



NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

THESIS

**FAILURE OF U.S. DRUG POLICY:
WOMEN AND THE OPIOID CRISIS**

by

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March 2023

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FAILURE OF U.S. DRUG POLICY: WOMEN AND THE OPIOID CRISIS

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ABSTRACT

Over a century of drug policy and law has failed to stop the flow of illegal drugs into the U.S. Drug policy and law have focused on reducing the supply of illicit drugs but have failed to consider factors that influence the demand for those drugs. The U.S. now faces an unprecedented crisis of opioid use, abuse, overdose, and death largely due to these failures.

A gap analysis was conducted to identify shortcomings in existing policy. Gap analysis is used to determine whether a policy as written reaches desired goals and outcomes through its implementation. Biopsychosocial theory (BPS) was used to frame the recommendations for policy change. The BPS framework of human behavior and well-being encompasses all known influences on a person when attempting to diagnose or treat an illness, permitting a thorough examination of a policy's ability to meet the needs of a population.

The gap analysis shows the current policy does not produce desired outcomes in terms of drug abuse prevention, and women are affected more negatively than men. Women are at greater risk of losing their children, losing their jobs, being unable to find educational resources, and becoming homeless if they become addicted to opioids. The BPS suggests a shift in policy and law from supply reduction to demand reduction, which is critical to the future of women most at risk for drug abuse, overdose, and death.

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LIST OF ACRONYMS AND ABBREVIATIONS

ACE	adverse childhood events
BIPOC	Black, Indigenous, people of color
BOP	Federal Bureau of Prisons
BPS	Biopsychosocial Theory
CCBHC	certified community behavioral health clinics
CDC	Centers for Disease Control and Prevention
DEA	Drug Enforcement Agency
FQHC	federally qualified health clinics
FSA	First Step Act
MOUD	medications for opioid use disorder
NIH	National Institutes of Health
ORWH	Office of Research on Women's Health
OWH	Office of Women's Health
RSS	recovery support systems
SAP	student assistance programs
SDOH	social determinants of health
SUD	substance use disorder
TCO	transnational criminal organization
WHM	women's health movement
WWII	World War II

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EXECUTIVE SUMMARY

Opioid use, abuse, and overdose have always been a homeland security matter, even before the Department of Homeland Security was established. The first federal law focused on opium products was passed in 1914, and since that time a multitude of laws and policies have been introduced to control the influx of opioids into the U.S. and to control the use, abuse, addiction to, and death from opium-based products, both licit and illicit.¹

The Department of Homeland Security is engaged in interdiction efforts and in the effort to combat individuals and groups who transport opioids and their precursors, which are used to manufacture opioid based drugs. This effort has not been successful; opioid use, addiction, and death from overdose increases in the U.S. every year. The threat of opioids to the U.S. has morphed from opium designed to be smoked, to crude opium manufactured into illicit substances such as morphine and heroin, to the driver of the current opioid crisis, synthetic fentanyl and new analogs that become undetectable as they change.

Drug policy and the war on drugs have been focused on supply reduction since their inception, yet attempts to prevent drug use and overdose deaths from opioids have failed miserably.² Much of the reason for this failure is that U.S. drug policy does not sufficiently consider the second challenge: demand for the drug that is rooted in systemic inequality that is beyond deterrence through punishment.

Data show that between 1999 and 2016 overdose deaths from prescribed opioids and fentanyl have increased 583 percent in women, as opposed to 404 percent in men; women are also more likely to use opioids to commit suicide than men.³ Moreover, though

¹ David T. Courtwright, *Dark Paradise: A History of Opiate Addiction in America* (Cambridge, MA: Harvard University Press, 2001), ProQuest, 1–2.

² Charles F. Manski, John V. Pepper, and Carol V. Petrie, eds., *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* (Washington, D.C.: The National Academies Press, 2001), <https://doi.org/10.17226/10021>, 141–144.

³ Teddy G. Goetz, Jill B. Becker, and Carolyn M. Mazure, “Women, Opioid Use and Addiction,” *Federation of American Societies for Experimental Biology* 35, no. 2 (January 12, 2021): 1–12, <https://doi.org/10.1096/fj.202002125R>.

there has been a decrease in the number of prescriptions for opioids since 1999, opioid overdoses continue to increase mainly due to overdose from illicit fentanyl and analogs. In 2021, there was a 23 percent increase in opioid overdoses over 2020.⁴

The U.S. is at a crossroads. The most recent rise in opioid addiction and overdose has introduced a new threat to the nation, and without momentous action to understand and confront women's biopsychosocial needs, not only will the war on drugs continue to be futile, but the women who are caught up in the failed war and those who depend on them will be lost.

A. RESEARCH DESIGN

In this thesis, I analyzed U.S. drug policy for its efficacy in helping women who are using or addicted to opiates stop using. I used gap analysis and biopsychosocial theory (BPS) for the analysis. The gap analysis identified shortcomings in past and existing policy, while BPS framed the recommendations for policy change.

Gap analyses are often used to determine the efficacy of public and private policy.⁵ Gap analysis is used to determine whether a policy as written reaches desired goals and outcomes through its implementation, and to fill the "gaps" between desired outcomes and the outcomes that will be realized through the policy.⁶ Though this method is a good framework to evaluate the efficacy of a policy, it does not adequately inform the researcher about how to close the gap between what is desired and what is possible through the current policy. To determine changes that must be made to the policy, further analysis of the gaps and scientific best practices must be employed.

Combined with gap analysis, the biopsychosocial theoretical framework of human behavior and well-being allows a thorough examination of a policy's ability to meet the

⁴ Mike Stobbe. "US Overdose Deaths Hit Record 107,000 Last Year, CDC Says," AP News, May 11, 2022, <https://apnews.com/article/overdose-deaths-opioids-fentanyl-8cb302a70ddb6a435f9e8fbb19f153b>.

⁵ Isabell Koske and Nigel Pain, *The Usefulness of Output Gaps for Policy Analysis* (Paris: Organisation for Economic Co-operation and Development, 2008), <https://doi.org/10.1787/18151973>, 5–8.

⁶ Koske and Pain, 6.

unique needs of a population through implementation.⁷ The BPS informs analysis of the changes needed to fill the gaps in a policy, should there be any.

B. ON DRUG POLICY AND LAW

Drug law and policy in the U.S. spans over 100 years. The intended purpose of the first laws was to control the distribution and use of opium products and remained the law of the land for over 50 years. Subsequent laws placed mandatory minimum sentences for drug manufacturers, distributors, and users of illicit opioid products. Though all laws speak to supply reduction, few include measures to confront demand for the drugs.

Drug laws in the U.S. have not always been implemented for the welfare of the people; rather, they are often guided by political priorities, the need or desire to control people's behavior, and pushed on the citizens using hyperbole, fear, and pandering to stereotypes of women drug abusers and racism. A pattern in the conception and tone of drug laws can be seen from the first federal narcotics law of 1909, to the National Drug Control Strategy of the Biden-Harris Administration in 2022.

From the inception of drug law and drug policy, physicians have been criticized for overprescribing. Physicians are accused of being too lazy to research patients' symptoms and diagnose the core sources of their illness. It is well documented that during opioid crises, physician overprescription has been a variable in every case.⁸ It is also clear from the history of drug law and policy that the legal course is not going to cure the ills of U.S. culture that lead to drug use and abuse.

The Nixon administration was the first to incorporate a treatment arm in its drug policy. Unfortunately, that policy was short-lived, and by 1980 treatment had been written out of drug policy. Only Nixon's drug policy and to some extent Carter's drug policy came

⁷ Francesc Borrell-Carrió, Anthony L. Suchman, and Ronald M. Epstein, "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry," *Annals of Family Medicine* 2, no. 6 (2004): 576–82, <https://doi.org/10.1370/afm.245>.

⁸ Micah L. Issitt, *Opinions Throughout History: Drug Use & Abuse*, 1st ed. (Boston: Grey House Publishing, 2018), 59–120.

close to addressing the core issues that underlie drug use, and those attempts were still miles short of what is needed to combat the drug problems found in the U.S.

Through over 200 years of drug policy and treatment it has become clear that as with any social issue, there is not one policy or program that can entirely address and eradicate a problem. There is a complex interaction between poverty, helplessness, despair, and hopelessness that is connected to drug use, abuse, addiction, overdose, and death. Acknowledging that the use of drugs that alter the consciousness of human beings will continue regardless of laws or policies, and then developing a system of counteracting the source of, and the most dangerous and harmful aspects of drug use, is a realistic and common-sense approach to drug policy and law.

As previous U.S. drug policy has done, the existing federal policy on opioids does little to address women's unique needs. This policy follows the same pattern as every other U.S. policy written to address drugs. It is punitive, it does not offer any substantive action to alleviate the core issues and social ills associated with drug use and abuse, and it lacks focus on women's experiences in the drugs arena. It risks failure because of these shortcomings.

C. ON WOMEN'S EXPERIENCE WITH OPIOIDS

Rich feminist scholarship that emerged in the early 20th century with the battle for women's reproductive rights underpins this research.⁹ Though the present research is not specific to reproductive rights, the discourse from those early disputes carries on through current women's health issues. Since the early 20th century, the Women's Health Movement (WHM) has emerged, arguing for inclusion of women in medical research and consideration of women's unique medical needs in diagnosis and treatment.¹⁰ Despite these calls, in many instances women's unique experiences are largely ignored. Diagnosis and treatment of opioid use and abuse, and public policy represent two of those instances.

⁹ Kristie Yasunari, "Peace Profile: Margaret Sanger," *Peace Review* 12, no. 4 (December 2000): 619–26, <https://doi.org/10.1080/10402650020014735>.

¹⁰ Nancy Tuana, "The Speculum of Ignorance: The Women's Health Movement and Epistemologies of Ignorance," *Hypatia* 21, no. 3 (2006): 1–19.

Though many great strides have been made in women's health care, health issues and conditions for which little progress has been made continue to persist.¹¹ One of these is use and abuse of opioids by women. While Sanger and her contemporaries spent decades fighting for bodily autonomy for women, women who struggled with drug abuse did not have the same advocacy.¹² Perhaps due to lack of advocacy, or perhaps due to the stigma associated with drug abuse, women's struggle with opioid use and abuse has not been met with sufficient action to overcome the core issues related to drug abuse in this nation.

The issue is not just about women and opioids, but about the recognition of women's experiences more broadly. Though there has recently been an increase in the examination of sex differences in many academic, medical, and sociocultural arenas, these examinations often fall short. There is more to the differences between men and women than research is generally willing to explore. Women's experience of the world differs greatly from men on many levels that are not widely addressed. Patriarchy and Protestant morality have set the standard for where women fit in the world, and what women are expected to do and be.¹³

Benevolent patriarchy is framed such that it seems that the choices and decisions taken away from women are done for their own good.¹⁴ In the case of women who use or are addicted to drugs, it is benevolent to save women from themselves by creating punitive measures to punish, and thereby dissuade, them from using drugs. Since the primary issue is one of control, the social and psychological influences of drug use and drug addiction are not examined since that could lead to conclusions that run counter to the concepts of benevolent patriarchy (i.e., it is harmful, not beneficial). Given this mindset, drug policy

¹¹ Institute on Medicine, *Women's Health Research: Progress, Pitfalls, and Promise* (Washington, DC: The National Academies Press, 2010), <https://doi.org/10.17226/12908>, 143–170.

¹² Natasha Du Rose, *The Governance of Female Drug Users: Women's Experiences of Drug Policy* (Chicago: Bristol University Press, 2015), <https://doi.org/10.2307/j.ctt1t89h83>, 68–115.

¹³ Du Rose, 44–85.

¹⁴ Melanie Tannenbaum, "The Problem When Sexism Just Sounds So Darn Friendly...", *Scientific American Blog Network* (blog), April 2, 2013, <https://blogs.scientificamerican.com/psysociety/benevolent-sexism/>.

cannot be centered around demand or curbing the demand for opiates as it brings up questions about the functioning of society as a whole.

D. CONCLUSION

The research in this thesis demonstrated that drug policy must not stand alone. Rather it must be incorporated in sweeping social changes that remove the long-standing patriarchal tone toward women and rid sociocultural institutions of Protestant morality that restricts women from full participation in their own lives. These changes cannot be made instantaneously, however steps toward the goal of women's full participation in choices and decisions that affect them must begin immediately, and that includes their experiences with drug use and abuse, as well as the life experience that may have initiated drug use.

The biopsychosocial theory posits that to successfully counter drug abuse, an individual's unique biology, psychological well-being, and sociocultural experiences must be considered. For women to fully participate in their journey to avoid and recover from opioid use and abuse, many barriers must be removed. First, the biological pathway to substance addiction and abuse must be identified for women. Second, programs and policies that improve social determinants of health must be implemented alongside treatment options and recovery support and an infrastructure must be put in place to provide the resources women need to succeed. And finally, women must gain bodily autonomy and be freed from patriarchal and protestant expectations, allowing them to have full agency in the choices and decisions that affect them.

There is little known about women's biological experiences with drugs, including opioids; past research on biological determinants and other physiological aspects of drug use have focused on men.¹⁵ To increase knowledge and better prevent opioid use, abuse, overdose, and death in women, women centered research must be expanded within the science community. While progress has been made toward this goal, it has been slow moving, and even when women began to be included in research protocols, focus was

¹⁵ Department of Health and Human Services: Office on Women's Health, *Final Report: Opioid Use, Misuse, and Overdose in Women*. (Washington, DC: U.S. Department of Health and Human Services, 2017), <https://www.rmtlc.org/wp-content/uploads/2017/08/final-report-opioid-508.pdf>.

placed on a small population of them and provided very little insight.¹⁶ Research protocols must change so that women who are addicted to drugs can be best served.

Further, the focus of any drug policy must be on improving social determinants of health and individual well-being; women who become addicted to drugs must feel safe in seeking treatment without the fear of judgment. While treatment has become more readily available, women are still less likely than men to receive treatment, an indication that there are social barriers in place keeping them from seeking the treatment they need. The National Survey on Drug Use and Health indicated that while one in three people with substance use disorders were women, women only accounted for one in five people in treatment.¹⁷ This is an indication that women do not feel safe seeking help, and for good reason. In the U.S., women are at greater risk of losing their children, becoming homeless, experiencing physical abuse, losing a job, being denied social services including financial assistance and educational grants to help pay for job training, and longer terms in prison for lesser charges than men.¹⁸ Each of these affect women's ability and willingness to seek help when they find themselves addicted to drugs, which leads to fewer women getting treatment and other assistance they need.

It is not surprising given the political atmosphere that there are no calls for social change. The U.S. is sliding into more conservative mindset in which women are losing ground socially, economically, and in their bodily autonomy. With the ongoing fight for income equality, more women than men living in poverty, loss of bodily autonomy for many women, and still no ratification of the Equal Rights Amendment after 100-years of negotiating and arguing, women's lives today, and our futures, look bleaker than they did for our mothers and grandmothers. It remains to be seen how these factors will affect women and drug use. If there is a decline in quality of social determinants of health, which

¹⁶ Jaimie P. Meyer et al., "Research on Women with Substance Use Disorders: Reviewing Progress and Developing a Research and Implementation Roadmap," *Drug and Alcohol Dependence* 197 (April 1, 2019): 158–63, <https://doi.org/10.1016/j.drugalcdep.2019.01.017>.

¹⁷ Meyer et al.

¹⁸ Elizabeth A. Wahler, "Retribution or Rehabilitation? Conflicting Goals of Us Policies Pertaining to Drug Felonies and Their Impact on Women," *Journal of Women, Politics & Policy* 36, no. 1 (January 2, 2015): 95–106, <https://doi.org/10.1080/1554477X.2015.985155>.

according to some has already begun, the chance of drug use diminishing for women is very low.

Drug policy and laws have failed women since their inception over 100 years ago. Women's unique needs and life experiences must be considered and included in all discussion of, and legislation developed, concerning drug use, abuse, overdose, and death. It is becoming more urgent for substantive action on drug use as the U.S. finds itself in the midst of a crisis that is killing more people every day, a group of which women are a growing percentage.

Decades of drug supply reduction efforts have done little to keep drugs from ruining lives, as evidenced by growing prison overcrowding and soaring death rate. The time is long overdue for more efforts toward demand reduction. Inclusion of meaningful efforts to improve social determinants of health must be made. Drug use, abuse, overdose, and death are a lifespan issue that begins long before the first drug is consumed.

It is time to end the Drug Policy Theater and institute policies that tackle the core issues behind drug use, abuse, overdose, and death head on. The federal government knows what is necessary and are willing to put money and time into helping other nations fight these issues: poverty, helplessness, violence, economic inequality, and instability, to name a few.

Unless and until the U.S. is willing to put the same efforts into improving SDOH in our nation, the drug problem, the opioid crisis, and the ongoing and meaningless war on drugs are not going to end. Women in the U.S. and the people, communities, and the nation that needs them will continue to suffer.

ACKNOWLEDGMENTS

No woman should be told she can't make decisions about her own body.
When women's rights are under attack, we fight back.

—Kamala Harris

For too long, women's experiences in this world have been overlooked, underappreciated, and ignored. Through centuries of hard work by our grandmothers and mothers, women had begun to overcome sexism and inequality, and we had gained recognition of our right to autonomy in all arenas, including our bodies. Appallingly, women in the U.S. have seen the fruits of those labors begin to wither and die.

In acknowledgement of our grandmothers' and mothers' tireless efforts, I focus on one small aspect of women's experiences with the hope that my generation and the generations that follow are worthy of the struggle of our ancestresses, and that we will all continue to take up the gauntlet of women's rights for ourselves, our daughters, and our granddaughters.

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I. INTRODUCTION

A. OPIOIDS AND HOMELAND SECURITY

Opioid use, abuse, and overdose have always been a homeland security matter, even before the Department of Homeland Security was established. The first federal law focused on opium products was passed in 1914, and since that time a multitude of laws and policies have been introduced to control the influx of opioids into the U.S. and to control the use, abuse, addiction to, and death from opium-based products, both licit and illicit.¹

The Department of Homeland Security is engaged in interdiction efforts and in the effort to combat individuals and groups who transport opioids and their precursors, which are used to manufacture opioid based drugs. This effort has not been successful; opioid use, addiction, and death from overdose increases in the U.S. every year. The threat of opioids to the U.S. has morphed from opium designed to be smoked, to crude opium manufactured into illicit substances such as morphine and heroin, to the driver of the current opioid crisis, synthetic fentanyl and new analogs that become undetectable as they change.

1. The Cost of the War on Drugs

There are two distinct challenges within the war on drugs that must be fought. Challenge one is stopping the supply of drugs. The U.S. spends billions of dollars per year to stop the flow of illegal drugs, to locate drugs and the people selling and using them, to stem the violence that accompanies illegal drug manufacture and distribution, to incarcerate individuals who are involved in the illegal drug trade, and to a lesser extent, provide treatment for individuals who find themselves addicted to opioids.² Though the financial cost of the war on drugs is exceedingly large, there are secondary and non-financial costs associated with the drug war as well. For example, loss of productivity, medical costs for addicts who return time and again to emergency rooms, the human cost

¹ David T. Courtwright, *Dark Paradise: A History of Opiate Addiction in America* (Cambridge, MA: Harvard University Press, 2001), ProQuest, 1–2.

² Courtwright, 161–185.

of lives lost, children left without a parent, and parents grieving the loss of their children to addiction or death.³

Drug policy and the war on drugs have been focused on supply reduction since their inception yet attempts to prevent drug use and overdose deaths from opioids have failed miserably.⁴ Much of the reason for this failure is that U.S. drug policy does not sufficiently consider the second challenge; demand for the drug that is rooted in systemic inequality that is beyond deterrence through punishment.

