

## **Opioids and Converging Interests**

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*Seton Hall Law Review’s Symposium on “Race and the Opioid Crisis: History and Lessons” provided a valuable forum for scholars, researchers, policy makers, clinicians, and activists to share their insights, findings, and experiences bearing on the vexing problem of the racialization of the opioid epidemic. Other contributors to this volume address a range of issues on that topic. My contribution in this Article is circumscribed: To consider whether applying the lens of Professor Derrick Bell’s interest convergence theory to the opioid crisis offers the prospect of advancing racial justice. This Article will describe Bell’s interest convergence thesis, identify racial justice interests that African Americans have related to the opioid crisis, and consider whether these interests might converge with white interests to produce real progress toward racial justice. Spoiler alert, I am not terribly optimistic that interest convergence will occur in this context, but this Article concludes with thoughts about how the Medicaid program could provide a space where racial justice interests might align with white interests.*

I. THE INTEREST CONVERGENCE THEORY .....	1020
II. FRAMING RACIAL JUSTICE INTERESTS RELATING TO SUBSTANCE USE AND ADDICTION .....	1022
III. WHITE INTERESTS CONVERGING? .....	1026
IV. EXPANDING MEDICAID, TREATING ADDICTION, STATES’ SELF INTEREST, AND RACIAL JUSTICE.....	1029
V. CHANGING OUR MESSAGING AND NARRATIVE.....	1035

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## I. THE INTEREST CONVERGENCE THEORY

Interest convergence is Professor Derrick Bell's theory for explaining why the United States Supreme Court decided *Brown v. Board of Education*<sup>1</sup> when it did, as well as why the Court in later cases retreated from a strong commitment to school desegregation. Bell's insight in his 1980 article<sup>2</sup> was that the Court decided *Brown* in 1954 only because blacks' interests in racial equality converged with the interests of white elites.

Bell's analysis went something like this: In *Brown*, the plaintiffs sought to advance a black racial justice interest, defined specifically as ending state-sponsored school segregation. In the early 1950s, the white elite had several pragmatic interests that aligned with the plaintiffs' goals. The whites' interests included the Cold War tactic of bolstering capitalism's attractiveness to the developing world as an economic system, a desire to reassure black World War II veterans that the ideals they had fought for on foreign soil were not hollow, and an economic incentive to stimulate the South's industrial development.<sup>3</sup>

From this historical data point, Bell drew a broader conclusion about the prospects of racial justice in the United States. He wrote:

The interest of blacks in achieving racial equality will be accommodated only when it converges with the interests of whites. . . . Racial remedies may . . . be the outward manifestations of unspoken and perhaps subconscious judicial conclusions that the remedies, if granted, will secure, advance, or at least not harm societal interests deemed important by middle and upper class whites. Racial justice—or its appearance—may, from time to time, be counted among the interests deemed important by the courts and by society's policymakers.<sup>4</sup>

To be clear, Bell articulated the interest convergence thesis in 1980 as a way of explaining history, not as a playbook for effecting racial progress going forward. Indeed, Bell recognized that any progress achieved when blacks' interests converged with the interests of privileged whites could dissipate when those interests began to diverge, and that recognition fed Bell's pessimism regarding the prospects of true racial equality in the United States.<sup>5</sup> Nonetheless, Bell eventually confirmed his view that blacks should

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<sup>1</sup> 347 U.S. 483 (1954).

<sup>2</sup> Derrick A. Bell, Jr., *Brown v. Board of Education and the Interest-Convergence Dilemma*, 93 HARV. L. REV. 518, 524 (1980).

<sup>3</sup> See *id.* at 524–25. For a fuller description of Bell's theory in another context, see Richard Delgado, *Why Obama: An Interest Convergence Explanation of the Nation's First Black President*, 33 L. & INEQ. 345 (2015).

<sup>4</sup> Bell, Jr., *supra* note 2, at 523.

<sup>5</sup> *Id.* at 528; cf. Stephen M. Feldman, *Do the Right Thing: Understanding the Interest-Convergence Thesis*, 106 NW. U. L. REV. COLLOQUY 248, 249–52 (2012) (describing stages

not simply be the beneficiaries of happenstance, but could act to “forge fortuity” by making continued racial injustice costly to whites, thus creating a convergence of interests.<sup>6</sup>

Drawing on Bell’s insight, later scholars have explored whether interest convergence might explain other steps by white elite decisionmakers that advance racial justice concerns. For example, legislative actions to abolish the death penalty can be understood as reflecting interest convergence.<sup>7</sup> Commentators have also examined areas ranging from immigration reform,<sup>8</sup> to prison reform,<sup>9</sup> to college sports<sup>10</sup> using an interest convergence lens. Early work extending interest convergence theory focused primarily on public (i.e., governmental) decisionmakers, but more recently scholars have applied it to electoral politics<sup>11</sup> and private decision-making implicating racial justice.<sup>12</sup>

This Article considers whether some potential for interest convergence exists today in relation to the opioid crisis. Can we imagine how the interests of white elite decision makers relating to that crisis might align with related interests of blacks to produce progress toward racial justice? One point worth noting preliminarily is that, in *Brown*, a single entity made up of powerful white men (namely, the Supreme Court) had the authority to recognize convergence and act decisively. The same is not true with respect to the racial justice interests that figure most prominently today in relation to opioid and other addictions. No single equivalent actor could play that role currently. That said, it merits considering how to frame contemporary interests—both racial justice interests and white elite interests—that could possibly converge.<sup>13</sup>

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in Bell’s intellectual development).

<sup>6</sup> DERRICK BELL, *SILENT COVENANTS: BROWN V. BOARD OF EDUCATION AND THE UNFULFILLED HOPES FOR RACIAL REFORM* 276 (2004) (citing to sit-ins as an example of “forging fortuity” and teaching that “a great many whites would not maintain discriminatory policies if the cost was too high”).

<sup>7</sup> See Jolie McLaughlin, Note, *The Price of Justice: Interest-Convergence, Cost, and the Anti-Death Penalty Movement*, 108 NW. U. L. REV. 675 (2014).

<sup>8</sup> María Pabón López & Natasha Ann Lacoste, *Immigration Reform in 2013-14: An Essay on the Senate’s Bipartisan Plan, the House’s Standards for Immigration Reform, Interest Convergence and Political Realities*, 17 HARV. LATINO L. REV. 121 (2014).

<sup>9</sup> SpearIt, *Economic Interest Convergence in Downsizing Imprisonment*, 75 U. PITT. L. REV. 475 (2014).

