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The War on Drugs in the US Economy

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This thesis will discuss the ways in which the War on Drugs has failed the US economy. It will provide the reader with a full understanding around the history of the War on Drugs in the United States of America, as well as around addiction and drug use. I will cover areas such as health care, incarceration and homelessness and discuss through research and studies how they have impacted and been affected by the War on Drugs.

Throughout the thesis I will discuss the economic impacts the War on Drugs has had on the US economy, considering those who have profited from it, and those who have contributed to the costs of the failed global campaign.

Finally, I will go through possible solutions to the US drug crisis, which have been found to work in prior trials in the US or in other countries, while discussing the impacts that changes to programs, services, policies, regulations and laws can have on decreasing the demand for drugs. There will be criticism towards the US for continuing the failed policies on drugs, resulting in health issues, mass incarceration, poverty, social inequality, increased drug use and for causing significant costs to the US taxpayers, for increased spending of tax revenue on the already failed War on Drugs.

Keywords	

Contents

1 Introduction

The War on Drugs is a global campaign that began in the United States of America (US) in 1971 with the aim of removing specific drugs from society by criminalising their sales, possession and use. This goal of removing the supply of drugs which still have a high demand, has led to several grave issues in US economy, such as health and social inequality, increased addiction and drug use and many more. In my thesis, I will be analysing some of the reasons the War on Drugs has failed the US economy, particularly with respect to health care, incarceration and homelessness, and consider some possible solutions that could help tackle the current drug crisis in the US.

The War on Drugs has caused a lot of suffering among US citizens, and because of the social inequality behind the War on Drugs, most issues have been apparent on lower- to middle-class multiracial citizens and minorities. The criminalization of drugs has caused the law enforcement to use their time, effort and resources on incarcerating addicts and non-violent drug users. It has been shown in research, of which I will discuss more later, that this can lead addicts into a loop of drugs, incarceration and homelessness. It does not come as a surprise that the US suffers from a greedy and finance-based health care system, which has a large role in the US drug crisis.

The US has already spent an estimated $1 trillion on the War on Drugs (Pearl 2018). However, when considering that every 16 minutes, someone in the US dies from an opioid overdose, the War on Drugs has not accomplished to remove drugs from society. Instead, it has created a stigma around addiction, which has been tested and confirmed to be a false theory. There will always be a demand for drugs, but the supply systems have become much riskier, since they became illegal.

2 History of the War on Drugs

When discussing issues and solutions to the War on Drugs, it is important to look back on its history, and understand where and why it began.

Since the United States of America was founded, drug use has been present in both medical and recreational uses. Drug addiction in US began to increase in the 19th century, when morphine was given to solders during the Civil War and many veterans became addicted. Opioids, cocaine, morphine and alcohol products became commonly prescribed by doctors for practically everything and to everyone, including babies and children, and some products containing opioids could even be bought without a prescription. (Henderson 2001: 126). Also, several products contained currently illegal substances, such as famously known Coca-Cola Company, who used active cocaine in their tonic ingredients when it was first produced. The first regulations on drugs were passed in the 1800s, in a few states. In 1890, the first congressional act to impose taxes on opium and morphine was passed.

The long-term effects of opioid use finally were discovered in the 19th century. Due to this, in 1909, The Smoking Opium Exclusion Act became the first federal law to ban the recreational use, possession and importation of smokable opium. In 1914, the Harrison Narcotics Tax Act was created to regulate and tax the production, importation and distribution of cocaine and opiates. (History.com Editors 2018)

The Prohibition Era went to effect in 1920, when the manufacturing, transporting and sales of intoxicating liquors were banned. This contributed to a growth of the underground black market, leading to increased amounts of organized crime (Henderson 2001: 125). Other issues the prohibition brought were corruption of public officials and a widespread disregard and disrespect for the rule of law. Due to many anti-prohibition campaigns, rise in crime and the onset of the Great Depression, the prohibition era was ended in 1933. (Khan Academy 2008)

Marijuana made its way to the United States of America through Mexico during the Mexican Revolution of 1910-1911. Since cannabis was brought to the country by Mexican immigrants, there became a racial prejudice around marijuana. Americans created racial

stereotypes and stigma around Mexican immigrants and marijuana. The first state to outlaw marijuana was Utah in 1915. After this several US states decided to make the drug illegal, with 29 states having criminalized it in 1931. In 1937, the Marijuana Tax Act was created to restrict and control the use and distribution by placing taxes on the sales of marijuana. (McNearney 2018.)