Generations of drug policy have used fear, misinformation, distraction, punishment, and incarceration of drug users as their foundation, and those tactics are insufficient. These laws and policies have led to overcrowded prisons, resulted in an increase in homelessness, stigma placed on drug users, and former users who cannot reenter their communities because of federal programs that exclude individuals who have been convicted of drug offenses. The most recent rise in opioid addiction and overdose has introduced a new threat to the nation, and without immediate action not only will the war on drugs be lost, but the individuals who are caught up in the failed war will be lost as well.

2. The Newest Issue in the War on Drugs

Though the war on drugs has been fought for decades, a new wave of addictions and overdose deaths has swept the U.S. What started as a problem in a small number of states in the early 1990s has become a national crisis.⁵ The Centers for Disease Control and Prevention (CDC) identified three waves of the current opioid crisis beginning in the mid-1990s. The first wave was the result of physicians overprescribing opiates to their

³ Charles F. Manski, John V. Pepper, and Carol V. Petrie, eds., *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* (Washington, D.C.: The National Academies Press, 2001), <https://doi.org/10.17226/10021>, 193–210.

⁴ Manski, Pepper, and Petrie, 141–144.

⁵ “Opioids in the Homeland: DHS Coordination with State and Local Partners to Fight the Epidemic: Field Hearing Before the Subcommittee on Oversight and Management Efficiency” (Washington, D.C.: 115th Congress, 2nd Session, 2018), <https://www.govinfo.gov/content/pkg/CHRG-115hhrg32929/html/CHRG-115hhrg32929.htm>.

patients, a percentage of whom ultimately became addicted.⁶ The second wave of the epidemic began in 2010 with an increase in heroin availability.⁷ The third wave, which is still ongoing, began in 2013 with the introduction of illicitly manufactured synthetic opioids to the illegal drug market.⁸

Data show that between 1999 and 2016 overdose deaths from prescribed opioids and fentanyl have increased 583 percent in women, as opposed to 404 percent in men; women are also more likely to use opioids to commit suicide than men.⁹ Moreover, though there has been a decrease in the number of prescriptions for opioids since 1999, opioid overdoses continue to increase due mainly to overdose from illicit fentanyl and analogs.¹⁰ In 2021, there was a 23% increase in opioid overdoses over 2020.

The U.S. is at a crossroads. The most recent rise in opioid addiction and overdose has introduced a new threat to the nation, and without momentous action to understand and confront women's biopsychosocial needs, not only will the war on drugs continue to be futile, but the women who are caught up in the failed war and those who depend on them will be lost.

B. STATEMENT OF THE PROBLEM

Feminist scholars argue that the disproportionate impact of opioid abuse on women is due to draconian drug laws that target women for behavior that a patriarchal system has decided is not appropriate for women.¹¹ Because of the punitive and moralistic nature of

⁶ Centers for Disease Control and Prevention, "Understanding the Epidemic: Drug Overdose," March 19, 2020, <https://www.cdc.gov/drugoverdose/epidemic/index.html>.

⁷ Centers for Disease Control and Prevention, "U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%," May 11, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

⁸ Centers for Disease Control and Prevention, "Understanding the Epidemic."

⁹ Teddy G. Goetz, Jill B. Becker, and Carolyn M. Mazure, "Women, Opioid Use and Addiction," *Federation of American Societies for Experimental Biology* 35, no. 2 (January 12, 2021): 1–12, <https://doi.org/10.1096/fj.202002125R>.

¹⁰ Mike Stobbe, "US Overdose Deaths Hit Record 107,000 Last Year, CDC Says," AP News, May 11, 2022, <https://apnews.com/article/overdose-deaths-opioids-fentanyl-8cb302a70ddb6a435f9e8fbb19f153b>.

¹¹ Drug Policy Alliance, *Women, Prison, and the Drug War* (New York: Drug Policy Alliance, 2018), https://drugpolicy.org/sites/default/files/women-and-the-drug-war_0.pdf.

U.S. drug laws, women who use or are addicted to opioids are vulnerable to negative consequences that they would not otherwise be; for example, facing stigma that often leads to homelessness, loss of their children, and inability to find employment.¹² Sanctions placed upon drug users are especially detrimental for women and often stop them from seeking treatment or other resources that would help them recover from addiction, or stop them from using drugs before addiction sets in.¹³

The current policy and drug postures fail to recognize the unique adversities women experience that drive them to use drugs and the actions necessary to attend to those adversities and curb the demand for opioids. Policy makers must realize that the social construction of *woman* binds us to behaviors and actions that are deemed suitable and acceptable, and when women step outside of those bindings the consequences are detrimental. As consequence of U.S. policy, women have nowhere to turn when they find themselves spiraling into opioid use and abuse.

C. RESEARCH QUESTION

How should U.S. drug policy on opioids be (re)written to achieve full consideration of women's experience with opioid use and abuse, treatment, and women's health?

D. RESEARCH DESIGN

In this thesis, I analyzed U.S. drug policy for its efficacy in helping women who are using or addicted to opiates stop using. I used gap analysis and biopsychosocial theory (BPS) for the analysis. The gap analysis identified shortcomings in past and existing policy, while BPS framed the recommendations for policy change.

Gap analyses are often used to determine the efficacy of public and private policy.¹⁴ Gap analysis is used to determine whether a policy as written reaches desired goals and outcomes through its implementation, and to fill the "gaps" between desired outcomes and

¹² Natasha Du Rose, *The Governance of Female Drug Users: Women's Experiences of Drug Policy* (Chicago: Bristol University Press, 2015), <https://doi.org/10.2307/j.ctt1t89h83>, 12–50.

¹³ Du Rose, 12–50.

¹⁴ Koske and Pain, *The Usefulness of Output Gaps for Policy Analysis*.

the outcomes that will be realized through the policy.¹⁵ Though this method is a good framework to evaluate the efficacy of a policy, it does not adequately inform the researcher about how to close the gap between what is desired and what is possible through the current policy. To determine changes that must be made to the policy, further analysis of the gaps and scientific best practices must be employed.

Combined with gap analysis, the biopsychosocial theoretical framework of human behavior and well-being allows a thorough examination of a policy's ability to meet the unique needs of a population through implementation.¹⁶ The BPS informs analysis of the changes needed to fill the gaps in a policy, should there be any.

Introduced by Engle as an alternative to the medical model through which all ailments were treated as though medication or medical intervention was the only cure, the biopsychosocial theory encompasses all known influences on a person when attempting to diagnose or treat an illness.¹⁷ Engle argued that the medical model discounted the role of the psychological, social, and behavioral aspects of illness, all of which have a direct effect on individuals and their presentation of "disease." Biopsychosocial theory focuses not only on any "disease" of the individual and corrective actions that must be taken on an individual level, but also on the environment and society in which the individual lives and any environmental or social changes that must be made to improve the health of the individual.¹⁸

E. LITERATURE REVIEW

A historical review of U.S. drug policy is examined to know where we have come from in order to understand how we have come to be where we are. Drug policy in the U.S.

¹⁵ Koske and Pain.

¹⁶ Francesc Borrell-Carrió, Anthony L. Suchman, and Ronald M. Epstein, "The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry," *Annals of Family Medicine* 2, no. 6 (2004): 576–82, <https://doi.org/10.1370/afm.245>.

¹⁷ Dennis Saleebey, *Human Behavior and Social Environments: A Biopsychosocial Approach* (New York: Columbia University Press, 2001), <https://doi.org/10.7312/sale11280>, 13–14.

¹⁸ George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, no. 4286 (1977): 129–36.

was first created as a punitive measure to discourage the use of opium and its derivatives.¹⁹ Policy discourse was heavily influenced by patriarchal beliefs and Protestant morals which held women in low esteem and made no effort to address women's needs.²⁰ Drug policy has evolved little through the decades, it has consistently ignored the failure of punitive measures to decrease drug use and abuse, and the need to address demand for drugs.²¹

Literature was drawn from feminist scholarship and research allowing us to focus on opioid abuse and women since women's fight for autonomy, and the policy and laws that guided social conceptions of what it means to be a woman addicted to opioids are deeply intertwined.

F. THESIS ROADMAP

The intersection of women's rights, the women's health movement, and U.S. drug policy is investigated and analyzed throughout this thesis. Threads of patriarchy and Protestant morality permeate U.S. drug policy and have been translated into arguments against women's right to make choices for themselves.²² Often, the sexism written into policy and law is explained away by framing it as a benevolent measure to protect women from their own bad choices. This framework is called benevolent sexism and refers to the perceived need for men to "take care" of women.²³ Benevolent sexism is based on the conclusion that women are inferior to men physically, morally, and intellectually. Belief that women are lesser-than and need protection from themselves leads to restrictions placed

¹⁹ Micah L. Issitt, *Opinions Throughout History: Drug Use & Abuse*, 1st ed. (Boston: Grey House Publishing, 2018), 59–120.

²⁰ Regina M. Morantz, "Making Women Modern: Middle Class Women and Health Reform in 19th Century America," *Journal of Social History* 10, no. 4 (1977): 490–507, <https://doi.org/205.155.65.56>.

²¹ Courtwright, *Opioid Addiction in America*, 132–155.

²² Nancy Campbell, *Using Women: Gender, Drug Policy, and Social Justice* (New York: Routledge, 2000), Google Books, 4–9.

²³ Melanie Tannenbaum, "The Problem When Sexism Just Sounds So Darn Friendly...", *Scientific American Blog Network* (blog), April 2, 2013, <https://blogs.scientificamerican.com/psysociety/benevolent-sexism/>.

on women regarding making choices for, or taking care of, themselves and those who depend on them.²⁴

The focus of the thesis is on women's experience with opioids and U.S. laws from the first opioid crisis in the U.S. during the 19th century through the latest opioid crisis that began in the late 1990s. Drug policy and laws in the U.S. have never worked to stop drug use and addiction and in fact have led to many unintended consequences that have been detrimental to women.

Chapter II contains the history of U.S. drug law and a comprehensive examination of U.S. drug policy and its effects on women. From the beginning, U.S. policy and law has failed to address the core issues behind drug use and addiction, and the choice to write punitive policy and laws that used punishment as a deterrent to drug use have failed.

Chapter III explores the rise of the women's health movement (WHM). Though the focus of this thesis is on women's experience with opioids, there is a direct link to women's ability to make choices for themselves without the input or "permission" of men and the disregard of women's needs in the drugs arena. The WHM was the beginning of women's fight for autonomy in all aspects of their lives and as such is an integral piece of women's experiences with drug use, abuse, overdose, and death. The failure of drug policy and law to recognize the unique experiences of women has been detrimental, causing long-term drug abuse, family disruption, individual tragedy, scorn, judgement, and stigma. Chapter IV summarizes recent research addressing women's experiences with opioids and explores treatment protocols that have been found through research to be efficacious for women.

Chapter V contains the gap analysis. This chapter dissects and analyzes the newest drug policy, that of the Biden-Harris Administration. Each of the 2022 National Drug Control Policy strategies is discussed in detail and the pros and cons of each is considered, leading to an examination of the efficacy of the Policy to meet the needs of women in the drugs arena.

²⁴ Du Rose, *The Governance of Female Drug Users*, 113–117.

Biopsychosocial theory is used in Chapter VI to detail the best way to write a drug policy to make it effective for women. There are a number of issues not considered in any past or present drug policy that must be included in future efforts to lessen demand for drugs.

II. U.S. DRUG POLICY AND LAW: HOW WE GOT HERE

Drug law and policy in the U.S. spans over 100-years. The intended purpose of the first laws was to control the distribution and use of opium products and remained the law of the land for over 50-years. Subsequent laws placed mandatory minimum sentences for drug manufacturers, distributors, and users of illicit opioid products. Though all laws speak to supply reduction, few include measures to confront demand for the drugs.

A. THE FIRST FEDERAL DRUG LAWS

Prior to formal laws, drug use and abuse were deemed a social issue that was in the purview of local communities, doctors, churches, and local governments.²⁵ In the late 19th and early 20th centuries physicians were generous with morphine and laudanum prescriptions for women. Opium based drugs were prescribed for pain, and several ailments such as reproductive complaints and anxiety-induced emotions and behaviors.²⁶ Women who were unhappy with their circumstances and openly displayed their consternation were often prescribed opioids to calm them and make life more bearable for them and for the people in their lives. As it became clear that some patients who used morphine were becoming addicted, physicians greatly reduced the number of prescriptions they were writing for opioids. By 1895 addiction rates had begun to fall.²⁷ Regardless of the decrease in addiction, the federal government saw an opportunity to expand its authority.

The Angell treaty (1887) was implemented to increase tariffs on and ban the import of smoking opium by Chinese individuals living in the U.S.²⁸ Though the treaty slowed the import of smoking-grade opium by Chinese nationals, the treaty did nothing to curb import by American individuals and companies, resulting in a net increase in opium

²⁵ Courtwright, *Opioid Addiction in America*, 133–134.

²⁶ Audrey Redford and Benjamin Powell, “Dynamics of Intervention in the War on Drugs: The Buildup to the Harrison Act of 1914,” *The Independent Review* 20, no. 4 (2016): 509–30.

²⁷ Erick Trickey, “Inside the Story of America’s 19th-Century Opiate Addiction,” *Smithsonian Magazine*, January 4, 2018, <https://www.smithsonianmag.com/history/inside-story-americas-19th-century-opiate-addiction-180967673/>.

²⁸ Redford and Powell, “Buildup to the Harrison Act.”

importation and use over the following decade.²⁹ Opium dens became common in larger cities and White Americans were engaging in opium smoking at an “alarmingly high” rate. New, higher, tariffs were implemented to further curb importation of smoking-grade and crude opium, yet White American’s use of the drug continued unabated.³⁰

Stating concern for the health and safety of the American public, the Federal Government enacted the Opium Exclusion Act in 1909 to criminalize importation of smoking-grade opium into the U.S. regardless of the nationality of the importer.³¹ The passage of the Opium Exclusion Act unintentionally increased the importation of crude opium, which was manufactured into morphine and heroin, both of which were consumed in ever larger quantities.³² Lawmakers made it clear that a key reason for writing drug policy that limited access to morphine and opium was to keep White women from consorting with Chinese men from whom women could obtain the drugs.³³

To counteract the effects of the Opium Exclusion Act, the Harrison Act (1914) was passed. The Act limited dispensing of opioids to prescriptions written by physicians who had registered with his or her state’s internal revenue office.³⁴ Later, the Supreme Court of the U.S. clarified that physicians were only allowed to prescribe opium-based drugs to treat ailments, not to maintain or treat addiction to the drugs.³⁵

In addition to criminalizing drug use, there were a number of unintended consequences resulting from the passage of the Harrison Act. The shift from community responsibility for caring for those who were addicted and the perception of the addict as a person who deserved help, to the criminal who must be separated from their community was one unintended consequence of the Harrison Act.³⁶ Criminalizing drug use and

²⁹ Redford and Powell.

³⁰ Redford and Powell.

³¹ Redford and Powell.

³² Redford and Powell.

³³ Courtwright, *Opioid Addiction in America*, 3–6.

³⁴ Courtwright.

³⁵ Redford and Powell, “Buildup to the Harrison Act.”

³⁶ Redford and Powell.

addiction removed resources from women who wanted or needed help to stop using drugs. Community clinics that existed for the very reason of helping people get off drugs closed because they were no longer allowed to treat addiction.³⁷ The first consequence led to the second unintended consequence of the Harrison Act.

The second unintended consequence was an increase in demand for illegal drugs. Though the Opioid Exclusion Act and the Harrison Act both reduced legal use of opium and its derivatives, they increased demand for illegal opium and morphine. The Supreme Court decision not to allow physicians to assist with maintenance or detoxification from morphine or opium by providing prescriptions for opioids throughout recovery, left people with addictions to find drugs illegally. Additionally, because the laws placed a limit on the amount of opium that could be imported to the U.S., addicts began to turn to other drugs such as alcohol, cocaine, and heroin.³⁸ Though heroin is a derivative of opium and should not have been available, it was available due to the third consequence.

The third unintended consequence was a rise in American and Chinese criminal organizations that smuggled opium and heroin into the U.S.³⁹ While criminal organizations existed before federal drug laws, their power increased as did the number of organizations vying for access to the new customer base. The violent competition between the organizations increased as they fought for dominance. The two federal laws passed to address addiction to opium and morphine were directly responsible for the growth of criminal organizations and the increase in violence. Unintended consequences and failure to meet stated goals is a lingering effect of all federal drug policy.

Perhaps the most significant and lasting effect the Harrison Act had was criminalizing drug use and addiction which has become the enduring core of U.S. drug policy. Propaganda regarding the nature of drug users, such as the danger they posed to themselves, to their families, and their communities, coupled with stories of violent crimes committed by drug users and addicts were mostly hyperbole. While there is evidence to

³⁷ Courtwright, *Opioid Addiction in America*, 103–104.

³⁸ Courtwright, 104.

³⁹ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 120–124.

indicate that drug users and addicts committed acts of violence, the large majority of violent crime was, and still is, committed by people not using narcotics. In fact, narcotics generally have the effect of sedating users, not inciting them to behave violently.⁴⁰

B. A SHORTAGE OF OPIUM

Beginning in the early 1930s and through the early 1950s the U.S. experienced large shifts in the availability and use of heroin and other opioids. In the late 1930s the U.S. was preparing for World War II (WWII) and began stockpiling opium in anticipation of needing it for troops.⁴¹ Organized crime syndicates also entered the heroin business and increased prices. Internationally, quotas were set for the manufacture of opium which restricted the supply available globally.⁴² These three events resulted in a large increase in the price of heroin and a drop in the availability of the drug.⁴³

Social changes during WWII also contributed to a drop in opioid use. As men went to war, women were called to the workplace in greater numbers than ever before. Employment levels rose, the morale of the nation was high. The social and psychological issues of loneliness, boredom, helplessness, and to some extent depression had been managed, if unintentionally, by the war.⁴⁴

Addiction levels continued to drop through the early years of the war, but before the war ended rates of heroin addiction began to climb.⁴⁵ Organized crime syndicates began to import heroin in larger quantities than ever before and their sources in France and Italy were new and difficult to track.⁴⁶ The new wave of heroin addictions caught law enforcement and policy makers by surprise and though punitive actions had been

⁴⁰ Issitt, 50–58.

⁴¹ Courtwright, *Opioid Addiction in America*, 83–84.

⁴² Courtwright, 113–115.

⁴³ Courtwright, 113–115.

⁴⁴ Courtwright, 113–115.

⁴⁵ Courtwright, 113–115.

⁴⁶ Courtwright, 113–115.

unsuccessful in the past, lawmakers' reaction was to place more punitive sanctions on users and addicts.⁴⁷

The 1951 Boggs Act followed by the Narcotics Control Act of 1956 established mandatory minimum sentences for drug crimes in the U.S.⁴⁸ Proponents of the Acts argued that because the existing punitive threats did not reduce drug crime as they were designed to do there was a need to increase the sanctions placed upon those who participated in drug related offenses to further dissuade others.⁴⁹

The mandatory minimum sentencing laws of the 1950s did not succeed in decreasing opioid related offenses.⁵⁰ Just as the laws that came before them, mandatory minimum sentencing did not work to decrease illegal drug activity or addiction and carried with it unintended consequences. The reason for the failure of mandatory minimum sentencing was the same as the failure of past laws; it failed to address the core issues that drive individuals to use conscience-altering drugs.⁵¹

Medical experts argued that social institutions must be restructured in order to address many of the factors connected to opioid use.⁵² A report written by the first commissioner of the Federal Bureau of Narcotics made it clear that the rapid increase in Black and Hispanic addicts accompanied by the decrease of White addicts was an indication that addiction was a social problem rather than a problem of psychopathy or weakness of character as had been the narrative throughout the 1940s and 1950s.⁵³

⁴⁷ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 119–120.

⁴⁸ Laura Smith, "How a Racist Hate-Monger Masterminded America's War on Drugs," *Medium* (blog), February 28, 2018, <https://timeline.com/harry-anslinger-racist-war-on-drugs-prison-industrial-complex-fb5cbc281189>.