<sup>10</sup> Amy Christian McCormick & Robert A. McCormick, *Race and Interest Convergence in NCAA Sports*, 2 WAKE FOREST J.L. & POL’Y 17 (2012) (applying interest convergence analysis to integration of college athletics).

<sup>11</sup> See, e.g., Delgado, *supra* note 3.

<sup>12</sup> See, e.g., Patience A. Crowder, *Interest Convergence as Transaction?*, 75 U. PITT. L. REV. 693 (2014) (proposing a transactional approach to interest convergence in the context of metropolitan-level poverty alleviation efforts).

<sup>13</sup> Cf. Christine Minhee & Steve Calandrillo, *The Cure for America’s Opioid Crisis? End*

## II. FRAMING RACIAL JUSTICE INTERESTS RELATING TO SUBSTANCE USE AND ADDICTION

The opioid crisis in the United States today implicates a range of racial justice concerns. Although media coverage of and political discourse around the epidemic of opiate addiction and overdose-related deaths have focused on dramatic increases in death rates among white Americans, the rate of opioid-related deaths among blacks has also increased significantly. Since 2000, those deaths have nearly doubled,<sup>14</sup> and from 2014-2016, fatalities by overdose among blacks and Latinos rose at a higher percentage than among whites.<sup>15</sup> In addition, in a handful of states and Washington, D.C., the rates of opioid overdose deaths for blacks exceed the rates for whites.<sup>16</sup> The persistent focus on white deaths and characterization of the epidemic of addiction as novel fails to acknowledge the experiences of black people, in terms of both today's crisis and its historical precedents.<sup>17</sup>

Those historical precedents inform the racial justice interests relating to the opioid crisis. In general terms, the most obvious and ambitious prospect for advancing racial justice that might come out of efforts to address the opioid crisis is that we could change our approach to drugs in the United States, ending the decades-long "War on Drugs" that has been so destructive to black communities and has derailed the lives of so many black persons.<sup>18</sup> The basic thinking is that the opioid crisis might finally lead our society to recognize that substance use disorders ("SUDs") are medical conditions and that heightened mortality from overdoses is a public health issue, a recognition that could fundamentally shift our interventions to address these problems away from criminal justice and carceral responses towards

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*the War on Drugs*, 43 HARV. J.L. & PUB. POL'Y 547 (2019) (posing the question, "[a]ssuming racial bias, will the races of those dying from fatal overdoses today make the public health approach easier to take?").

<sup>14</sup> Keturah James & Ayana Jordan, *The Opioid Crisis in Black Communities*, 46 J.L. MED. & ETHICS 404, 404 (2018). For all racial groups, the rate of opioid-related overdose deaths has nearly quadrupled. *Id.* at 405.

<sup>15</sup> Martha Bebinger, *Opioid Overdoses Are Rising Faster Among Latinos than Whites or Blacks. Why?*, WASH. POST (May 22, 2018), [https://www.washingtonpost.com/national/health-science/opioid-overdoses-are-rising-faster-among-latinos-than-whites-or-blacks-why/2018/05/22/d1e7cf80-59b2-11e8-9889-07bcc1327f4b\\_story.html?utm\\_term=.2497b7e7a4bd](https://www.washingtonpost.com/national/health-science/opioid-overdoses-are-rising-faster-among-latinos-than-whites-or-blacks-why/2018/05/22/d1e7cf80-59b2-11e8-9889-07bcc1327f4b_story.html?utm_term=.2497b7e7a4bd).

<sup>16</sup> James & Jordan, *supra* note 14, at 406–07 (listing West Virginia, Wisconsin, Missouri, Illinois, Minnesota, and Washington, D.C.).

<sup>17</sup> *Id.* at 405.

<sup>18</sup> See generally Kenneth B. Nunn, *Race, Crime and the Pool of Surplus Criminality: Or Why the 'War on Drugs' Was a 'War on Blacks'*, 6 J. GENDER RACE & JUST. 381 (2002); see also James & Jordan, *supra* note 14, at 409–11 (describing the history of the heroin epidemic of the 1960s and 1970s, the crack cocaine epidemic of the 1980s and 1990s, and the resulting disproportionate involvement of blacks in the criminal justice system); Minhee & Calandrillo, *supra* note 13.

prevention and treatment.<sup>19</sup>

But this core racial justice interest in changing society's approach to drug use and dependence is quite broad, and it may be helpful to array more precise possible sub-framings of that interest on a spectrum, ranging from the most ambitious and sweeping on one end to more modest framings on the other. What follows is a brief sketch of how we might think about the racial justice interests at stake.

At the more ambitious end of the spectrum lies the decriminalization of drug possession. A full embrace of ending the "War on Drugs" would entail rejecting that the possession and use of drugs are practices that, in and of themselves, harm the social fabric in a way that justifies prosecuting and punishing participants. If we took this step, the government could strictly regulate the importation and sale of these substances and tax them, much as it does for alcohol. Although a growing number of states are moving towards legalization of marijuana, conceiving of decriminalization for a broad range of currently illicit drugs is more of a stretch, but is not beyond the pale.<sup>20</sup> In 2018, voters in the state of Ohio considered a ballot measure on a constitutional amendment downgrading all drug possession cases to misdemeanors. The measure failed, but it received support from the Democratic candidate for governor.<sup>21</sup> A majority of states have taken some steps in the past decade to decrease sentences for drug possession or to substitute community-based sanctions.<sup>22</sup> Experience from abroad demonstrates that decriminalization, combined with public health measures, can lead to a decline in overdose deaths.<sup>23</sup>

Somewhat less radically, racial justice interests relating to the opioid crisis might also be framed as requiring a change in how we enforce drug laws and talk about drug-related crimes. "War on Drugs" rhetoric and the disparate enforcement of drug laws have disproportionately cast black and brown people living in impoverished areas as enemies to be vanquished, and

<sup>19</sup> Vann R. Newkirk II, *The People Trump's War on Drugs Will Actually Punish*, ATLANTIC (Mar. 26, 2018), <https://www.theatlantic.com/politics/archive/2018/03/killing-drug-dealers-opioid-epidemic/555782/> (suggesting that states will need to "choose between joining in the administration's harsh prosecutorial campaign, or firmly rejecting it in favor of the public-health paradigm").

<sup>20</sup> See Minhee & Calandrillo, *supra* note 13, at 61.

<sup>21</sup> See Laura Hancock, *Ohio Voters Defeat Issue 1 on Drug Crimes*, CLEVELAND.COM (Nov. 6, 2018), <https://www.cleveland.com/open/2018/11/ohio-voters-defeat-issue-1-on-drug-crimes.html>.