In the 1960's, there was an outburst of an entire generation of Americans experimenting with drugs. The reason for this was the introduction of hallucinogenic drugs, such as marijuana, psilocybin mushrooms and LSD, providing users with a new view on drugs, as previously most drugs such as opioids, alcohol and morphine gave users mostly numbing and soothing affects. Youth began using drugs as a symbol of youthful rebellion, social upheaval, yet also as political dissent. During this century, the use of marijuana and cocaine rose to high rates. Cocaine was noticed to cause addiction easily and as addiction rates rose, the US policy holders decided to do something about it.

In 1970, President Richard M. Nixon signed the Controlled Substances Act (CSA), resulting in the regulation of certain drugs and substances. The CSA created five "schedules" in which drugs are classified based on their potential for abuse and medical properties. The substances posing the highest risk for addiction and with the least proven applications to medical use are placed in Schedule 1. Some drugs which were placed in this schedule were Marijuana, LSD, heroin and MDMA. In Schedule 5 were drugs such as cough medications and codeine, which were considered least likely to be addictive.

President Nixon officially declared a "War on Drugs" in June 1971, while he stated drug abuse to be "public enemy number one". His first actions included the increasing of federal funding of $400 million to drug control agencies, such as the Special Action Office for Drug Abuse Prevention (SAODAP), which he created. He also created strict measures such as mandatory prison sentencing for drug crimes. The Nixon Administration increased mandatory minimum sentences for possession of drugs, with possession of marijuana having a minimum sentencing of 2-10-years. A few years later, he created the Drug Enforcement Administration (DEA) to target illegal drug use and trafficking in the United States. The DEA received a budget of around $75 million and contained 1,470 special agents. (History.com Editors 2018)

The War on Drugs had its first set-back in the mid-1970s, when eleven states decriminalized marijuana possession. In 1977, Jimmy Carter was elected president after running a political campaign to decriminalize marijuana, which he did in his first year in office.

This did not last long however, since the following president Ronald Reagan reinforced and expanded the policies of Nixon's era once he was elected in 1980. During his presidency, there was a massive increase in non-violent drug crime incarcerations. In 1984, his wife Nancy Reagan launched a "Just Say No" campaign, aiming to increase the public knowledge on the dangers of drugs. In 1986, mandatory prison sentences for certain drug offences was established by the Anti-Drug Abuse Act. This law gained criticism for its racist ramifications, as offenses involving the same amounts of crack cocaine had longer prison sentences than those with powdered cocaine. Crack cocaine was more commonly used by black Americans, while powdered cocaine was more common in white Americans. This in addition with the clear data on people of colour being targeted and arrested on suspicion of drug use more often than white people, led to a clear racial divide.

In 1995, the National Institute of Health estimated the annual economic cost of alcohol and drug abuse to be over $240 billion. This amount included factors such as illness, premature death, health care costs, lost productivity, crime, motor vehicle accidents and incarceration. In 1998, the annual cost had increased to $246 billion, of which 60% were related to alcohol and 40% to drugs. (Henderson 2001: 118) The policies of the War on Drugs have led to rapid rises in incarcerations of non-violent offenses, from 50,000 in 1980 to 400,000 in 1997. More recently in 2014, nearly 50% of people serving time in US federal prisons have been incarcerated from drug offenses. (History.com Editors, 2018)

The War on Drugs has continued to be fought in the US, even with the decrease in public support. There have been small changes made to the drug laws, penalties and mandatory minimum sentences have been shortened in many states. Congress passed the Fair Sentencing Act (FSA) in 2010, to reduce the difference between crack cocaine and powdered cocaine sentences. Since then marijuana has overall been legalized in several states across the US.

3 Addiction

When analysing the War on Drugs and how it has failed US economy, an important aspect to understand is addiction. There are many myths still being taught about addiction and the people it affects. In this segment, I will be discussing the theory and science behind addiction, how it works, whom it affects and how the War on Drugs has been launched on a false understanding of addiction, causing it to be a failure from the start.

3.1 Defining Addiction

There are many types of addiction and anyone can get addicted to something, be it alcohol, gambling, sex, drugs, working out, social media or anything which can cause you pleasure and a dopamine "high". To avoid digressing, I will be only focusing on drug and alcohol addiction.

