 1–3 (2020) (same).

324. 985 F.3d 225 (3d Cir.), *cert. denied*, 142 S. Ct. 345 (2021).

325. Safehouse is a nonprofit "whose mission is to save lives by providing a range of overdose prevention services." *Frequently Asked Questions*, SAFEHOUSE, https://www.safehousephilly.org/frequently-asked-questions [https://perma.cc/LY96-F8Z7] (last visited Apr. 2, 2025).

§ 856(a)(2) of the Controlled Substances Act.[326] Specifically, Safehouse wanted to open a safe injection site[327] that would offer treatment and prevention services and access to a consumption room.[328] The U.S. Court of Appeals for the Third Circuit held that Safehouse's consumption room violated § 856(a)(2).[329] The court reasoned that, although Safehouse need not have the purpose of drug activity, by allowing for a consumption room, it would "manage [and] control the site" with the intention to make the consumption room available for visitors' use, with a significant purpose of visitors using illicit drugs.[330]

The court relied on a textualist reading of Title II of the Controlled Substances Act and the 1986 Act to find that Safehouse's intended operation violated § 856(a)(2).[331] The Third Circuit reasoned that Congress "found that [the national and international drug market] poses a national threat," and passed the Controlled Substances Act to better control the market.[332] Further, Congress passed § 856 to "stop drug use and dealing at crack houses and the like."[333] As such, the Third Circuit stated that it did not want to be an "arbiter[] of policy,"[334] was merely responsible for applying the laws, and if plaintiffs disagreed they could "lobby Congress to carve out an exception."[335] So, despite the shift in language accompanying the medicalization of the opioid epidemic, the Third Circuit opted for language echoing the potential dangers that drug use imposed upon society.[336]

Second, and most recently, the Supreme Court decided *City of Grants Pass v. Johnson*.[337] In *Grants Pass*, plaintiffs asserted that a city ordinance prohibiting public camping violated the Eighth Amendment.[338] Specifically, plaintiffs claimed that the ordinance effectively criminalized individuals on

326. *See Safehouse*, 985 F.3d at 232 (explaining that § 856(a)(2) prohibits managing or controlling a property and then knowingly and intentionally opening the property to visitors "for the purpose of . . . using a controlled substance").

327. *Id.* at 230–31 ("Safehouse will care for wounds, offer drug treatment and counseling, refer people to social services, distribute overdose-reversal kits, and exchange used syringes for clean ones."); *see also* Alex Kreit, *Safe Injection Sites and the Federal "Crack House" Statute*, 60 B.C. L. REV. 413, 414 (2019) ("A safe injection site is a place where injection drug users can self-administer drugs in a controlled environment under medical supervision.").

328. *See Safehouse*, 985 F.3d at 230–31 (explaining that a consumption room is where individuals can go to inject themselves with drugs and where Safehouse would monitor drug use to ensure safe use practices).

329. *Id.* at 232–38.

330. *Id.*

331. *Id.* at 236 ("[G]ood intentions cannot override the plain text of the statute.").

332. *Id.* at 241.

333. *Id.* at 242.

334. *Id.* at 230.

335. *Id.*

336. *See* Chloe Rigogne, Note, *Unsafe & Unsound: The Future of Supervised Injection Sites After* United States v. Safehouse, 90 FORDHAM L. REV. 2869, 2906–07 (2022) (explaining that courts "should not use [*Safehouse*] as an opportunity to criminalize life-saving actions that are otherwise legal . . . [jeopardizing] the lives of millions suffering from addiction and punish[ing] those who try to help them.")

337. 144 S. Ct. 2202 (2024).