<sup>22</sup> See generally RAM SUBRAMANIAN & REBECCA MORENO, VERA INST. FOR JUSTICE, DRUG WAR DÉTENTE? A REVIEW OF STATE-LEVEL DRUG LAW REFORM, 2009–2013, at 7 (2014).

<sup>23</sup> See, e.g., Linda M. Richmond, *Switzerland Halts War on Drugs, Cuts Deaths*, AM. PSYCHIATRIC ASS'N: PSYCHIATRIC NEWS (June 13, 2018), <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.6b15>.

entire communities of color have suffered the collateral damage.<sup>24</sup> Silencing that rhetoric and reforming laws and enforcement to ensure racially even-handed approaches would be a substantial step.

Further along the spectrum of racial justice interests connected to the opioid crisis lie possibilities relating to prevention and treatment. For example, we might extend the recent shift in both the messaging and resources addressing opioid addiction to *all* SUDs, whether or not they involve opioids. As the understanding that opioid addiction is a medical condition increases among the general public, the time may be ripe to extend that understanding to drugs more broadly.<sup>25</sup> Adopting a public health approach would entail devoting substantial resources to making evidence-based treatment more readily available to persons with a full range of SUDs, to adopting harm reduction strategies pervasively, and to developing and implementing effective prevention strategies.<sup>26</sup>

At their best, prevention strategies would devote attention to the social and structural determinants of health that, by feeding despair and pain, contribute to substance use and addiction. Although many explanations for the opioid epidemic in popular media have employed a supply-side or “vector” model, emphasizing the roles of greedy pharmaceutical companies who pushed misleading claims about the safety of prescription painkillers and doctors who overprescribed those drugs, scholars have also emphasized the role of structural and societal causes that have increased demand for opioids.<sup>27</sup> Recent discussions of “diseases of despair”—alcohol abuse, suicides, and the increase in rates of fatal overdoses—have focused on the trend among middle-aged whites without a college degree living in the economically challenged areas of the Midwest, Appalachia, and New England.<sup>28</sup> But this recognition of the impact of social and economic disadvantage on health, and, particularly, the demand for relief of the

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<sup>24</sup> See, e.g., Lisa D. Moore & Amy Elkavich, *Who's Using and Who's Doing Time: Incarceration, the War on Drugs, and Public Health*, 98 AM. J. PUB. HEALTH 782 (2008); Jonathan Rothwell, *How the War on Drugs Damages Black Social Mobility*, BROOKINGS (Sept. 30, 2014), <https://www.brookings.edu/blog/social-mobility-memos/2014/09/30/how-the-war-on-drugs-damages-black-social-mobility/>; cf. Lahny R. Silva, *Collateral Damage: A Public Housing Consequence of the “War on Drugs”*, 5 U.C. IRVINE L. REV. 783 (2015).

<sup>25</sup> A scientific network established by the United Nations Office of Drugs and Crime and the World Health Organization advocates for this approach. See Nora D. Volkow et al., *Drug Use Disorders: Impact of a Public Health Rather than a Criminal Justice Approach*, 16 WORLD PSYCHIATRY 213 (2017).

<sup>26</sup> See *id.*

<sup>27</sup> See Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182 (2018); see also Minhee & Calandrillo, *supra* note 13.

<sup>28</sup> See, e.g., Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY 397 (2017) <https://www.brookings.edu/wp-content/uploads/2017/08/casetextsp17bpea.pdf>.

suffering associated with that disadvantage should apply with equal, if not greater force, to African-American communities.<sup>29</sup>

Finally, at the most modest end of the spectrum, racial justice would be served by taking steps to end the racially disparate treatment and coverage of substance use disorders. To be clear, a distressingly low percentage of persons with substance use disorders receive specialized treatment for that disorder, whatever their race.<sup>30</sup> And some evidence suggests that because they are more likely to be eligible for Medicaid or receive mandated treatment as a result of their involvement with the criminal justice system, blacks overall do not receive treatment at a lower rate than whites.<sup>31</sup> That said, blacks with SUDs may face particular barriers in accessing treatment, such as a shortage of treatment resources in predominantly non-white areas and higher rates of uninsurance in black communities. Furthermore, those blacks who have health insurance are disproportionately covered by Medicaid, which many private substance abuse treatment programs refuse to accept<sup>32</sup> and which, in some states hit hard by the opioid epidemic, fails to cover at least some forms of medication-assisted therapy.<sup>33</sup> Beyond geographic and financial barriers lie attitudinal barriers to accessing substance use disorder treatment. Blacks' generally high level of mistrust of the medical profession, coupled with stigma regarding mental health issues, may inhibit them from seeking out treatment.<sup>34</sup> Addressing these barriers would make even the limited, existing system for treating addiction more equitable.

Beyond barriers to access, Dr. Helena Hansen, a psychiatrist and anthropologist on New York University's faculty, argues that medication-assisted therapy ("MAT"),<sup>35</sup> which experts view as the most effective

<sup>29</sup> See Issac J. Bailey, *Why Didn't My Drug-Affected Family Get Any Sympathy?*, POLITICO MAG. (June 10, 2018), <https://www.politico.com/magazine/story/2018/06/10/opioid-crisis-crack-crisis-race-donald-trump-218602> (asserting that African-Americans' problems with substances "started with systemic neglect and contempt"); Dasgupta et al., *supra* note 27, at 184 (noting that "we have spent decades pathologizing members of minority communities for turning to drugs to cope with social stressors and structural inequities").

<sup>30</sup> See RACHEL N. LIPARI & STRUTHER L. VAN HORN, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CBHSQ REPORT: TRENDS IN SUBSTANCE USE DISORDERS AMONG ADULTS AGED 18 OR OLDER 5 (2017), [https://www.samhsa.gov/data/sites/default/files/report\\_2790/ShortReport-2790.pdf](https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.pdf) (stating that, in 2014, 7.6% of adults with a substance use disorder received treatment at a specialty facility in the previous year).

<sup>31</sup> See Benjamin Lê Cook & Margarita Alegria, *Racial-Ethnic Disparities in Substance Use Treatment: The Role of Criminal History and Socioeconomic Status*, 62 PSYCHIATRIC SERV. 1273 (2011).

<sup>32</sup> See James & Jordan, *supra* note 14, at 413–14.

<sup>33</sup> See Dasgupta et al., *supra* note 27, at 184 (stating that "West Virginia and Kentucky[] prohibit Medicaid coverage of methadone maintenance").

<sup>34</sup> See James & Jordan, *supra* note 14, at 414.

