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Opioids Are The New Black

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The crack epidemic swept through the black community in the United States in the early 1980s. Despite the increasing use of powder cocaine in metropolitan areas and suburbs, the "crackheads" giving birth to "crack babies" were subject to narratives that portrayed black drug users as a threat to others, which was to be contained rather than treated. The Anti-Drug Abuse Act of 1986 created stricter penalties for users. The mandatory minimums disproportionately incarcerated African Americans and adversely impacted a number of urban neighborhoods. The psychology driving the mandate to incarcerate African American, impoverished drug addicts relied on tales of gang warfare, laziness, and child neglect.

Now, the opioid crisis is considered a national emergency, as declared by President Trump in October 2017. The users of these drugs span an economic and racial spectrum, with a particular emphasis in rural communities. For example, one in seven opioid users in Ohio is a construction worker. The employment of crack addicts in the 1980s was not a subject of research, legislation, or news.

This Article examines the importance of stories, particularly those with racial tropes, in the creation and enforcement of drug legislation. The environments in which crack was prevalent are marked by economic distress. Disinvestment and high poverty rates in these low-income, minority neighborhoods are more commonly framed as personal failures by criminals. The story of opioids is centered on a group of people who can be saved through healthcare, treatment, and leniency. If the stories of crack addicts focused on victims of external circumstances rather than villains by individual choice, it is likely that the persistence of poverty in African American neighborhoods would have a different ending.

Introduction

Public perception reinforced by negative stereotypes can have a devastating effect on oppressed communities. When fear and hate are embodied into a trope, it creates an opportunity to capitalize on racism and nationalism in an effort to codify irrational emotions into legislation and policies. This Article examines the use of narratives to drive drug policy in the United States, with particular attention to the stark differences in the crack epidemic and the current opioid crisis.

Part I provides an overview of the opioid crisis, including a timeline, demographics, and a look at the implementation of substance abuse treatment as an antidote. Part II revisits the crack versus cocaine debate, highlighting their distinctions and sentencing differences through the lens of imagery and storytelling. The imagery is expanded in Part III where crack, cocaine, and opioid tropes are explored—particularly as they relate to children—for the purpose of illustrating the different perspectives among the three. Part IV explores the use of narrative in other contexts to show the pervasiveness of racial and ethnic stereotypes on policies and law. Specifically, the use of narratives in the areas of terrorism, immigration, natural disasters, and welfare are described. This Article does not purport to solve the problems of racism. However, Part V explains that narratives, in the context of this Article, are a manifestation of implicit bias and negative stereotypes inherent in these stories, which can ultimately be tempered by real

interactions. This Part concludes by suggesting that experiential learning can be an effective opportunity to address the manipulation of laws by negative narratives.

I. The Opioid Crisis

A. Timeline and Overview

There are two distinct trends that drive the Opioid Crisis: prescription opioid overdoses and heroin overdoses.[1] The Opioid Crisis began in 1995 when the Food and Drug Administration (FDA) approved OxyContin.[2] Prior to this approval, opioid pain medications were only prescribed for acute pain and cancer pain.[3] The FDA believed OxyContin would not be an addictive drug based on the experience of a similar drug that was approved in 1987, MS Contin, which had no significant reports of abuse or misuse.[4] Opioid misuse and abuse took off in the early 2000s. An estimated one out of five patients with non-cancer or chronic–related pain are prescribed opioids.[5] From 1999 to 2014, prescription opioid sales quadrupled, but the amount of pain Americans reported did not increase.[6] The increase in prescription and use of opioids regarding chronic pain has been linked to abuse and overdose.[7] Approximately 21% to 29% of patients with chronic pain who have been prescribed opioids misuse them.[8] In 1999, approximately 400,000 people admitted to using OxyContin for non-medical purposes.[9] In 2002, approximately 1.9 million people admitted to using OxyContin for non-medical purposes, and in 2003, that number increased to 2.8 million.[10] The increased misuse of OxyContin and other opioid medication has led to a drastic increase in the number of over-

1. Ctrs. for Disease Control & Prevention, *Opioid Data Analysis and Resources*, CDC.gov (last updated May 7, 2019), https://www.cdc.gov/drugoverdose/data/analysis.html.

2. U.S. Food & Drug Administration, *Timeline of Selected FDA Activities & Significant Events Addressing Opioid Misuse & Abuse*, FDA.gov, https://www.fda.gov/media/85029/download [hereinafter FDA, *Timeline of Selected FDA Activities*].

3. *Id.*

4. *Id.*

5. Ctrs. for Disease Control & Prevention, *Prescription Opioid Data*, CDC.gov (last updated June 27, 2019), https://www.cdc.gov/drugoverdose/data/prescribing.html [hereinafter CDC, *Prescription Opioid Data*].

6. *Id.*

7. *Id.*

8. Nat'l Inst. on Drug Abuse, Opioid Overdose Crisis, DrugAbuse.gov (last updated Jan. 2019), https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis#six.

9. FDA, *Timeline of Selected FDA Activities*, *supra* note 2.

10. *Id.*

dose deaths involving opioids. About 60% of drug overdose deaths involve the use of an opioid.[11]

Since the spike in opioid prescriptions and misuse, the FDA and other government agencies have taken steps to reduce opioid abuse and addiction. In 2009, the FDA partnered with the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to help ensure that methadone[12] would be administered safely.[13] Methadone works by tricking the brain into thinking it is still getting an opioid so there are no withdrawals, but methadone does not get the person high.[14] In 2014, the FDA approved Evzio, a naloxone, for the emergency treatment of opioid overdose.[15] Naloxone is a medication that reverses the effects of an opioid overdose[16] by binding to opioid receptors and blocking the effects of other opioids.[17] Evzio is the first auto-injector to deliver naloxone outside of a healthcare setting.[18] In 2015, the FDA approved Narcan, a nasal spray version of naloxone.[19] Evzio and Narcan only prevent the possibility of death from an overdose and do not prevent at-risk persons from overdosing again. In 2016, the FDA began focusing on a plan to reverse the epidemic, while still providing patients access to effective pain relief.[20] The FDA released guidelines for use of methadone and buprenorphine[21] in

11. CTRS. FOR DISEASE CONTROL & PREVENTION, *Data Overview, Overview of the Drug Overdose Epidemic: Behind the Numbers*, CDC.GOV (last updated Dec. 19, 2018), https://www.cdc.gov/drugoverdose/data/index.html [hereinafter CDC, *Overview of the Drug Overdose Epidemic*].

12. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Methadone*, SAMHSA.GOV (last updated Aug. 1, 2019), https://www.samhsa.gov/medication-assisted-treatment/treatment/methadone ("Methadone is a medication used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates.").

13. FDA, *Timeline of Selected FDA Activities*, *supra* note 2.

14. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Medication and Counseling Treatment*, SAMHSA.GOV (last updated May 7, 2019), https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat [hereinafter SAMHSA, *Medication and Counseling Treatment*].

15. FDA, *Timeline of Selected FDA Activities*, *supra* note 2.

16. *Id.*; *see also* NAT'L INST. ON DRUG ABUSE, *Opioid Overdose Reversal with Naloxone (Narcan, Evzio)*, DRUGABUSE.GOV (last updated Apr. 2018), https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio [hereinafter NIDA, *Opioid Overdose Reversal with Naloxone*].

17. NIDA, *Opioid Overdose Reversal with Naloxone*, *supra* note 16.

18. FDA, *Timeline of Selected FDA Activities*, *supra* note 2.

19. *Id.*

20. *Id.*

21. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *Buprenorphine*, SAMHSA.GOV (last updated May 7, 2019), https://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine ("Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine.").

medication-assisted treatment (MAT) of opioid use disorder.[22] These steps taken by the FDA have slowed the opioid crisis but have not solved the issue.

Heroin use is another concern surrounding the opioid crisis, because opioid misuse and abuse is a key indicator of future heroin use and heroin-related overdose deaths. In 2017, the number of overdose deaths involving opioids and heroin was six times higher than 1999.[23] From 2005 to 2011, the population with the highest rate of heroin initiation was those with prior opioid misuse and abuse.[24] The heroin initiation rate was approximately nineteen times greater for those who previously misused opioids than those who did not.[25] Of the people that do use heroin, approximately 80% reported prior opioid misuse.[26] Heroin-related overdose deaths are usually in combination with another drug. Fifty-nine percent of heroin-related overdose deaths involved at least one other drug.[27] The problem with an increase of heroin use is that it is strongly correlated with heroin-related overdose deaths.[28]

B. Demographics

Deaths from drug overdose and prescription opioid use have increased across the board for adults of every gender, race, and age.[29] However, deaths from prescription opioid overdoses among certain subgroups are higher than others from 1999 to 2016.[30] Overdose rates were the highest among twenty-five to fifty-four-year-old adults.[31]

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22. FDA, *Timeline of Selected FDA Activities*, *supra* note 2.

23. CTRS. FOR DISEASE CONTROL & PREVENTION, *Understanding the Epidemic*, CDC.GOV (last updated Dec. 19, 2018), https://www.cdc.gov/drugoverdose/epidemic/index.html.

24. PRADIP K. MUHURI ET AL., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SAMHSA.GOV (Aug. 2013), https://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm ("At Risk for Initiation of Heroin Use is defined as persons who did not use heroin in their lifetime or who initiated heroin within 12 months before this interview.").

25. *Id.*

26. *Id.*

27. Christopher M. Jones et al., *Vital Signs: Demographic and Substance Use Trends Among Heroin Users—United States, 2002–2013*, 64 MORBIDITY & MORTALITY WKLY. REP. 709, 722 (July 10, 2015).

28. *Id.* at 722.

29. CDC, *Overview of the Drug Overdose Epidemic*, *supra* note 11.

30. HOLLY HEDEGARRD ET AL., Nat'l Ctr. For Health Statistics, U.S. Dep't of Health & Human Servs., NCHS DATA BRIEF NO. 294, DRUG OVERDOSE DEATHS IN THE UNITED STATES, 1999-2016 1, 1–2 (2017), https://www.cdc.gov/nchs/data/databriefs/db294.pdf.

31. CDC, *Overview of the Drug Overdose Epidemic*, *supra* note 11; *see also* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., HHS PUB.NO. SMA 15-4927, BEHAVIORAL HEALTH TRENDS IN THE UNITED STATES: RESULTS FROM THE 2014 NATIONAL SURVEY ON

Overdose rates were higher for non-Hispanic whites compared to non-Hispanic blacks and Hispanics.[32] Overdose rates were higher among men compared to women.[33] However, the subgroups that have shown the greatest increase in prescription opioid use, and those more likely to use prescription opioids, are different from the subgroups who display higher rates of overdoses.[34] Adults forty years or older are more likely to use prescription opioids than twenty to thirty-one-year-old adults.[35] Women are more likely to use prescription opioids than men.[36] Additionally, non-Hispanic whites are more likely to use prescription opioids than Hispanics, however, the rate between non-Hispanic whites and non-Hispanic blacks are not significantly different.[37]

Similar to opioids, rates of heroin use and overdose have increased across all subgroups.[38] Rates for heroin use are the highest among males, adults between the ages of eighteen and twenty-five, and adults with an annual household income of $20,000 or less, adults living in urban areas, and persons with no health insurance or with Medicaid.[39] However, "the greatest increases in heroin use occurred in demographic groups that historically have had lower rates of heroin use . . . ."[40] Heroin use doubled for women and more than doubled for non-Hispanic whites.[41] Heroin use has also increased for those who are privately insured and those with higher incomes.[42] This increase among women and non-Hispanic whites for heroin use is due to several factors, but of those factors, opioid use is the strongest risk factor.[43] Based on the high rate of prescription use among women and non-Hispanic whites, the doubling rate of heroin use does not come as much of a surprise.

DRUG USE AND HEALTH 1, 26 (2015), https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf [hereinafter SAMHSA, Behavioral Health Trends].