338. *Id.* at 2218.

the basis of status, that is being unhoused.[339] The Court held the ordinance constitutional, stating that it does not "criminalize mere status," but "forbids actions like occupy[ing] a campsite on public property for the purpose of maintaining a temporary place to live."[340]

Although not expressly related to drug use and drug sales, the Court's holding likely has implications for other marginalized communities.[341] In particular, the concurrence shed light on the court's broader practice of characterizing "status."[342] In his concurrence, Justice Thomas suggested that the Court wrongly decided *Robinson v. California*.[343] Justice Thomas reasoned that the holding that the Eighth Amendment prohibits the criminalization of an individual's status conflicted with the plain text and history of the Eighth Amendment.[344]

The dissent, however, suggested that the majority misinterpreted *Robinson*.[345] It reasoned that the majority, by holding the ordinance constitutional, did in fact criminalize the status of being homeless—conduct explicitly prohibited by *Robinson*[346] and a holding that amici for the respondents deemed particularly harmful for minority groups.[347] Further, the dissent expressed concern that the ordinances permitted by the majority "might also implicate other legal issues."[348] A concern for further criminalizing a status deemed defiant by society is therefore inherent in the dissent.[349]

III. PROPOSED SOLUTION: ADDRESSING ADDICTION THROUGH RACIAL REALISM AND INTEREST CONVERGENCE

This part explains the problem and offers a solution. Part III.A explains the past and current conflict of racism's influence on court decisions regarding addiction. Part III.B stresses the necessity in addressing addiction through a CRT lens. Specifically, this Note argues that racial realism and interest convergence support the decriminalization of Schedule II substances

339. *Id.* at 2213–14.

340. *Id.* at 2218.

341. *See* Tony Stanley-Becker, *Challenging the Criminalization of Homelessness Under Fair Housing Law*, 42 MINN. J.L. & INEQ. 109, 153 (2024) ("Because people experiencing homelessness are disproportionately people of color and people with disabilities.").

342. *Grants Pass*, 144 S. Ct. at 2226–27 (Thomas, J., concurring).

343. 370 U.S. 660 (1962); *see Grants Pass*, 144 S. Ct. at 2226–27.

344. *See Grants Pass*, 144 S. Ct. at 2226–27.

345. *See id.* at 2238 (Sotomayor, J., dissenting).

346. *Id.* ("The Ordinances' purpose, text, and enforcement confirm that they target status, not conduct.")

347. *See id.* at 2243; *see also* Brief of Professors William P. Quigley, Jeffrey Adler, Erwin Chemerinsky, Martha Davis, Helen Hershkoff, Stephen Loffredo, Nantiya Ruan, & Laurence H. Tribe as Amici Curiae in Support of Respondents at 22–25, City of Grants Pass v. Johnson, 144 S. Ct. 2204 (2024) (No. 23-175) (explaining that vagrancy laws, similar to the ordinance at issue, have historically been used to subordinate minorities).

348. *Grants Pass*, 144 S. Ct. at 2243 (noting that "similar ordinances will face more days in court").

349. *See generally id.*

as a means of offering some relief to Black individuals with a substance use disorder.

A. Black Lives and Addiction Still Matter: Past Court Decisions Remain Instructive in Understanding the Implications of Recent Court Decisions Related to Addiction

Although opioid related deaths are decreasing in the aggregate, they continue to increase in other communities, specifically Black communities.[350] Therefore, the rhetoric employed by prior court decisions related to addiction elucidates the need to remain attentive to present court rhetoric. Part III.A.1 clarifies the racialization of addiction via court decisions issued during the crack and opioid epidemics. Part III.A.2 discusses the problem with current court language related to addiction.

1. Prior Court Language Evinces the Disparate Treatment of Black and White Individuals with a Substance Use Disorder

In the 1980s and 1990s, courts used language related to crack offenses that perpetuated racial stereotypes and, in part, the subordination of Black individuals.[351] At face value, the language courts used presented as race neutral. Their decisions parroted Congress's concerns, reasoning that crack was dangerous and caused societal harm.[352] However, when closely examining its origins, the meaning of the language Congress used and courts relied on shifts.