<sup>35</sup> Medication-assisted therapy combines either methadone, buprenorphine, or naltrexone

therapy for opioid addiction, has become racialized. The Food and Drug Administration's approval of buprenorphine in 2002 permitted the monthly prescribing of that synthetic opiate by physicians practicing in private offices.<sup>36</sup> This practice stands in contrast to using methadone in MAT, which requires patients to receive directly observed therapy, available only in closely regulated clinics, on a daily basis.<sup>37</sup> Advertisements for buprenorphine contain images of white addiction patients; methadone clinics are disproportionately located in inner-city neighborhoods.<sup>38</sup> Blacks receiving MAT are more likely to be treated in methadone clinics, while whites are more likely to be treated with buprenorphine in doctors' offices.<sup>39</sup> This difference matters, because the daily regimen of methadone treatment hinders patients' ability to obtain employment or an education. It also carries with it greater stigma than treatment with buprenorphine, and it entails a more severe intrusion on the patient's privacy. Addressing these differences would make even the limited, existing system for treating addiction more equitable.<sup>40</sup>

### III. WHITE INTERESTS CONVERGING?

It is easy to imagine multiple ways in which racial justice interests could be served by serious and substantial policy efforts to address the opioid crisis. But do the white elites have their own interests that might converge? Sadly, my optimism fades when I consider this side of the interest convergence equation, despite some statements by powerful whites that our society needs to change its approach and attitudes towards opioid addiction.

For example, former New Jersey Governor Chris Christie led President Trump's Commission on Combating Drug Addiction and the Opioid Crisis. Christie was famously captured on video talking about a law school classmate who died as a result of his addiction and saying that his death convinced Christie that anyone could become addicted.<sup>41</sup> As a result,

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with counseling and other support services to integrate the individual back into society.

<sup>36</sup> See Helena B. Hansen et al., *Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic and Income Characteristics of Residential Social Areas in New York City*, 40 J. BEHAV. HEALTH SERV. & RES. 367 (2013).

<sup>37</sup> See *id.*

<sup>38</sup> Mark Moran, *How the Opioid Addiction Crisis was Rendered 'White'*, AM. PSYCHIATRIC ASS'N: PSYCHIATRIC NEWS (Apr. 27, 2018), <https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2018.5a14> (describing address by Dr. Helena Hansen).

<sup>39</sup> Hansen et al., *supra* note 36.

<sup>40</sup> But cf. Alexandra E. Hatcher et al., *At the Expense of a Life: Race, Class, and the Meaning of Buprenorphine in Pharmaceuticalized "Care"*, 28 SUBST. USE & MISUSE 301 (2018) (interview-based study finding that low-income black and Latino patients experienced office-based buprenorphine treatment as isolating).

<sup>41</sup> See German Lopez, *When a Drug Epidemic's Victims Are White*, VOX MEDIA (Apr. 4, 2017), <https://www.vox.com/identities/2017/4/4/15098746/opioid-heroin-epidemic-race>.



according to Christie, we should have compassion with those struggling with addiction and respond to their struggles with support and treatment, rather than condemnation and criminal punishment. Taken at face value, Christie's stance, which other white politicians have echoed,<sup>42</sup> appears to signal a public health-oriented approach to addiction, and one might argue that it represents a white elite interest primed to converge with the racial justice interests laid out above.

But here is where I think that Professor Bell would caution us to be careful and would suggest that whites' feelings of compassion or empathy, even if sincere, are *not* the equivalent of pragmatic self-interest. And only true *self*-interest is likely to prompt action that may also advance the interest of people of color. Moreover, compassion on the part of the white elite may be limited to those persons suffering who seem familiar (i.e., middle-class or wealthy whites, and to some lesser degree, working-class or poor whites). Black drug users, by contrast, remain "the other" and are less likely to receive compassion or empathy from whites.<sup>43</sup> Recent polling indicates that, while Americans express sympathy for persons addicted to opioids (drugs that have been racially coded as "white"), that sympathy does not extend to addiction to other substances, like crack cocaine (a drug racially coded as "black").<sup>44</sup>

In addition, the political virulence of today's "law and order" and racially tinged rhetoric serves to counterbalance any inclination toward compassion toward black and brown users. Even as whites increasingly recognize opioid addiction as a medical condition, some elite whites continue to advance their personal political self-interest by espousing "get tough" policies.<sup>45</sup> For example, President Trump pledged in March 2018 that the Justice Department would begin seeking the death penalty for drug traffickers.<sup>46</sup> This highly punitive proposal seeks to impose an artificial

<sup>42</sup> See Rachel Rouben, *Opioid Crisis Takes Personal Toll on Washington*, HILL (Apr. 16, 2018), <https://thehill.com/policy/healthcare/public-global-health/383075-opioid-crisis-takes-personal-toll-on-washington>; James & Jordan, *supra* note 14, at 413.

<sup>43</sup> Cf. Lopez, *supra* note 41 (discussing research suggesting that people show more empathy to persons of the same race than to similarly suffering persons of a different race).

<sup>44</sup> See Travis Johnston, *Americans Think Opioid Addiction Is a Crisis. They're Not Sure Federal Dollars Will Solve It.*, WASH. POST (Aug. 10, 2017), [https://www.washingtonpost.com/news/monkey-cage/wp/2017/08/09/americans-think-opioid-addiction-is-a-crisis-theyre-not-sure-federal-dollars-will-solve-it/?utm\\_term=.3bfed1829488](https://www.washingtonpost.com/news/monkey-cage/wp/2017/08/09/americans-think-opioid-addiction-is-a-crisis-theyre-not-sure-federal-dollars-will-solve-it/?utm_term=.3bfed1829488); Bailey, *supra* note 29. The racially differentiated understanding of pain and addiction has historical roots. See Joseph M. Gabriel, *Opiate Addiction and the History of Pain and Race in the US*, CONVERSATION (June 19, 2018), <http://theconversation.com/opiate-addiction-and-the-history-of-pain-and-race-in-the-us-97430>.

<sup>45</sup> See Minhee & Calandrillo, *supra* note 13 ("The War on Drugs approach fracks considerable political power from fear.").

<sup>46</sup> See Newkirk II, *supra* note 19.

distinction between persons who use drugs and persons who sell drugs, when in reality many people fall into both groups.<sup>47</sup>

The concern is that if both approaches to addiction (the public health approach and the law-and-order approach) operate simultaneously, whites' addictions will be addressed as a public health concern, while addiction among people of color will continue to be viewed as a matter for the criminal justice system. As Dr. Helena Hansen put it, "[w]e have a clinical track for whites and a criminal track for the rest."<sup>48</sup> Rather than advancing racial justice interests, this bifurcated policy approach threatens to "deepen the vast racial divides within the American criminal-justice system: sympathy for a mostly white base of users, and naked aggression toward people of color."<sup>49</sup> Thus, the idea that sympathy expressed by the white elite toward white persons addicted to opioids might support interest convergence that will lead to advances in racial justice for persons of color seems far-fetched.