32. CDC, *Prescription Opioid Data*, *supra* note 5.

33. *Id.*

34. STEVEN M. FRENK ET AL., NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., NCHS DATA BRIEF NO. 189, PRESCRIPTION OPIOID ANALGESIC USE AMONG ADULTS: UNITED STATES, 1999-2012 1, 3 (2015), https://www.cdc.gov/nchs/data/databriefs/db189.pdf.

35. *Id.*

36. *Id.*

37. *Id.*

38. Jones et al., *supra* note 27, at 719.

39. *Id.*

40. *Id.* at 722.

41. *Id.*

42. *Id.* at 723.

43. *Id.* at 722; *see also* MUHURI ET AL., *supra* note 24.

America's struggles with opioids are grounded in a multibillion-dollar pharmaceutical industry. A combination of marketing to doctors to push pills, coupled with pressure on doctors to see more patients faster, led to a rise in the number of opioid prescriptions written in the United States.[44] Additionally, the United States is one of the few countries that allows pharmaceutical companies to advertise on television—adding even more pressure on doctors to prescribe when their patients come in requesting a certain drug.[45] On top of that, the training and research on opioid use given to prescribing doctors was primitive at the time that the number of opioid prescriptions began to climb, with many believing there was a low risk of addiction absent family history.[46] Only too late, did our nation realize the addictive power of these drugs.[47]

The overall national prescription rate for opioid prescriptions peaked in 2012 at more than 255 million prescriptions and with a prescribing rate of approximately 81 prescriptions per 100 persons.[48] The states with the highest prescription rate of 107 prescriptions per 100 persons or more in 2012 include: Alabama, Arkansas, Indiana, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and West Virginia.[49] The prescription rate from 2012 to 2016 decreased to about 66 prescriptions per 100 persons, the lowest it has been in a decade.[50] However, in 2016, eleven states had a prescribing rate of 83 prescriptions per 100 persons.[51] Of those eleven states Alabama, Tennessee, and Arkansas had a prescribing rate of 107 prescriptions per 100 persons.[52] In Alabama, two counties have a prescribing rate of 200+ prescriptions per 100 persons,[53] which is 2 prescriptions per 1 person. In Tennessee, 64 out of the 95 counties have a prescription rate of 100+

44. Owen Amos, *Why opioids are such an American problem*, BBC NEWS, Oct. 25, 2017, https://www.bbc.com/news/world-us-canada-41701718.

45. *Id.*

46. *Id.*

47. *Id.*

48. CTRS. FOR DISEASE CONTROL & PREVENTION, *U.S. Opioid Prescribing Rate Maps*, CDC .GOV (last updated Oct. 3, 2018), https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html [hereinafter CDC, *U.S. Opioid Prescribing Rate Maps*].

49. CTRS. FOR DISEASE CONTROL & PREVENTION, *U.S. State Prescribing Rates, 2012*, CDC .GOV (last updated July 31, 2017), https://www.cdc.gov/drugoverdose/maps/rxstate2012.html [hereinafter CDC, *U.S. Prescribing Rates, 2012*].

50. CDC, *U.S. Opioid Prescribing Rate Maps*, *supra* note 48.

51. CTRS. FOR DISEASE CONTROL & PREVENTION, *U.S. State Prescribing Rates, 2016*, CDC .GOV (last updated, July 31, 2017), https://www.cdc.gov/drugoverdose/maps/rxstate2016.html.

52. *Id.*

53. *Id.*

prescriptions per 100 persons.[54] Across the United States, about a quarter of the counties had a prescription rate of 100 prescriptions per 100 persons.[55]

C. Focus on Treatment

Medication-assisted treatment (MAT) is the use of medications, such as methadone, with counseling and behavioral therapies to help treat opioid use disorder.[56] MAT is primarily used for persons with an opioid use disorder and heroin addiction.[57] Since the Opioid Crisis involves both opioid and heroin addiction, MAT seems to be a great solution. In 2013, an estimated 1.8 million people had an opioid use disorder with regard to prescription pain relievers and about 517,000 had such a disorder with regard to heroin use.[58] MAT has a high level of treatment retention and can effectively reduce opioid use[59] by lessening opioid cravings and relieving the effects of opioid withdrawals.[60] Abstinence-based treatment has shown limited effectiveness for recently detoxified opioid users.[61] This treatment can also be considered more harmful to persons with opioid use disorder because the loss of tolerance from the abstinence leads to an increased risk of fatal overdose if one relapses.[62] MAT has not been widely accepted, some believe this is due to the public misconception that MAT just replaces one drug with another.[63]

Treatment costs for opioid addiction have become a prominent issue surrounding the Opioid Crisis. In 2009, "health insurance payers spent $24 billion on substance use disorders (SUDs) treatment . . . ."[64] Of that $24 billion, Medicaid was responsible for 21%.[65] Medicaid has

54. CTRS. FOR DISEASE CONTROL & PREVENTION, *U.S. County Prescribing Rates, 2016*, CDC .GOV (last updated July 31, 2017), https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html.

55. *Id.*

56. SAMHSA, *Medication and Counseling Treatment, supra* note 14.

57. *Id.*

58. *Id.*

59. Catherine Anne Fullerton et al., *Medication-Assisted Treatment With Methadone: Assessing the Evidence*, 65 PSYCHIATRIC SERVS. 146, 157 (2014); *see also* Cindy Parks Thomas et al., *Medication-Assisted Treatment With Buprenorphine: Assessing the Evidence*, 65 PSYCHIATRIC SERVS. 158, 167 (2014).

60. Hilary Smith Connery, *Medication-Assisted Treatment of Opioid Use Disorder: Review of the Evidence and Future Directions*, 23 HARVARD REV. OF PSYCHIATRY 63, 65 (2015).

61. *Id.* at 69.

62. *Id.*

63. SAMHSA, *Medication and Counseling Treatment*, *supra* note 14.

64. KINIKA YOUNG, *Medicaid's Important Role to Curb Opioid Abuse: An Underutilized Tool in Tennessee*, TENNESSEE JUSTICE CENTER 1, 2 (Oct. 23, 2017), https://tnjustice.org/wp-content/uploads/2016/08/TJC-Opioid-Epidemic-Policy-Brief.pdf.

65. *Id.*

paid for about a quarter of all buprenorphine MAT for opioid use disorder.[66] However, these payments by Medicaid do not take into account the fact that many people with substance use disorders do not have employment, so other healthcare costs such as mental health treatment, emergency room services, and inpatient care are not covered by employer coverage.[67] Without coverage from an employer or Medicaid expansion to cover more costs of treatment for substance use disorder, persons with the disorder will not be able to seek the help they need. In 2015, all states covered the first component of MAT—the medication—through the state's Medicaid program.[68] However, states do not cover all three medications for MAT and only one medication is covered by every state.[69] The second component, therapy, varies from state to state and some states do not cover this component at all.[70]

Even though some states do not fully cover substance use disorder treatments such as MAT for opioid use disorder, the expansion of Medicaid under the Affordable Care Act (ACA) has given states tools to fund such treatments.[71] State Medicaid agencies can design and pay for a variety of programs to address the Opioid Crisis through the State Plan Amendments.[72] Through State Plan Amendments, states can adjust their benefit packages to improve opioid prevention and treatment.[73] States can limit opioid prescriptions obtained through Medicaid, expand Medicaid's access to and use of the state's Prescription Drug Monitoring Program (PDMP), improve access to medications used in MAT, and add naloxone to Medicaid's preferred drug lists.[74] By expanding Medicaid's access to PDMP, Medicaid can identify enrolled individuals who may be at risk of opioid abuse (such as the demographic groups mentioned above) and identify providers that

66. *Id.*

67. *Id.*

68. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, REPORT TO CONG. ON MEDICAID & CHIP, CH. 2: MEDICAID & THE OPIOID EPIDEMIC 59, 71 (June 2017), https://www.macpac.gov/wp-content/uploads/2017/06/June-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

69. *Id.*

70. *Id.*

71. Deborah Bachrach et al., *Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis*, STATE HEALTH REFORM ASSISTANCE NETWORK 1, 1 (July 2016), https://www.shvs.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf.

72. *Id.* at 2.

73. *Id.*

74. *Id.* (Prescription Drug Monitoring Program (PDMP) is defined as "a state database containing information about prescriptions for controlled substances, to identify Medicaid enrolled individuals who may be at-risk of opioid abuse and providers with lenient prescribing practices.").

are lenient with prescribing opioids.[75] To improve access to medications in MAT, states can modify or eliminate authorization requirements to allow access to those medications.[76] States can also review MAT drug policies to be sure they do not impose limits on those drugs that are evidence-based and found to be effective.[77] Some states have incorporated some of the State Plan Amendments into their Medicaid program.[78] For example, Washington's Medicaid Agency uses PMDP to identify beneficiaries with frequent controlled substance prescriptions and providers that write above average prescriptions.[79]

State Medicaid programs, with the ACA, can start Health Homes that provide care services to persons with a substance use disorder.[80] These Health Homes would provide individualized care plans, such as primary health care providers, behavioral therapists, and community-based organizations.[81] Health Homes also provide MAT programs that individuals can use.[82] Vermont uses Health Homes to combat opioid addiction and calls this initiative the Hub and Spoke Initiative.[83] The hubs are regional opioid treatment program (OTP) facilities that coordinate care and support for complex patients and dispense methadone, which is restricted by federal law to OTP facilities.[84] The spokes provide patient-centered medical homes for patients with less complex needs, such as buprenorphine.[85] Medicaid may not be a popular topic for discussion, but it definitely offers several solutions to reduce the Opioid Crisis and prevent overdose deaths related to opioid and heroin addiction.

The opioid crisis is not the first drug epidemic in the United States. Crack and cocaine use skyrocketed in the 1980s. The next Parts compare these drugs to one another and to opioids.

II. Cocaine and crack

A. Cocaine

Cocaine is derived from coca leaves typically grown in Bolivia, Peru, and Colombia, and has been used around the world for hun-

75. *Id.*
76. *Id.*
77. Bachrach et al., *supra* note 71, at 2.
78. *Id.*
79. *Id.*
80. *Id.* at 3.
81. *Id.*
82. *Id.*
83. Medicaid & CHIP Payment & Access Comm'n, *supra* note 68, at 72.
84. *Id.* at 72–73.
85. *Id.* at 73–74.

dreds of years.[86] Commonly referred to as "coke," "crack," "flake," or "snow," the stimulant is used primarily for its euphoria-producing qualities.[87] Early in American history, drug use was not met with the negative stigma it is today. In 1884, when cocaine was introduced to the United States, it was widely popular and viewed as an over-the-counter cure for common illnesses.[88] The stimulant was prescribed as an anesthetic for everything ranging from common allergies to morphine addiction.[89] It was also a common ingredient in various medications, pharmaceuticals, wines, cigarettes, and the great American drink, Coca-Cola.[90] As use proliferated, Americans did not equate drugs with crime or violence.[91] However, by the end of the nineteenth century, cocaine's adverse health effects and addictive nature came to light.[92] In 1906, Congress enacted the Pure Food and Drug Act, which limited the distribution of cocaine by requiring medicine labels to identify the contents and active ingredients of drugs.[93] The Act was the first of a series of laws aimed at consumer protection. As a result, the Pure Food and Drug Act did not set a limit on a quantity contained in the medicine, only that the labeling of the medication's ingredients be labeled accurately.[94]

Beginning around the turn of the twentieth century, the link between drugs and violence began to grow.[95] Americans began arguing that cocaine use correlated with the commission of violent crimes.[96] Until major federal programs were enacted, state and local governments dealt with the growing concern surrounding drug use.[97] The paradigm in which cocaine use is viewed today was perpetuated in the

86. Spencer A. Stone, *Federal Drug Sentencing—What Was Congress Smoking? The Uncertain Distinction Between "Cocaine" and "Cocaine Base" in the Anti-Drug Abuse Act of 1986*, 30 W. NEW ENG. L. REV. 297, 303 (2007); U.S. DEP'T OF JUSTICE, DRUG ENF'T ADMIN., DRUGS OF ABUSE: A DEA RES. GUIDE 2017 EDITION 51 (2017), https://www.https://www.dea.gov/sites/default/files/drug_of_abuse.pdf.