First, in reliance on information disseminated by medical professionals, legislators, and law enforcement, courts described crack as "dangerous to society," "highly addictive," and "a menace," and expressed the need to "protect the public" from crack use.[353] Courts did not necessarily praise powder cocaine, but compared to crack, they understood it as 100 times less dangerous.[354] Chemically, the two substances differ very little.[355] Rather, the race of the perceived user and seller exemplified the only quality markedly different between crack and cocaine.[356] For instance, during the 1980s and 1990s, society no longer saw cocaine as a substance of fixation for the "Negro cocaine fiend," but a drug of pleasure for White middle-class and upper-class individuals.[357] Society saw crack, however, as a drug that infiltrated Black communities and caused high rates of crime, disease, and

350. *See* Rosen & Cunningham, *supra* note 173, at 1083.
351. *See supra* Part II.A.
352. *See supra* Part II.A.
353. *See supra* Part II.A.
354. *See* Spade, *supra* note 46, at 1253, 1255–56, 1256 n.136; *see also* James & Jordan, *supra* note 13, at 410.
355. *See* Spade, *supra* note 46, at 1253, 1255–56.
356. *See supra* Part I.A.2 (discussing the minimal differences between crack and cocaine and the racial disparities between individuals who use cocaine and individuals who use crack).
357. *See* Huntington Williams, *supra* note 37, at M12.

the deterioration of the moral "fabric of society."[358] Therefore, legislators, and by default, courts, did not premise their treatment of crack on the drug's chemical composition or effects on the user, but on the drug's association with Black individuals.

Second, courts failed to recognize a notable racial difference in conviction and sentencing rates between crack users and dealers and cocaine users and dealers. Across multiple district and circuit courts, defendants brought claims alleging that crack sentencing laws disproportionately afflicted Black individuals.[359] Courts asserted that Congress did not desire to intentionally criminalize Black individuals but intended to protect society from the evils of crack by instating harsher sentencing guidelines.[360] However, the history of congressional action, and thus the intent that courts so heavily relied on, possesses far more sinister origins than those explicated by the courts.

During slavery and the Reconstruction Era, out of fear of losing their position atop the racial hierarchy, White individuals followed information disseminated by medical professionals.[361] They believed that the freed Black person, absent White supervision or control, was a danger to themselves and society.[362] The concept of the "Negro cocaine fiend" extended this mindset to Black people and drugs.[363] In response, Congress enacted a string of antidrug legislation that increased in punitiveness.[364] Over time, racism became more covert, shrouded in race-neutral language where crime and social and urban ills became code words for the Black existence and, more specifically, Black drug use.[365] Congress then connected the dots between crack and Blackness. In line with preceding antidrug policies, White legislators enacted policies that ensured a disparate impact.[366] Therefore, relying on the assumption that Congress operated with a nondiscriminatory purpose stands indifferent to over 400 years of history.

Conversely, in the early to mid-2000s, the language courts employed in discussing addiction noticeably softened. Even following the introduction of street opioids (e.g., fentanyl), the medicalization framework and the newly adopted language of the courts prevailed. Courts emphasized the risks posed to the individual user, rather than the risks that the individual user posed to society. Accordingly, the harm faced by society did not result from crime or the apprehension of potential danger, but from a wider concern for the public's health and well-being.

Courts parallelled this understanding in their decisions. First, when the government brought actions against individual doctors, courts held against doctors, not for the threat they posed to society, but for their contribution to

358. *See supra* Part II.A.
359. *See supra* Part II.A.
360. *See supra* Part II.A.
361. *See* WASHINGTON, *supra* note 12, at 26–30.
362. *Id.* at 36–38.
363. *See supra* note 357 and accompanying text.
364. *See supra* Part I.A.
365. *See supra* Part I.A.
366. *See supra* notes 193–94 and accompanying text.

addiction, a disease.[367] Second, courts and legislators no longer treated individual users as individuals with a faulty moral compass, but as victims of an epidemic.[368] Third, nuisance claims emphasized the scientific conceptualization of OUD by portraying opioids as a public health emergency, demonstrating courts' willingness to prioritize the health concerns affiliated with opioid use and addiction.[369] Fourth, bankruptcy proceedings classified the opioid epidemic as a public health emergency where individual users and their communities were "victims" who should be treated and provided with a monetary remedy, not punished and placed in jail.[370]