That said, white elites do have some concerns about addressing high rates of addiction to a range of substances, not just opioids, that might produce an alignment or convergence of interests. Without plumbing these interests in depth, I will suggest several here, and explore one in particular. These interests—on the part of businesses, the military, and state governments—are fiscal or economic in nature. As such, they represent the types of pragmatic self-interest that Professor Bell identified as the basis for the convergence of interests leading to *Brown*.

First, businesses, as employers, have an interest in advancing solutions to the opioid crisis. Some evidence suggests a connection between the opioid epidemic and low labor participation rates in the United States. Although a causal relationship is not clear, places with high levels of opioid prescriptions have seen a significant decline in the labor force, particularly among men, over the past fifteen years.<sup>50</sup> Industries that use drug testing, like construction and manufacturing, may lose applicants and employees disqualified for failing drug tests. The difficulty in filling open positions prevents some employers from taking advantage of a strong economy by

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<sup>47</sup> *Id.*

<sup>48</sup> Aaron Levin, *Addictive Drugs and Treatments Said to Have Racial Component*, AM. PSYCHIATRIC ASS'N: PSYCHIATRIC NEWS (July 17, 2017), <https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2017.7a7> (quoting Dr. Hansen); see also James & Jordan, *supra* note 14, at 412 ("This practice of employing a public health strategy for white middle-class groups, but a crime-control agenda in urban minority neighborhoods is deeply entrenched in American political culture.").

<sup>49</sup> Newkirk II, *supra* note 19.

<sup>50</sup> Caitlin Owens, *Why Businesses Have a Stake in Solving the Opioid Epidemic*, AXIOS (Aug. 20, 2018), <https://www.axios.com/business-jobs-opioid-epidemic-employment-662f6dd0-c8af-4c05-ac6c-13ea193b01fd.html>.

expanding.<sup>51</sup>

Similarly, drug use and criminal justice involvement are among numerous contributors to the Pentagon's finding in 2017 that seventy-one percent of young Americans (aged seventeen to twenty-four) are ineligible to serve in the military.<sup>52</sup> Thus, as the opioid epidemic exacerbates persistent challenges in military recruiting,<sup>53</sup> policy makers concerned about military readiness could experience greater interest in addressing drug usage and addiction more broadly. This concern about America's strength on the world stage echoes the interest identified by Professor Bell in advancing American dominance during the Cold War.

The other area where strong white elite self-interest seems likely to emerge is in statehouses. States are experiencing growing fiscal burdens from the opioid epidemic's impacts on healthcare costs, addiction treatment costs, and criminal justice spending.<sup>54</sup> Given these escalating costs, states have dual incentives: to shift these costs to another payer, such as the federal government, and to eventually decrease these costs by funding effective prevention and treatment services. As explained below, focusing on Medicaid could help states meet both these objectives. Moreover, it is plausible that a focus on Medicaid could also align with the racial justice interests described above.

#### IV. EXPANDING MEDICAID, TREATING ADDICTION, STATES' SELF INTEREST, AND RACIAL JUSTICE

As enacted, the Affordable Care Act (ACA) required all states to expand their Medicaid programs to cover non-elderly persons with family

<sup>51</sup> See *id.*

<sup>52</sup> THOMAS SPOEHR & BRIDGET HANDY, HERITAGE FOUND., *THE LOOMING NATIONAL SECURITY CRISIS: YOUNG AMERICANS UNABLE TO SERVE IN THE MILITARY* 1 (2018), <https://www.heritage.org/sites/default/files/2018-02/BG3282.pdf>. The other main reasons for ineligibility include inadequate education and obesity. *Id.* at 2.

<sup>53</sup> See Dave Philipps, *As Economy Roars, Army Falls Thousands Short of Recruiting Goals*, N.Y. TIMES (Sept. 21, 2018), <https://www.nytimes.com/2018/09/21/us/army-recruiting-shortage.html> (asserting that "drug use" is making recruiting more difficult); Ming Xu & Jonathan Sawtelle, *Opioids: A Dark Allure with Deep National Security Implications*, REALCLEAR DEF. (Feb. 19, 2018), [https://www.realcleardefense.com/articles/2018/02/19/opioids\\_a\\_dark\\_allure\\_with\\_deep\\_national\\_security\\_implications\\_113074.html](https://www.realcleardefense.com/articles/2018/02/19/opioids_a_dark_allure_with_deep_national_security_implications_113074.html).

<sup>54</sup> See, e.g., RILEY SULLIVAN, FED. RESERVE BANK OF BOS., *POLICY REPORT 18-1: THE FISCAL IMPACT OF THE OPIOID EPIDEMIC IN THE NEW ENGLAND STATES* 3 (2018), <https://www.bostonfed.org/publications/new-england-public-policy-center-policy-report/2018/the-fiscal-impact-of-the-opioid-epidemic-in-the-new-england-states.aspx>; see also Associated Press, *White House: True Cost of Opioid Epidemic Tops \$500 Billion*, CNBC (Nov. 20, 2017), <https://www.cnbc.com/2017/11/20/white-house-true-cost-of-opioid-epidemic-tops-500-billion.html> (reporting on an analysis by the White House Council of Economic Advisers).

incomes of up to 133% of the federal poverty level.<sup>55</sup> This expansion would have made Medicaid available to an additional estimated 21.3 million persons who were not previously eligible for the program, many of them single or childless adults.<sup>56</sup> To make the expansion less financially burdensome for states, the ACA provided that the federal government would provide 100% of the funding for the mandate through 2016, with the federal share then declining to 90% for 2020 and thereafter.<sup>57</sup> In 2012, however, the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*<sup>58</sup> effectively transformed the ACA's expansion mandate to an option for the states. As of early 2019, thirty-seven states and Washington D.C. have chosen to expand their Medicaid programs.<sup>59</sup>

Expanding Medicaid may be particularly valuable for low-income persons with SUDs, as the expansion provides, according to the Surgeon General, "a key lever for expanding access to substance use treatment because many of the most vulnerable individuals with substance use disorders have incomes below 138[%] of the federal poverty level."<sup>60</sup> Under federal law, state Medicaid programs are required to include reimbursement for substance use treatment. Persons with Medicaid coverage are more likely to receive treatment for addiction than persons who are uninsured or who have private insurance, though states vary in the breadth and generosity of their coverage.<sup>61</sup>

Because of the generous federal funding included as part of the ACA's Medicaid expansion, a state's decision not to expand Medicaid represents a choice to forgo millions of federal dollars that would go toward providing health coverage for low income residents of a state, including many with

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<sup>55</sup> 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2018), *declared unconstitutional by Texas v. United States*, 340 F. Supp. 3d 579 (N.D. Tex. 2018), *appeal docketed*, No. 19-10011(5th Cir. Jan. 7, 2019).