87. U.S. DEP'T OF JUSTICE, *supra* note 86, at 51.

88. Shima Baradaran, *Drugs and Violence*, 88 S. CAL. L. REV. 227, 236 (2015).

89. Stone, *supra* note 86, at 303–04.

90. *Id.* at 303.

91. *Id.*

92. *Id.* at 304.

93. Milton Mollen et al., *What are the Objectives of Our Drug Policy?*, 28 FORDHAM URB. L.J. 24, 28 (2000); Pure Food and Drugs Act of 1906, Pub. L. No. 59-384, 34 Stat. 768 (1906) (repealed 1938).

94. Mollen et al., *supra* note 93; Pure Food and Drugs Act, Pub. L. No. 59-384, 34 Stat. 768 (1906) (repealed 1938).

95. Deborah Ahrens, *Methademic: Drug Panic in an Age of Ambivalence*, 37 FLA. ST. U. L. REV. 841, 850 (2010) [hereinafter Ahrens, *Methademic*].

96. *Id.*

97. *Id.* at 849–50.

South in the early nineteenth century.[98] "Fear of cocaine-using African Americans came at a time when lynching, disenfranchisement, and legally-enforced segregation were still central features of the American landscape."[99] States in the South enacted anti-cocaine legislation to address the concerns of the "drug-crazed, sex-mad negroes" and "cocainized black[s]."[100] A federal survey even argued that cocaine use was the direct cause of rapes committed by African Americans.[101] Several journals and medical reports even linked cocaine use to "violent attacks by black men on southern white men."[102] In 1911, a report was released that stated it was the opinion of government entities that the "misuse of cocaine is a direct incentive to crime."[103]

As concerns grew, linking cocaine and other drug use to violent crimes, Congress enacted the Harrison Act in 1914.[104] This was the first federal act enacted to penalize drug use.[105] The Act was aimed at limiting the quantity of narcotics dispensed over the counter.[106] The Act required a patient to obtain a prescription for cocaine.[107] However, by 1918, the Act was viewed as an outright ban on drugs by the executive and judicial branches of government.[108] Seemingly overnight, the drugs many Americans were accustomed to and relied on were unavailable. This led to increased criminal activity to support addictions—fortifying the link between drug use and criminal activity.[109] The Pure Food and Drug Act and, subsequently, the Harrison Act reflected the anti-drug sentiment of Americans in the early twentieth century.

Due to the Harrison Act's perpetuation of fear surrounding cocaine violence, the United States saw a dramatic increase in drug convictions in the 1920s.[110] It is estimated that in 1928, almost one-third of

98. Baradaran, *supra* note 88, at 238.

99. Ahrens, *Methademic*, *supra* note 95.

100. Baradaran, *supra* note 88, at 238; Kathleen Auerhahn, *The Split Labor Market and the Origins of Antidrug Legislation in the United States*, 24 L. & SOC. INQUIRY 411, 426 (1999).

101. Baradaran, *supra* note 88, at 238.

102. *Id.*; Catherine Carstairs, "*The Most Dangerous Drug": Images of African-Americans and Cocaine Use in the Progressive Era*, 7 LEFT HIST. 46, 46 (2000).

103. Baradaran, *supra* note 88, at 239.

104. Harrison Narcotics Act, Pub. L. No. 63-223, 38 Stat. 785 (1914) *repealed by* Controlled Substances Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236 (codified as amended at 21 U.S.C. § 801 (2012)).

105. Baradaran, *supra* note 88, at 240.

106. *Id.* at 241.

107. *Id.*

108. *Id.*

109. *Id.* at 241–42.

110. *Id.* at 242.

federal inmates were Harrison Act violators.[111] The 1940s saw legislation aimed at marijuana possession and use.[112] The 1950s were characterized by strict drug laws.[113] The Boggs Act of 1951 "increased penalties for drug use by four times and included mandatory penalties."[114] In 1954, President Dwight Eisenhower coined the term "war on drugs."[115] This led to the enactment of the Narcotic Control Act of 1956, which established even stricter punishments for drug use and possession by increasing the mandatory minimum sentences for many narcotic violations.[116] The 1960s saw a more liberal view of drug use as marijuana became popular in the middle class.[117] Despite this relaxed perception of drugs, between 1940 and 1970, politicians and the media promoted the perception that drugs lead to violence and criminal activity.[118]

In 1971, President Richard Nixon followed President Eisenhower's lead and initiated a "war on drugs," condemning drug abuse as "public enemy number one in the United States."[119] In 1970, Congress passed the Comprehensive Drug Abuse Prevention and Control Act.[120] Title II of the Act, entitled the Controlled Substances Act, "is the source of the five schedules currently in use to define federally regulated drugs."[121] Section 841(a) made "it unlawful to manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance"; the Act also "punished all cocaine violations with 'not more than 15 years' of imprisonment."[122]

During the Gerald Ford and Jimmy Carter administrations, drug policy was lax compared to the Nixon administration. However, in 1980, President Ronald Reagan returned the country to the anti-narcotic stance it embodied with the previous "war on drugs" slogan. By 1984, over 4 million Americans were using cocaine.[123] President Rea-

111. Baradaran, *supra* note 88, at 242.

112. *Id.* at 242–44.

113. *Id.* at 244–46.

114. *Id.* at 245.

115. *Id.*

116. Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567. (1956); Baradaran, *supra* note 88, at 245.

117. Baradaran, *supra* note 88, at 246.

118. *Id.*

119. *Id.* at 246–47.

120. Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. § 802 (1970).

121. Stone, *supra* note 86, at 309–10.

122. 21 U.S.C. § 841(a) (1970); Stone, *supra* note 86, at 310.

123. Office of Drug Abuse Policy, 1984 National Strategy for Prevention of Drug Abuse and Drug Trafficking 1, 3 (1984).

gan intended to "turn the tide against illegal drugs," so in 1984 he employed the National Strategy for the Prevention of Drug Abuse and Drug Trafficking, which set the "national goal to conquer drug abuse and ensure a safe and productive future for our children and our nation."[124]

Despite President Reagan's attempt at eliminating drug use, "crack cocaine" became popular in the mid-1980s, especially in inner cities.[125] The 1980s also saw the enactment of a major anti-drug law, the Anti-Drug Abuse Act of 1986.[126] The Act continued the precedent of established mandatory minimum sentences.[127] The Anti-Drug Abuse Act of 1988[128] distinguished crack cocaine from both powder cocaine and other drugs by creating a mandatory minimum for simple possession.[129] This provision was "the only such federal penalty for a first offense of simple possession of a controlled substance."[130]

B. Crack vs. Cocaine

"'Crack' is the street name for a form of cocaine base, usually prepared by processing cocaine hydrochloride [powder cocaine] and sodium bicarbonate, and usually appearing in a lumpy, rocklike form."[131] As previously mentioned, cocaine was not a new drug when "crack" cocaine burst onto the national stage.[132] It had been manufactured in San Francisco in the 1970s, but was confined to a small number of users.[133] In 1986, crack cocaine made national headlines when University of Maryland basketball phenom Lenny Bias died of an apparent overdose "two days after the Boston Celtics drafted him."[134]

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124. Stone, *supra* note 86, at 313, 310.

125. *Id.* at 311.

126. Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat. 3207 (codified as amended in scattered sections of U.S. Code).

127. 21 U.S.C. § 841(b) ("[S]uch person shall be sentenced to a term of imprisonment which may not be less than 10 years or more than life and if death or serious bodily injury results from the use of such substance shall be not less than 20 years or more than life. . .").

128. Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, 102 Stat. 4181 (codified as amended in scattered sections of U.S. Code).

129. 21 U.S.C. § 844 (1988); U.S. SENTENCING COMM'N, SPECIAL REPORT TO THE CONG.: COCAINE & FED. SENTENCING POLICY v (1995), https://www.ussc.gov/sites/default/files/pdf/news/congressional-testimony-and-reports/drug-topics/199502-rtc-cocaine-sentencing-policy/EXECSUM.pdf.

130. *Id.*

131. Jelani Jefferson Exum, *Forget Sentencing Equality: Moving from the "Cracked" Cocaine Debate Toward Particular Purpose Sentencing*, 18 LEWIS & CLARK L. REV. 95, 99 (2014).

132. William Spade, Jr., *Beyond the 100:1 Ratio: Towards a Rational Cocaine Sentencing Policy*, 38 Ariz. L. Rev. 1233, 1243 (1996).

133. *Id.*

134. Ben Fabens-Lassen, *A Cracked Remedy: The Anti-Drug Abuse Act of 1986 and Retroactive Application of the Fair Sentencing Act of 2010*, 37 TEMP. L. REV. 645, 646 (2015).

Sensationalized media coverage caused a public panic as politicians warned of availability and use of a "cheap, highly addictive, and deadly form of cocaine."[135] The crack cocaine "panic" of the 1980s ensued.

Crack "is abused because it produces an immediate high and because it is easy and inexpensive to produce."[136] Instead of being snorted like powder cocaine, crack cocaine is inhaled and rapidly absorbed through the lungs into the bloodstream and ultimately reaches the brain.[137] However, compared to powder cocaine, crack cocaine carries a higher risk of overdosing and poisoning.[138] In New York City, from 1987 to 1995, the rate of crack use was approximately 70%.[139] From 1989 to 1996, crack use in Washington D.C. decreased from 24% to 35%.[140] Additionally, "[t]he affordability of crack opened up new markets of users, such as juveniles and the poor."[141] Crack is also a more profitable endeavor than its powdered counterpart, yielding nearly twice the value.[142]

1. Crack Down: Imagery in Media

Despite cocaine's status as a Schedule II narcotic,[143] a 1970s survey revealed that cocaine use was "rapidly attaining unofficial respectability" and that it was "accepted as a relatively innocuous stimulant, casually used by those who can afford it to brighten the day or the evening."[144] Thus, cocaine use was "gradually spreading in the upper middle class."[145] By the 1980s, the once apathetic social perception of cocaine changed with respect to the rocklike form, crack cocaine.[146] In

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135. Jason A. Gillmer, United States v. Clary*: Equal Protection and the Crack Statute*, 45 AM. U. L. REV. 497, 500 (1995).

136. T. Michael Andrews, *Unequal Sentences: The Crack and Powder Cocaine Disparity*, 44 ARIZ. ATT'Y 22, 24 (2008).

137. *Id.*

138. *Id.*

139. Andrew Lang Golub & Bruce D. Johnson, *Crack's Decline: Some Surprises Across U.S.* Cities, NAT'L INST. OF JUSTICE, RES. IN BRIEF 6 (July 1997), https://www.ncjrs.gov/pdffiles/165707.pdf.

140. *Id.* at 7.

141. Spade, Jr., *supra* note 132, at 1263.

142. *Id.*

143. LESTER GRINSPOON & JAMES B. BAKALAR, Cocaine: A Drug AND ITS SOCIAL EVOLUTION 20 (1976) ("Coca and cocaine are classified, along with a number of opiates, barbiturates, and amphetamines, as Schedule II: high abuse potential with restricted medical use.").

144. *Id.* at 64.