⁴⁹ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 199.

⁵⁰ Issitt, 199–202.

⁵¹ Issitt, 199–202.

⁵² Courtwright, *Opioid Addiction in America*, 133–144.

⁵³ Courtwright, 118.

However, the head of the Federal Narcotics Bureau was convinced that addiction was not treatable and could not be dissuaded from mandatory sentencing.⁵⁴ There was little known about addiction at that time, and the harsher sentences mandated in the Acts were very popular.⁵⁵ Policy makers and the public were convinced that punitive measures would work to end drug use and addiction and drug laws continued to reflect their belief.⁵⁶

C. SEX, DRUGS, AND ROCK AND ROLL

The 1960s and 1970s in the U.S. were characterized by an unpopular war, protest, social changes, sex, drugs, and rock and roll. The second wave of the women's movement began, divorce became more common and the number of single-parent households increased.⁵⁷ The population of people using drugs changed yet again and more young White men and women began using opioids, and added to that cocaine and psychedelic drugs.⁵⁸ The use of drugs during the 1960s and 1970s was not more prevalent than during any other time in history.⁵⁹ Rather, the counterculture revolution was in full swing and drugs infiltrated social classes that had never been affected by drug use. The drug culture moved the drug war out of the poor neighborhoods and into middle- and upper-class homes.⁶⁰

By the early 1960s, public and political sentiment regarding drug abuse and addiction was changing as medical alternatives to addiction treatment became better understood leading to the Drug Abuse Control Amendments in 1965.⁶¹ Mandatory

⁵⁴ Smith, "How a Racist Hate-Monger Masterminded America's War on Drugs."

⁵⁵ Molly M. Gill, *Correcting Course: Lessons from the 1970 Repeal of Mandatory Minimums* (Washington, DC: Families Against Mandatory Minimums, 2008).

⁵⁶ David F. Musto and Pamela Korsmeyer, *The Quest for Drug Control: Politics and Federal Policy in a Period of Increasing Substance Abuse, 1963–1981* (New Haven, Ct: Yale University Press, 2002), ProQuest Ebook Central, 187.

⁵⁷ Courtwright, *Opioid Addiction in America*, 154–155.

⁵⁸ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 226–264.

⁵⁹ Claire Clark, *The Recovery Revolution: The Battle Over Addiction Treatment in the United States* (New York: Columbia University Press, 2017), ProQuest, 77–94.

⁶⁰ Clark, 77–94.

⁶¹ Courtwright, *Opioid Addiction in America*, 162–163.

sentencing was relaxed, parole and probation alternatives for offenders were introduced, and the responsibility for enforcement moved out of the Treasury Department and to the Food and Drug Administration's Bureau of Drug Abuse Control.⁶² During this time, the Narcotic Addict Rehabilitation Act (1966) was passed, opening the door for rehabilitative services. While some applauded the new focus on decreasing demand for drugs, critics were disparaging of these changes, stating that the measures toward rehabilitation, namely civil commitment rather than legal detention, were an extension of the punitive measures of incarceration and would do little to change outcomes for addicts.⁶³

D. THE U.S. DECLARES A WAR ON DRUGS

The counterculture movement was in full swing when the Nixon administration began in 1969.⁶⁴ The first drug policy enacted by the Nixon administration was the Controlled Substances Act of 1970.⁶⁵ The Act superseded the Harrison Act, allowing positive movement toward treatment for opioid addiction.⁶⁶ The new Act led to the development of the Special Action Office for Drug Abuse Prevention, the precursor to the Substance Abuse and Mental Health Services Administration which coordinates and monitors the activities of federally funded demand reduction services.⁶⁷ The Act also established the Drug Enforcement Agency (DEA), which remains the department responsible for the enforcement of federal drug law and policy.⁶⁸ The purpose of the Act was to place drugs into categories, called schedules, based on the risk for addiction and the

⁶² Courtwright, 162–163.

⁶³ Courtwright, *Opioid Addiction in America*, 169–174.

⁶⁴ Courtwright, 169–174.

⁶⁵ Victor J. St. John and Vanessa Lewis, “‘Vilify Them Night After Night’: Anti-Black Drug Policies, Mass Incarceration, and Pathways Forward,” *Harvard Journal of African American Public Policy* 20 (2019): 18–29.

⁶⁶ Courtwright, *Opioid Addiction in America*, 169–174.

⁶⁷ Lana D Harrison, Michael Backenheimer, and James A Inciardi, “Cannabis Use in the United States: Implications for Policy,” in *Cannabisbeleid in Duitsland, Frankrijk En de Verenigde Staten*, ed. Peter Cohen and Arjan Sas (Amsterdam: Universiteit van Amsterdam, 1996), 179–276, <http://www.cedro-uva.org/lib/harrison.cannabis.05.html>.

⁶⁸ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 220–232.

medical benefits of the drug. It was not long after the passage of this amendment that Nixon declared his War on Drugs.⁶⁹

The drugs Nixon was waging war on were primarily heroin and cannabis. Again, fear and hyperbole were the tactics used to sell the new law. In his speech to congress in 1969, Nixon overstated the threat of drugs, saying that drug use had become a national threat.⁷⁰ He stoked fear in parents by overstating the number of university students who had experimented with drugs and grossly overstated the addictive qualities of the drugs. The law the Nixon administration implemented was not much different from past laws, focusing primarily on punitive measures.⁷¹ However, the face of opiate users had changed significantly over the past decade, and that change influenced the future of drug policy and law.

Though a surge of heroin addiction had occurred in larger cities and most predominantly in Black neighborhoods, the largest group of new users and addicts were college students and returning Vietnam Veterans, comprising White men and women between the ages of 20 and 30.⁷² While writing the new policy, the Nixon administration had to take into consideration the demographic changes in drug users.⁷³

Critics contended that Nixon's drug policy reflected that the administration was in a difficult position due to the change in drug user demographics and introduced measures that they did not want to include. The administration wanted to vilify the counterculture left, and they wanted to continue the myth that drug addiction led to heinous crimes perpetrated by addicts who were primarily Black men, but they could not vilify returning veterans.⁷⁴ Critics argued that the administration included treatment protocols in their

⁶⁹ Issitt, 220–232.

⁷⁰ The American Presidency Project, "Special Message to the Congress on Control of Narcotics and Dangerous Drugs," The American Presidency Project, accessed March 1, 2023, <https://www.presidency.ucsb.edu/documents/special-message-the-congress-control-narcotics-and-dangerous-drugs>.

⁷¹ Musto and Korsmeyer, *The Quest for Drug Control*, 40–41.

⁷² Clark, *The Recovery Revolution*, 2–13.

⁷³ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 220–221.

⁷⁴ St. John and Lewis, "Vilify Them Night After Night."

policy only because of addicted veterans, not because they had concern for all drug addicts.⁷⁵

Regardless of the intention of the policy, the introduction of treatment protocols influenced drug laws implemented by future administrations and introduced the use of methadone to treat opioid addiction to mainstream Americans.⁷⁶ In 1972, the Nixon administration created the Drug Abuse Office and Treatment Act in response to veterans returning home from Vietnam addicted to heroin.⁷⁷ This was the first federally sanctioned use of maintenance drugs for those addicted to opium and its derivatives. For decades addicts were expected, and forced, to stop using drugs immediately without medical assistance, or to find illegal means through which to obtain their drugs.⁷⁸ With the introduction of medically assisted maintenance treatment, regardless of the motivation behind it, U.S. drug policy made a move toward harm reduction.⁷⁹

Though the intentions of the treatment arm of the policy may have been less than pure, the introduction of a risk mitigation feature into federal policy moved medication-assisted treatment into the minds of the nation, and supporters of medical treatment for addictions saw this as a positive move toward a shift in federal policy from punitive measures to more person-centered treatments.⁸⁰

The narrative of the drug addict began to change, and discourse around drug abuse and addiction followed. After Nixon resigned, the Ford and Carter administrations built on the foundation of the treatment arm of drug policy and in Carter's case, attempted to

⁷⁵ Clark, *The Recovery Revolution*, 2–13.

⁷⁶ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 220–221.

⁷⁷ Clark, *The Recovery Revolution*, 77–84.

⁷⁸ Redford and Powell, “Buildup to the Harrison Act.”

⁷⁹ Veerajalandhar Allareddy, Sankeerth Rampa, and Veerasathpurush Allareddy, “Opioid Abuse in Children: An Emerging Public Health Crisis in the United States!,” *Pediatric Research* 84, no. 4 (2017), <https://doi.org/doi:10.1038/pr.2017.166>.

⁸⁰ Courtwright, *Opioid Addiction in America* 170–174.

decriminalize marijuana use.⁸¹ The administrations and the physicians who were responsible for designing and implementing treatment framed the effort as a humanitarian one, redefining addicts as patients. Heroin deaths decreased from over 2,000 per year during Nixon's administration, to fewer than 800 per year by the end of the Carter administration.⁸²

Treatment of opioid addicts was inarguably a success. However, a conservative backlash against, in part, the involvement of government in private matters was coming.⁸³

E. JUST SAY NO

The hope for human centered treatment for people addicted to drugs ended in 1980 with the election of Ronald Reagan. The social climate before and during the Reagan administration created the perfect environment for an escalated war on drugs. Unemployment was high, public morale was down, and though the crime rate was not higher than during any other crisis time, the Reagan administration pushed the narrative of an elevated crime rate due to drug users and used that narrative to increase penalties for drug offenses.⁸⁴

Moreover, though severe restriction of opioids had been established through policy and law, pharmaceutical companies began to market new products that were going to allow people to live pain free. Oxycodone, hydrocodone, morphine, and other opioids were reintroduced to the U.S. as miracle drugs. A supporting letter claiming that addiction to these drugs was rare was published in 1980. According to the letter to the *New England Journal of Medicine*, only 1 in 100,000 users became addicted.⁸⁵ Physicians, who had been very careful in their use of opioids for decades, began to offer these drugs to their

⁸¹ Cheryl Hudson and Gareth Davies, eds., *Ronald Reagan and the 1980s; Perceptions, Policies, Legacies*, Studies of the Americas (New York: Palgrave Macmillan, 2008), https://doi.org/10.1057/9780230616196_5, 41–56.

⁸² Hudson and Davies, 41–56.

⁸³ Hudson and Davies, 41–56.

⁸⁴ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 4.

⁸⁵ Pamela T.M. Leung et al., “A 1980 Letter on the Risk of Opioid Addiction,” *New England Journal of Medicine* 376, no. 22 (June 2017): 2194–95, <https://doi.org/10.1056/NEJMc1700150>.

patients for many types of ailments. It was a repeat of the opioid crisis of the late 19th and early 20th centuries. Prescriptions were written for pain that had previously been controlled through over-the-counter analgesics such as aspirin or ibuprofen.⁸⁶ The result of physicians overprescribing opiates to their patients was a large increase in opioid addicts as a larger percentage of patients became addicted than was initially touted.⁸⁷

Because the Nixon and subsequent administrations had been so successful in lowering the number of deaths due to heroin use, Reagan focused on cannabis, the drug middle- and upper-class parents were most concerned with.⁸⁸ The choice to combat cannabis was reinforced by a campaign of fear led by Reagan's first advisor on drug policy, Dr. Carlton Turner, who espoused the dangers of cannabis as a gateway drug to heroin. His assertions were in direct conflict with scientific findings which indicated that there was not enough evidence to support such a claim.⁸⁹ Dr. Turner was a proponent of criminalized drug use and worked to increase legal penalties for drug users and abusers.⁹⁰

The Reagan administration set drug policy and law back decades. The Reagan constituency and conservatives in congress, mostly White middle- and upper-class, did not think that drug addiction was caused by anything more than immoral behavior and bad choices. Nor did they believe that the government should pay for treatment when individuals chose to use illicit drugs and became addicted.⁹¹ Conservatives held that treatment was a private issue and should be handled by the private sector.⁹²

⁸⁶ Denise G. Link, "Women in a Man-Made Epidemic," *Journal for Nurse Practitioners* 14, no. 7 (2018): 569–70, <https://doi.org/10.1016/j.nurpra.2018.04.012>.

⁸⁷ Centers for Disease Control and Prevention, "Understanding the Epidemic."

⁸⁸ Hudson and Davies, *Ronald Reagan and the 1980s*, 41–56.

⁸⁹ David M. Fergusson, Joseph M. Boden, and L. John Horwood, "Cannabis Use and Other Illicit Drug Use: Testing the Cannabis Gateway Hypothesis," *Addiction* 101, no. 4 (April 2006): 556–69, <https://doi.org/10.1111/j.1360-0443.2005.01322.x>.

⁹⁰ Hudson and Davies, *Ronald Reagan and the 1980s*, 41–56.

⁹¹ Hudson and Davies, 41–56.

⁹² Hudson and Davies, 41–56.

Though the war on drugs had been declared a decade before, Reagan militarized the war with statements such as “we’re running up the battle flag”.⁹³ It was at this point, during the Reagan administration, that women became the focal point of the war on drugs and were further marginalized as drug users and addicts. Though the Reagan administration was focused on cannabis, a new drug infiltrated poor, minority neighborhoods and drew the attention of lawmakers. Crack cocaine gave the Reagan administration a minority population to focus on, and a drug that they could fight a war over.⁹⁴ Crack was marketed as a “Black” drug that was so addictive someone could try it just once and become addicted. Crack users were portrayed as prostitutes or violent thugs. The stigma that was placed on women who used crack was generalized to include all illicit drugs and all women who used them.⁹⁵

The escalated drug war was brought further into the public’s conscience when reports of babies born addicted to crack began in the media in the late 1980s. The “crack baby” epidemic brought further stigma and judgement on women who used or abused drugs.⁹⁶ Media and the Reagan administration exaggerated the horror of the situation by depicting addicted mothers as child abusers, almost always minority, mostly Black, who had chosen to use drugs throughout their pregnancy and risk the lives of their children. The public began to see these mothers as monsters. They were depicted as criminals who should be punished rather than as the product of failed U.S. policies and generational racism and inequality.⁹⁷

The Reagan administration did not discuss drugs individually; there was no distinction in their policy between cannabis, heroin, or cocaine. Rather, all drugs were bad, all drugs were evil, and all drug users were vilified.⁹⁸ The nation became obsessed with discovering drug users. Everyone who worked for the federal government had to provide

⁹³ Hudson and Davies, 41–56.

⁹⁴ Hudson and Davies, 41–56.

⁹⁵ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 276–285.

⁹⁶ Issitt, 276–285.

⁹⁷ Issitt, 276–285.

⁹⁸ Hudson and Davies, *Ronald Reagan and the 1980s*, 41–56.

urine samples for drug testing, large companies began to test all their employees, and parents scrambled to test their children.⁹⁹

Drug testing became a multi-billion dollar business, and private rehabilitation, or “rehab,” clinics proliferated as drug users who could afford such treatment sought an end to their drug addiction.¹⁰⁰ Or more likely, the people surrounding the drug user put them into rehab clinics because they were using drugs and did not comply with the new drug policy’s push for abstinence in all things, including drugs.¹⁰¹ Privatizing drug treatment cost citizens who could afford them unimaginable amounts of money. More importantly, it cost citizens who could not afford them a life of hopelessness, helplessness, and in some cases, despair.¹⁰²

The narrative of the drug user and addict as bad and evil has persisted through many years and across many administrations and drug policies. More than the Harrison Act, the Reagan years caused terrible consequences for women who became addicted to drugs. Women became, and still are, fearful of seeking help due to the cost-prohibitive nature of treatment, but more so due to the stigma they knew they would invite.¹⁰³

F. RECENT DRUG POLICY

The Clinton administration was a proponent of mandatory minimum sentencing and his administration failed to break from the penalization of drug use. The 1994 Violent Crime Control and Law Enforcement Act enhanced mandatory minimum sentences for drug offenses, increased spending on prison construction, implemented three-strikes sentencing to federal offenses, and expanded the federal death penalty to cover more drug

⁹⁹ Hudson and Davies, 41–56.

¹⁰⁰ Hudson and Davies, 41–56.

¹⁰¹ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 276–285.

¹⁰² Issitt, 276–285.

¹⁰³ Judith D. Auerbach and Anne E. Figert, “Women’s Health Research: Public Policy and Sociology,” *Journal of Health and Social Behavior* Extra Issue (1995): 115–31, <https://doi.org/10.2307/2626960>.

related crimes.¹⁰⁴ As a result, mass incarceration rose steeply leading to the current issues of prison overcrowding.¹⁰⁵

While the laws of the 1980s increased incarceration rates by sending low-level criminals to prison, it is the 1994 Crime Bill that is seen as the driver of a disastrous rise in prison populations.¹⁰⁶ Critics of the Crime Bill brought arguments from past debates, that the federal government must end increased penalties and focus on eliminating social, financial, and racial disparities.¹⁰⁷ Proponents of the law remained committed to the protestant ideology of legislating consequences for what was believed to be poor choices and actions, without any consideration of the environment in which the actions occurred.¹⁰⁸

An emphasis on demand reduction was again brought into focus in 1997 with the passage of the Drug Free Communities Act. Over 700 community programs were developed in a state and federal partnership to reduce youth drug use.¹⁰⁹ This law also created research grants to aid in developing efficacious programs for youth.¹¹⁰ One year later the Media Campaign Act was passed, and documents were created and disseminated around the country to advise and guide media campaigns focused on keeping youth off drugs.¹¹¹ In 2010, the U.S. saw a large increase in heroin availability, which led to another growth in opioid addicts.¹¹²

¹⁰⁴ Lauren-Brooke Eisen, “The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System,” *Our Work* (blog), October 9, 2019, <https://www.brennancenter.org/our-work/analysis-opinion/1994-crime-bill-and-beyond-how-federal-funding-shapes-criminal-justice>.

¹⁰⁵ Eisen.

¹⁰⁶ Barbara Dority, “Anti-Crime Hysteria,” *The Humanist*, January 1994.

¹⁰⁷ Eisen, “The 1994 Crime Bill and Beyond.”

¹⁰⁸ Carroll J. Doherty, “Tough Anti-Crime Bill Faces Tougher Balancing Act,” *CQ Weekly*, January 29, 1994.

¹⁰⁹ Centers for Disease Control and Prevention, “Drug-Free Communities Support Program,” September 22, 2021, <https://www.cdc.gov/drugoverdose/drug-free-communities/about.html>.

¹¹⁰ Substance Abuse and Mental Health Services Administration, “Drug-Free Communities Support Program,” November 23, 2022, <https://www.samhsa.gov/grants/grant-announcements/sp-14-002>.

¹¹¹ Office of National Drug Control Policy, *The National Youth Anti-Drug Media Campaign*, 1995, <https://www.ojp.gov/pdffiles1/ondcp/171694.pdf>.

¹¹² Centers for Disease Control and Prevention, “Understanding the Epidemic.”

The 2010 National Drug Control Strategy coupled with the Fair Sentencing Act eliminated many draconian mandatory minimum sentencing guidelines and increased funding for aspects of demand including prevention and treatment.¹¹³ Supporters of the bills and subsequent public health actions lauded the move as necessary for the war on drug to succeed, stating that addiction cannot be cured through prosecution.¹¹⁴ Followed by the passing in 2016 of the 21st Century Cures Act and the Comprehensive Addiction Recovery Act, there was a distinct turn from criminal justice based punitive actions to a health-centered focus on drug use and addiction.¹¹⁵

The 2016 Ensuring Patient Access and Effective Drug Enforcement Act further removed opioid oversight from law enforcement, placing a more stringent requirement on the DEA before the department could suspend physician licenses or drug company registration to manufacture or distribute opioid-based drugs.¹¹⁶ Critics complained that these Acts would increase drug use, drug related crime, and remove responsibility for drug addiction from the pharmacological and medical fields.¹¹⁷ By then, illicitly manufactured synthetic opioids had been introduced into the illegal drug market, causing an even greater surge in opioid addiction, which is continuing to escalate to the present day.¹¹⁸

After a startling increase in opioid related deaths, the Trump Administration declared a nationwide public health emergency in October 2017 and the Opioid Abuse Prevention and Treatment Act was passed.¹¹⁹ In following with the past decade's worth of

¹¹³ Michael's House, "Drug Laws in America," Michael's House Treatment Centers, accessed August 7, 2022, <https://www.michaelshouse.com/drug-abuse/drug-laws-in-america/>.