<sup>56</sup> JOHN HOLAHAN ET AL., KAISER FAMILY FOUND., THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 4 (2012), <https://www.kff.org/wp-content/uploads/2013/01/8384.pdf>.

<sup>57</sup> By contrast, the federal government pays a much smaller share of the Medicaid costs of other enrollees, ranging from seventy-three percent of Medicaid costs in the poorest states to only fifty percent in the wealthiest states. See CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS: INTRODUCTION TO MEDICAID 4 (2016), [https://www.cbpp.org/sites/default/files/atoms/files/policybasics-medicaid\\_0.pdf](https://www.cbpp.org/sites/default/files/atoms/files/policybasics-medicaid_0.pdf) [hereinafter CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS].

<sup>58</sup> 567 U.S. 519 (2012).

<sup>59</sup> *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Apr. 26, 2019), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

<sup>60</sup> U.S. DEP'T OF HEALTH & HUMAN SERVS., FACING ADDICTION IN AMERICA: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH 6-7 (2016).

<sup>61</sup> See Nicolas P. Terry, *Structural Determinism Amplifying the Opioid Crisis: It's the Healthcare, Stupid!*, 11 NE. U. L. REV. 315 (2019).

SUDs.<sup>62</sup> A low-income person without insurance coverage faces significant barriers in accessing treatment. Indeed, because a significant number of persons with untreated SUDs end up involved with the criminal justice system,<sup>63</sup> any treatment received by uninsured low-income persons with SUDs may well be in a correctional setting. But few jails and prisons offer MAT, the most effective form of treatment.<sup>64</sup> As a result, too few incarcerated persons receive effective treatment, which increases the chances of overdose and recidivism when a person with SUD reenters the community following incarceration.

Moreover, it is in states' fiscal interest to provide treatment for SUDs in the community instead of imprisoning persons for criminal activity related to their addiction. The cost of providing community-based SUD treatment has been estimated to be \$20,000 less annually than the cost of incarcerating a person.<sup>65</sup> For persons eligible for Medicaid under the ACA expansion, at least ninety percent of their treatment cost will be funded by the federal government.<sup>66</sup> Medicaid does not provide coverage to incarcerated persons, nor does the federal government provide matching funds for state corrections spending, as it does for state Medicaid spending.<sup>67</sup> In short, state Medicaid spending leverages federal dollars to pay for Medicaid's reimbursement for SUD treatment services received by Medicaid beneficiaries, but that leverage is not available for prison spending. Thus, states have a clear self-interest in maximizing Medicaid coverage for their residents suffering from SUDs, including by expanding Medicaid if that step has not yet been taken. Doing so both decreases the costs incurred and shifts some of those costs to the federal government.

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<sup>62</sup> About twelve percent of adults covered by Medicaid suffer from a SUD. See CTR. ON BUDGET & POLICY PRIORITIES, MEDICAID WORKS FOR PEOPLE WITH SUBSTANCE USE DISORDERS 1 (2018), <https://www.cbpp.org/sites/default/files/atoms/files/1-19-18health-factsheet-suds.pdf>.

<sup>63</sup> See Terry, *supra* note 61, at 366 (estimating that, each year, between a quarter and a third of persons with heroin addiction "pass through the corrections system").

<sup>64</sup> See *id.*

<sup>65</sup> See JUSTICE POLICY INST., HOW TO SAFELY REDUCE PRISON POPULATIONS AND SUPPORT PEOPLE RETURNING TO THEIR COMMUNITIES 8 (2010), [http://www.justicepolicy.org/images/upload/10-06\\_FAC\\_ForImmediateRelease\\_PS-AC.pdf](http://www.justicepolicy.org/images/upload/10-06_FAC_ForImmediateRelease_PS-AC.pdf).

<sup>66</sup> Even if the person's eligibility for Medicaid is based not on the expansion, but on one of the traditional categories, the federal government provides a significant match for state Medicaid spending, ranging from paying seventy-three percent of Medicaid costs in the poorest states to paying only fifty percent in wealthiest states. See CTR. ON BUDGET & POLICY PRIORITIES, POLICY BASICS, *supra* note 57, at 4.

<sup>67</sup> Cf. MELISSA S. KEARNEY ET AL., HAMILTON PROJECT, POLICY MEMO: TEN ECONOMIC FACTS ABOUT CRIME AND INCARCERATION IN THE UNITED STATES 13 (2014), [http://www.hamiltonproject.org/papers/ten\\_economic\\_facts\\_about\\_crime\\_and\\_incarceration\\_in\\_the\\_united\\_states](http://www.hamiltonproject.org/papers/ten_economic_facts_about_crime_and_incarceration_in_the_united_states) (stating that in 2010 more than fifty-seven percent of spending for corrections was by state governments, thirty-three percent from local governments, and only ten percent from the federal government).

Expanding Medicaid (for states that have not already done so), and investing resources to ensure that Medicaid recipients can access effective treatment, are also in line with an understanding of SUDs as medical conditions, rather than moral failings. As explained above, shifting policy responses to addiction away from incarceration and towards prevention and treatment of SUDs is in states' fiscal interest. These strong pragmatic self-interests of state-level policy makers may converge with interests in advancing racial justice, as suggested below.

For states that have not yet expanded Medicaid, taking that step could advance racial justice interests in several ways. Many of the states that have not yet chosen to implement the Medicaid expansion pursuant to the ACA are southern states with large black populations.<sup>68</sup> Thus, many poor adults who stand to gain health coverage under the expansion—including many suffering from addiction or substance use disorders—are left uncovered.<sup>69</sup> Decisions by the remaining non-expansion states to expand could decrease the number of uninsured persons in those states and narrow racial disparities in insurance coverage.