145. *Id.*

146. Alyssa L. Beaver, *Getting a Fix on Cocaine Sentencing Policy: Reforming the Sentencing Scheme of the Anti-Drug Abuse Act of 1986*, 78 FORDHAM L. REV. 2531, 2539 (2010); In 1985, the term "crack cocaine" was first used by the major media outlet, *The New York Times*. *Id.*

1986, media coverage of crack skyrocketed.[147] In July of that year, "the three major TV networks offered seventy-four evening segments on drugs, half of these about crack."[148] Despite crack cocaine and powder cocaine being virtually identical chemically, the media portrayed crack as a substance "far more addictive and far more menacing than powder cocaine or any other drug."[149]

Conservative politicians and mass media pushed crime, especially violent crime, onto the national stage—primarily on the premise of crack cocaine use. Republican politicians like Presidents Nixon and Reagan sensationalized violent crime to promote "get tough" policies, while using their positions in the national spotlight to shape public perception.[150] Following the "war on drugs," Republican lawmakers consistently volunteered for interviews. Media coverage of drug use increased accordingly, reinforcing conservative rhetoric that perpetuated unequal treatment of powder and crack cocaine.[151]

By the end of 1986, the term "crack-head" was employed as the popular moniker for the dangerous drug addict.[152] The 1980s saw "widespread fear that [crack use] was expanding beyond the ghetto into suburbia."[153] "Drug abuse was transformed in the public mind from a social problem of moderate importance to a national crisis of the first order."[154] The mass hysteria over crack cocaine during the "1980s took all of the imagery, emotions, and predictable policy responses of prior panics and ratcheted them up a notch."[155] The combination of the tragic death of Lenny Bias, several murders involving New York City police officers, and reports of a potential "crack baby" epidemic fueled media coverage.[156] "An expansive and sophisticated modern media fed the fire; offering hundreds of stories portraying crack as the most addictive, deadly drug of all time," which perpetuated the conservative narrative of crack cocaine as the more danger-

147. Beaver, *supra* note 146.

148. CRAIG REINARMAN & HARRY G. LEVINE, PUNITIVE PROHIBITION IN AMERICA, IN CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE 323.

149. Ahrens, *Methademic*, *supra* note 95, at 856.

150. Barry C. Feld, *Race, Politics, and Juvenile Justice: The Warren Court and the Conservative "Backlash"*, 87 MINN. L. REV. 1447, 1555 (2003).

151. *Id.* at 1556.

152. David A. Sklansky, *Cocaine, Race, and Equal Protection*, 47 STAN. L. REV. 1283, 1291 (1995).

153. *Id.* at 1293.

154. *Id.* at 1286; Michael A. Simons, *Departing Ways: Uniformity, Disparity and Cooperation in Federal Drug Sentences*, 47 VILL. L. REV. 921, 928–29 (2002).

155. Deborah Ahrens, *Drug Panics in the Twenty-First Century: Ecstasy, Prescription Drugs, and the Reframing of the War on Drugs*, 6 ALB. GOV'T L. REV. 397, 403 (2013) [hereinafter Ahrens, *Drug Panics*].

156. *Id*. at 403.

ous form of cocaine used primarily by inner-city African Americans.[157] At a period in American history when underlying racial tensions became more evident, whites fled urban-centers in droves.[158] As society transitioned from an industrial period, crack cocaine and its users were the scapegoats.[159] Legislators "responded" to the delirium with legislation that imposed strict penalties for drug use, mandatory minimums, and "the 100:1 ratio[160] that treated crack cocaine much more harshly than powdered forms of the drug for federal sentencing purposes."[161]

2. White-Nosed Privilege: From Wall Street to the Suburbs

In *United States v. Clary*, Judge Clyde Cahill observed that "[w]hile it may not have been intentional, it was foreseeable that the harsh penalties imposed upon blacks would be clearly disproportional to the far more lenient sentences given whites for use of the same drug—cocaine."[162] Judge Cahill also stated that the media created a "stereotype of the crack dealer as a young black male who was unemployed, belonged to a gang, and toted a gun[,]" all while ignoring the reality that Caucasian men and women also used crack.[163] Despite the fact that Caucasians comprise nearly 80% of drug users, "African-Americans comprise the majority of those arrested and incarcerated. African-Americans are, in fact, less likely than their Caucasian counterparts to have tried all illicit drugs except heroin. Caucasian Americans are doing the drugs; African-Americans are doing the time."[164]

Public perception of drug use has evolved over our history. The 1980s saw drug abuse transformed from a social problem to a national crisis, seemingly overnight.[165] The 1986 Anti-Drug Abuse Act imposed strict "mandatory minimum sentences upon conviction for trafficking in quantities of drugs exceeding specific quantity thresholds

157. *Id.*

158. *Id.* at 402–03.

159. *Id.*

160. Ahrens, *Methademic*, *supra* note 95, at 856–57 (The infamous "100:1 ratio" is named as such because "the United States Sentencing Guidelines require 100 grams of powder cocaine to trigger the same mandatory minimum sentence as one gram of crack cocaine, and this ratio is included in the Guidelines generally for cocaine and crack-cocaine offenses.").

161. Ahrens, *Drug Panics*, *supra* note 155.

162. 846 F. Supp. 768 (E.D. Mo. 1994), *rev'd,* 34 F.3d 709 (8th Cir. 1994).

163. Spade, Jr., *supra* note 132, at 1255.

164. Erik Grant Luna, *Our Vietnam: The Prohibition Apocalypse*, 46 DEPAUL L. REV. 483, 561 (1997).

165. Sklansky, *supra* note 152, at 1286.

. . . ."[166] These mandatory sentences mainly apply to large-scale dealing.[167] For quantities considered by Congress to represent a "kingpin" amount, 1,000 grams of heroin or 5,000 grams of powder cocaine, the law imposes a mandatory minimum sentence of ten years.[168] Individuals caught with one-tenth of a "kingpin" quantity are given a five-year mandatory minimum sentence.[169]

"Crack cocaine is treated differently."[170] While there are quantity thresholds triggering mandatory sentences of five and ten years, Congress did not use the "kingpin" theory to set the threshold.[171] Instead, Congress simply divided the threshold for powder cocaine, 5,000 grams, by 100.[172] Thus, 50 grams of crack cocaine is treated the same as 5,000 grams of powder cocaine. The 100:1 ratio was "controversial since its inception for two principal reasons: first, it has a disproportionately high impact on African Americans; and second, it mandates dramatically different sentences for two forms of the same drug."[173] This discrepancy between powder and crack cocaine is echoed by the Sentencing Guidelines promulgated in 1987.[174] The 1987 Guidelines illustrated that although crack cocaine is produced from powder cocaine—thus sharing an identical, active ingredient—the mandatory minimum for the two drugs is decidedly different.[175]

These discordant sentencing measures reinforced the inequity among cocaine consumers, since "[t]he one-hundred-to-one ratio adversely affects African Americans because crack cocaine is disproportionately consumed by African Americans as compared to Caucasians, and the low cost of crack cocaine makes crack cocaine much more prevalent in inner cities."[176] In 1992, African Americans accounted for 92.6% of convictions for federal crack cocaine offenses.[177] In 1995, the *Los Angeles Times* reported that no Caucasian had been charged with

166. David Bjerk, *Mandatory Minimum Policy Reform and the Sentencing of Crack Cocaine Defendants: An Analysis of the Fair Sentencing Act*, 14 J. EMPIRICAL LEGAL STUD. 370, 370 (2017); Sklansky, *supra* note 152, at 1286.

167. Sklansky, *supra* note 152, at 1287.

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.*

172. *Id.*

173. Jessica R.F. Grassley, *Federal Cocaine Sentencing Policy Following the 1995 Cocaine Report: Issues of Fairness and Just Punishment*, 21 HAMLINE L. REV. 347, 378 (1998).

174. Sklansky, *supra* note 152, at 1287.

175. Bjerk, *supra* note 166, at 370.

176. Beaver, *supra* note 146, at 2549.

177. Kimani Paul-Emile, *Making Sense of Drug Regulation: A Theory of Law for Drug Control Policy*, 19 CORNELL J. L. & PUB. POL'Y 691, 735 (2010).

crack cocaine possession in federal court in Boston, Chicago, Dallas, Miami, or Los Angeles.[178]

Moreover, by 2000, over 80% of crack cocaine offenders were African American, compared to only 6% of Caucasian offenders.[179] These numbers indicate a strikingly unjust treatment of crack cocaine consumers. "[T]he American Civil Liberties Union (ACLU) and the Drug Policy Alliance (DPA) report that African Americans comprise only 15% of regular drugs users, but represent 37% of arrested individuals, 59% of those convicted, and 74%" of all drug offenders sentenced to prison.[180] By 2006, only one Caucasian was tried for crack cocaine possession for every ten African Americans.[181] In 2006, 81.8% of all federal crack cocaine defendants were African American.[182] Also in 2006, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) calculated that 5,553,000 Caucasians used crack cocaine, compared to 1,537,000 African Americans.[183]

According to a recent SAMHSA survey, African Americans account for 8% of those that have used cocaine and 21% of those that have used crack cocaine.[184] Thus, in a perfect world, these numbers would correlate to arrests. However, racial disparities persist. African Americans are more likely to be arrested for drug-related offenses than their Caucasian counterparts. In most urban areas, police can focus their attention on obvious drug-related activity. African Americans made up 15.6% of crack cocaine users but 63.1% of those arrested for crack cocaine use, while Caucasians made up 68.8% of users but only 26.3% of arrestees for possession.[185] Additionally, "[m]ost crack cocaine defendants were [b]lack (83.0%) while 10.0[%] were Hispanic, and 6.1[%] were [w]hite. In contrast, the race/ethnicity distribution of powder cocaine defendants was 58.4[%] Hispanic, 24.5[%] [b]lack, and 15.8[%] [w]hite."[186]

178. *See* Dan Weikel, *War on Crack Targets Minorities Over Whites*, L.A. TIMES (May 21, 1995, 12:00 AM), https://www.latimes.com/archives/la-xpm-1995-05-21-mn-4468-story.html.

179. Beaver, *supra* note 146, at 2549.

180. Joseph J. Palamar et al., *Powder Cocaine and Crack Use in the United States: An Examination of Risk for Arrest and Socioeconomic Disparities in Use*, 149 DRUG ALCOHOL DEPEND. 108, 110 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4533860/.

181. Beaver, *supra* note 146, at 2549.

182. Paul-Emile, *supra* note 177, at 735.

183. Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, 20 STAN. L. & POL'Y REV. 257, 266 (2009).

184. *Id.* at 266–67.

185. Cassia Spohn, *Race, Crime, and Punishment in the Twentieth and Twenty-First Centuries*, 44 CRIME & JUSTICE 49, 69 (2015).

186. Exum, *supra* note 131, at 131.

Despite the notorious unequal treatment of crack and powder cocaine under the 1986 Anti-Drug Abuse Act, it took Congress over twenty years to address the issue. Bills that would address the disparity were introduced in Congress in 1993, 1995, 1996, 1997, 1998, 1999, 2001, 2002, 2003, 2005, 2006, 2007, 2008, and 2009, but each failed.[187] The Fair Sentencing Act of 2010 amended the ratio from 100:1 to 20:1, yet the disparity in treatment, arrests, conviction, and sentencing remains.[188]

In the late 1960s, Congress passed the Alcoholic and Narcotic Rehabilitation Act authorizing "special grants to support the building and staffing of community mental health centers in order to 'provide incentives for localities to initiate and develop new services for alcoholics and alcohol and drug abusers.'"[189] In 1970 and 1972, Congress revised the structure of this Act and established a "system of project and formula grants designed to support state and local treatment and rehabilitation efforts."[190]

In 1981, Congress consolidated the numerous programs and directed the Alcohol, Drug Abuse, and Mental Health Administration to distribute funds to the states for alcohol and drug abuse programs.[191] Despite the increased spending during the 1970s, federal spending for these programs decreased during the 1980s—the height of the crack epidemic. Between 1972 and 1979, grants increased from $69.3 million to $336.5 million.[192] By 1986, funding for the new block grant program had declined to $235 million.[193]

Decreased federal spending for drug abuse treatment coincided with inner-city crack abuse that eventually rose to epidemic proportions. In several cities, more women than men smoked crack.[194] "Most crack-addicted women are of child-bearing age, and . . . [s]ome experts estimate that as many as 375,000 drug-exposed infants are born every year."[195] In 1987, the height of the crack epidemic, the "mortality rate

187. Kyle Graham, *Sorry Seems to be the Hardest Word: The Fair Sentencing Act of 2010, Crack, and Methamphetamine*, 45 U. RICH. L. REV. 765, 766–67 (2011).

188. Bjerk, *supra* note 166, at 371.

189. Morgan Cloud, III, *Cocaine, Demand, and Addiction: A Study of the Possible Convergence of Rational Theory and National Policy*, 42 VAND. L. REV. 725, 782 (1989).