¹¹⁴ German Lopez, "How Obama Quietly Reshaped America's War on Drugs," Vox, December 19, 2016, <https://www.vox.com/identities/2016/12/19/13903532/obama-war-on-drugs-legacy>.

¹¹⁵ Lopez.

¹¹⁶ Healthcare Distribution Alliance, "Important Context About the Ensuring Patient Access and Effective Drug Enforcement Act," September 2019, <https://www.hda.org/news/2019-09-12-important-context-about-epaede>.

¹¹⁷ Emily Walden, "REPEAL The Ensuring Patient Access and Effective Drug Enforcement Act of 2016," *FedUp!* (blog), June 29, 2019, <https://feduprally.org/repeal-the-ensuring-patient-access-and-effective-drug-enforcement-act-of-2016/>.

¹¹⁸ Centers for Disease Control and Prevention, "Understanding the Epidemic."

¹¹⁹ Michael's House, "Drug Laws in America."

drug policy, the Act increased funding to demand-based programs such as harm reduction and treatment.

Though not specific drug policy, the 2018 First Step Act (FSA) reformed federal prison sentencing for some drug offenses.¹²⁰ The FSA allowed the Federal Bureau of Prisons (BOP) to use measures of recidivism risk among other things to offer early release to some drug offenders. Additionally, mandatory minimum sentences for some offenders were lowered. The FSA has been lauded as a step in the right direction toward lessening prison populations by retroactively allowing for resentencing of offenders in prison due to crack cocaine offenses and through lower sentencing of some drug crimes.¹²¹ This Act also increases rehabilitative programming and anti-recidivist programs, a distinct shift from punishment to rehabilitation in the federal prison system.¹²² Though BOP has worked toward meeting the Act's mandates, the programs have been consistently underfunded and critics argue that the Department of Justice (DOJ) has placed barriers to early release and rehabilitative programs.¹²³

The Biden-Harris Administration expanded the 2017 Opioid Abuse Prevention and Treatment Act, adding detailed goals and priorities. Further, the new National Drug Control Policy and Strategy (2022) proposes to expand treatment, prevention, and harm reduction to levels not previously attempted.¹²⁴ While funding for treatment has been increased and some measures are proposed in the policy to improve education and community support, it is not clear how this existing policy will address the issues that surround the demand for

¹²⁰ Drug Policy Alliance. "President Trump Signs 'First Step Act' Into Law," accessed August 7, 2022, <https://drugpolicy.org/press-release/2018/12/president-trump-signs-first-step-act-law>.

¹²¹ Ames Grawert, "What Is the First Step Act — And What's Happening with It?," *Research & Reports* (blog), June 23, 2020, <https://www.brennancenter.org/our-work/research-reports/what-first-step-act-and-whats-happening-it>.

¹²² Grawert. "What Is the First Step Act."

¹²³ Grawert.

¹²⁴ Office of National Drug Control Policy, "National-Drug-Control Strategy," Report to Congress (Washington, D.C., April 2022), <https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf>.

opioids, especially for women.¹²⁵ To curtail the use and abuse of opioids, there must be an effort made to reduce the number of people who want to, or must, use opioids. The urgency is increasing as the chemical compounds of illegally trafficked or domestically manufactured synthetic opioids change, increasing the difficulty in detecting and stopping the supply.¹²⁶

G. CONCLUSION

The billions of dollars spent on military action to eradicate the supply of drugs has not reduced drug use or addiction rates.¹²⁷

Drug laws in the U.S. have not always been implemented for the welfare of the people, rather they are often guided by political priorities, the need or desire to control people's behavior, and pushed on the citizens using hyperbole, fear, and pandering to stereotypes of women drug abusers and racism. A pattern in the conception and tone of drug laws can be seen from the first Federal narcotics law of 1909, to the National Drug Control Strategy of the Biden-Harris Administration in 2022.

From the inception of drug law and drug policy, physicians have been criticized for overprescribing. Physicians are accused of being too lazy to research patients' symptoms and diagnose the core sources of their illness. It is well documented that during opioid crises, physician overprescription has been a variable in every case.¹²⁸ It is also clear from the history of drug law and policy that the legal course is not going to cure the ills of U.S. culture that lead to drug use and abuse.

The Nixon administration was the first to incorporate a treatment arm in their drug policy. Unfortunately, that policy was short-lived and by 1980 treatment had been written

¹²⁵ Human Rights Watch, "Nearly 100 Groups Oppose Biden's Plan to Make Misguided Temporary Drug Criminalization Policy Permanent," *Human Rights Watch* (blog), October 22, 2021, <https://www.hrw.org/news/2021/10/22/nearly-100-groups-oppose-bidens-plan-make-misguided-temporary-drug-criminalization>.

¹²⁶ *Homeland Security Implications of the Opioid Crisis* | House Committee on Homeland Security (Washington, D.C., 2019), <https://homeland.house.gov/activities/hearings/homeland-security-implications-of-the-opioid-crisis>.

¹²⁷ Courtwright, *Opioid Addiction in America*, 161–185.

¹²⁸ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 120–149.

out of drug policy. Only Nixon's drug policy and to some extent Carter's drug policy came close to addressing the core issues that underlie drug use, and those attempts were still miles short of what is needed to combat the drug problems found in the U.S.

Through over 200 years of drug policy and treatment it has become clear that as with any social issue, there is not one policy or program that can entirely address and eradicate a problem. There is a complex interaction between poverty, helplessness, despair, and hopelessness that is connected to drug use, abuse, addiction, overdose, and death. Acknowledging that the use of drugs that alter the consciousness of human beings will continue regardless of laws or policies, and then developing a system of counteracting the source of, and the most dangerous and harmful aspects of drug use, is a realistic and common-sense approach to drug policy and law.

As previous U.S. drug policy has done, the existing federal policy on opioids does little to address women's unique needs. This policy follows the same pattern as every other U.S. policy written to address drugs. It is punitive, it does not offer any substantive action to alleviate the core issues and social ills associated with drug use and abuse, and it lacks focus on women's experiences in the drugs arena. It risks failure because of these shortcomings.

III. THE WOMEN'S HEALTH MOVEMENT

A. SANGER AND THE BIRTH OF THE WOMEN'S HEALTH MOVEMENT

Rich feminist scholarship that emerged in the early 20th century with the battle for women's reproductive rights underpins this research.¹²⁹ Though the present research is not specific to reproductive rights, the discourse from those early disputes carries on through current women's health issues. Since the early 20th century, the Women's Health Movement (WHM) has emerged, arguing for inclusion of women in medical research and consideration of women's unique medical needs in diagnosis and treatment.¹³⁰ Despite these calls, in many instances women's unique experiences are largely ignored. Diagnosis and treatment of opioid use and abuse, and public policy represent two of those instances.

The beginning of feminist discourse on women's health is largely attributed to the work accomplished by Margaret Sanger, who spent her adult life helping women gain agency over their choices on childbirth and family planning.¹³¹ She recognized the toll that large families and the inability to care for many children took on women, especially poor and minority women. Sanger's argument placed women's health issues into the realm of social responsibility.¹³²

The idea of women's choice to restrict pregnancy became equivalent to a moral violation. Opposing arguments often focused on religious and moral tenets; the most significant voice of opposition was Anthony Comstock who served as the Secretary of the New York Society for the Suppression of Vice, for whom the Comstock Act of 1873 was named.¹³³ The Act served, in part, to make birth control and knowledge of such illegal by

¹²⁹ Kristie Yasunari, "Peace Profile: Margaret Sanger," *Peace Review* 12, no. 4 (December 2000): 619–26, <https://doi.org/10.1080/10402650020014735>.

¹³⁰ Nancy Tuana, "The Speculum of Ignorance: The Women's Health Movement and Epistemologies of Ignorance," *Hypatia* 21, no. 3 (2006): 1–19.

¹³¹ Yasunari, "Peace Profile: Margaret Sanger."

¹³² Margaret Sanger, "Women and Birth Control," *North American Review* 227, no. 5 (1929): 529–34.

¹³³ Amy Werbel, *Lust on Trial: Censorship and the Rise of American Obscenity in the Age of Anthony Comstock* (New York: Columbia University Press, 2018), 8–9.

using the argument that contraception was immoral and would lead to promiscuous activity.¹³⁴ Birth control, and by extension women's control over their health and the size of their family was lumped together with nude photography, "lewd" lyrics in songs, and "raunchy" films or stage plays.¹³⁵

Though there was opposition from religious societies and other social groups, activism for women's reproductive rights continued. Women, especially middle-class women, were infuriated when legal restrictions were placed on them regarding their health and they took up Sanger's message, spreading it to poor and minority women.¹³⁶ Women's health care has progressed to include more than reproductive issues.¹³⁷ Through the work of Sanger and her supporters, women gained agency and realized they could control not only the size of their families, but also their health and well-being. Regardless of restrictive laws put in place to oppress and inhibit their knowledge and autonomy, women learned to manage their homes and the health of their families.¹³⁸ They also took further control of their reproductive role and changed the focus of childbirth from something to fear to a social responsibility to bring wanted children into the world and ensure their future success.¹³⁹

B. THE SECOND WAVE

The struggle for reproductive rights became institutionalized, as the fight for medical and bodily autonomy continued through what is termed the second wave of the Women's Health Movement in the 1960s.¹⁴⁰ The WHM has become an umbrella term

¹³⁴ Heather E. Holcombe, "Faulkner on Feminine Hygiene, or, How Margaret Sanger Sold Dewey Dell a Bad Abortion," *Modern Fiction Studies* 57, no. 2 (June 4, 2011): 203–29, <https://doi.org/10.1353/mfs.2011.0057>.

¹³⁵ Werbel, *Lust on Trial*, 8–9.

¹³⁶ Morantz, "Making Women Modern."

¹³⁷ Institute on Medicine, *Women's Health Research: Progress Pitfalls, and Promise*, 15–31.

¹³⁸ Morantz, "Making Women Modern."

¹³⁹ Morantz.

¹⁴⁰ Francine H. Nichols, "History of the Women's Health Movement in the 20th Century," *Journal of Obstetric, Gynecologic & Neonatal Nursing* 29, no. 1 (January 31, 2000): 56–64, <https://doi.org/10.1111/j.1552-6909.2000.tb02756.x>.

used to discuss several foundations, government offices and departments, and advocacy groups that work to advance the health of women. The WHM comprises organizations such as the National Women's Health Network, Our Bodies Our Selves, the National Black Women's Health Project, the Office of Research on Women's Health (ORWH) at the National Institutes of Health (NIH), Lamaze International, and the Office of Women's Health (OWH) at the Centers for Disease Control.¹⁴¹

The second phase of the WHM began in the 1960s with a push for legalization of abortion. With the passage of *Roe v. Wade* in 1973, the movement's focus expanded to address the lack of medical care available for issues specific to women.¹⁴² As happened during Sanger's time, women began to take control of their own health needs, forming women's health self-help groups and empowering women to fight the existence of paternalism and condescension in the medical field.¹⁴³ Over the next four decades, recognition and treatment of women's health issues experienced astounding progress.¹⁴⁴

The first federal action of this era on women's health was the creation of the Task Force on Women's Health Issues in 1983.¹⁴⁵ The Task Force's mandate was ensuring women's health needs were met and producing recommendations for future research and care. The Task Force began with a study including data from women employed by federal agencies. It soon grew to include data gathered from women in communities across the United States.¹⁴⁶ Unsurprisingly, findings indicated women's displeasure over an inability to access information and the lack of comprehensive care for women's health issues.

From the report produced by the Task Force, the NIH in 1986 implemented a policy requiring that all clinical research include women. Despite the new policy, an audit three

¹⁴¹ Judy Norsigian, "Our Bodies Ourselves and the Women's Health Movement in the United States: Some Reflections," *American Journal of Public Health* 109, no. 6 (May 8, 2019): 844–46, <https://doi.org/10.2105/AJPH.2019.305059>.

¹⁴² Nichols, "History of Women's Health Movement."

¹⁴³ Nichols.

¹⁴⁴ Jennifer Nelson, *More Than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015), <https://www.jstor.org/stable/j.ctt15r3z67.1>, 1–14.

¹⁴⁵ Auerbach and Figert, "Women's Health Research."

¹⁴⁶ Nichols, "History of Women's Health Movement."

years later indicated that NIH-funded research was not including women in studies. Of newly started NIH funded research only 13.5 percent of NIH money was allocated for research specific to women's health.¹⁴⁷

Investigators provided the NIH with their findings, pointing out four concerns in NIH practices that must be addressed to meet the dictates of the policy:

(1) the lack of inclusion of women in major clinical studies; (2) inadequate attention to gender differences and gender analysis in medical research; (3) inadequate attention to diseases and conditions specific to, more prevalent among, or more serious in women, or for which there are different risk factors or interventions for women than for men; and (4) the dearth of women researchers in senior positions in science and medicine.¹⁴⁸

In response to the findings, the NIH instituted the ORWH, providing adequate funding for a 14-year research program addressing women's health needs. Additionally, the Food and Drug Administration in 1993 lifted restrictions on pregnant women participating in clinical research, and the CDC in 1994 established the Office of Women's Health.¹⁴⁹ Clinical research specific to women expanded exponentially with allocation of over \$300 million dollars for research on woman-centered health care.¹⁵⁰ In response to a call for more focused care for women, physicians and nurses began to specialize in women's health issues, federal programs and policies were implemented and enacted, research specific to women's health expanded, and women's health centers were introduced.¹⁵¹ Furthermore, a holistic view of women's experiences was implemented for diagnosing and treating diseases, and paternalistic attitudes toward women from medical practitioners began to fade away. In this way, a cascade of changes followed research and policy changes that addressed women's health needs in more substantially.

¹⁴⁷ Nichols.

¹⁴⁸ Auerbach and Figert, "Women's Health Research."

¹⁴⁹ Nichols, "History of Women's Health Movement."

¹⁵⁰ Auerbach and Figert, "Women's Health Research."

¹⁵¹ Institute on Medicine, *Women's Health Research: Progress Pitfalls, and Promise*.

C. CRITICISM AND BACKLASH

The advancement of women's health care has had its critics, even in the ranks of the WHM. Critics within the WHM suggested that specializing in issues specific to women would marginalize the care of women, removing the issue from mainstream medicine, and would result in a future of care only for men.¹⁵² Some feared that the WHM would have too much control over services provided and the clientele served, warning that the medical industry would be controlled by the special interests of the WHM.¹⁵³

Criticism from researchers cited concerns about the difficulty of including women because of hormonal changes associated with menstrual cycles, the fear of damaging a fetus during experimentation on pregnant women, too much variability among women of different ages (due to pregnancy, menstrual cycles, and menopause), an increase in the cost of research due to many of the issues mentioned above, and the lack of evidence regarding significant sex differences in disease or treatment.¹⁵⁴ Of course, no significant sex differences can be detected when researchers do not include women in their studies. In addition, in 2022, *Roe vs. Wade* was overturned, rekindling the fight for reproductive rights and bodily autonomy at all levels of government.

¹⁵² Nichols, "History of Women's Health Movement."

¹⁵³ Nichols.

¹⁵⁴ Auerbach and Figert, "Women's Health Research."

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IV. WOMEN AND OPIOIDS

Though many great strides have been made in women's health care, health issues and conditions for which little progress has been made continue to persist.¹⁵⁵ One of these is use and abuse of opioids by women. While Sanger and her contemporaries spent decades fighting for bodily autonomy for women, women who struggled with drug abuse did not have the same advocacy.¹⁵⁶ Perhaps due to lack of advocacy, or perhaps due to the stigma associated with drug abuse, women's struggle with opioid use and abuse has not been met with sufficient action to overcome the core issues related to drug abuse in this nation.

A. SEXISM AND SOCIETAL INFLUENCES

The issue is not just about women and opioids, but about the recognition of women's experiences more broadly. Though there has recently been an increase in the examination of sex differences in many academic, medical, and sociocultural arenas, these examinations often fall short. There is more to the differences between men and women than research is generally willing to explore. Women's experience of the world differs greatly from men on many levels that are not widely addressed. Patriarchy and Protestant morality have set the standard for where women fit in the world, and what women are expected to do and be.¹⁵⁷ A quote from Gustave Le Bon, a founder of Social Psychology captures the essence of how women were conceptualized in the late 19th and early 20th centuries: "Without a doubt there exist some distinguished women, very superior to the average man but they are as exceptional as the birth of any monstrosity, as, for example, of a gorilla with two heads; consequently, we may neglect them entirely."¹⁵⁸ Le Bon's statement speaks to the mentality of the time in which the first U.S. drug policies were written.

¹⁵⁵ Institute on Medicine, *Women's Health Research: Progress Pitfalls, and Promise*, 15–31.

¹⁵⁶ Du Rose, *The Governance of Female Drug Users*, 68–115.

¹⁵⁷ Du Rose, 68–115.

¹⁵⁸ Margaret Hobbs and Carla Rice, eds., *Gender and Women's Studies: Critical Terrain*, Second (Toronto: Women's Press, 2018), Google Books, 145–148.

At the time of Le Bon's statement, opium-based drugs were frequently prescribed to women for everything from reproductive complications to anxiety and depression.¹⁵⁹ Women who were unhappy with their circumstances and openly displayed their consternation were prescribed opioids rather than even starting discussions of sexism or sexual discrimination. The social and psychological issues of loneliness, boredom, helplessness, and depression that are linked directly to drug addiction were never considered.¹⁶⁰ Given this reality, the passage of the Harrison Act and its subsequent interpretation by the Supreme Court was particularly difficult for women as they were abruptly cut-off from the very medications that had been prescribed to them by doctors with no assistance to wean off the medications.¹⁶¹

An unintended consequence of the first drug law and criminalization of addiction was that women who had been previously overprescribed opioids had no access to the drug and had to resort to illegal means of obtaining the opium they needed.¹⁶² It no longer mattered if a woman was addicted because of overprescribed medications or because she frequented opium dens for euphoric experiences: women who were addicted to opium and its derivatives were perceived as outcasts, as people who had no willpower, wanted to be addicted, and they were identified as low-life drug fiends.¹⁶³ Harsher judgement fell on women because they had been held to a social contract to which they had not agreed. The social contract implicitly held that women were wives and mothers, they were pure, wholesome, and caregivers to their families and communities.¹⁶⁴ By becoming addicted they broke that social contract.¹⁶⁵

¹⁵⁹ Redford and Powell, "Buildup to the Harrison Act."

¹⁶⁰ Issitt, *Opinions Throughout History: Drug Use & Abuse*, 3–5.

¹⁶¹ Courtwright, *Opioid Addiction in America*, 85–98.

¹⁶² Courtwright, 85–98.

¹⁶³ Jill Jonnes, "The Rise of the Modern Addict," *American Journal of Public Health* 85, no. 8 (August 1995): 1157–62, https://doi.org/10.2105/AJPH.85.8_Pt_1.1157.

¹⁶⁴ Mary Barbara Walsh, "Feminism, Adaptive Preferences, and Social Contract Theory," *Hypatia* 30, no. 4 (2015): 829–45, <https://doi.org/10.1111/hypa.12175>.

¹⁶⁵ Walsh.