Expanding Medicaid has significance beyond simply increasing rates of coverage, however. Policy analysts have recognized Medicaid's important role in responding to the growing number of persons addicted to illicit substances.<sup>70</sup> Not only are persons with SUDs more likely to receive some treatment if they are covered by Medicaid (as compared to private insurance or no insurance), but the range of treatment-related services that states can cover as part of their Medicaid program (either as part of their state plan or through a section 1115 waiver) is broad.<sup>71</sup> In addition to providing inpatient treatment or short-term residential treatment, some states are trying out innovative services like peer-support and wraparound services, which seek to increase the sustainability of recovery.<sup>72</sup> Furthermore, a provision of

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<sup>68</sup> See SAMANTHA ARTIGA ET AL., KAISER FAMILY FOUND., CHANGES IN HEALTH COVERAGE BY RACE AND ETHNICITY SINCE IMPLEMENTATION OF THE ACA, 2013-2017, at 10 (2019), <http://files.kff.org/attachment/Issue-Brief-Changes-in-Health-Coverage-by-Race-and-Ethnicity-since-Implementation-of-the-ACA-2013-2017>.

<sup>69</sup> See Christina M. Andrews et al., *The Medicaid Expansion Gap and Racial and Ethnic Minorities with Substance Use Disorders*, 105 AM. J. PUB. HEALTH S452 (2015).

<sup>70</sup> See JULIA ZUR & JENNIFER TOLBERT, KAISER FAMILY FOUND., THE OPIOID EPIDEMIC AND MEDICAID'S ROLE IN FACILITATING ACCESS TO TREATMENT 1 (2018), <http://files.kff.org/attachment/Issue-Brief-The-Opioid-Epidemic-and-Medicoids-Role-in-Facilitating-Access-to-Treatment>; Josh Katz, *How a Police Chief, a Governor and a Sociologist Would Spend \$100 Billion to Solve the Opioid Crisis*, N.Y. TIMES (Feb. 14, 2018), <https://www.nytimes.com/interactive/2018/02/14/upshot/opioid-crisis-solutions.html>; Emma Sandoe et al., *Policy Levers that States Can Use to Improve Opioid Addiction Treatment and Address the Opioid Epidemic*, HEALTH AFF. BLOG (Oct. 2, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180927.51221/full/>.

<sup>71</sup> ZUR & TOLBERT, *supra* note 70, at 5.

<sup>72</sup> See MATT BROADDUS ET AL., CTR. ON BUDGET & POLICY PRIORITIES, MEDICAID

the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act), enacted in the fall of 2018, partially eliminates a long-time limitation on Medicaid coverage by permitting states to use Medicaid funds to cover services for SUD treatment received by persons in facilities that treat mental disorders.<sup>73</sup>

States that seek to maximize Medicaid's effectiveness in responding to the opioid crisis could take several steps that would also advance racial justice interests in effective and more equitable treatment. First, as suggested above, states should ensure that their programs cover the full range of medical and supportive services that could aid in recovery for their residents with SUDs, either by amending their state plans or seeking section 1115 waivers.<sup>74</sup> More specifically, state Medicaid plans should cover the full range of MAT and provide reimbursement at a level that will attract a sufficient number of MAT providers willing to treat Medicaid recipients.<sup>75</sup> Similarly, states should provide coverage for SUD treatment rendered in an IMD to the extent permitted under the SUPPORT Act. And states should develop models for making sure that incarcerated persons eligible for Medicaid are enrolled prior to their release in order to avoid a gap in care and predictable relapse.<sup>76</sup>

Unfortunately, a growing number of states are considering changes to their Medicaid programs that experts predict will diminish their effectiveness in addressing the opioid crisis and are likely to disproportionately harm black Medicaid recipients. The most widely discussed of these changes is the imposition of work requirements as a condition of Medicaid eligibility. These requirements, which the federal government first granted waivers for in 2018, could diminish Medicaid's ability to address the opioid epidemic by hitting persons with SUDs particularly hard.<sup>77</sup> Although states that impose

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EXPANSION DRAMATICALLY INCREASED COVERAGE FOR PEOPLE WITH OPIOID-USE DISORDERS, LATEST DATA SHOW 6 (2018), <https://www.cbpp.org/sites/default/files/atoms/files/2-28-18health.pdf>.

<sup>73</sup> See Cindy Mann & Jocelyn Guyer, *Medicaid Provisions in the SUPPORT Act: An Important Step Forward in the Opioid Epidemic, but the Road Ahead is Long*, COMMONWEALTH FUND (Nov. 13, 2018), <https://www.commonwealthfund.org/blog/2018/medicaid-provisions-support-act-important-step-forward-opioid-epidemic-road-ahead-long>. The so-called "IMD exclusion" has historically prevented states from using federal Medicaid dollars to cover services provided to adult recipients who resided in an Institution for Mental Disease (IMD). *Id.*

<sup>74</sup> See Terry, *supra* note 61, at 354.

<sup>75</sup> See Sandoe et al., *supra* note 70 (noting experiments by Maryland and Virginia to see whether increasing reimbursement rates for MAT providers leads to increased use).

<sup>76</sup> See Jocelyn Guyer et al., *State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid*, COMMONWEALTH FUND (Jan. 11, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicare>.

<sup>77</sup> See CTR. ON BUDGET & POLICY PRIORITIES, TAKING AWAY MEDICAID FOR NOT

work requirements are supposed to exempt from the requirements persons who are deemed “medically frail,” not all persons with SUDs will fall within the scope of a “medically frail” exemption. Besides, even those persons who may qualify as “medically frail” because of their SUDs are at risk of losing Medicaid coverage if they fail to meet often burdensome documentation and reporting obligations that the work requirement schemes entail. And persons with SUDs who do not fall within the “medically frail” exemption are likely to face particular challenges in obtaining and maintaining the employment on which Medicaid eligibility is conditioned.<sup>78</sup>

In short, a commitment simply to maximizing Medicaid’s usefulness in addressing the opioid crisis should warn states against implementing work requirements. To top it off, though, work requirements also can be expected to disproportionately disqualify blacks from Medicaid coverage.<sup>79</sup> Thus, implementing work requirements transforms state Medicaid programs into the antithesis of interest convergence. No longer could focusing on expanding and strengthening Medicaid simultaneously serve white elite interests (in statehouses) in leveraging federal funding to address the opioid crisis, while also advancing a more racially just approach to addiction and SUDs.

For states that can resist conservative pressure to impose work requirements, however, beefing up Medicaid’s services for SUDs may also make sense as a political matter. First, as discussed above, state Medicaid spending on SUD treatment leverages particularly generous federal funding for the newly covered expansion population (which includes many persons with SUDs), and thus is a more efficient use of state funds than providing treatment (or simply confinement) in a carceral setting.<sup>80</sup> Beyond this common-sense appeal of Medicaid, directing attention and funding to that program may also be politically more feasible than other interventions seeking to advance racial justice interests.