This Note does not mean to deny the patent differences between crack and opioids. Crack was circulated in the streets by individual dealers and had the potential to adversely affect the health of the individual user.[371] Alternatively, at least at the start, opioids were distributed by medical providers and manufacturers beholden to the false understanding that the substances were safe and nonaddicting.[372] But opioids and crack are both Schedule II substances, with a high potential for abuse and with the potential consequence of severe psychological and physical dependence.[373] Thus, they are not so different as to warrant such vastly disparate responses by Congress and, more importantly, by the courts.[374]

Further, this Note does not deny the other factors that likely contributed to differential responses, such as a lack of understanding surrounding crack and the scientific advancements and research in support of addiction that accompanied opioids. But to entirely abandon the influence of race and the role that courts played in perpetuating the disparities discussed here would ignore an important piece of a complicated picture.

2. Present Court Language Signals a Potential Repeat of the 1980s and 1990s in the Courts' Treatment of Addiction in Black Communities

Unfortunately, within the context of drug use and addiction, and more broadly, an individual's status, the present rhetoric of courts appears akin to the harmful language relied on during the 1980s and 1990s. Specifically, courts have reinjected their language with mentions of "crack houses" and the lingering "threat" of drug use.[375] Additionally, there exists a desire from members of the Supreme Court to criminalize status—a holding that the *Robinson* decision, within the context of addiction, has protected for

367. *See supra* Part II.B.1.
368. *See supra* Parts II.B.1–2.
369. *See supra* Part II.B.2.
370. *See supra* note 313 and accompanying text.
371. *See supra* Part I.A.2.
372. *See supra* Part I.A.3.
373. *See supra* Part I.A.
374. *See supra* Part I.A.
375. *See supra* Part II.C.

decades.[376] Therefore, the reemergence of this rhetoric may, as it did in the past, have an adverse effect on Black individuals with a substance use disorder.

B. Critical Race Theory and Addiction

This part offers a solution, guided by CRT, to the issue highlighted above. First, this part explains the reality of the current problem through racial realism. Second, this part explains how interest convergence justifies decriminalizing Schedule II substances as a means of resolving the problem.

1. Real Talk: Racial Realism and Addiction

A logical solution to the aforementioned problem might be to abandon racism, the root cause of these disparities. The idea being that if courts disengage from racial biases, then Black and White defendants, specifically those convicted of drug offenses, will receive equal treatment. However, Professor Bell's racial realism theory recommends abandoning such idealistic thinking and taking a more pragmatic approach.[377]

Black individuals with OUD, in the judiciary's eyes, are "by no means equal to whites" with OUD.[378] However, according to Professor Bell, "the very absence of visible signs of discrimination creates an atmosphere of racial neutrality which encourages whites to believe that racism is a thing of the past."[379] This concept applies aptly to the courts and their language and conduct surrounding addiction. Throughout each stage of illicit drug use in America, there existed no "visible signs of discrimination."[380] Although courts tailored their rhetoric to the drug at issue and the race of the perceived user, they refrained from explicit racial classification of the defendants and victims. Therefore, White individuals likely believed that racism, as it pertains to addiction, remained a "thing of the past."[381] This issue lingers in the present day—although the judiciary's current language related to addiction lacks clear indicators of racial animus, they are not excused from the use of and failure to recognize more covert sentiments in their decisions. Simply put, courts, legislators, and the public must be more realistic because racism is alive, well, and here to stay.

376. *See supra* Part II.C.
377. See Bell, *supra* note 186, at 302.
378. *Id.*
379. *Id.* at 306.
380. *Id.*
381. *Id.*; *see supra* Part I.A.1.