Subsequent laws have increased penalties associated with drug addiction, further punishing women more than men. Women are at greater risk of losing their children, becoming homeless, experiencing physical abuse, losing a job, being denied social services including financial assistance and educational grants to help pay for job training, and longer terms in prison for lesser charges than men.¹⁶⁶

Further, drug policy was largely developed by White men who wished to control individuals who were considered inferior.¹⁶⁷ While much attention has been given to racism injected into U.S. drug policy, sexism is just as much a part, though often it is explained away and referred to as benevolent patriarchy.¹⁶⁸ Benevolent patriarchy refers to the perceived need for men to “take care” of women and is based on a belief system that portrays women as inferior, not smart enough or capable of making choices for, or taking care of themselves.¹⁶⁹

Benevolent patriarchy is framed such that it seems that the choices and decisions taken away from women are done for their own good.¹⁷⁰ In the case of women who use or are addicted to drugs, it is benevolent to save women from themselves by creating punitive measures to punish, and thereby dissuade, them from using drugs. Since the primary issue is one of control, the social and psychological influences of drug use and drug addiction are not examined since that could lead to conclusions that run counter to the concepts of benevolent patriarchy (i.e., it is harmful, not beneficial). Given this mindset, drug policy cannot be centered around demand or curbing the demand for opiates as it brings up questions about the functioning of society as a whole.

Women have fought against benevolent patriarchy for generations, seeking autonomy to make choices about their own lives without being subjected to punishment or negative judgement. Through multiple waves of the women’s health movement, autonomy

¹⁶⁶ Wahler, “Retribution or Rehabilitation?”

¹⁶⁷ Du Rose, *The Governance of Female Drug Users*, 140–141.

¹⁶⁸ Du Rose, 44–85.

¹⁶⁹ Tannenbaum, “The Problem When Sexism Just Sounds So Darn Friendly...”

¹⁷⁰ Tannenbaum.

for seeking medical care, controlling reproductive health and women's health more generally, and having the freedom to seek help when it is needed have been fought for by advocates.¹⁷¹ Critics of the women's health movement denied or ignored these calls, either overtly or covertly concluding that women were not capable of making decisions for themselves.¹⁷²

B. FEMALE DIFFERENCES

It has become clear that the experience of opioid use cannot be examined without including social, psychological, and physiological aspects of drug use. The social history of drug use, abuse, policy, and law indicates that women and their specific needs have been, and still are, largely ignored.¹⁷³

Before the 2010s, very little research on sex or gender differences in drug use and abuse or treatment existed, and the findings of the research available rarely affected practice, let alone policy.¹⁷⁴

In the arena of opioid use and abuse, the first aspect to recognize is the use of baseline data developed from research performed only on men. The use of data gathered from men to assess women has been the norm for centuries because women have been largely ignored as important entities unto themselves. Knowledge of what works for men has been considered sufficient, and women were fit into the male mold.¹⁷⁵ An understanding of the physiological underpinnings of addiction in men was generalized to women without a thought to any differences that may exist between men and women.

Perhaps because of the findings from the Committee on Women's Health Research, new studies of women's experiences with opioids have increased. The OWH in 2017

¹⁷¹ Micola Slawson, "Women Have Been Woefully Neglected: Does Medical Science Have a Gender Problem?," *The Guardian*, December 18, 2019, <http://www.theguardian.com/education/2019/dec/18/women-have-been-woefully-neglected-does-medical-science-have-a-gender-problem>.

¹⁷² Nelson, *More Than Medicine*, 1–14.

¹⁷³ Du Rose, *The Governance of Female Drug Users*, 17–41.

¹⁷⁴ Du Rose, 17–41.

¹⁷⁵ Du Rose, 17–41.

proposed a national study of women and the misuse of opioids, antecedents to opioid use disorders, and the factors associated with overdoses in women.¹⁷⁶ The medical community knew that women metabolize opioids differently than men, that they become addicted faster than men and with smaller dosage use, and that treatment was less effective for women.¹⁷⁷ Until the 2017 review, explaining why these differences exist and what can be done to improve understanding, women's experience with opioids was not a consideration.

Women's unique needs change as they move through phases of life. In the adolescent phase, prevention is most important.¹⁷⁸ Adolescence is a time of vast development, including physiological and psychological changes that lead to a better awareness of self, and how others in their peer group judge them. Moreover, neurological development during this period is easily corrupted with the use of illicit substances.¹⁷⁹

Women who use opioids during pregnancy face a different set of circumstances in their lives and treatment becomes the most important step to assist them. Medically assisted treatment with buprenorphine and methadone has been found to be effective in weaning a woman who is pregnant off opioids, though buprenorphine is safer for the fetus.¹⁸⁰ But just medical treatment is not sufficient; psychological therapy is also necessary. Many times, women turn to opioids in their late teens and twenties to numb feelings of shame and pain associated with early-life abuse and other experiences.¹⁸¹ To successfully stop using opioids and not begin again, psychological and emotional needs must be treated as

¹⁷⁶ Department of Health and Human Services: Office on Women's Health, *Final Report: Opioid Use*, 4.

¹⁷⁷ Department of Health and Human Services: Office on Women's Health, *Final Report: Opioid Use*, 8.

¹⁷⁸ Donald E. Greydanus et al., eds., *Substance Abuse in Adolescents and Young Adults: A Manual for Pediatric and Primary Care Clinicians* (Berlin: De Gruyter, Inc., 2013), ProQuest, 64–128.

¹⁷⁹ Greydanus et al., 14–27.

¹⁸⁰ Stacey L. Klaman et al., "Treating Women Who Are Pregnant and Parenting for Opioid Use Disorder and the Concurrent Care of Their Infants and Children: Literature Review to Support National Guidance," *Journal of Addiction Medicine* 11, no. 3 (May 2017): 178–90, <https://doi.org/10.1097/ADM.0000000000000308>.

¹⁸¹ Lamya Khoury et al., "Substance Use, Childhood Traumatic Experience, and Posttraumatic Stress Disorder in an Urban Civilian Population," *Depression and Anxiety* 27, no. 12 (2010): 1077–86, <https://doi.org/10.1002/da.20751>.

well. Once the woman stops using opioids, she will need somewhere to go, and community aid must be available. A home to raise her child in, a support system that she can turn to when she needs help, or even just to have coffee, education that can lead to employment so that she can support her child, child-care so that she can freely attend classes or go to work without worrying about the well-being of her child or children or how she will pay for their care.¹⁸²

As a woman ages she is more prone to issues of chronic pain.¹⁸³ For generations this pain has been treated by prescribed opioids. However, science has shown us that diet and exercise, as well as a solid support system can aid in reducing pain. Often older women are also faced with loneliness and the loss of a spouse or others they loved. Their peer group is aging as well, and losing friends and family can lead to depression, so psychological therapy is also necessary.¹⁸⁴ There may be a need for analgesics to address chronic pain, but the addition of these other activities may decrease pain, depression, and loneliness, decreasing the amount of the opioid necessary.¹⁸⁵

Any drug policy implemented must consider all these barriers and hurdles faced by women. Prevention, treatment, pain management, job related education, economic considerations, safe shelter, access to nutrition, childcare, and health care just to name a few, are essential to meeting the needs of women who are most at risk of abusing, overdosing, and dying from opioid use.

¹⁸² Edward Kruk and Kathryn Sandberg, “A Home for Body and Soul: Substance Using Women in Recovery,” *Harm Reduction Journal* 10, no. 39 (2013): 1–16, <http://dx.doi.org.libproxy.nps.edu/10.1186/1477-7517-10-39>.

¹⁸³ Mary C. Davis, Kirti Thummala, and Alex J. Zautra, “Stress-Related Clinical Pain and Mood in Women with Chronic Pain: Moderating Effects of Depression and Positive Mood Induction,” *Annals of Behavioral Medicine* 48, no. 1 (August 2014): 61–70, <http://dx.doi.org.libproxy.nps.edu/10.1007/s12160-013-9583-6>.

¹⁸⁴ Carolyn J. Gibson et al., “Menopausal Symptoms and Higher Risk Opioid Prescribing in a National Sample of Women Veterans with Chronic Pain,” *Journal of General Internal Medicine* 34, no. 10 (2019): 2159–66, <https://doi.org/10.1007/s11606-019-05242-w>.

¹⁸⁵ “Musculoskeletal Diseases and Conditions – Chronic Pain; Investigators from University of Montreal Zero in on Chronic Pain,” accessed June 2, 2020, <http://search.proquest.com/docview/1832845146?OpenUrlRefId=info:xri/sid:primo&accountid=12702>.

Following is a critical review of the Biden-Harris Administration's drug policy; the National Drug Control Policy and Strategy. A gap analysis is used throughout to identify the pros and cons of each strategy proposed in the policy, and how each of the strategies discussed in the policy affect women.

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V. THE PRESENT U.S. RESPONSE TO OPIOID USE, ABUSE, OVERDOSE, AND DEATH

Since their inception, U.S. drug policies have been designed to punish users rather than assist them to heal from, or prevent, drug use and abuse. The newest U.S. drug policy, the National Drug Control Policy and Strategy as written by the Office of National Drug Control Policy in 2022 contains some measures to address demand for drugs. However, it falls far short of what is needed by women. The policy, its priorities, and the strategies put forth to tackle the growing opioid crisis are reviewed below. For each strategy, the gap analysis will discuss the pros and cons of each.

A. NATIONAL DRUG CONTROL POLICY PRIORITIES

The following priorities were presented as the National Drug Control Strategy by the Biden-Harris Administration in 2022:

1. Expanding access to evidence-based treatment, particularly medication for opioid use disorder.
2. Advancing racial equity in our approach to drug policy.
3. Enhancing evidence-based harm reduction efforts.
4. Supporting evidence-based prevention efforts to reduce youth substance use.
5. Reducing the supply of illicit substances.
6. Advancing recovery-ready workplaces and expanding the addiction workforce.
7. Expanding access to recovery support services.¹⁸⁶

The strategies discussed below are designed to meet the goals of each of the seven priorities through suggested and proposed action. Metrics have been suggested through which to measure the success or failure of achieving the seven priorities. The strategies set forth to counter demand and supply of illicit drugs, each based on the seven priorities, are discussed below.

¹⁸⁶ Office of National Drug Control Policy, “National Drug-Control Strategy.”

B. STRATEGY I: PREVENTION AND EARLY INTERVENTION

Based on research indicating a sharp increase in drug use between the ages 12 and 19, strategies to prevent early onset of drug use have been put forward. Because early-onset use of substances has been linked to substance use disorder (SUD) in later life, this strategy focuses on public school education and prevention programs, as well as treatment resources for children and young adults entering public universities, correctional facilities, and the labor force.¹⁸⁷

The narrative that accompanies this strategy asserts that social determinants of health (SDOH) such as societal, environmental, genetic, and family dynamics all form complex matrices that can increase the chances a child or young adult will begin using drugs, including opioids. Food and housing insecurity, social isolation, mental health issues, and lack of resources can all contribute to early-onset use. Adverse childhood events (ACE) such as exposure to violence, neglect, and abuse are also implicated.¹⁸⁸

The following three strategic propositions have been proposed to *delay* onset of drug use for children and young adults:

(1) Preventing Substance Use among School-Aged Children is Effective

To prevent substance use in school-aged children, the strategy calls for increased technical assistance to public schools to implement and sustain Student Assistance Programs (SAP). These programs are purported to be flexible in that they can be modified to serve a wide variety of children based on their at-risk factors (i.e., poverty, homelessness, children with ACEs). The strategy includes federal assistance to screen, prevent, intervene, and provide recovery resources for children.¹⁸⁹

Further, there should be guidance and funding-based support. Federal agencies should work with schools not only to identify children at risk of substance use, but to focus on universal prevention through school-based programs. Additionally, federal agencies

¹⁸⁷ Office of National Drug Control Policy.

¹⁸⁸ Office of National Drug Control Policy.

¹⁸⁹ Office of National Drug Control Policy.

should guide schools toward programs that have been proven efficacious through the findings of rigorous research and provide guidance to schools regarding federal funding available to support SAPs.¹⁹⁰

Finally, increased research on clinically and culturally appropriate screening tools to identify problematic substance use in children aged 12 to 17 is proposed. Primary care physicians and dentists should begin screening for ACEs and other factors known to relate to early onset substance use and work with resources such as the Department of Justice, the CDC, and the Department of Education to form multi-tiered system-of-support programs within schools and communities.¹⁹¹

(2) Preventing Substance Use among Young Adults Promotes Overall Health

This policy recognizes that there are unique challenges regarding substance use as people mature. With this understanding, it is proposed that at or around the age of 18, the focus of prevention expand to include stressors associated with people who identify with the LGBTQIA+ community and those who have left public K-12 schools. Increased resources that can be utilized by people who fall into this age group include prevention services in colleges and universities, military, homeless programs, and correctional facilities.¹⁹²

Further, medical professionals should increase and expand screening for mental health and substance use to include more people who fall in the 18–25-year-old demographic. Referral to treatment is encouraged, as is the expansion of behavioral health screening opportunities through the Department of Health and Human Services.¹⁹³

This strategy calls for partnerships between state Departments of Health and Motor Vehicle Agencies to disseminate information and tools to new drivers that will help them avoid substance use as well as better understand the dangers associated with impaired

¹⁹⁰ Office of National Drug Control Policy.

¹⁹¹ Office of National Drug Control Policy.

¹⁹² Office of National Drug Control Policy.

¹⁹³ Office of National Drug Control Policy.

driving. To best assist this age-group avoid substance use and recover from substance abuse, this strategy also suggests the implementation of better workplace wellness programs and raising awareness of the stressors and harm associated with substance use and abuse in a collegiate setting.¹⁹⁴

(3) Preventing Youth Substance Use Requires Community-Level Interventions

This strategy proposes to support the creation of Drug-Free Communities Support Programs. Community-based programs have been most effective in providing long-term collaboration within communities to support prevention efforts.¹⁹⁵

Further, communities of practice (aka multi-tier systems-of-support) should be encouraged and guided to leverage best-practices and engage in research to determine the best way to serve the youth in their communities. It is proposed that existing resources be expanded to include information on many substances and behaviors that negatively affect health and well-being. Existing resources offer communication strategies for use by parents, communities of practice, and educators to engage in positive mentoring of at-risk youth. Communities of practice should also increase in education and awareness of proper disposal of prescription drugs.¹⁹⁶

(4) Pros and Cons of Strategy 1: Prevention and Early Intervention

Pros: Inclusion of early intervention is sound, and in this policy has been given a prominence not seen since the Reagan administration. There is also mention of including research and best-practices for traditionally underserved communities such as Tribal partners, LGBTQIA+ youth, children who experience ACEs and whose SDOHs may be detrimental to substance use onset; this is the first policy to address those specific communities or speak to culturally appropriate techniques through which to reach them. Expansion of treatment resources to include college and university students, homeless youth, young people in the military, entering the labor force, or incarcerated is long

¹⁹⁴ Office of National Drug Control Policy.

¹⁹⁵ Office of National Drug Control Policy.

¹⁹⁶ Office of National Drug Control Policy.

overdue. This is the first time in national drug policy in which racial, sexual, and environmental differences are considered.

Focus on community support and parental involvement is an extension of past drug policy and has been shown to be effective in helping youth stay away from drug use. There is an existing infrastructure to support this expansion and so may be successful. A priority of strengthening public-school and college/university-based education programs and treatment availability is encouraging. Further, education programs that supplement new driver licensing training will focus on a group of youth who are especially vulnerable to increased risks of consuming mind-altering substances. An increased awareness of serious injury or death caused by impaired driving may decrease unnecessary tragedy. While each of these strategies holds promise, there are many shortcomings as well.

Cons: First and foremost, there is little in this strategy that addresses the unique needs of girls and young women. Missing from this strategy is any consideration of the social pressures and expectations placed on girls and young women as they mature and enter the world after a K-12 education, or those who do not complete the traditional high school experience. As has been the trend in drug policy since its inception, there is no distinction between girls' unique experiences in this world compared to boys. For any meaningful progress to be made for women, and more broadly for communities and our nation, considerations of sex and gender; what it means to be a female in our world and how girls and young women cope with the expectations of femaleness, must be prioritized just as every other marginalized community should.

Further, though there is a suggestion to consider LGBTQIA+ youth, the expansion of care is not proposed to occur until after the youth has left K-12 institutions, long after some kids need this type of support. Additionally, there is no focus on the complex intersectionality of puberty and sexuality. Also concerning, there is nothing proposed or suggested in this strategy to eliminate, or even attempt to lessen, the core factors related to drug use, abuse, overdose, and death. Throughout the policy document, ample evidence is provided that poverty, social and systemic inequality, lack of resources including medical and mental health services, and food and housing insecurity to name a few, are all associated with at-risk youth and contribute to drug use and abuse, yet none of the

suggested strategies in this section tackle these social ills on a community or individual level. Rather they offer suggestions on how to clean up after the damage has already been done. While treatment is essential, it is good only for aftercare. Treatment must be part of any drug policy, but eliminating the factors associated with early onset drug use should take priority. Without tackling the root causes of drug use and abuse there will be limited success in stopping youth from using drugs.

There is every opportunity to intervene in children's early life experiences by decreasing poverty, ensuring sufficient food and a safe, stable place to live, and stopping abuse and neglect. Yet there are no proposals to put forward to help children live lives in which they will not be tempted by drug use in order to escape the effects of ACEs or SDOHs, or to remove these factors from children's lives.

C. STRATEGY II: HARM REDUCTION

Harm reduction is essential to any drug policy. People who use drugs or have SUDs often face barriers to care that can be overcome with support, guidance, and empathy. Harm reduction emphasizes working with individuals to prevent overdose and the spread of infectious disease. Attempts must also be made to improve physical, mental, and social well-being of drug users.¹⁹⁷

To this end, expansion of the availability of naloxone to reverse overdose and prevent death, drug test strips to ensure drugs are not tainted with deadly chemicals, and syringe services programs that provide safe and clean syringes are suggested. It is also suggested that, coupled with syringe services programs, communities expand access to, and options for, SUD treatment. In the spirit of meeting people where they are, there is a call for expansion of programs to mobile units that would offer harm reduction services to drug users and those with SUDs who otherwise would not have access to them, such as homeless individuals, people living in rural areas, and incarcerated individuals.¹⁹⁸

¹⁹⁷ Office of National Drug Control Policy.

¹⁹⁸ Office of National Drug Control Policy.

The following three strategic propositions have been proposed to increase harm reduction for drug users and individuals who are addicted to substances:

(1) Integrating Harm Reduction into the U.S. Substance Use Disorder System of Care is Necessary to Save Lives and Increase Access to Treatment

To ensure harm reduction programs are most effective, more funding must be provided. There are several federal funding sources available for implementation and continued support of community-based programs, however more funding is needed to expand these programs so all drug users can access them when they need them. Further, to keep people who use drugs safe, healthy, and alive it is proposed that the manufacture and supply of naloxone and buprenorphine, both effective in the treatment of opioid addiction, be increased, and that distribution of the drugs is systematic and uninterrupted.¹⁹⁹

Insurance coverage of harm reduction programs as well as expansion of Medicare and Medicaid are also encouraged. Increased insurance coverage could lead to better psychological and medical care focused on improving well-being. This type of medical oversight would place a person into a comprehensive system of care through which they would find the support they need to successfully stay off drugs. This strategy also recommends states develop support programs to provide safe homes, job training, and transportation as part of an expanded harm reduction effort.²⁰⁰

A critical piece to the implementation of harm reduction programs is personnel. This strategy suggests an increase in trained personnel to staff the programs, including individuals who have lived experience with drug use and abuse. Increased research into the effects of harm reduction programs will shape future policy and lead to the discovery of best practices for further expansion of these programs.²⁰¹

¹⁹⁹ Office of National Drug Control Policy.

²⁰⁰ Office of National Drug Control Policy.

²⁰¹ Office of National Drug Control Policy.