The (relative) political feasibility of expanding and improving Medicaid comes from the fact that doing so may also be seen as a “postracial remedy.”<sup>81</sup> Professors Derrick Darby and Richard Levy use this phrase to

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MEETING WORK REQUIREMENTS HARMS PEOPLE WITH SUBSTANCE USE DISORDERS (2018), <https://www.cbpp.org/sites/default/files/atoms/files/2-8-18health.pdf> [hereinafter CTR. ON BUDGET & POLICY PRIORITIES, TAKING AWAY MEDICAID]; ZUR & TOLBERT, *supra* note 70.

<sup>78</sup> CTR. ON BUDGET & POLICY PRIORITIES, TAKING AWAY MEDICAID, *supra* note 77, at 4.

<sup>79</sup> See Mary Crossley, *Threats to Medicaid and Health Equity Intersections*, ST. LOUIS U. J. HEALTH L. & POL’Y (forthcoming 2019).

<sup>80</sup> Cf. Newkirk II, *supra* note 19 (suggesting that states will need to “choose between joining in the administration’s harsh prosecutorial campaign, or firmly rejecting it in favor of the public-health paradigm”).

<sup>81</sup> See Derrick Darby & Richard E. Levy, *Postracial Remedies*, 50 U. MICH. J.L. REFORM 387 (2017).



describe pragmatic solutions to decrease racial inequality without treating people differently because of their race.<sup>82</sup> Both low-income whites and blacks will benefit from expanding and improving Medicaid. Indeed, in some states, the absolute number of whites who benefit from Medicaid's expansion will be greater than the number of blacks.<sup>83</sup> Even in those states, though, the expansion and improvements in Medicaid's coverage may have a greater proportional impact on blacks because that group typically starts from a baseline of higher rates of uninsurance and poorer health status. Thus, in Darby and Levy's framework, expanding and improving Medicaid could help address the reality of racial injustice without triggering the political polarization associated with race-specific remedies.<sup>84</sup>

#### V. CHANGING OUR MESSAGING AND NARRATIVE

Though expanding and improving Medicaid could provide some progress on racial justice issues relating to the opioid epidemic, the Medicaid program will never be a panacea. That is because, while substance use disorder is a medical condition, it is not *just* a medical condition. Social, economic, and environmental factors often play important causal roles in creating the conditions that lead persons to use and abuse substances and in erecting barriers to effective medical treatment.<sup>85</sup>

Substance use disorders and addictions have been a problem plaguing American society for decades. The problem did not become a "crisis," however, until it increasingly affected white people (some of whom were middle class or affluent) who were becoming addicted to a particular class of drugs and dying as a result. The media narrative around addiction among whites often decries the wasted lives and lost potential and portrays the person suffering addiction as a victim, of either greedy pharmaceutical companies or ignorant (and greedy) doctors.<sup>86</sup> That narrative of victims deserving of compassion and assistance has not been the narrative used to describe blacks' experiences with substance use and addiction. Similarly, the recent rhetoric around "diseases of despair" most often invokes the

<sup>82</sup> *Id.* Others, however, have advocated for the importance of "specific, targeted and evidence-based interventions" to address the particular barriers that black people face and to "counterbalance the effects of racial and ethnic inequalities on drug policy." James & Jordan, *supra* note 14, at 414–15.

<sup>83</sup> See David Kindig, *Population Health Equity: Rate and Burden, Race and Class*, 317 J. AM. MED. ASS'N 467 (2017).

<sup>84</sup> Darby & Levy, *supra* note 81, at 394; see also Kindig, *supra* note 83, at 468 ("Seeking support for health policies that help poor people of all races could garner more broad-based support than policies that solely address racial gaps.").

<sup>85</sup> See Dasgupta et al., *supra* note 27, at 183–84.

<sup>86</sup> See Julie Netherland & Helena B. Hansen, *The War on Drugs that Wasn't: Wasted Whiteness, "Dirty Doctors," and Race in Media Coverage of Prescription Opioid Misuse*, 40 CULTURE MED. & PSYCHIATRY 664, 674–75 (2016).

despair experienced by whites living in areas like the Rust Belt, Appalachia, and small towns where economic opportunities have vanished. Less attention is paid to the despair that has grown in intensity as jobs and resources have left the urban core in many cities, leaving areas of concentrated poverty disproportionately populated by persons of color.

Instead, those neighborhoods too often have been a battleground in our country's fruitless and destructive "War on Drugs." Some have suggested that the opioid crisis, popularly depicted as involving primarily white persons, is leading to a "gentler" war on drugs.<sup>87</sup> I would suggest, instead, that we are most likely to advance racial justice if we reframe the challenge before us and set out to vanquish addiction, rather than drugs.

Declaring a "War on Addiction" could help reinforce and broaden the conceptual shift that is already underway—the shift in popular understanding occasioned by the opioid crisis that addiction is a medical condition requiring treatment, rather than an individual's moral failing requiring punishment.<sup>88</sup> Use of the "war" metaphor can be powerful in arousing a sense of commitment and common purpose among members of society.<sup>89</sup> The "War on Cancer," declared by President Nixon in 1971 with the signing of the National Cancer Act, provides a precedent for a broad-based, well-funded effort to address a leading cause of death through research, prevention, and treatment. The idea of a "War on Addiction" is neither novel nor radical. Indeed, it is the approach reflected in the Surgeon General's 2016 report, *Facing Addiction in America*, issued in the waning days of the Obama administration.<sup>90</sup> But it has not yet sufficiently captured the public's imagination in a way that would allow it to displace the "War on Drugs" as our primary commitment. Only when whites truly recognize their self-interest in combatting all drug addictions as medical disorders will the opportunity for interest convergence and racial justice be realized.

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<sup>87</sup> See Katharine Q. Seelye, *In Heroin Crisis, White Families Seek Gentler War on Drugs*, N.Y. TIMES (Oct. 30, 2015), <https://www.nytimes.com/2015/10/31/us/heroin-war-on-drugs-parents.html>.

<sup>88</sup> Cf. Taleed El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*, 48 U. MEMPHIS L. REV. 1357, 1368–75 (2018) (using U.S. drug policy to illustrate how pressure groups have played a role in describing addiction as either a problem attributable to disease or a problem attributable to deviancy and thereby influenced legislative problem definition and policy development).

<sup>89</sup> E.g., Lori Hartmann-Mahmud, *War as Metaphor*, 14 PEACE REV. 427 (2002).

<sup>90</sup> See Steven Reinberg, *U.S. Surgeon General Declares War on Addiction*, WEBMD (Nov. 17, 2016), <https://www.webmd.com/mental-health/addiction/news/20161117/us-surgeon-general-declares-war-on-addiction#1>.