190. *Id.*

191. *Id.*; This consolidation was accomplished by Title IX of the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 901, 95 Stat. 357, 535 (codified at 42 U.S.C. § 300x-4(c)(6)(A) (1982 & Supp. 1986)).

192. Cloud, III, *supra* note 189, at 783.

193. *Id.*

194. Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419, 1428 (1991).

195. *Id.*

for [b]lack infants in the United States was 17.9 deaths per thousand births—more than twice that for white infants . . . ."[196] In Central Harlem, a predominately low-income, African American, community the mortality rate reached 27.6 per thousand births.[197]

Despite the exponential rise in drug abuse, during the 1980s, no state-of-the-art treatment system was developed for users addicted to cocaine as compared to heroin users. As a result, traditional and even some experimental treatment methods were employed.[198]

Despite Congress' decreased spending on drug abuse during the 1980s, the Anti-Drug Abuse Act of 1986 allocated $455 million in 1987 for drug abuse treatment, prevention, and education.[199] In 1989, the United States had approximately five thousand different programs to treat drug addiction.[200] These treatment programs typically fell into one of five categories: (1) detoxification; (2) chemical dependency units; (3) methadone maintenance programs (for heroin users); (4) residential therapeutic communities; and (5) community-based support groups.[201]

Detoxification treatment alleviates a user's short-term withdrawal symptoms by using either a drug-free method or medication.[202] While this method addresses the user's physical dependence on the drug, it does not address psychological perceptions and habits. To address persistent psychological patterns, chemical dependency units or inpatient programs usually spanning three to four weeks were used to treat cocaine addicts.[203] In addition to an inpatient treatment approach, medical professionals experimented with outpatient treatment that typically varied by patient and included: "individual psychotherapy,

196. *Id.* at 1446.

197. *Id.*

198. U.S. GOV'T ACCOUNTABILITY OFF., GAO/HRD-91-55FS, U.S. GEN. ACCOUNTING OFF.: THE CRACK COCAINE EPIDEMIC: HEALTH CONSEQUENCES AND TREATMENT 24 (1991) [hereinafter GAO Report]. The GAO REPORT states:

> Cocaine users are often young and female and have other characteristics that distinguish them from heroin addicts and may affect the treatment process. Some of these characteristics include: severe cravings for crack that may last for months or years after the initiation of treatment and a tendency to binge or engage in high-dose use during a short period of time.

199. Cloud, III, *supra* note 189, at 785.

200. Megan R. Golden, *When Pregnancy Discrimination Is Gender Discrimination: The Constitutionality of Excluding Pregnant Women From Drug Treatment Programs*, 66 N.Y.U. L. REV. 1832, 1840 (1991).

201. NATIONAL DRUG CONTROL STRATEGY: DRUG TREATMENT 35–36 (1989), https://www.ncjrs.gov/pdffiles1/ondcp/119466.pdf.

202. GAO REPORT, *supra* note 198, at 26.

203. Golden, *supra* note 200, at 1840.

group therapy, family therapy, and behavior [therapy]."[204] Within the treatment options, "Approximately eighty-five percent of users treated [were] treated in outpatient programs."[205] Moreover, residential treatment, a drug-free environment that varied in length from a few months to a couple of years depending on the needs of the user, was widely used to treat addiction.[206]

Since the 1980s, in addition to traditional methods of drug treatment, municipalities and other jurisdictions have adopted drug courts to address drug-offense defendants and substance abuse problems.[207] These specialized courts "focus on providing therapeutic services to those identified as substance abusers."[208] In the twenty years since the first drug court was established in 1989, over 3,100 jurisdictions have adopted them.[209] Some states have even required judicial circuits to establish such programs.[210] Evidenced by rapid growth and intermittent mandatory establishment, drug courts reflect a growing dissatisfaction with the traditional treatment and sentencing of drug offenders. The prevalence of drug courts is not the only difference in reactions to crack and opioid use. Specific stereotypes are discussed below and further distinguish crack, cocaine, and opioids.

III. Perspectives: Crack, Cocaine, and Opioids

"Crack babies"—a name for babies born to mothers addicted to crack cocaine—is a name synonymous with deficiency. The crack epidemic began in the 1980s as a cheaper alternative to heroin. Its use grew rapidly because of its affordability, immediate and intense high, and its potential for profit in the eyes of street dealers.[211] The babies born to crack addicted mothers were subjected to heightened scrutiny in the media and were treated as irreparably "damaged."[212] One report by *Rolling Stone* described two adopted children whose biological mother had used crack while pregnant as having an "unknowable"

204. GAO Report, *supra* note 198, at 26.

205. Golden, *supra* note 200, at 1840.

206. GAO Report, *supra* note 198, at 26.

207. Don Stemen, *Beyond the War: The Evolving Nature of the U.S. Approach to Drugs*, 11 Harv. L. & Pol'y Rev. 375, 411 (2017).

208. *Id.*

209. U.S. Department of Justice, Drug Courts (2018), https://www.ncjrs.gov/pdffiles1/nij/238527.pdf.

210. Stemen, *supra* note 207, at 411–12.

211. Deonna S. Turner, *Crack Epidemic*, Britannica, https://www.britannica.com/topic/crack-epidemic (last visited Aug. 31, 2019).

212. Ellen Hopkins, *Childhood's End: What Life is Like for Crack Babies*, Rolling Stone, Oct. 18, 1990, https://www.rollingstone.com/culture/features/childhoods-end-19901018.

amount of long-term damage.[213] The long-list of allegedly associated health problems for the two children included: "cerebral hemorrhaging, seizures, fluid on the brain, lesions of the brain, atrophy of the brain, countless episodes of apnea (arrested breathing), tremors, and crumbling cartilage . . . ."[214] The author went on to say these children never smiled and insinuated that they would not be able to assimilate into elementary school.[215]

Another school of thought was that it was not the damage to babies in utero that was crack's real devastation, but rather the way it caused addicted mothers to neglect their children.[216] A 1989 *Washington Post* article portrayed the mothers as the worst threat.[217] The article opened by describing a mother who demanded that her seven-week old child be released to her from the hospital, despite the fact that she was allegedly drug addicted and homeless.[218] The hospital did so, with an oxygen monitor for the child and special instructions to come back if the baby's oxygen level dropped.[219] The author then alleged that the mother left the child with someone else, without the oxygen monitor, to go out and "party."[220] The baby died that evening.[221] The author went on to state that "[c]rack is a mean drug that can induce parents to neglect and even violence. 'These mothers don't care about their babies and they don't care about themselves.'"[222] Finally, the article alleged that "crack-crazed parents" become violent and often beat their children.[223]

It is no secret that this portrayal of crack-addicted mothers as neglectful and uncaring, and their babies as damaged and unfixable, fell heavily on African American mothers.[224] Crack's cheap cost and

213. *Id.*

214. *Id.*

215. *Id.*

216. *See, e.g.*, Douglas J. Besharov, *Crack Babies the Worst Threat is Mom Herself*, WASH. POST, Aug. 6, 1989, https://www.washingtonpost.com/archive/opinions/1989/08/06/crack-babies-the-worst-threat-is-mom-herself/d984f0b2-7598-4dc1-9846-3418df3a5895/?utm_term=.a21d3bf3d23f.

217. *Id.*

218. *Id.*

219. *Id.*

220. *Id.*

221. *Id.*

222. Besharov, *supra* note 216.

223. *Id.*

224. *See* Vann R. Newkirk II, *What the 'Crack Baby' Panic Reveals About the Opioid Epidemic*, THE ATLANTIC (July 16, 2017), https://www.theatlantic.com/politics/archive/2017/07/what-the-crack-baby-panic-reveals-about-the-opioid-epidemic/533763/ (The term "crack babies" "connotes inner-city blackness, and also brings to mind careless, unthinking black mothers who'd knowingly exposed their children to the ravages of cocaine.").

quick high made it particularly marketable to poor minorities who were unable to afford heroin. But the stigma associated with its use had much more to do with race than with any scientific data.[225] The reality of the damage done to children of crack-addicted mothers is a different story than the media coverage at the time portrayed.

Studies show that "cocaine is no more harmful to a fetus than nicotine use, poor nutrition, lack of prenatal care, or other conditions commonly associated with the urban poor."[226] In *McKnight v. State*, Regina McKnight, a pregnant mother from South Carolina, had her conviction for homicide by child abuse overturned by the Supreme Court of South Carolina on the grounds that the lower court relied on "outdated" studies that touted unprecedented damage to fetuses when a mother uses cocaine while pregnant.[227]

One of the biggest myths of the crack baby hysteria was that the babies were born "addicted" to crack.[228] Addiction describes compulsive behavior that continues regardless of adverse effects—behavior that cannot be exhibited by a newborn baby.[229] In fact, in contrast to babies exposed to opioids in utero, babies exposed to crack in utero are not born physiologically dependent on the drug.[230] A 2009 *New York Times* article attempted to set the record straight about the myths of the crack epidemic by describing the true effects of in utero crack exposure as about the same as in utero tobacco use.[231] The article also stated that in utero crack exposure is less severe than in utero alcohol abuse, which can result in lifetime deficiencies in the form of fetal alcohol syndrome.[232] Most concerning is that many of the harmful effects alleged to be attributed to in utero-crack use could have been attributed to poverty and poor pre-natal care.[233]

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225. *See id.* (In regard to "crack babies": "[t]he term made brutes out of people of color who were living through wave after wave of what were *then* the deadliest drug epidemics in history.").

226. Lynn Paltrow & Katherine Jack, *Pregnant Women, Junk Science, and Zealous Defense*, 34 CHAMPION 30, 31 (2010) (quoting McKnight v. State, 661 S.E.2d 354, 358 n.2 (S.C. 2008)).

227. Paltrow & Jack, *supra* note 226, at 30–31.

228. *Id.* at 31 (quoting David C. Lewis et al., *Physicians, Scientists to Media: Stop Using the Term 'Crack Baby'* (Feb. 27, 2004), http://www.come-over.to/FAS/CrackBabyTerm.htm).

229. *Id.* (quoting *Leading Doctors, Scientists, and Researchers Request that Media and Policymakers Stop Perpetuating "Meth Baby" Myths*, 14 CESAR FAX 33 (2005)).

230. *Id.* (quoting Lewis et al., *supra* note 228) ("In utero physiologic dependence on opiates (not addiction), known as Neonatal Narcotic Abstinence Syndrome, is readily diagnosed, but no such symptoms have been found to occur following prenatal cocaine exposure.").

231. Susan Okie, *The Epidemic That Wasn't*, N.Y. TIMES, Jan. 26, 2009, https://www.nytimes.com/2009/01/27/health/27coca.html.

232. *Id.*

233. *See* Libby Copeland, *Oxytots*, SLATE (Dec. 7, 2014), https://slate.com/human-interest/2014/12/oxytots-and-meth-babies-are-the-new-crack-babies-bad-science-and-the-rush-to-demonize-the-most-vulnerable-pregnant-women.html.

The opioid epidemic hit the United States around 2010, with the number of babies born with opiates in their systems increasing five-fold between 2003 and 2012.[234] Babies born with opiates in their systems often experience withdrawal symptoms, more accurately known as Neonatal Abstinence Syndrome (NAS).[235] The symptoms are a result of the sudden halt of the opiate that the baby was accustomed to receiving in utero.[236] NAS is entirely treatable, with the best course of treatment being a few days in a neonatal intensive care unit (NICU) and close contact with the mother.[237] However, the prevailing treatment includes separation and medication, which has been shown to slow recovery and extend the length of the NICU stay.[238]

Whereas mothers of so called "crack babies" were almost always deemed to be uncaring monsters, mothers of "oxytots" are empathized with and seen as caught up among an "epidemic."[239] The media attention (or lack thereof) surrounding the two epidemics is similarly telling. Though a Google search for "crack babies" returns approximately 36.2 million results, a search for "oxytots" returns only 4,940.[240] Another difference between the two epidemics may be to blame: the fact that crack use is most strongly correlated with the African American population, whereas prescription drug and opioid use is most correlated with the Caucasian population.[241]

Although the tides may be beginning to turn on the perception of opioid users as addicts with a mental condition rather than violent

234. Catherine Saint Louis, *A Tide of Opioid-Dependent Newborns Forces Doctors to Rethink Treatment*, N.Y. TIMES July 13, 2017, https://www.nytimes.com/2017/07/13/health/opioid-addiction-babies.html.