(2) Collaboration on Harm Reduction with Public Safety Agencies

Collaboration between local and state law enforcement and court systems to divert people who use drugs from jails and prisons into harm reduction programs is encouraged. Harm reduction focuses on person-centered care for recovery, and incarceration inhibits this type of care, criminalizing behavior and adding stigma to an already stigmatized person. Though public safety should always be the first concern of law enforcement, diversion of low-level offenders into harm reduction programs can be beneficial economically and socially.²⁰²

(3) Foster Changes in State Laws and Policies to Support Harm Reduction

In some cases, state laws inhibit the implementation or expansion of harm reduction programs. Introducing or expanding Good Samaritan laws, access to clean syringes and testing supplies, and expansion of the legal use of buprenorphine are all essential to the necessary progression of harm reduction programs nationwide. States should be encouraged to work toward harm reduction focused legislation, and federal agencies and the federal government should work with the states to provide guidance and funding to support this goal.²⁰³

(4) Pros and Cons of Strategy II: Harm Reduction

Pro: This is the first time in the history of drug policy that harm reduction has been a focal point. Reducing stigma and other barriers to recovery and returning to one's community must occur in order to encourage women to seek treatment when they are addicted to opioids.

Cons: A common fault of all drug policy is a lack of meaningful action to affect long-term and lifesaving change for women, and this policy is no different. This section of the strategy speaks to the availability of overdose and recovery medications, clean syringes, and safe spaces for individuals to seek out treatment. All necessary for people who use or are addicted to drugs. However, there is no mention of *preventive* harm reduction measures;

²⁰² Office of National Drug Control Policy.

²⁰³ Office of National Drug Control Policy.

rather this strategy is another call for more efficient measures to clean up the mess after disaster strikes. Harm reduction that is meaningful begins with ending poverty, ridding our nation of systemic racism and economic instability, and ensuring that every person has food to eat and a safe place to live, eliminating the despair and helplessness that accompany these and other social ills.

In addition, the suggestion that barriers to drug use be lowered as an attempt at harm reduction have largely failed due to public backlash, lack of legislative support and financial support. Targeting overdose-reversing drugs to people at risk of overdose has been controversial to say the least. Similarly, the mere suggestion of syringe services programs has been so controversial as to spur protests and lawsuits in some U.S. states.²⁰⁴ This section of the policy reads like it was written by a timid child asking for permission to have an extra cookie before dinner, knowing that the request will be denied.

Harm reduction as it is presented in this strategy is not a preventive measure; it is a factor that presents itself AFTER addiction has begun and has escalated to crisis level. Harm reduction must equate to demand reduction and become a priority in drug policy, otherwise the crisis will not end, and countless women and their families will be negatively affected. Though the inclusion of harm reduction is a positive step forward for drug policy, this first attempt at defining it in the drugs arena is flaccid, failing to address even the simplest of tribulations faced by women.

D. STRATEGY III: SUBSTANCE USE DISORDER TREATMENT

Substance use treatment has expanded in recent years with new sources of funding becoming available. However, the availability of screening and testing is far below what is needed to reach all people who use drugs and desire treatment, as is the availability of treatment in hard to reach, at-risk, and marginalized populations.²⁰⁵

²⁰⁴ Alexander R. Bazazi et al., “Preventing Opiate Overdose Deaths: Examining Objections to Take-Home Naloxone,” *Journal of Health Care for the Poor and Underserved* 21, no. 4 (2010): 1108–13, <https://doi.org/10.1353/hpu.2010.0935>.

²⁰⁵ Office of National Drug Control Policy.

There are many barriers for people of color and people who live in rural areas, as well as for women with children, all of whom have limited access to treatment facilities and face stigma or life circumstances that make finishing treatment protocols more difficult. Medications, such as buprenorphine, shown to be effective in treating opioid addiction, are not accessible to many rural, marginalized Black, Indigenous, people of color (BIPOC), or other addicted people, making recovery more difficult for these underserved communities. Stigma and lack of trust are also barriers to treatment.²⁰⁶

The following strategic propositions are proposed to improve access to, and better outcomes from, substance abuse treatment:

(1) Improve Treatment Engagement by Meeting People Where They Are

Locating individuals in need of substance use treatment should be expanded to include increased screening by medical professionals and engagement of law enforcement partners. Medical professionals should be encouraged to increase substance abuse screenings, thereby detecting SUDs more often and offering treatment to more people who need it. Law enforcement should work to divert individuals with SUDs into specialty programs and treatment rather than into the traditional criminal justice system.²⁰⁷

It is proposed that barriers such as homelessness, lack of transportation, and lack of childcare be removed by offering housing and other benefits to individuals who enter treatment. Tailored treatment for everyone who wants treatment is recommended because research indicates that long-term recovery is more likely when individualized treatment is administered. Increasing access to online treatment options and making medication available to people in their homes is also suggested.²⁰⁸

Further, the policy calls for offering mobile treatment opportunities to reach people who cannot travel to, or stay in, treatment facilities. Relaxing abstinence-only entry mandates to treatment programs should also be considered. Removing the mandates from

²⁰⁶ Office of National Drug Control Policy, “National Drug-Control Strategy.”

²⁰⁷ Office of National Drug Control Policy.

²⁰⁸ Office of National Drug Control Policy.

drug programs and working with individuals to manage co-use of drugs and medications may lead to better recovery outcomes.²⁰⁹

(2) Improving Treatment Quality Including Payment Reform

Improved treatment quality includes expanding the availability of medication assisted treatment. Coupled with this should be better access to cognitive behavioral therapies if a person wishes to participate.²¹⁰ Further, local, state, and federal laws should be reexamined and barriers to comprehensive treatment removed. Also, offering better and more flexible payment options for treatment may lead to more people who want treatment being able to get the help they need.²¹¹

To facilitate success in recovery, motivational incentives should be introduced. Providing cell phone applications to remind those in recovery of appointment times, medication schedules, and that offer self-guided cognitive behavioral therapies is recommended. Evidence-based use of medication assisted treatment, motivational incentives, digital and other online treatment options, and access to newer and more effective treatment protocols must be considered and legal barriers removed through legislative action. Further, overregulation of treatment providers makes it difficult to expand treatment options and opportunities and should be revisited. Moreover, technical support and education programs directed at legislators will increase understanding of newer protocols and assist in new legislation being passed to support recovery efforts.²¹²

Finally, streamlining the recovery process and closing gaps of care is necessary for successful recovery. Ensuring there are processes through which to guide drug users will increase chances of individual success in recovery. Individuals and their family members are not always familiar with the processes necessary for successful recovery, having a professional guide them from withdraw management, into medication assisted recovery, to

²⁰⁹ Office of National Drug Control Policy.

²¹⁰ Office of National Drug Control Policy.

²¹¹ Office of National Drug Control Policy.

²¹² Office of National Drug Control Policy.

a cognitive behavioral program, and finally into aftercare services could dramatically increase the chances of success.²¹³

To fund the proposed actions, it is suggested that Medicaid and private insurers increase coverage and reimbursement of mental health and substance use disorder treatment. Federal grants and other funding are also available and should be used to cover costs.²¹⁴

(3) Supporting At-Risk Populations

At-risk populations include individuals who are incarcerated or are leaving jails or prisons as well as those who face barriers to seeking treatment such as no access to transportation, childcare, or untreated health issues. Using federal grants to expand access to treatment for these individuals is proposed.²¹⁵

Federal grant money and Medicaid should be used to provide wrap-around care for individuals recovering from substance abuse. Many barriers to recovery services could be removed by providing child-friendly housing, transportation, and mobile treatment units that not only travel to underserved areas, but also service individuals in prisons and jails.²¹⁶

Expansion of treatment services is also essential. More at-risk individuals can be helped by implementing new legislation to allow for federal money to be used in prison drug treatment and recovery programs. Prisons should leverage their medical staff and expand the availability of recovery medications to individuals with substance use disorders. Further, case management should include ensuring that individuals leaving prisons have access to treatment and transportation to that treatment.²¹⁷

²¹³ Office of National Drug Control Policy.

²¹⁴ Office of National Drug Control Policy.

²¹⁵ Office of National Drug Control Policy.

²¹⁶ Office of National Drug Control Policy.

²¹⁷ Office of National Drug Control Policy.

(4) Build the Treatment Workforce and Infrastructure

There has been a shortage of medical personnel trained in SUD treatment for years. To serve all people who are addicted to drugs it is imperative to increase not only the number of trained personnel, but to also increase diversity in the drug treatment arena.²¹⁸

To address treatment infrastructure, this policy proposes expansion of Certified Community Behavioral Health Clinics (CCBHC) and Substance Use Disorder Services in Federally Qualified Health Centers (FQHC). Both types of treatment facilities already exist, but both are in need of more space, more trained personnel, and better access to medications for opioid use disorder (MOUD). Further, CCBHCs and FQHCs are not widely used, and their efficacy is limited by policies and laws that do not allow federal funds to be used for certain types of treatment, as well as a lack of funding overall.²¹⁹

To overcome the underuse of these resources, this policy calls for federal agencies to work together to increase knowledge and awareness about CCBHCs and FQHCs, both of which have access to federal monies, and to expand the workforce by training individuals to work with people with SUDs. Federal loans and grants should also be used to develop curriculum for medical schools, ensuring that nurses and physicians are better prepared to detect and treat individuals with SUDs. This same type of curriculum should be developed for psychologists, social workers, and pharmacists.²²⁰

To further meet the goal of removing barriers, telemedicine should be available across state lines to increase access to treatment for individuals living in states that do not offer as many options. Expansion of telemedicine and increased support for buprenorphine treatment in physician offices, rather than having it approved for use only in treatment centers, are suggested to increase the treatment infrastructure.²²¹

²¹⁸ Office of National Drug Control Policy.

²¹⁹ Office of National Drug Control Policy.

²²⁰ Office of National Drug Control Policy.

²²¹ Office of National Drug Control Policy.

(5) Pros and Cons of Strategy III: Substance Use Disorder Treatment

Pros: Treatment disparities, or the Treatment Gap, have always existed. It is a positive move forward that this policy lists closure of the gap as a priority. The strategy calls for a concerted effort to increase the number of addiction specialists, the number and location of treatment facilities, and developing new options to pay for treatment. Treatment expansion includes bringing in community resources and expanding treatment into after-recovery support, the first time in national policy this type of federally funded and supported treatment programming has been proposed. Moreover, many of the barriers to seeking treatment are discussed in this strategy including lack of childcare, women's fear of losing their children, and difficulties faced by rural women who must travel to treatment facilities. Additionally, racial disparities in treatment are discussed, though in very vague terms.

Cons: This strategy indicates that treatment is a big priority of the policy, yet the tone is anything but urgent. Rather, the action items are framed as suggestions or helpful hints and tips than directive guidance to fight drug use, abuse, overdose, and death. Though this strategy speaks to treatment and mentions some marginalized communities, there is no discussion of LGBTQIA+ individuals, and most disheartening, there is little recognition of the unique needs of women or any concrete action toward removing barriers to treatment.

There are some suggestions and proposals to maybe, possibly, hopefully, implement a program or two that might, maybe help women with childcare or transportation. But once again, there is nothing in this strategy to help women struggling with SDOH, ACE, or any other core indicator of drug use, abuse, overdose, and death.

As with the entirety of this policy, the actions suggested in this section are focused on the aftermath of drug use rather than prevention. One of the most disheartening propositions in this section calls for incentives, such as money, to be given to drug users to motivate them to stop using drugs. This is entirely misguided. While there is no doubt that improving social, cultural, and economic well-being through incentives and increasing people's income, especially to the point that it may lift someone out of poverty, will help to abate drug use and abuse, providing this type of assistance to individuals *prior* to their

use of drugs would be much more effective, and it may even keep these folks off drugs to begin with. This is one more strategy designed to come in AFTER drug use or abuse has begun. This policy's focus on cleaning up the mess after disaster strikes is antithetical to the goal of creating a healthier and safer nation; demand reduction in the form of elimination of social ills must be at the forefront if the U.S. is to see any decrease in drug use, abuse, overdose, or death.

E. STRATEGY IV: BUILDING A RECOVERY-READY NATION

Recovery support systems (RSS) have been successful in helping substance users recover from addiction and maintain abstinence after recovery. Well known programs such as Alcoholics Anonymous and Women for Sobriety have been in existence for decades and have assisted millions of people to become sober and maintain sobriety.²²²

Expansion of RSSs through introduction to new venues and by training more individuals to act as support personnel will expose more people who need and want help stopping substance use to resources they can use. An examination of multiple RSSs indicates that individuals who use such resources are more likely to be successful in their sobriety; this includes high school students in specialized school settings, college students who use RSS programs as part of their college experience, and recovering or newly sober individuals who use halfway houses or other supporting living facilities.²²³

The following three strategic propositions have been proposed to help build a recovery ready nation:

(1) Expand the Science of Recovery

The first step to expansion of any program is to establish what works and how best to leverage that knowledge to offer efficacious programs to more people who want and need them. To this end, this strategy proposes that a comprehensive evaluation of existing

²²² Office of National Drug Control Policy.

²²³ Office of National Drug Control Policy.

treatment programs be performed to identify best practices and build upon recovery efforts based on the findings of those evaluations.²²⁴

Once identified, successful programs should be expanded and monitored using resources that are readily available but that are currently used for less effective programs. When programs are found to be efficacious and expansion necessitates resources that are not readily available, funds should be requested from the Federal Drug Control Budget.²²⁵

(2) Make Recovery Possible for More Americans

This strategy proposes that individuals who have overcome addiction receive training and be employed as support personnel and councilors for those attempting to recover. Further, to ensure systematic and consistent quality of recovery services for addicted individuals nationwide, training of support personnel and housing standards for recovering individuals should be standardized through federal efforts.²²⁶

Further, training and credentialing of RSS personnel should be standardized so that all those involved in RSSs are giving the same quality care and support to those who need it. Standardization of credentials and accreditation should also be implemented for facilities that wish to house those in recovery and offer support services. Because there are several standards of care across the nation for each individual or in each situation, locality, or service system, the standardization of credentials and accreditation of both support personnel and housing must be implemented by state, as well as federal, departments.²²⁷

Funding for this strategy is proposed to come from existing Medicaid funds as well as block grants already available for use. It is suggested that federal agencies and departments guide states toward these funding opportunities. Another option to support recovery housing is to mandate that the individuals living in the homes seek employment and pay for their room and board. Funding for youth and young adult support services is

²²⁴ Office of National Drug Control Policy.

²²⁵ Office of National Drug Control Policy.

²²⁶ Office of National Drug Control Policy.

²²⁷ Office of National Drug Control Policy.

currently available through competitive grants. As with other forms of RSS and funding, it is recommended that federal agencies assist youth and young adult focused RSSs in locating and applying for these funds.²²⁸

(3) Eliminate Barriers and Increase Opportunities

There are many barriers that substance addicted individuals face, including the stigma of being an addict and a criminal, as well as the assumption that they lack character or that they are weak and unable to control themselves. To remove these barriers, the very language we use to discuss substance use and abuse must be reconceptualized and legal barriers to community reentry must be removed.²²⁹

It is well known that the language we use shapes our perception of the world around us. Language surrounding addiction and individuals who become addicted to substances has been derogatory and demeaning. It is proposed that professionals in the addiction arena, from researchers to support services personnel, to those in the criminal justice profession begin using language based in science. Toward this effort, federal agencies should coordinate the adoption of neutral terminology by developing information campaigns focused on the general public.²³⁰

This strategy also proposes a focus on assisting those in recovery with employment. Because there is such stigma associated with addiction and involvement with the criminal justice system, employment can often be difficult to find once a person is in recovery. This strategy includes a proposal to expand a program called the Recovery-Friendly Workplace which offers financial incentives to employers to provide support to individuals in recovery, or even who are experiencing active addiction. Employers are also encouraged to offer accommodations to individuals seeking recovery or who have recovered from substance abuse and need support to maintain their sobriety.²³¹

²²⁸ Office of National Drug Control Policy.

²²⁹ Office of National Drug Control Policy.

²³⁰ Office of National Drug Control Policy.

²³¹ U.S. Department of Labor, “Recovery-Ready Workplace,” Recovery Ready Workplace: What is a Recovery Ready Workplace?, accessed January 29, 2023, <https://www.dol.gov/agencies/eta/RRW-hub/Recovery-ready-workplace>.

(4) Pros and Cons of Strategy IV: Building a Recovery Ready Nation

Pros: Many of the proposals in this section are meaningful and could lead to positive changes for individuals in active drug abuse situations and those who have recovered. Moreover, the call for inclusion of broader treatment options based on scientific findings and evidence-based practices is almost unprecedented in U.S. drug policy. Further, funding for peer-support and stable housing may ensure that expansion of these recovery support systems become a reality. Additionally, shifting to neutral language to discuss and refer to individuals recovering from addiction may help to reduce stigma. Finally, increasing employer awareness and supportive workplaces for individuals who are actively using or in recovery could encourage women who want help with problematic drug use to seek out that help. Knowing they have job security decreases the chances they will face stigma, potential loss of their children, homelessness, and hopelessness.

Cons: Though it is important to prepare communities to support drug addicted individuals, there is very little in this strategy that is innovative or that will meet the needs of women. Rather, the suggestions made in this section mirror prior sections and offer no meaningful actions to win a war on drugs. This is another strategy focused on cleaning up a mess after the disaster occurs; nothing in this strategy will decrease demand or prevent drug abuse.

While increasing employment opportunities and increasing support systems for individuals living in, or returning to, communities either during or after addiction recovery could help them reenter and be successful, many of the suggestions in this strategy are misguided and again, do not tackle any of the social ills associated with the onset of drug use, abuse, overdose, and death. Additionally, this strategy proposes giving incentives to individuals to encourage them to seek out and be successful in treatment, yet there is no consideration that those same incentives can be employed to prevent the onset of drug use to begin with. Too much of this policy is focused on the aftermath of drug abuse; this section is not an exception.

Further, proposals in this strategy include providing stable housing and food sources, as well as transportation to treatment, each of these activities only come into being

after drug abuse has begun. Throughout this policy, the authors make a point to discuss the SDOHs that are associated with drug use, yet this policy and associated strategies will fail miserably in removing, improving, or even offsetting most of them. U.S. drug policy must focus on creating a drug RESISTANT nation; thereby reducing the need of having to help folks recover once they are addicted.

F. STRATEGY V: REDUCE THE SUPPLY OF ILLICIT SUBSTANCES THROUGH DOMESTIC COLLABORATION

Stopping the supply of illicit drugs has been the focus of drug policy since its inception more than a century ago. The present policy specifically emphasizes not only efforts to stop foreign supply, but also spotlights domestic illicit drug production and distribution.²³²

The following four strategic propositions are proposed to meet the goals of reducing the supply of illicit substances domestically:

- (1) Improve Information Sharing and Cooperation across all Levels of Government to Strengthen the Domestic Response to Drug Trafficking

This strategy calls for better cooperation between federal, state, local, and Tribal law enforcement, and drug interdiction entities to revisit and reform policies and practices that hinder attempts to stop the supply of illicit drugs in the U.S. This action will increase chances of success in stopping the flow and distribution of illicit substances in the U.S.²³³

- (2) Deny and Disrupt Domestic Production, Trafficking, and Distribution of Illicit Substances

A list of drug cartels, syndicates, and other organized crime entities of concern has been compiled by the Organized Crime Drug Enforcement Task Force. The list identifies specific regions and priority organizations within those regions, including highways, airspace, mail services, and railways most often used to move drugs into and around the U.S. Because there are limited resources available in the interdiction efforts of the U.S., it

²³² Office of National Drug Control Policy.