2. Interest Convergence and Addiction: Decriminalizing Schedule II Substances Mutually Benefits White and Black Individuals

Interest convergence, however, may offer a potential solution.[382] Specifically, it would allow for a change in legislation that would protect individuals from racially inflammatory court rhetoric. This part proposes decriminalizing crack, prescription opioids, and street opioids ("Schedule II substances") because it would limit the effects of continued disparities in court language regarding Black and White individuals who use drugs.[383]

a. Decriminalizing Schedule II Substances Satisfies the Interests of White Individuals

White individuals would reap several benefits from decriminalizing Schedule II substances. During the 1980s and 1990s, White individuals prioritized community safety, whereas in the early to mid-2000s, White individuals prioritized the health of epidemic "victims" and the well-being of their communities. Decriminalizing Schedule II drugs would address these concerns and would create an additional economic benefit.

First, communities would experience a likely economic benefit from decriminalizing Schedule II substances.[384] Specifically, a study from 2017 estimated that the costs of OUD and fatal opioid overdoses in 2017 totaled approximately $1.02 trillion.[385] More than one half of this value represented the economic value lost from fatal opioid overdoses.[386] By decriminalizing drugs, economists recognize monetary costs related to addiction would decrease.[387] Therefore, decriminalizing Schedule II substances would decrease costs related to opioid use and would benefit the economy.

Second, decriminalizing Schedule II substances would benefit public health. If Schedule II substances were decriminalized, communities would spend fewer resources on punishing drug use and sales. Thus, communities could allocate more resources and money to managing and treating addiction.[388] Further, individuals with a substance use disorder would experience increased access to treatment absent stigma or punishment for

382. *See* Bell, *supra* note 183, at 22.

383. *See supra* note 82 (discussing Schedule II substances). This part does not address other illicit drugs given the scope of this Note.

384. *See* Florence et al., *supra* note 172, at 7–9.

385. *Id.*

386. *Id.*; *see also* Ropero-Miller & Speaker, *supra* note 172, at 227 (explaining that in 2017 the United States spent $8 billion on the criminal justice system related to the opioid epidemic).

387. *See* Dennis, *supra* note 172, at 129–30 (noting that even if drug use rates increased, spending and costs related to drug use and sales would decrease); *see also* Duke & Gross, *supra* note 172, at 32–40 (discussing the economic benefit of decriminalizing drugs).

388. Wakeman & Rich, *supra* note 171, at 17–18.

seeking care.[389] As a result, rates of infection[390] and death related to substance use would likely decrease.[391] Ultimately, substance use disorder is a treatable condition if the proper resources are made available.[392] However, such treatment is limited because existing legislation, like 21 U.S.C. § 856(a)(2), precludes treatment mechanisms that would otherwise be beneficial.[393] Therefore, decriminalizing Schedule II substances would expand addiction treatment and decrease drug-related illnesses and death.

Third, communities afflicted by drug epidemics will benefit from decriminalizing Schedule II substances. As made clear through nuisance claims, communities were particularly burdened by the effects of the opioid epidemic.[394] Altering the schedule classification for certain substances will decrease the prevalence of such incidents.[395] For instance, a 2022 study found that increasing access to treatment for OUD resulted in decreased levels of public injections and dropped syringes in the community.[396] Additionally, communities likely would not experience an increase in crime and may even experience a decrease in crime.[397] Therefore, decriminalizing Schedule II substances will benefit the well-being of communities.

As such, decriminalizing Schedule II substances will satisfy and may even advance the interests of White individuals—particularly those that arose during the crack and opioid epidemics.

b. Decriminalizing Schedule II Substances Satisfies the Interests of Black Individuals

As the interest convergence theory dictates, this Note next examines how such legislation would advance the goals of Black people. Most importantly, the inflammatory language courts use would have a lesser bearing on Black individuals using and selling drugs. Specifically, the use of rhetoric, whether it dehumanized Black individuals or empathized with White individuals, would be less likely to perpetuate stigma and poor judicial outcomes related to drug use and sales. Further, racial subordination, through the criminalization of drug use and sales, would be a less effective tactic because, pursuant to the proposed solution, there would be no criminal penalties for drug possession.