235. Elaine Pawlowski, *A Baby Was Born A "Junkie"*, HUFFINGTON POST (Mar. 9, 2017, 10:04 AM), https://www.huffingtonpost.com/elaine-pawlowski/a-baby-was-born-a-junkie_b_9394230.html; Saint Louis, *supra* note 234 ("Babies in serious withdrawal can't eat, sleep or settle down. Their bodies can be unusually stiff: When they are picked up, their heads may not fall back. Sleep may be interrupted by full-body 'startles.'").

236. Pawlowski, *supra* note 235.

237. Saint Louis, *supra* note 234.

238. *Id.* ("The standard treatment is to drip tiny doses of morphine into the mouth with a syringe to make the newborn comfortable enough to eat and sleep. Then, over two to 12 weeks, the infant is weaned off morphine.").

239. *Id.*

240. *Compare* CRACK BABIES https://www.google.com/search?q=crack+babies&oq=crack+babies&aqs=chrome.69i57j69i61j0l4.1622j0j7&sourceid=chrome&ie=UTF-8, *with* OXYTOTS https://www.google.com/search?q=oxytots&oq=oxytots&aqs=chrome.69i57j0l3.4903j0j7&sourceid=chrome&ie=UTF-8 (As of 5:46 PM, Aug. 28, 2019).

241. *See generally* Eloise Dunlap et al., *The Severely-Distressed African American Family in the Crack Era: Empowerment Is Not Enough*, J. SOCIOL. SOC. WELF., May 2006, at 115; Interview by Noel King with Dr. Andrew Kolodny, Co-director, Opioid Pol'y Res., in Brandeis Univ., Mass. (Nov. 4, 2017). *But see* Copeland, *supra* note 233 (contending that the difference may be due to perceptions about the safety of illegal versus legal drugs to developing fetuses).

criminals, crack users during the crack epidemic were not given such fair treatment.[242] During the crack epidemic, the tough-on-crime approach seemed to be the only approach.[243] Jail, not rehabilitation, was the best option.[244] In fact, the Anti-Drug Abuse Act was passed during the crack epidemic, and was the first law to establish mandatory minimums for cocaine users.[245] Notably, the minimums were much more stringent for crack cocaine users as opposed to powdered cocaine users.[246] At the time, drug treatment courts as an option were unheard of, and the first drug court was not created until near the end of the crack epidemic.[247]

Plain and simple, drug courts work: "Under the drug court model, first-time non-violent offenders who are arrested for crimes stemming from their substance abuse are given the opportunity for a strict program of treatment and supervision in lieu of jail time."[248] While drug courts were unavailable until the early 1990s, their use has spread rapidly across the country and they serve as the best option the courts currently have against the opioid epidemic.[249] The idea behind them is simple: to "treat individuals as individuals," rather than as a class of people.[250] Today, there are roughly 2,800 drug courts in operation.[251]

Judge Mark W. Bennett[252] defines implicit biases as "the plethora of fears, feelings, perceptions, and stereotypes that lie deep within our subconscious, without our conscious permission or acknowledgement."[253] Implicit biases develop in the subconscious due to "repeated negative associations—such as the association of a particular race with crime—that establish neurological responses in the area of the brain responsible for detecting and quickly responding to danger."[254] Racially-based implicit biases are likely formed due to a societal narra-

242. Dahleen Glanton, *Race, the Crack Epidemic, and the Effect on Today's Opioid Crisis*, CHI. TRIB. (Aug. 21, 2017), http://www.chicagotribune.com/news/columnists/glanton/ct-opioid-epidemic-dahleen-glanton-met-20170815-column.html.

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. Lauren Kirchner, *Remembering the Drug Court Revolution*, PAC. STANDARD (Apr. 25, 2014), https://psmag.com/news/remembering-drug-court-revolution-80034.

248. *Id.*

249. *Id.*

250. *Id.*

251. *Id.*

252. Mark W. Bennett, *Unraveling the Gordian Knot of Implicit Bias in Jury Selection: The Problems of Judge-Dominated Voir Dire, The Failed Promise of Batson, and Proposed Solutions*, 4 HARV. L. & POL'Y REV. 149, 149 (2010).

253. *Id*.

254. *Id.* at 152.

tive that African Americans are intellectually and socially inferior to Caucasians, more aggressive, and have a natural propensity for criminal behavior.[255] The harm this causes is not simply limited to pervasive racism, but acts to reinforce systemic racist oppression. This is exemplified by the dearth of treatment-oriented policies aimed at addressing drug abuse when the users are portrayed as black, rather than white. Negative media portrayals can quickly escalate to political rhetoric, transforming to laws creating punitive measures for racial minorities and sympathy for individuals who engage in the same behavior, but do not belong to the same demographic group.

IV. Narrative Driving Policies

The previous Part illustrated the adverse effects on rehabilitative and preventative substance abuse policies that stereotypes and tropes can have on minority populations, particularly when enhanced by the media and public figures. Harmful narratives [steeped] in racial bias extend beyond the context of drug use to encompass additional policies with similarly harmful effects. Similar to African American drug users, immigrants are often portrayed as villainous outsiders whose presence will harm and endanger the rest of society. Notions of Muslim terrorists immediately invoke the tragedy of 9/11, while dialogue focusing on mental health, bullying and gun control surround terrorist activity enacted by white individuals. The Welfare Queen characterization of African American women living in poverty underlies depictions of these women as lazy. Understanding this bias is a necessary step to preventing the prejudice from negatively impacting policy decisions.

A. Welfare

The idea of the "Welfare Queen" was popularized by Former Californian Governor Ronald Reagan in the late 1970s.[256] During his campaign, Reagan, "at nearly every stop," told the story of a woman from Chicago who "has 80 names, 30 addresses, 12 Social Security cards

255. See R. Richard Banks et al., *Discrimination and Implicit Bias in a Racially Unequal Society*, 94 Calif. L. Rev. 1169, 1172–73 (2006) ("Psychologists have documented and explored the longstanding stereotype of African Americans as violent and prone to criminality. Indeed, this is the stereotype most commonly applied to Blacks—or at least to young Black males.") (citing Patricia G. Devine & Andrew J. Elliot, Are Racial Stereotypes Really Fading? The Princeton Trilogy Revisited, 21 Personality & Soc. Psychol. Bull. 1139 (1995) and Paul M. Sniderman & Thomas Piazza, The Scar of Race 43–45 (1993)).

256. *'Welfare Queen' Becomes Issue in Reagan Campaign*, N.Y. Times, Feb. 15, 1976, https://www.nytimes.com/1976/02/15/archives/welfare-queen-becomes-issue-in-reagan-campaign-hitting-a-nerve-now.html [hereinafter *'Welfare Queen'*].

and is collecting veterans' benefits on four non-existing deceased husbands."[257] Reagan's story further stated that "[s]he's collecting Social Security on her cards. She's got Medicaid, getting food stamps and she is collecting welfare under each of her names. Her tax-free cash income alone is over $150,000."[258] Reagan used this rhetoric and other anti-public-assistance rhetoric to enrage working-class whites at his campaign rallies, while he touted the ways he reduced welfare expenses in California as Governor.[259]

The "Welfare Queen" is now described as a narrative script with two central pieces of imagery: (1) The majority of welfare recipients are women, and (2) most women on welfare are African American.[260] A 1999 experiment, "The Welfare Queen Experiment," indicated that the Welfare Queen narrative script had assumed the status of "common knowledge" and that Americans were much more likely to draw an association between women of color and welfare, than between Caucasian women and welfare.[261] This is true notwithstanding the fact that Aid to Families with Dependent Children (AFDC), the pre-Clinton welfare program, administered aid to more African American mothers than Caucasian mothers.[262]

In a related study, content analysis of media from 1988 through 1992 revealed the following: 62% of poverty stories from *TIME*, *Newsweek*, and *U.S. News and World Report* featured African Americans; 65.2% of network television news stories about welfare featured African Americans; fewer African Americans were portrayed in "sympathetic" stories about poverty and welfare; and news magazines depicted almost 100% of the "underclass" as African Americans.[263] Yet, African Americans accounted for only 29% of America's poor at the time this study was conducted.[264] Multiple surveys administered at this time showed that the average American thought that African Americans made up at least half of the country's poor, demonstrating the powerful effects of the media's over reporting.[265] As a result of

257. *Id.*

258. *Id.*

259. *Id.*

260. Franklin D. Gilliam, Jr., *The 'Welfare Queen' Experiment: How Viewers React to Images of African-American Mothers on Welfare*, NIEMAN REP., Summer 1999, at 2, 49.

261. *Id.* at 52.

262. U.S. CENSUS BUREAU, ECON. & STATISTICS ADMIN., MOTHERS WHO RECEIVE AFDC PAYMENTS: FERTILITY AND SOCIOECONOMIC CHARACTERISTICS (1995), https://www.census.gov/population/socdemo/statbriefs/sb2-95.html.

263. Martin Gilens, *Race and Poverty in America: Public Misperceptions and the American News Media*, 60 PUB. OPINION Q. 515, 520, 525 (1996).

264. *Id*. at 516.

265. *Id.*

these mischaracterizations of race, poverty, and welfare, there was large-scale support from the white voting class to end AFDC.[266]

The impact on public policy from these beliefs is clear: the attitudes held by white Americans about black and poor Americans drive the formation of anti-welfare public policy. A study published in the *American Political Science Review* shows that Caucasians' racial attitudes toward African Americans is the strongest predictor for Caucasians' views on welfare.[267] After racial attitudes, the second biggest predictor for Caucasians' welfare views was whether the subject believed that "poor people are lazy."[268] "[W]hites' perceptions of blacks as lazy appear more important in shaping opposition to welfare than do their perceptions of poor people as lazy."[269] Thus, Reagan's "Welfare Queen," which unquestionably plays on white Americans' perceptions of black and poor Americans as lazy, accompanied by excessively disproportionate media reinforcement, has a continuing impact on white Americans' opinions on welfare policy.[270] This is another example of how narratives steeped in racial stereotypes can adversely effect minorities. African Americans seeking social services are viewed as unwilling to work, while this characterization is not the same for Caucasian Americans who receive the same benefits. In the opioid versus crack context, the racial divide has resulted in minorities being penalized and incarcerated at disproportionately high rates, rather than benefit from treatment policies.

B. Natural Disasters

Media framing plays a significant role in promulgating belief systems about disaster behavior that impacts levels of government disaster response.[271] Looking to the wake of Hurricane Katrina, media framing played an important role in characterizing and aiding the citizens of New Orleans. In the immediate wake of the crisis, media outlets described "post-Katrina looting as very widespread, wanton, irrational, and accompanied by violence . . . ."[272] Further, the media confined their reporting to the putative lawless behavior of young

266. Joe Soss & Sanford F. Schram, *Welfare Reform as a Failed Political Strategy: Evidence and Explanations for the Stability of Public Opinion*, 24 FOCUS 17, 19–22 (2006).

267. Martin Gilens, *"Race Coding" and White Opposition to Welfare*, 90 AM. POL. SCI. REV. 593, 597 (1996).

268. *Id.*

269. *Id.* at 598.

270. '*Welfare Queen', supra* note 256.

271. Kathleen Tierney et al., *Metaphors Matter: Disaster Myths, Media Frames, and Their Consequences in Hurricane Katrina*, 604 ANNALS AM. ACAD. POL. & SOC. SCI. 57, 57 (2006).