²³³ Office of National Drug Control Policy, “National Drug-Control Strategy.”

is suggested that agencies in the fight against illicit drugs focus those resources on the organizations on that list, and in the regions most affected.²³⁴

(3) Improve Assessments of Supply Reduction Initiative Effectiveness and Efficiency and Allocate Resources Accordingly

This strategy calls for better assessment of existing programs and policies. Because of the costs associated with supply reduction efforts, it is imperative to know which of them are most effective so that limited resources can be used most effectively. This strategy proposes a rigorous investigation of the efficacy of international efforts on reducing the supply of illicit drugs in the U.S. These types of assessments may help focus efforts on the programs that are most cost-effective and direct the use of U.S. resources to efforts that will make the biggest improvement here at home.²³⁵

(4) Protect Individuals and the Environment at Home from Criminal Exploitation by Those Associated with Drug Production and Trafficking

Substantial harm is done to public and private land in the U.S. by illegal marijuana grows. Further, marijuana and other illegal crops use water that is vital to the survival of native plants, animals, and humans that live downstream. Growers of illegal marijuana often use fertilizers and pesticides that are banned in the U.S. and cause further damage to the environment.²³⁶

To protect the environment from illegal activity on our public and private land federal, state, and local agencies must continue their eradication efforts. Additionally, thorough investigations, prosecutions, and reclamation efforts must be increased. Prosecutors are strongly encouraged to seek federal penalties for illegal marijuana grows on public lands.²³⁷

²³⁴ Office of National Drug Control Policy.

²³⁵ Office of National Drug Control Policy.

²³⁶ Office of National Drug Control Policy.

²³⁷ Office of National Drug Control Policy.

(5) Pros and Cons of Strategy V: Reduce the Supply of Illicit Substances through Domestic Collaboration

Pros: There is always a need for supply reduction and cooperation between domestic agencies, it is an integral piece of supply reduction efforts. Further, the call to evaluate the efficacy of existing supply reduction efforts is long past due and could save money and time on future endeavors in supply reduction.

Should this policy and the strategies be implemented, the money saved by streamlining reduction efforts can be shifted to demand and harm reduction efforts. Removing barriers such as lack of childcare, lack of health care and bodily autonomy, stigma, and poverty will improve the lives of women, and by extension the people and communities who count on them.

Additionally, though not explicitly stated in the strategy, the negative effects of illicit drugs to regions and communities are disproportionate in BIPOC and other marginalized communities; this strategy advances the Administrations priority to right racial disparity.

Cons: Supply reduction has been the conventional strategy to combat illicit drugs in the U.S. As has been discussed previously, these efforts have failed miserably, costing billions of dollars and millions of lives. Rather than put more money and time into programs that have not worked to lessen the influx and availability of illicit drugs, a shift from supply reduction to demand reduction is crucial. There is nothing new introduced in this proposed strategy. Rather, the same interdiction efforts that have been in place for decades or more are scrutinized and the authors of the policy have offered ideas for improvement on these already existing activities. In addition to the lack of innovative ideas, there are no suggestions or proposals that will likely improve the U.S.s pitiable state of drug abuse, overdose, and death.

Unfortunately, supply disruption does not end drug use or abuse, rather it causes people to shift to other drugs more available to them. This section is more of the same failed policy that has never considered the needs of women who use or are addicted to drugs. Further, unless and until the focus of drug policy shifts to demand reduction and

policies begin to call for action to improve social, economic, criminal justice, and other inequities in the U.S., relief for the ills of drug use, abuse, overdose, and death will not come.

G. STRATEGY VI: REDUCE THE SUPPLY OF ILLICIT SUBSTANCES THROUGH INTERNATIONAL ENGAGEMENT

Drug users in the U.S. may obtain illicit drugs locally, but most are supplied by transnational criminal organizations (TCO). Stopping the influx of illicit drugs from these TCOs is crucial to the Administration's goal of supply reduction. Because most illicit drugs are brought into the U.S. from outside foreign countries and organizations, it is important to develop strong partnerships abroad and share the responsibility for ending the production and distribution of illicit drugs. Depending on the type of drug, certain nations should be the focus of U.S. drug supply reduction efforts. According to this policy, Mexico, Columbia, and to a lesser extent, China are the most problematic nations.²³⁸

The following four strategic propositions are proposed to reach the goal of reducing the supply of illicit substances through international engagement:

(1) Strengthen Foreign Partnerships to Address Drug Production and Trafficking as a Common and Shared Responsibility

This strategy focuses on partnering with foreign nations to stop TCOs in their drug production and distribution efforts. To this end, the strategy suggests helping nations strengthen their economies and expand land ownership, as well as establishing agricultural and other legal jobs for the citizens of these nations to lower poverty rates and eliminate the need for citizens to grow and produce illicit drugs. Proposals also include working with governments to fight social and economic causes of illicit crop cultivation, drug manufacture and distribution.²³⁹

In addition, destruction of crops from which illicit drugs are produced is an ongoing effort and must be expanded through cooperation with the Mexican and Columbian

²³⁸ Office of National Drug Control Policy.

²³⁹ Office of National Drug Control Policy.

governments. Further, the governments of the People's Republic of China (RPC) and India must be engaged, and relationships developed to control the production and disbursement of illicit synthetic drugs and precursors.²⁴⁰

(2) Obstruct and Disrupt Financial Activities of Transnational Criminal Organizations that Manufacture Illicit Drugs and Traffic Them into the United States

To eliminate the funds that flow to TCOs through cash smuggling, trade-based money laundering, cyber-laundering, and many other illegal means of moving ill gotten money, this policy proposes working with nations that have weak or unenforced laws and policies to strengthen their systems. Further, the Department of Treasury should continue and strengthen their partnerships with public and private entities to locate illegal drug money laundering through shell companies, casinos, and cash intensive businesses.²⁴¹

Coupled with efforts by the DEA to increase awareness of the critical steps in drug manufacturing and distribution, increased penalties for cooperation should limit TCOs ability to traffic illegal fentanyl and precursors, hindering TCOs ability to move and benefit from the money generated from these illegal activities. Educating private and public retailers and other entities about the signs of illegal drug manufacturing, distribution, and movement of funds will disrupt the synthetic opioid supply chain.²⁴²

(3) Leverage the Influence of Multilateral Organizations to Tackle Shared Challenges from Synthetic Drugs

Because illicit drugs affect nations and citizens globally, it is imperative the U.S. engage and form partnerships with international groups focused on ending the supply of illicit drugs. This policy proposes that the Department of State continue working with international partners to share information and best practices, identify new trends in the

²⁴⁰ Office of National Drug Control Policy.

²⁴¹ Office of National Drug Control Policy.

²⁴² Office of National Drug Control Policy.

illegal drug trade, and work with the United Nations to promote U.S. drug policy priorities.²⁴³

(4) Protect Individuals and the Environment Abroad from Criminal Exploitation by Those Associated with Drug Production and Trafficking

From clear-cutting jungles and forests to the toxic wastewater generated by illegal drug production and manufacturing, TCOs cause a lot of damage to the environment and to the people who live in or near TCO controlled areas. This policy proposes that the U.S. work with other nations and global entities to stop production of illicit drugs to ensure that vulnerable people and their environments are protected.²⁴⁴

(5) Pros and Cons of Strategy VI: Reduce the Supply of Illicit Substances through International Engagement

Pros: Strengthening U.S. relationships abroad is always a good strategy and may increase international focus on drug abatement. As discussed in Strategy V, enhancing efforts to protect the global environment is new to U.S. drug policy and reflects the willingness of law makers to tackle one of the little considered effects of illicit drug production and manufacture.

Cons: This is a reiteration of a tried and failed effort at supply reduction. While it is imperative that the U.S. work and cooperate internationally to reduce drug supply, the same social and economic barriers that face drug users, manufacturers, dealers, and addicts in the U.S. apply to people around the world. Until elimination of the central issues surrounding drug use, including poverty, inequality, hopelessness, and despair are undertaken not just in the U.S., but globally, there will be little if any success in supply reduction efforts.

Several of the suggestions made in this strategy are exactly what is needed in the U.S. to reduce demand. Given that knowledge, it is fascinating to see so much discussion of, and so many proposed solutions to, the social, economic, and environmental issues

²⁴³ Office of National Drug Control Policy.

²⁴⁴ Office of National Drug Control Policy.

faced by our allies and other foreign nations that produce and sell illicit drugs to the U.S., while they are largely ignored on the domestic side of the policy. By virtue of this strategy then, U.S. policy makers recognize these core issues and have at least a rudimentary idea of how to solve them, but are unwilling to take those steps in the U.S. This should enrage the citizens of the U.S.

If the U.S. put this strategy in place domestically, increased job opportunity, land ownership, increased equity (racial, economic, gender-based), many of the issues related to drug use, abuse, overdose, and death in our nation would change for the better. The proposed assistance to drug producing countries are a slap in the face to the women who struggle to overcome each of these barriers in this nation.

H. STRATEGY VII: CRIMINAL JUSTICE AND PUBLIC SAFETY

The criminal justice system is an integral piece of any drug policy. This system has traditionally been used as a punishment arm, incarcerating not just people who manufacture or distribute drugs, but also those who use the drugs. The criminalization of drug use has been controversial for decades because of the systemic inequality that exists in sentencing and rates of incarceration, yet the practice continues.²⁴⁵

The following strategies are set forth in this policy to outline the role of the criminal justice system:

(1) Improve Access to MOUD for Incarcerated and Reentry Populations

Jails and prisons must increase the availability of MOUD not only during incarceration, but also after release. It is proposed that jails and prisons screen incoming inmates for SUDs and initiate treatment while the person is incarcerated. To this end, increased funding for MOUD treatment through Medicaid, the inception of mobile MOUD treatment that travels to prisons and jails, and less restrictive sentencing mandates are proposed.²⁴⁶

²⁴⁵ St. John and Lewis, “Vilify Them Night After Night.”

²⁴⁶ Office of National Drug Control Policy.

Further, removing legislative barriers to Medicaid funding for inmates will open a new source of funding to treat drug addiction in those individuals, easing the way to reentry into communities. Because most jails and prisons do not have the facilities or trained personnel to administer proper SUD treatment, the implementation of mobile treatment units as discussed in Strategy III is essential.²⁴⁷

Finally, sentencing and reentry practices must be revisited. Many times, individuals who are receiving treatment while incarcerated lose their treatment options when released. This strategy proposes that the criminal justice system and departments of health collaborate to ensure that once released, whether pre-trial, parole or probation, or after having served their sentences, continued community care be provided to ensure ongoing sobriety.²⁴⁸

(2) Advance Racial Equity in Investigation, Arrest, and Sentencing for Drug Related Offenses

Research shows that the criminal justice system is systemically racist and that BIPOC individuals are much more likely to be arrested, found guilty, and sent to prison for low-level drug offenses. To right this wrong, this strategy proposes that all inequities in the system should be removed, and that individuals should not be incarcerated just for using drugs. While it is known that the BIPOC community is more often arrested and jailed for drug use, the data do not currently exist on the federal level to determine the breadth of this problem. To overcome the barrier to reliable data, better data collection and disaggregation of racial indicators are proposed.²⁴⁹

In addition, to further remove biases and practices that negatively affect BIPOC and other marginalized communities, all individuals, including judges, prosecutors, and other individuals involved in the criminal justice system should receive expanded training. Further, all arrestees should be screened for SUDs, increasing the chances that all

²⁴⁷ Office of National Drug Control Policy, “National Drug-Control Strategy.”

²⁴⁸ Office of National Drug Control Policy.

²⁴⁹ Office of National Drug Control Policy.

individuals moving through the criminal justice system who need treatment are detected and guided toward the help they need.²⁵⁰

Further, mandatory minimum sentencing for drug offenses removes the court's ability to be flexible and explore alternatives to incarceration. This strategy proposes relaxing mandatory minimum sentences to increase the weight and monetary thresholds of drug possession necessary to trigger those types of sentencing mandates.²⁵¹

(3) Promote Alternatives to Incarceration

This strategy suggests that local law enforcement, attorneys, and judges educate themselves on alternatives to incarceration including programs designed to divert drug users from arrest and incarceration. An integral piece of this strategy is to expand SUD screening at the time of arrest and use the results of those screening tools to determine if the person might benefit from treatment or other diversionary processes that will keep them out of jails or prisons. Existing laws or policies that hinder the use of diversion programs should be revisited.²⁵²

(4) Improve Reentry – Expand and Remove Barriers to Support Services

To improve reentry, this strategy suggests that individuals in the criminal justice system who have SUDs be offered treatment from arrest through release. Providing naloxone to those reentering their communities and ensuring that individuals who are on MOUDs have appointments with community providers before release, will increase the chances of successful reentry.²⁵³

Successful reentry also includes removing barriers such as access to housing, job opportunities, student aid, and public assistance. All these supports may be necessary for a

²⁵⁰ Office of National Drug Control Policy.

²⁵¹ Office of National Drug Control Policy.

²⁵² Office of National Drug Control Policy.

²⁵³ Office of National Drug Control Policy.

person to successfully reenter their community and maintain their sobriety. Finally, it is stated that efforts to meet the goals of successful reentry must be advanced.²⁵⁴

(5) Pros and Cons of Strategy VII: Criminal Justice and Public Safety

Pros: Any attempt at reforming the criminal justice system to be more racially equitable, provide better access to treatment, find alternatives to incarceration, and to improve integration into communities after incarceration will improve the experiences of individuals who find themselves addicted to illicit drugs. For too long the system has been skewed against BIPOC individuals, and especial those in our Black and Indigenous communities. Further, relaxing mandatory minimum sentencing standards is a good starting place to decrease prison populations and end some systemic inequalities that exist in the criminal justice system. Also, increased attention to finding individuals who have SUDs will keep women out of jails and prisons and potentially get them the treatment and support they need to successfully recover and remain in their communities and homes.

This proposed strategy is the most focused of the policy, the main goal is to reintroduce addicts back into society and support their journey back into society. This has been missing from all prior drug policy. The barriers discussed in this strategy all affect women disproportionately. Inability to secure housing and employment can leave mothers with no avenue to reunite with their children. Further, not having access to educational opportunities due to funding leaves them with far fewer options to improve their economic well-being, further pushing them back into the despair that most likely drove them to find mind altering substances with which to self-medicate.

Cons: Though this strategy speaks to the unique needs of women more than any of the others in the policy, there are still concerns about its effectiveness and utility. It is disconcerting that this section states the impact of drug abuse begins when a person is arrested. This is a clear lack of understanding for the links between social, economic, and systemic inequality that are related to drug use and incarceration. Like most of this policy, this strategy focuses efforts on the after-effects of drug abuse and addiction. Further,

²⁵⁴ Office of National Drug Control Policy.

placing this strategy with the criminal justice reform section begs the question of the understanding of barriers outside of the criminal justice system. Again, this is a measure designed to clean up after trouble has presented itself. These barriers and others must be removed for women long before they are involved with the criminal justice system. Access to jobs, childcare, housing, nutrition, health care, and safety are all essential for women to avoid the despair and helplessness that often accompanies drug abuse.

Further, though mandatory minimum sentencing laws are discussed in this policy, not one meaningful action is proposed to reduce or eliminate their negative effects on people, communities, and the nation. Mandatory minimum sentencing is directly linked to prison overcrowding and systemic inequality and should be abolished, not just relaxed. This is especially true for low-level offenders who are serving time for small amounts of possession and use. Too often, once in the criminal justice system, women are caught in the cycle of incarceration, stigma, and lack of support when they try to reenter their communities, a cycle that could be eliminated if proper demand reduction efforts existed.

I. DATA SYSTEMS AND RESEARCH

Though not included in the list of strategies, data systems and research are an important piece of this policy and are included in the text of the strategies. Data quality and quantity are essential to develop sound, evidence-based, science-driven drug policy. Timely and accurate data often do not exist in the drugs arena, in part because the landscape of drug use, trafficking, manufacture, and distribution change rapidly.²⁵⁵

The following three strategic propositions are proposed to strengthen data collection systems and subsequent research:

(1) Strengthen Existing Data Systems

There are many existing data collection systems that inform law enforcement, health departments, policy makers, and others concerned with the illegal drug market in the U.S. Unfortunately, many of these data collection and storage systems are disparate

²⁵⁵ Office of National Drug Control Policy.

and cannot be used to share information between stakeholders.²⁵⁶ Additionally, data collection and storage are only part of the problem, the methodology and design of data collection are also problematic.

Data is only useful when it is representative of the population of interest. While drug use surveys conducted with the public are useful, they often do not include individuals who are most at-risk for use and are in the realm of interest, such as youth surveys conducted in schools that do not include youth who have left school early, or community-based surveys that do not include homeless individuals or people who are hard to reach such as those living in poverty.²⁵⁷

This strategy proposes multiple lines of inquiry into drug use when using surveys. For example, household surveys that depend on self-reported drug use should be supplemented by medical information, or blood or urine samples for testing. Further, death that is attributed to drug use is often missed because of the limitations placed on entities that complete death certificates, one of the largest sources of drug-related death. To broaden opportunities for research and drug abatement activities, the International Classification of Diseases used for coding cause of death should be expanded to include detail on specific drugs.²⁵⁸

Though the federal government cannot mandate data collection or sharing, incentives can be offered to improve those activities. Federal funding that is available to local, state, or Tribal entities can be used to improve training, supply hardware and software, and augment other resources necessary to improve timeliness and accuracy of data collection and sharing.²⁵⁹

Commercial and other private data sources that provide drug testing for employers are valuable sources of data and can provide geographic information useful to law enforcement personnel as well as medical and treatment facilities. Other private or

²⁵⁶ Office of National Drug Control Policy.

²⁵⁷ Office of National Drug Control Policy.

²⁵⁸ Office of National Drug Control Policy.

²⁵⁹ Office of National Drug Control Policy.

commercial data sources can share prescribing information which, when coupled with federal, local, state, or Tribal data can help track dispensing patterns and trends. These efforts are especially critical regarding the Administration's focus on equity.²⁶⁰

To track trends in drug use and treatment in underserved populations, it is imperative that data are granular enough to determine outcomes for drug affected individuals by age, race, sex, incarceration, treatment, LGBTQIA+, and other subgroupings that are disproportionately affected by drug use, abuse, overdose, and death. Data collection must be expanded to include these and other pieces of information about individuals so that better treatment protocols and interventions can be developed.²⁶¹

The newly developed Interagency Drug Data Working Group (IWG) has made strides toward these goals in the federal level, and work to coordinate data collection and sharing on that level will continue. Using the new IWG resources, the Office of National Drug Control Policy (ONDCP) will increase its number and quality of researchers and data scientists, contract with research resources to conduct studies, or work with contracted entities to supervise and direct meaningful research.²⁶²

Further, using the example of the IWG, federal agencies should collaborate with local, state, and Tribal organizations to increase data sharing and collection quality efforts. Data from international and commercial resources will also complement federal data efforts and improve timely reporting, enabling better drug abatement and policy making ability in this fast-moving drug arena.²⁶³

(2) Establish New Data Systems and Analytical Methods

To improve the quality, utility, and timeliness of data collection and reporting, this strategy proposes a process through which to establish new data systems and analytical methods. As a first step, the IWG should partner with the ONDCP to review existing

²⁶⁰ Office of National Drug Control Policy.

²⁶¹ Office of National Drug Control Policy.

²⁶² Office of National Drug Control Policy.

²⁶³ Office of National Drug Control Policy.

research for innovative ideas that have been implemented both inside and outside of the federal government. Once identified, these innovative programs should be evaluated for efficacy in efforts to improve data and research efforts.²⁶⁴

In addition, leveraging existing programs for use in the drugs arena may be possible. Broad implementation of data collection techniques such as wastewater epidemiological testing for the presence of drugs could provide real-time geospatial information on the types and quantities of drugs being used, assisting in criminal justice and treatment protocols and planning. Further, leveraging the methodology of past programs to monitor drug use of arrestees and mothers giving birth in hospitals by using biological samples (blood and urine tests) can provide better, more granular data from which to develop policy, implement harm reduction processes, and improve treatment programs.²⁶⁵

While developing and implementing new systems and methods it is imperative that measures and methods are standardized and focused on measuring the outcomes of interest. The real-time effect of supply reduction efforts on public health is difficult to measure. It is imperative that data collection efforts and research methodologies focus on outcomes of existing policy. Without sufficient data it is difficult to determine the efficacy of existing policy and make the changes necessary to improve success.²⁶⁶

(3) Enhance the Utility of Drug Data for Practitioners, Researchers, and Policy-Makers

To ensure the data collected can be used by practitioners across disciplines, timeliness and data sharing must be prioritized. Online resources are available but are disparate and exist in in silos. This strategy proposes the implementation of multiple online dashboards that can be used for analysis by all stakeholders.²⁶⁷

²⁶⁴ Office of National Drug Control Policy.