---

389. *See* Spencer, *supra* note 171, at 16; Buchman et al., *supra* note 28, at 615–16; *see also* NYU LANGONE HEALTH, *supra* note 171 (explaining that research supports the theory that decriminalizing drugs does not lead to an increase in overdose-related deaths).

390. *See* Buchman et al., *supra* note 28, at 615–16; Wakeman & Rich, *supra* note 171, at 17–18.

391. *See* Spencer, *supra* note 171, at 16.

392. *Id.*

393. *See supra* Part II.C.

394. *See supra* Part II.B.2.

395. *See* Ptucha, *supra* note 171, at 942.

396. *Id.*

397. *See* Saito, *supra* note 170, at 271, 389–90 (explaining that decriminalizing opioids would not lead to an increase in crime); Davis et al., *supra* note 170, at 6 (same).

Therefore, through altering the schedule classification for Schedule II substances, the interests of Black individuals converge with the interests of White individuals such that "the remedies, if granted, will secure, advance, or at least not harm societal interests deemed important by middle- and upper-class whites."[398]

c. Potential Limitations in Applying the Interest Convergence Theory to Addiction

The primary critique of this proposed solution is twofold. First, CRT scholars, such as Professor Justin Driver, reject interest convergence as a plausible theory. Second, courts and legislators, despite the benefits of decriminalizing Schedule II substances, continue to see a need for punishing substance use.

First, Professor Driver's critiques of interest convergence should be reexamined within the realm of drug use and addiction.[399] Professor Driver contends that interest convergence "sharply discounts the capacity of black people to participate in their own uplift."[400] However, this proposed solution is not operating under the assertion that Black individuals are incapable of fighting for equitable treatment by the courts.[401] As identified by Professor Bell's theory of racial realism, racial subordination precludes even the most aggressive battles from succeeding in their full capacity.[402] Thus, according to Professor Driver, proposing a solution that acknowledges this reality, while also attempting to uplift Black individuals and reduce Black suffering, falls short of treating Black individuals as mere bystanders.[403] Additionally, Professor Driver expresses the concern that interest convergence enforces a false perception of judges and courts: that they exist for the sole purpose of serving White interests and disparaging Black interests.[404] And although this Note does not propose a solution on grounds so extreme as Professor Driver's, it evinces the exact concern he overlooks. As made clear by differences in rhetoric, courts appear to, explicitly or implicitly, respond more favorably when White interests, and more specifically White lives, are at stake. This observation, and the recent shift in language similar to that of the 1980s and 1990s, emphasizes the need for following a framework that acknowledges this history. Further, Professor Driver purports that interest convergence too closely compares the existence of Black individuals to that

398. Bell, *supra* note 183, at 22.
399. *See* Driver, *supra* note 184, at 175–79. Professor Driver makes several critiques. *Id.* For the purpose of this Note, the author has selected the few that best apply to the problem and proposed solution.
400. *Id.*
401. *See id.*
402. *See* Bell, *supra* note 186, at 302; *see also supra* Part III.B.1.
403. *See* Driver, *supra* note 184, at 175–79.
404. *See id.* at 180.

of their enslaved ancestors.[405] Again, this Note pushes proponents of this argument to revisit the rhetoric courts and legislators employed, starting in the 1600s to present day. Instead of enslaving Black individuals or issuing decisions and legislation exhibiting explicit racial animus, courts rely on racially coded language to issue decisions that disregard blatant racial disparities in conviction and incarceration rates, limit the potential for necessary treatment, or establish precedent that could make the very status of an individual with a substance use disorder a federal crime.[406] This Note does not intend to discount the significant progress made but instead stresses that, when it comes to addiction, progress may not be as significant as some believe.