272. *Id*. at 66.

black males, which produced a profile of looters that overlooked all other explanations or behaviors of the individual actors.[273] Media outlets additionally "looped" videos of these "looters" and published stories of gang violence, rape, and lawlessness that was allegedly occurring among the victims of the disaster.[274]

This portrayal of the "lawlessness" taking place in New Orleans colored the national response. While it is common knowledge at this point that the overall response was bungled by multiple actors and agencies, the military response was significant.[275] On September 11, 2005, National Guard troops "stormed" the convention center, and "hundreds of disaster evacuees were searched like criminal suspects for guns, illicit drugs, alcohol, contraband, and other items that had been designated as 'undesirable' . . . ."[276] By September 13, over 72,000 troops had been deployed to New Orleans—the largest number for any national disaster in U.S. history at that point in time. President George W. Bush even made statements pledging to bring "law and order" to the City of New Orleans.[277] Unfortunately, harmful narratives expand beyond incidents and policies relating to drug abuse. Racial stereotypes in this situation caused narratives of African Americans as violent criminals to drive the enforcement of a police state during the city's most vulnerable moments.

C. Terrorism

A cursory examination of newspaper articles highlights gross disparities in the way acts of terrorism are reported. For example, Dylann Roof, a white supremacist, shot and killed 9 African Americans in a South Carolina church.[278] The *New York Times* wrote an article about Mr. Roof titled: *Dylann Roof's Past Reveals Trouble at Home and School*.[279] Stephen Paddock shot and killed 58 concert-goers in Las Vegas and caused 851 injuries.[280] The *New York Times* wrote an article about Stephen Paddock titled: *Who Was Stephen Paddock?*

273. *Id.*
274. *Id.* at 68.
275. *Id.* at 71.
276. *Id.*
277. Tierney et al., *supra* note 271, at 71–72.
278. Francis Robles & Nikita Stewart, *Dylann Roof's Past Reveals Trouble at Home and School*, N.Y TIMES, July 16, 2015, https://www.nytimes.com/2015/07/17/us/charleston-shooting-dylann-roof-troubled-past.html.
279. *Id.*
280. Sabrina Tavernise et al., *Who Was Stephen Paddock? The Mystery of a Nondescript 'Numbers Guy'*, N.Y. TIMES, Oct. 7, 2017, https://www.nytimes.com/2017/10/07/us/stephen-paddock-vegas.html?mtrref=www.google.com&gwh=937A45A3378E51C1EE9BDFE3894B9771&gwt=pay; Jennifer Medina, *A New Report on the Las Vegas Gunman Was Released. Here Are*

The Mystery of a Nondescript 'Numbers Guy.'[281] Nikolas Cruz shot and killed 17 high school students and injured another 17 during his school shooting rampage.[282] The *New York Times* wrote an article about Nikolas Cruz titled: *Nikolas Cruz, Florida Shooting Suspect, Described as a 'Troubled Kid.'*[283] All these shooters were Caucasian Americans, and their stories are colored with sympathy or confusion.

However, the articles' themes change when the terrorist is Muslim. For instance, Omar Mateen shot and killed 49 people and wounded 53 others at the Pulse nightclub in Orlando, Florida, and he targeted the club because it was frequented by members of the L.G.B.T.Q.I.A.+ community.[284] Omar Mateen was a United States Citizen.[285] He had brown skin, was of Afghan descent, and was a Muslim.[286] The *New York Times* wrote an article about Omar Mateen titled: *'Always Agitated. Always Mad': Omar Mateen, According to Those Who Knew Him*.[287]

Sayfullo Saipov is charged with driving a rented pickup truck into cyclists and runners in New York City, killing 8 people and injuring 12 others.[288] Saipov immigrated to America in 2010, and is a lawful permanent resident of the United States.[289] Saipov has brown skin, emigrated from Uzbekistan, and is a Muslim.[290] The *New York Times*

Some Takeaways, N.Y. TIMES, Jan. 19, 2018, https://www.nytimes.com/2018/01/19/us/las-vegas-attack-shooting-paddock.html.

281. Tavernise et al., *supra* note 280.

282. Matthew Haag & Serge F. Kovaleski, *Nikolas Cruz, Florida Shooting Suspect, Described as 'Troubled Kid,'* N.Y. TIMES, Feb. 14, 2018, https://www.nytimes.com/2018/02/14/us/nikolas-cruz-florida-shooting.html?mtrref=www.google.com&gwh=76A948997E06EA70DBF03220B6F26581&gwt=pay; Jessica Contrera, *'Why Did You Do This?'*, WASH. POST, Jan. 25, 2019, https://www.washingtonpost.com/news/local/wp/2019/01/25/feature/his-brother-confessed-to-gunning-down-17-people-in-parkland-but-hes-the-only-family-zach-cruz-has-left/.

283. Haag & Kovaleski, *supra* note 282.

284. Dan Barry et al., *'Always Agitated. Always Mad': Omar Mateen According to Those Who Knew Him*, N.Y. TIMES, June 18, 2016, https://www.nytimes.com/2016/06/19/us/omar-mateen-gunman-orlando-shooting.html?mtrref=www.google.com&gwh=5539F6C417821E053CEC3078286BFA43&gwt=pay.

285. *Id.*

286. *Id.*

287. *Id.*

288. Kim Barker et al., *Finding a Rootless Life in U.S., Sayfullo Saipov Turned to Radicalism*, N.Y. TIMES, Nov. 1, 2017, https://www.nytimes.com/2017/11/01/nyregion/sayfullo-saipov-truck-attack-manhattan.html?mtrref=www.google.com&gwh=45E59428A4FC6B2C9C2A30E8F8A62E74&gwt=pay; Benjamin Weiser, *U.S. Seeks Death Penalty in Terror Attack on Manhattan Bike Path*, N.Y. TIMES, Sept. 28, 2018, https://www.nytimes.com/2018/09/28/nyregion/sayfullo-saipov-death-penalty.html.

289. Barker et al., *supra* note 288.

290. *Id.*

wrote an article about Saipov titled: *Finding a Rootless Life in U.S., Sayfullo Saipov Turned to Radicalism*.[291]

Syed Rizwan Farook and Tashfeen Malik, a married couple, shot and killed 14 people at a holiday party in San Bernardino.[292] Farook was born in America, but was of Pakistani descent.[293] Malik was from Pakistan and Saudi Arabia, and she entered the United States on a visa.[294] Both have brown skin, and both were practicing Muslims.[295] The *New York Times* wrote an article about Farook and Malik titled: *Killers Were Long Radicalized, F.B.I. Investigators Say*.[296] All of these killers have brown skin and practice Islam, their stories are told without the sympathetic characterizations afforded their white counterparts, and there is a ready focus on the idea of "radicalization."

Although this examination of the *New York Times*'s headlines is anecdotal, it is illustrative of one of the issues our media needs to address: Who does the media identify as terrorists, and is that designation related to race, religion, ethnicity, etc.? While this question remains largely unanswered, a related trend is observable based on a recent study. According to a Georgia State University study, terrorist attacks perpetrated by Muslims are vastly over reported, as explained in the following section.[297]

New research from Georgia State University and the University of Alabama concludes that attacks perpetrated by Muslims receive a disproportionate amount of media coverage.[298] In all of the aggregated news reports considered in the study, 12.5% of the attacks were perpetrated by Muslims, yet these attacks received 50.4% of the news coverage.[299] Controlling for other variables, when an attack was perpetrated by a Muslim, on average, 357% more coverage existed about the attack.[300] The study additionally shows that when the targets of terrorist attacks are members of minority, racial, or religious groups,

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291. *Id.*

292. Adam Nagourney et al., *Killers Were Long Radicalized, F.B.I. Investigators Say*, N.Y. TIMES, Dec. 7, 2015, https://www.nytimes.com/2015/12/08/us/fbi-says-san-bernardino-assailants-were-radicalized.html?mtrref=www.google.com&gwh=0798587AE6EE0D206237709D0638B4F4&gwt=pay.

293. *Id.*

294. *Id.*

295. *Id.*

296. *Id*.

297. Erin M. Kearns et al., *Why Do Some Terrorist Attacks Receive More Media Attention Than Others?* 1, 11 (2019), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2928138.

298. *Id*.

299. *Id*. at 18.

300. *Id*.

the event receives less media coverage.[301] "By covering terrorist attacks by Muslims dramatically more than other incidents, media frame this type of event as more prevalent."[302] The study argues that this framing directly leads to Americans' fear of Muslims and desire to create policies that prevent Muslims from entering the United States.[303]

It follows that if media framing of terrorism more closely matched the realities of such actions, American opinions and public policy would fall in line with reality. In contrast to American public opinion;[304] *Newsweek* recently reported that between 2008 and 2016, American right-wing extremists carried out nearly twice as many attacks as Muslim extremists.[305] Not only were the right-wing extremists more successful in carrying out their attacks (fewer attacks were foiled by police), but those attacks more often involved death; between 2008 and 2016, one-third of right-wing attacks involved fatalities, whereas Muslim extremists' attacks only involved fatalities thirteen percent of the time.[306] The extensive media coverage of Muslim-led attacks, the dearth of reporting when victims are minorities, and the mental health framing set forth when the perpetrator is Caucasian, all show a connection between narratives and race—which can continue to the perpetuation of racist attitudes and beliefs that influence laws and policies.

D. Immigration

In current political discourse, immigration has been brought to the forefront of many conversations among the voting class and among elected officials. As a result, the media and various politicians, including the President, often frame the immigration issue for the electorate, impacting the way Americans view and discuss immigration.[307] When media outlets and elected officials frame issues differently along lines

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301. *Id*. at 23.

302. *Id*. at 27.

303. Kearns et al., *supra* note 297.

304. *Terrorism*, GALLUP, http://news.gallup.com/poll/4909/terrorism-united-states.aspx (last visited Sept. 1, 2019).

305. Mirren Gidda, *Most Terrorists in the U.S. Are Right Wing, Not Muslim: Report*, NEWSWEEK (June 22, 2017, 12:53 PM), http://www.newsweek.com/right-wing-extremism-islamist-terrorism-donald-trump-steve-bannon-628381.

306. *Id.*

307. *See, e.g.*, *Little Partisan Agreement on the Pressing Problems Facing the U.S.*, Pew Res. Ctr. (Oct. 15, 2018), https://www.people-press.org/2018/10/15/little-partisan-agreement-on-the-pressing-problems-facing-the-u-s/ ("[I]llegal immigration is the highest-ranked national problem among GOP voters, but it ranks lowest among the 18 issues for Democratic voters.").

of race, ethnicity, religion, etc., the impact on public opinion and policy formation is readily observable.

A flamboyant example of immigration commentary by President Donald Trump, was his alleged[308] statement that he did not want people from "shithole countries" immigrating to the United States.[309] President Trump, in a meeting with lawmakers, referred to "Haiti, El Salvador, and African nations" as the "shithole countries."[310] President Trump then immediately suggested that the United States should "bring more people from countries such as Norway."[311]

Assessing the demographics of the "shithole countries" illuminates the comment's inherent racial undertones. Haiti is a nation that is 95% black,[312] and El Salvador is 86.3% mestizo.[313] Additionally, among all African nations, the nation with the highest percentage of white people is South Africa, with only 7.8% of the population being white.[314] Therefore, it is evident that each of the President's "shithole countries" are predominantly non-white.

Moreover, the President's desire to gain more immigrants from Norway is illustrative—Norway is 91.5% white.[315] While this pattern seems clear, President Trump additionally stated that he wanted more immigrants from "Asian countries" because he believes that "they help the United States economically."[316] While this appears to deviate from President Trump's message—i.e., white immigrants are desirable and non-white immigrants are undesirable—it does not. The "alt-

308. President Trump denies that he ever made the statements; however, the statements were corroborated by people who were present. Caroline Kenny, *Trump Denies Making 'Shithole Countries' Comment*, CNN (Jan. 12, 2018, 4:46 PM), https://www.cnn.com/2018/01/12/politics/donald-trump-tweet-daca-rejection/index.html; Josh Dawsey, *Trump Derides Protections for Immigrants From 'Shithole' Countries*, WASH. POST (Jan. 12, 2018), https://www.washingtonpost.com/politics/trump-attacks-protections-for-immigrants-from-shithole-countries-in-oval-office-meeting/2018/01/11/bfc0725c-f711-11e7-91af-31ac729add94_story.html?utm_term=.aa204541ec6c.