²⁶⁵ Office of National Drug Control Policy.

²⁶⁶ Office of National Drug Control Policy.

²⁶⁷ Office of National Drug Control Policy.

Data dashboards that are compiled and made available to practitioners can improve the utility of the data for all stakeholders. The work done by SAMHSA and the CDC is often complementary and can be supplemented by death certificate information, yet it can be difficult to connect the various sources of information to form a full picture of the effects of drug use, abuse, overdose, and death because these data exist in such disparate places.²⁶⁸

This strategy proposes that pertinent entities and organizations collaborate to develop and maintain data dashboards that can be accessed by all interested stakeholders. Ensuring that all interested parties can access the data they need to identify at-risk individuals, employ effective treatment, implement criminal justice reform, and ensure policy makers have the best and latest information from which to make decisions. Part of this process should include expanding the datasets to include more granular information regarding at-risk and marginalized individuals and communities.²⁶⁹

To improve efforts at supply reduction, this policy recommends that law enforcement and intelligence agencies expand their collaboration and strengthen their information sharing programs. Because the drugs arena is fast changing it is imperative that these institutions use their data in a timely and effective way to disrupt TCO operations. Part of this effort should be including measures that indicate success in supply reduction efforts so that the limited resources available can be used most efficaciously.²⁷⁰

(4) Pros and Cons of Strategy VIII: Data Systems and Research

Pros: Data is always a good thing. There are many existing data sources that record drug use, abuse, overdose, and death that can be leveraged to support this priority. Opening the door to data sharing and development of useable and accessible dashboard-type resources for law enforcement, medical and treatment personnel, and other stakeholders may increase success in the drugs arena. Inclusion of granulated data with detailed

²⁶⁸ Office of National Drug Control Policy.

²⁶⁹ Office of National Drug Control Policy.

²⁷⁰ Office of National Drug Control Policy.

information regarding ethnicity and sexual orientation may lead to better treatment options and better outcomes for individuals who are addicted to drugs.

Cons: There is no discussion of research into prevention. Every suggested change in data collection and research made in this section refers to use, abuse, overdose, and death. Rather, much of this section calls for resources to be placed into treatment, tracking trends of use, and tracking TCOs which supply illicit drugs. There are at least three problems with this strategy.

First, the call for data to become more granular, including data on race, sexual orientation, and even individual level data on arrestees and women giving birth. There are several privacy and ethical considerations in this call for granularity. Though granular data would move research forward by leaps and bounds, there are many ethical and privacy associated questions that must be answered. How will they be used to “track” at-risk individuals, who defines what at-risk means? Who will have access to these data, and what might it be used for? These are just a few of the questions that must be considered. The implications of such data collection can be grave, designating individuals at-risk could lead to unfounded levels of scrutiny, further marginalizing already marginalized people. Further, because this strategy is focused on drug use, abuse, overdose, death, and supply reduction, there is little here that bodes well for prevention efforts.

The second problem is that the focus of data collection, utility, and sharing must pivot toward demand reduction. Decades of supply reduction have failed to end the illicit drug problem in the U.S., in fact it has now become a crisis. While there is a need to stop illicit drugs from entering the U.S., there would be less need for supply reduction if demand were not so high.

Third, there is only a passing mention of using the data to strengthen our understanding of the outcomes of existing policy, yet outcome information and program evaluation are the key to determining which aspects of the policy is the most efficacious in terms of economic, health, and well-being of the individuals most affected by these policies.

Finally, and most salient to this thesis, there are no proposals or suggestions to increase data collection or to use existing data to understand the unique needs of women. Throughout the policy, the authors make at least some attempt to address issues such as childcare, access to educational opportunities, and reducing stigma. This policy and the strategies that accompany it fall short of realizing the potential for improving the lives of women who use or abuse drugs.

J. CONCLUSION

In many ways, the National Drug Control Strategy (2022) is a continuation of all past drug policy and does not make a concerted effort to offer solutions for the core issues surrounding opioid use, abuse, overdose, and death. Moreover, the strategies that may have introduced innovative ideas and actions that might have led to meaningful improvements in the lives of individuals fall far short. People who are currently experiencing the negative effects of drugs, as well as people who are caught up in a cycle of poverty, systemic inequity, and other life experiences that put them at risk for drug use are not going to be well served by this policy. Further, and most important to the theme of this thesis, the policy does little address issues unique to women. The possible efficacy of this policy in preventing women from abusing opioids, helping them recover if they become addicted, and ending overdose and death for women using opioids is woefully lacking.

Finally, there is no discussion of prevention or recovery efforts through social change, rather this policy is a band aid offered to make it seem as though something is being done. These efforts are akin to Drug Policy Theater, wherein empty or sub-optimal actions are taken to placate the public, while no real effort is made. It is shameful that an administration whose close family has been severely negatively affected by drug use is so seemingly blind to the core causes of drug use, abuse, and overdose, and offers no meaningful solutions in its drugs policy. Unless and until drug policy offers solutions to public and social ills that drive demand for drugs, women and the people who depend on them will suffer.

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VI. WHAT DRUG POLICY SHOULD INCLUDE

Chapters II and V provide a comprehensive look at the history of drug policy in the U.S., including the existing National Drug Control Policy and Strategy. While one arm of a comprehensive policy must confront the supply of opioids entering the country, that is only half of the story. U.S. drug policy must also decrease demand. Policymakers must follow the advice and guidance of social scientists, economists, and medical and clinical experts, basing policy on science rather than patriarchal and moralistic choices. Drug policy cannot be focused on controlling behavior, it must be focused on serving individuals who are in desperate need of help even before drug use begins. Policy must also account for the different resources men and women need. Chapter IV made the case that women have been ignored in the development of treatment protocols for drug abuse. Policy must include the unique needs of women when considering the demand for drugs.

Policy is written to address social issues and behaviors deemed to be destructive or outside the normative expectations of society. Policy should be written with goals clearly stated, measures of efficacy well defined, and the route to meet the goals should be designed and communicated such that users of the policy can easily understand what is expected.²⁷¹ Unfortunately, in government, policy development does not often meet this level of rigor. Government policy can be purposely vague, giving other bodies who write laws and subsequent policies the flexibility to follow governmental guidelines in a way that best addresses their needs. Because of this, federal policy can be very hard to evaluate for efficacy.²⁷² However, in this case, due to some of the misguided proposals and strategies in this and past drug policy, critique and suggested changes are easy endeavors.

Drug policy must not stand alone. Rather it must be incorporated in sweeping social changes that remove the long-standing patriarchal tone toward women and rid sociocultural institutions of Protestant morality that restricts women from full participation in their own

²⁷¹ Mike Tannian, “How to Write Policies and Procedures: A Guide to Writing Effective Policies and Procedures,” *PowerDMS* (blog), 2017, <https://www.powerdms.com/blog/how-to-write-policies-and-procedures/>.

²⁷² Tannian.

lives. These changes cannot be made instantaneously, however steps toward the goal of women's full participation in choices and decisions that affect them must begin immediately, and that includes their experiences with drug use and abuse, as well as the life experience that may have initiated drug use.

The biopsychosocial theory posits that to successfully counter drug abuse, an individual's unique biology, psychological well-being, and sociocultural experiences must be considered. For women to fully participate in their journey to avoid and recover from opioid use and abuse, many barriers must be removed. First, the biological pathway to substance addiction and abuse must be identified for women. Second, programs and policies that improve social determinants of health must be implemented alongside treatment options and recovery support and an infrastructure must be put in place to provide the resources women need to succeed. And finally, women must gain bodily autonomy and be freed from patriarchal and protestant expectations, allowing them to have full agency in the choices and decisions that affect them.

A. BIOLOGICAL DETERMINANTS

There is little known about women's biological experiences with drugs, including opioids; past research on biological determinants and other physiological aspects of drug use have focused on men.²⁷³ To increase knowledge and better prevent opioid use, abuse, overdose, and death in women, women centered research must be expanded within the science community. While progress has been made toward this goal, it has been slow moving, and even when women began to be included in research protocols, focus was placed on a small population of them and provided very little insight.²⁷⁴ Research protocols must change so that women who are addicted to drugs can be best served.

The methodological design, data gathering, and analysis processes in science must be reconsidered to capture women's experiences with drugs. Research questions must encompass the effect of the variables of interest on gender. For example, if the variable of

²⁷³ Department of Health and Human Services: Office on Women's Health, *Final Report: Opioid Use*, 45.

²⁷⁴ Meyer et al., "Research on Women with Substance Use Disorders."

interest is hormonal variations and their effects on drug use, the complex interplay of hormonal change in women through menstrual cycles, pregnancy, and through menopause must be considered; a point in time measure of hormone levels is not sufficient. Further, researchers must explore measurement invariance, accounting for how their variables of interest and the way they measure them may differ among women, and be affected by race, socioeconomic status, region of the country, and prior lived experience. In addition, sex disaggregated data are essential when studying men and women together, however, it is preferable that some research be done in women only studies. Because the biology of sex is varied among women in that chromosomal patterns can be different, understanding the disparate effects those differential patterns may be crucial to isolating more effective prevention and treatment options. Lastly, many women who use drugs have comorbidities that may affect opioid use. Depression, a history of trauma, homelessness, poverty, and physical health issues such as hepatitis C or HIV, to name just a couple, make identification of SUD and treatment of such more complex.²⁷⁵

Modifying clinical and scientific studies to better understand the physiology and the complex interplay of life experiences with opioid use, addiction, overdose, and death should be a priority of any drug policy. Policy should include funding and broaden support for the types of studies discussed above. Increasing the number of women centered studies as well as modifying the methodology of those studies will add to the understanding of women's unique experiences with opioids, but it is only one piece of the puzzle. To truly help women and end the opioid crisis, the social and psychological aspects of women's lives must also be understood.

²⁷⁵ Meyer et al.

B. IMPROVE SOCIAL DETERMINANTS OF HEALTH ALONGSIDE PREVENTIVE MEASURES, TREATMENT OPTIONS, AND RECOVERY SUPPORT

Though the focus of any drug policy must be on improving SDOH and individual well-being, women who become addicted to drugs must feel safe in seeking treatment without the fear of judgment. While treatment has become more readily available, women are still less likely than men to receive treatment, an indication that there are social barriers in place keeping them from seeking the treatment they need. The National Survey on Drug Use and Health indicated that while one in three people with SUDs were women, women only accounted for one in five people in treatment.²⁷⁶ This is an indication that women do not feel safe seeking help, and for good reason. In the U.S., women are at greater risk of losing their children, becoming homeless, experiencing physical abuse, losing a job, being denied social services including financial assistance and educational grants to help pay for job training, and longer terms in prison for lesser charges than men.²⁷⁷ Each of these affect women's ability and willingness to seek help when they find themselves addicted to drugs, which leads to fewer women getting treatment and other assistance they need.

To make women feel safer in seeking out the help they need when they become addicted to drugs, an effort to improve SDOH throughout the lifespan is crucial. Researchers, the medical profession, and other professional caregivers in the drugs arena have long argued that the social and psychological issues of loneliness, boredom, helplessness, and to some extent depression that are root causes of addiction have never been considered by policymakers.²⁷⁸ Social determinates of health have rarely been discussed in drug policy, and even now are just words on paper with no real effort put into improving them.

While the narrative that accompanies the current policy is clear that they understand SDOH such as societal, environmental, genetic, and family dynamics are all implicated in

²⁷⁶ Meyer et al.

²⁷⁷ Wahler, "Retribution or Rehabilitation?"

²⁷⁸ Department of Health and Human Services: Office on Women's Health, *Final Report: Opioid Use*, 8–18.

individuals using drugs, including opioids, nothing substantive is proposed to improve SDOH. The current policy also acknowledges that adverse childhood events such as exposure to violence, neglect, and physical and sexual abuse are also implicated.²⁷⁹ Yet there is no proposal or suggestion for meaningful social change.

It is not surprising given the political atmosphere that there are no calls for social change. The U.S. is sliding into more conservative mindset in which women are losing ground socially, economically, and in their bodily autonomy. With the ongoing fight for income equality, more women than men living in poverty, loss of bodily autonomy for many women, and still no ratification of the Equal Rights Amendment after 100-years of negotiating and arguing, women's lives today, and our futures, look bleaker than they did for our mothers and grandmothers. It remains to be seen how these factors will affect women and drug use. If there is a decline in quality of SDOHs, which according to some has already begun, the chance of drug use diminishing for women most likely very low.

Through over 200 years of drug policy and treatment it has become clear that as with any social issue, there is not one policy or program that can entirely address and eradicate a problem. However, there are obvious steps that can be taken, and the current policy even suggests them, but in the context of assisting other nations, there are no suggestions for these measures to be used in the U.S. For example, Strategy VI calls for strengthened partnerships with foreign nations to include strengthening their economies, establishing jobs for their citizens, lower the poverty rates in those nations, and to work with them to fight root causes of the drug trade in their nations.²⁸⁰ The U.S. knows that SDOHs play a large part in the drugs arena, from growing, to manufacturing, to distributing, to using, and they also know how to resolve these issues. They just are not willing to do it here in the U.S.

Though one policy cannot resolve all the social ills women in the U.S. face, there are steps that must be taken to better the SDOHs of women. Foremost, poverty must be eliminated. There is no end to the debate about how to end poverty. Protestant morality has

²⁷⁹ Office of National Drug Control Policy, "National Drug-Control Strategy."

²⁸⁰ Office of National Drug Control Policy.

primed us for years to believe that individuals live in poverty because they have some inner character flaw that makes them responsible for their fate. However, there are structural systems in place that make it more difficult for a woman to prosper, and those systems can and should be changed.

First, unpaid caregiving, also known as motherhood, is one of the largest factors associated with poverty for women. Women, even when married or in committed relationships, are often the primary caregiver not just for their children, but for their spouses and partners as well. When children are pre-school aged it can be financially impractical for both parents to work outside of the home, and mothers who have no partners or spouses often sacrifice their career or may simply choose to stay home with their children, lowering household income. Providing childcare to women, especially single mothers, can significantly change their ability to support their families. Additionally, ensuring that women have bodily autonomy and can choose when or if they want to become mothers will ensure that fewer women fall into poverty.

Bodily autonomy and full agency encompass several matters that have never been addressed in drug policy. Patriarchal sexism and protestant belief systems must be dismantled. With the recent overturning of *Roe vs. Wade*, women are in a more precarious situation than they have been in over 50-years. A woman's ability to plan her future hinges on bodily autonomy. Choosing when or if to have children should never be questioned, yet some places in the U.S. are attempting to restrict not just abortion, but contraceptive use. In 2023, nine states had laws restricting emergency contraceptives, three of them allow pharmacists to refuse dispensing them. Similarly, and more troubling, 20 states in the U.S. allow insurers or employers who pay for health insurance to refuse to cover any contraceptive at all.²⁸¹

Restrictions placed on women due to patriarchal sexism are inexcusable. Patriarchal sexism is an especially dangerous barrier to women because many women buy

²⁸¹ Guttmacher Institute, "State Laws and Policies," February 2023, <https://www.guttmacher.org/state-policy-resources>.

into it alongside men.²⁸² Take the role of caregiver for children, aka motherhood. For centuries patriarchal sexism has pointed to women as nurturers, more fit to care for children than men. When women with children enter the workplace, it is expected that they will need accommodations to care for their children, and those accommodations often hold them back. However, when men with children enter the workplace, the patriarchal systems in place do not expect any accommodations will be necessary, because men are not nurturing nor do they wish to care for their children, that's women's work.²⁸³ The accommodations granted to women, but held back from men, slow women's career paths, limit their ability to earn money and support their families, and ultimately tie back in to bodily autonomy. Why does a woman need to prevent or end a pregnancy just for work when the employer, and federal and state laws, ensure she can come back to work after a 90-day period? These types of accommodations seem so, well, accommodating. And many people do not look beyond the policies and practice to see how women are harmed by such patriarchal arrangements.

Further, these types of accommodations do nothing to offset the financial burden of pregnancy, childbirth, or any other medical expense that may be incurred, all of which are also linked to poverty. A third option to reduce poverty is to ensure quality healthcare for women and their families. A mother who stays home with her sick child is pulled from the workplace, decreasing her earning power, and the medical bills associated with prolonged or chronic illnesses can push an otherwise middle-class family into poverty.²⁸⁴

Another proposition to improve women's livelihood, economically, psychologically, and socially, is to pass the Equal Rights Amendment (ERA). In the over 400 years the U.S. has existed, women have never achieved equality with men. It is nauseating that the "right" to be equal is something that must be given to women, but over centuries it has become clear that equality is never going to be achieved without

²⁸² Tannenbaum, "The Problem When Sexism Just Sounds So Darn Friendly..."

²⁸³ Robin J. Ely and Irene Padavic, "What's Really Holding Women Back?," *Harvard Business Review*, March 1, 2020, <https://hbr.org/2020/03/whats-really-holding-women-back>.

²⁸⁴ Heather E. Bullock, *Women and Poverty: Psychology, Public Policy, and Social Justice* (Hoboken, UK: John Wiley & Sons, Inc., 2013), ProQuest.

intervention of some kind. While 26 states have adopted their own versions of the ERA, there are millions of women who are not given the same protections regarding sex discrimination, including employment and wage security. The provisions of the ERA would remove patriarchal systems that hold women back and put in place systems in which women can move themselves and their families out of poverty.²⁸⁵

This is but one aspect of the barriers that affect women disproportionate to men. These barriers must be identified and eliminated. Protection of girls and women must begin when they are young. Adverse childhood events such as neglect, physical and sexual abuse, exploitation, and exposure to violent situations absolutely must end. Not just for girls, but for boys and adults as well. There is no justification, explanation, excuse, or defense for behaviors that cause harm to others. As a nation, culture, and species, there must be a movement against these behaviors and the victimization of others. We must teach our sons and daughters that violence and brutality are never acceptable, that boundaries and bodily autonomy are the law of the land, and respect for others is what is expected from every human.

C. CONCLUSION

Drug policy and laws have failed women since their inception over 100 years ago. Women's unique needs and life experiences must be considered and included in all discussion of and legislation developed concerning drug use, abuse, overdose, and death. It is becoming more urgent for substantive action on drug use as the U.S. finds itself in the midst of a crisis that is killing more people every day, a group of which women are a growing percentage.

Decades of drug supply reduction efforts have done little to keep drugs from ruining lives, as evidenced by growing prison overcrowding and soaring death rate. The time is long overdue for more efforts toward demand reduction. Inclusion of meaningful efforts to improve social determinants of health must be made. Drug use, abuse, overdose, and death are a lifespan issue that begins long before the first drug is consumed.

²⁸⁵ Equal Rights Amendment, "Equal Rights Amendment," accessed February 9, 2023, <https://www.equalrightsamendment.org>.

It is time to end the Drug Policy Theater and institute policies that tackle the core issues behind drug use, abuse, overdose, and death head on. The federal government knows what is necessary and are willing to put money and time into helping other nations fight these issues; poverty, helplessness, violence, economic inequality, and instability, to name a few.

Unless and until the U.S. is willing to put the same efforts into improving SDOH in our nation, the drug problem, the opioid crisis, and the ongoing and meaningless war on drugs are not going to end. Women in the U.S. and the people, communities, and the nation that needs them will continue to suffer.

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