Lastly, Professor Driver ends his critique of interest convergence, not by fully discrediting the theory, but by asserting that it still contains value if combined with other change-enabling strategies.[407] Here, the proposed solution is accompanied by the theory of racial realism and several benefits that extend beyond those of convergent interests.[408]

Second, courts and legislatures must step away from the continued implementation of punitive drug policy and legislation. Adversaries to the decriminalization of controlled substances often echo the concerns of courts and legislators of the past. That is, more individuals will use drugs leading to more deaths from overdoses, and crime and disease will increase as dangerous drug analogues continue to become more prevalent.[409] But such a mindset stifles progress and precludes resolving a decades-long problem.

Despite the increased public health efforts accompanying the opioid epidemic, Black freedom and lives remain at stake.[410] Part III.B.2.i and Part III.B.2.ii highlight several benefits to decriminalizing Schedule II substances.[411] Further, other countries have successfully decriminalized the same substances.[412] And, although this solution will not rid America of its

405. *See id.* at 171–72. ("This misperception—that the status of blacks and whites has been characterized by continuity rather than change during the last several decades—erroneously minimizes one of the leading transformations of American society . . . .").

406. *See* supra Parts II.B–C.

407. *See* Driver, *supra* note 184, at 197.

408. *See supra* Parts III.B.2.i–ii.

409. *See* Saito, *supra* note 170, at 389–90.

410. *See supra* Parts I.B.2–3; *see also* James & Jordan, *supra* note 13, at 416 ("Despite the shift to a public health framework, not enough has changed for Black people, in terms of treatment.").

411. *See supra* Parts III.B.2.i–ii.

412. One notable example includes Portugal. *See* Mann, *supra* note 169; O'NEILL INST., *supra* note 169, at 1; Paun & Hernandez-Morales, *supra* note 169. Portugal is smaller than the United States; however, it serves as a small-scale example of how decriminalizing illicit substances might play out. *See* O'NEILL INST., *supra* note 169, at 1. In 2001, Portugal decriminalized the consumption, acquisition, and possession for personal consumption of illicit drugs. *See id.* Over a twenty-year period, drug overdose related deaths have decreased by over 75 percent. *See id.*; *see also* Paun & Hernandez-Morales, *supra* note 169. Oregon attempted to implement similar legislation in 2020, but ultimately failed. *See* Paun & Hernandez-Morales, *supra* note 169. Legislators attributed this failure to factors other than the law itself (e.g., delayed implementation and gauging the success of the program on only three months of data). *See id.*

history surrounding racism and drugs, it possesses the potential to lessen the effects for future generations.

As discussed throughout this Note, court conduct related to drug use is a problem that disproportionately affects Black people, but attempting to resolve it will also benefit White people. This reasoning may present as a cynical or reactive solution. However, America is not in a place where it is ready to place Black rights on equal footing with White rights.[413] Therefore, acknowledging racial realism and applying an interest convergence framework allow for a degree of progress that is plausible at this point in American history.

CONCLUSION

Judicial interpretation and reasoning do not occur in a vacuum. Rather, they occur against a backdrop of heated congressional debates, public outcry, and hot-button news articles. Courts are neither immune to their own biases nor the biases of the public and legislators—a phenomenon that becomes exceedingly clear in court rhetoric pertaining to addiction.

To limit the effects of harmful court language related to addiction, this Note proposes remediating drug policy pursuant to CRT. By acknowledging the persistent subordination of Black individuals by White individuals and the necessity of recognizing a mutual interest in decriminalizing Schedule II substances, Black individuals may experience some relief from the adverse effects of racism in the context of addiction. Although the idea of decriminalization of drug use itself is not novel, rethinking it through a CRT lens emphasizes the necessity of its implementation and explains why the solution might work given modern racial climates.

413. *See* Bell, *supra* note 186, at 308; *see also* Bennett Capers, *Evidence Without Rules*, 94 NOTRE DAME L. REV. 867, 886 (2019) ("[T]he habit of ignoring race is understood to be a graceful, even generous, liberal gesture." (quoting TONI MORRISON, PLAYING IN THE DARK: WHITENESS AND THE LITERARY IMAGINATION 9 (1992))).