309. Dawsey, *supra* note 308.

310. *Id.*

311. *Id.*

312. *Haiti*, THE WORLD FACTBOOK, https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html (last updated Aug. 26, 2019).

313. *El Salvador*, THE WORLD FACTBOOK, https://www.cia.gov/library/publications/the-world-factbook/geos/es.html (last updated Aug. 21, 2019).

314. *South Africa*, THE WORLD FACTBOOK, https://www.cia.gov/library/publications/the-world-factbook/geos/sf.html#People (last updated Aug. 22, 2019).

315. *Norway*, THE WORLD FACTBOOK, https://www.cia.gov/library/publications/the-world-factbook/geos/no.html (last updated Aug. 21, 2019) (including "Norwegian" and "other European" in the calculation of the "white" population).

316. Dawsey, *supra* note 308.

right" and white-nationalist groups have long been obsessed with the idea of Asian exceptionalism.[317]

Right-wing media and President Trump often push conversations of immigration to focus on one specific concept: chain migration. Chain migration, also called family reunification, permits lawful permanent residents of the United States to petition Immigration Services to bring over their spouses and their minor children from foreign nations.[318] When, or if, a lawful permanent resident becomes a naturalized citizen, "they can then apply to bring over parents, married children, and adult siblings."[319] Fox News, quoting President Trump, reported that "[u]nder the current broken system [of chain migration], a single immigrant can bring in virtually unlimited numbers of distant relatives."[320] President Trump even went so far as to say that multiple terrorist attacks were made possible through this immigration system.[321]

This "chain migration" argument necessarily presumes that the immigration visa and citizenship process in the United States moves quickly enough for these "chains" to form and for endless immigrants to access the United States. The reality is starkly different. The family reunification system ("chain migration" system) is horribly backlogged. "The [United States] is currently processing sibling visa requests for China that were filed in 2004."[322] For Mexico and the Philippines, the total wait time now exceeds twenty-five years.[323] Despite these staggering wait times, the rhetoric causes real damage through the process of social priming.

While the previously mentioned examples are extreme and specific, large swaths of data indicate that anti-immigrant attitudes are not isolated to the far right. Instead, the media has played a significant role in "priming" Caucasian Americans to associate illegal immigration, job insecurity, and excessive government aid with Latino immi-

317. *See, e.g.*, Audrea Lim, *The Alt-Right's Asian Fetish*, N.Y. TIMES (Jan. 6, 2018), https://www.nytimes.com/2018/01/06/opinion/Sunday/alt-right-asian-fetish.html?_r=0.

318. John Burnett, *Explaining 'Chain Migration'*, NPR (Jan. 7, 2018, 8:06 AM), https://www.npr.org/2018/01/07/576301232/explaining-chain-migration.

319. *Id.*

320. Kaitlyn Schallhorn, *What is Chain Migration and Why Does Trump Want it Ended?*, FOX NEWS (Jan. 31, 2018), http://www.foxnews.com/politics/2018/01/31/what-is-chain-migration-and-why-does-trump-want-it-ended.html.

321. *Id.*

322. Celia Muñoz, *The Myth of Chain Migration*, POLITICO (Jan. 26, 2018), https://www.politico.com/magazine/story/2018/01/26/myth-chain-migration-trump-family-immigration-216536.

323. *Id.*

grants.[324] "Priming" refers to the process by which exposure to socially relevant stimuli facilitates the emergence of impressions, attitudes, and beliefs.[325]

As it plays out in the context of immigration, according to a report from the Brookings Institution, American news media has been dramatically overreporting negative stories about Latino immigration.[326] This exact type of overreporting, according to a University of Michigan study, causes Caucasians significant anxiety about Latino immigration.[327] Because this media exposure to negative portrayals of Latino immigration primes Caucasian Americans, these Caucasian Americans consciously and unconsciously begin to blame immigrants for their problems.[328] This generated anxiety is crucial to developing anti-immigration policy and electing officials who denigrate immigrants.[329]

In dispelling other causes for anti-immigration attitudes, another University of Michigan study on political psychology, excluded general white ethnocentrism as the primary driving force behind Caucasians' negative opinions on immigration.[330] Instead, Caucasians' feelings about their own group compared to their feelings about Latinos has the largest impact on Caucasians' perceptions of immigration, indicating that the opinions are primarily driven by racial attitudes.[331] Specifically, the Caucasian community's perception of the Latino community had the largest impact on Caucasians' opinions of: (1) whether immigration causes harm to American jobs or harm to American values; (2) support for immigration restrictions; (3) allowing immigrants to have jobs in the United States; and (4) allowing immigrants to receive public benefits from the government.[332] Further, the study concluded that when Caucasian Americans think of immigrants generally, they think specifically of Latino immigrants.[333]

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324. Ted Brader et al., *What Triggers Public Opposition to Immigration? Anxiety, Group Cues, and Immigration Threat*, 52 AM. J. POL. SCI. 959, 975 (2008); Nicholas A. Valentino et al., *Immigration Opposition Among U.S. Whites: General Ethnocentrism or Media Priming of Attitudes About Latinos*, 34 POL. PSYCHOL. 149, 164 (2013).

325. Daniel C. Molden, *Understanding Priming Effects in Social Psychology: What is "Social Priming" and How Does it Occur?*, 32 SOC. COGNITION 1, 1, 4 (2014).

326. BANU AKDENIZLI ET AL., BROOKINGS INST., DEMOCRACY IN THE AGE OF NEW MEDIA: A REPORT ON THE MEDIA AND IMMIGRATION DEBATE 12, 30–31 (2008).

327. Brader et al., *supra* note 324; Valentino et al., *supra* note 324.

328. Valentino et al., *supra* note 324*; see also* Molden, *supra* note 325, at 7.

329. Brader et al., *supra* note 324.

330. Valentino et al., *supra* note 324.

331. *Id.*

332. *Id.*

333. *Id.*

Thus, when these Americans are prompted to think of any immigration-related idea, all of the negative ideas associated with Latinos and Latino immigration will inform the response.[334]

Making matters worse in the American South, a Louisiana State University study concluded that increasing proximity to the U.S.–Mexico border is strongly correlated with a higher volume of news stories about Latino immigration, particularly the negative or illegal aspects of immigration.[335] Interestingly, the study also showed that corporate media organizations are more likely than local news sources to generate negative and sensational stories as they get closer to the border.[336] These findings, combined with the previous studies on priming, suggest the development of major Caucasian anxieties about Latino immigration increases as one draws closer to the U.S.–Mexico border. These studies, especially when read together, highlight the importance of the President's and the media's over reporting of negative aspects of Latino immigration. Not only is this over reporting occurring, but it is increasingly occurring with closer spatial proximity to the border. This clearly leads to Caucasians' anxieties about Latino Immigration, which, in turn, informs anti-immigration policies. Immigration-related anxiety is influenced and enhanced by media portrayals. As a result, anti-immigration policies become more palatable, particularly when minority groups are the target of overreporting and sensational reporting.

The examples above illustrate the pervasiveness of stereotypical narratives and the impact that follows when they are perpetuated by powerful figures or integrated into the media. Although the erasure of stereotypes is not likely to occur by a plan set forth in this Article, the following section addresses the issue by suggesting that law schools proactively expose students to real representation of marginalized communities through experiential learning.

V. Mitigating Negative Narratives Through Experiential Exposure

Of course, there are those who advocate for the use of narratives, primarily to create empathy for underserved individuals or increase representation. Further, many believe the use of narratives fits with

334. *See id.*

335. Regina P. Branton & Johanna Dunaway, *Spatial Proximity to the U.S.-Mexico Border and Newspaper Coverage of Immigration Issues*, 62 Pol. Res. Q. 289, 299 (2009).

336. *Id.*

modern society and that perception is actual reality.[337] However, "[n]arrative turns out to be exceedingly effective at transmitting untruthful, incomplete, and unrepresentative anecdotes—particularly those that trigger a 'flash of recognition' because they confirm preexisting suspicions or stereotypes—or are themselves simply stereotypes."[338] It is for this reason that law schools should counter negative stereotypes that are amalgamations of fear and narrative bias with exposure to individuals who identify as racial and ethnic minorities.

American Bar Association (ABA) Standard Law schools requires all law students to complete a minimum number of credit hours of experiential learning[339] that must provide opportunities for performance and self-evaluation; develop the concepts underlying the skills being taught; integrate doctrine, theory, skills, and legal ethics; and engage student performance in the skills identified in ABA Standards 302.[340] The learning outcomes articulated in Standard 302 are listed as follows:

> (a) Knowledge and understanding of substantive and procedural law; (b) Legal analysis and reasoning, legal research, problem-solving, and written and oral communication in the legal context; (c) Exercise of proper professional and ethical responsibilities to clients and the legal system; and (d) Other professional skills needed for competent and ethical participation as a member of the legal profession.[341]

David Thomson asserts in the *Journal of Experiential Learning*, that experiential learning courses "focus on the student experience," with students positioned "in the role of attorneys," helping students to develop an identity, and preparing students to "build their legal careers in the ever changing legal landscape of their future" as "life-long

337. *See* Anne M. Coughlin, *Regulating the Self: Autobiographical Performances in Outsider Scholarship*, 81 VA. L. REV. 1229, 1238 n.12 (1995) ("While it would be an exaggeration to claim that everybody is doing autobiography, certainly many law professors, insiders as well as outsiders, have made in their scholarship explicit references to their personal experiences."); Richard Delgado, *Storytelling for Oppositionists and Others: A Plea for Narrative*, 87 MICH. L. REV. 2411, 2412 (1989).

338. David A. Hyman, *Lies, Damned Lies, and Narrative*, 73 IND. L.J. 797, 847 (1998); *see also* Daniel A. Farber & Suzanna Sherry, *Telling Stories Out of School: An Essay on Legal Narratives*, 45 STAN. L. REV. 807, 836–37 n.2 (1993).

339. *See generally* 2014-2015 ABA STANDARDS AND RULES OF PROCEDURE FOR APPROVAL OF LAW SCHOOLS (Am. Bar. Ass'n 2014) [hereinafter ABA STANDARDS] (setting forth new standards requiring law schools to establish learning outcomes, curricular standards, simulation experiences, and assessment standards).

340. ABA STANDARDS, *supra* note 339, at 15–16 (Standard 302(d) skills may include things like "interviewing, counseling, negotiation, fact development and analysis, trial practice, document drafting, conflict resolution, organization and management of legal work, collaboration, cultural competency, and self-evaluation.").

341. *Id.*

learners of the law."[342] Incorporating the identification and self-reflection of bias in experiential learning aligns with this goal of progressing the law while students direct their learning process.

Conclusion

Federal Rule of Evidence 404 outlines the prohibition against the government's use of character evidence to portray a defendant as violent.[343] The policy behind the limitation of propensity evidence preservation of the presumption of innocence by avoiding negating this presumption by using evidence of the defendant's violent nature,[344] and Rule 403 which excludes evidence if its probative value is substantially outweighed by the likelihood of prejudice that will result from the exposure of such evidence.[345]

The same danger that exists in a court of law exists in the court of public opinion. Racial bias created an image of black drug users as violent and lazy, false narratives that have been applied to minorities in order to create opposition to policies related to immigration and government cash assistance, and to excuse government indifference in times of natural disasters. The false narrative in the realm of substance abuse is particularly jarring upon examination of the juxtaposition of crack users to opioid users. Misuse of opioids has caused several deaths in Caucasian communities, where crack is portrayed as relegated to the African American community, with sentencing laws constructing a more substantive dividing line between the two. The public portrayal, reaction and resulting laws to opioid abuse has been much more sympathetic than it was during the crack epidemic. Racism will never be outlawed, but training lawmakers to confront implicit and explicit biases by through client interaction can assist with the dissipation of harmful narratives that marginalize minorities.

342. David I.C. Thomson, *Defining Experiential Legal Education,* 1 J. Experiential Learning 1, 20–21 (2015).

343. *See generally* Fed. R. Evid. 404.

344. *Id.* at 404(a).

345. Fed. R. Evid. 403.