The National Council on Alcoholism and Drug Dependence came together in 1972, to find a definition for alcoholism, which was also found to apply to drug addiction. The definition they created is as follows:

> Alcoholism is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.
> (Henderson 2001: 11)

The main issues which have made diagnosing addiction difficult, it that there is a thin line between the abuse of a substance and dependence on a substance, as well as denial being one of the most common psychological defence mechanisms of an addict. Two key elements which can help in defining an addict is (1) loss of control over the use of the substance and (2) continued use despite negative consequences.
(Henderson 2001: 12)

3.1.1 Rat Park

An experiment done in the 1960s on rats and addiction was a large support to the ideology behind the War on Drugs (Alexander 2010). In this experiment rats were placed in skinner boxes as shown below. In the skinner box they were tethered to the ceiling with a tube and needle surgically implanted to their jugular veins. They were also provided a small lever, which they could push to send amounts of heroin, amphetamine, cocaine and other drugs into their veins. As a result, the rats would press the lever and increase the amounts of drugs until they eventually overdosed and died. The conclusion made by the mass media and politicians was that these drugs needed to be banned from circulating in society, since they proved so addictive. The belief that drugs cause addiction, unrelated to the circumstances of the individual, set the ongoing motivation on the War on Drugs to be set around eliminating the supply, which in turn should eliminate addiction.

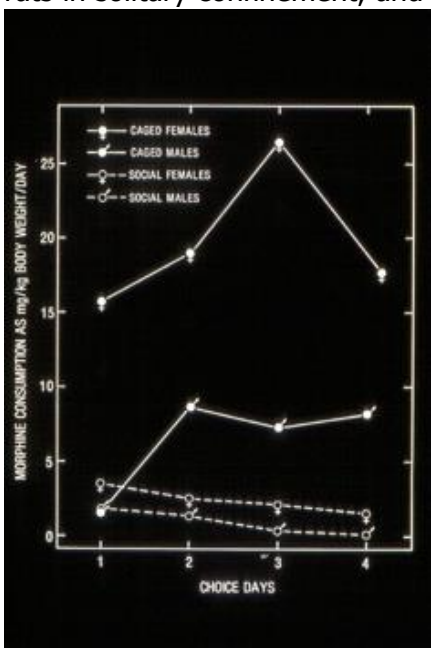
Figure 1.1. Skinner box, Alexander 2010

In the late 1970s, Bruce K. Alexander, a professor in Simon Fraser University and his colleagues, Robert Coambs, Patricia Hadaway and Barry Beyerstein realised there was something wrong with this experiment. The rats were kept in solitary confinement without any other stimulation than the drug, while they, as humans are highly social and sexual creatures. When humans are kept in solitary confinement, the results with the drug experiment would probably be similar with the rats, as both can be driven crazy from such isolation and lack of activity.

Alexander and the others decided to test the conclusion and compare the drug intake of half the rats kept in isolated cages to rats housed together with both sexes in a simulating environment they ended up naming "Rat Park" (Alexander 2010). Rat Park was built as a large 'natural' environment with stimulation for the rats to enjoy, such as climbing platforms, tin cans, wood chips, a running wheel and fulfil the rat's physical, emotional and social needs.


Figures 1.2. and 1.3. Rat Park, Alexander 2010

Then they gave the opportunity for rats to drink from a container with normal water, or another with morphine mixed with water. As a result, the rats placed in solitary confinement would always drink large amounts more of the morphine water than those in Rat Park. In the results shown in figure 1.4., the 'caged' females and males are the rats in solitary confinement, and the 'social' females and males are the rats in Rat Park.



As can clearly be seen the caged rats consumed the morphine-water in much higher frequency and in larger amounts than the social rats. Although the caged female rats had the highest results, implying they would be more prone to consuming the morphine water, it was debunked in further experiments. The relationship between caged and social rats with the morphine water stayed common in all tests.

Figure 1.4. Experiment Results, Alexander 2010

The results of the Rat Park experiment implied that the availability of the drugs was not the leading cause to addiction, but the environment and needs of the rats play a larger role in the cause of addiction. Many researchers have replicated the experiment with the same results implying that the isolated rats will always end up using the drugged water in much higher rates than the rats with their social, environmental and physical needs met.

Bruce K. Alexander had hoped this experiment would help correct the misconception of addiction. However, the addiction theory was integral to the War on Drugs and wouldn't be re-examined. This experiment and those subsequent it have shown a remarkable irony with the War on Drugs, as instead of the original "goal" of helping reduce drug use and addiction, the ideology of locking drug users into prison and jail and isolating them from society, will only make recovery and ending drug use that much more difficult.

3.2 Who Gets Addicted and Why?

The addiction theory of the past has had a strong effect on how current generations view addicts. When thinking of an addict, we often may think of an irresponsible, unreliable, self-centred disgrace to society. Addiction has a way of disrupting and affecting both the addict, the people around them and wider society. The issue of trying to define who gets addicted is nearly impossible, as it affects all groups, classes and races.

Addiction is a brain disorder and there are many factors which cause individuals to be especially prone to it. One of the largest factors that has been found to increase the risk of addiction is genetics. It has been observed that those with alcoholic or drug addicted parents, are often highly more likely to get a substance addiction, than those without. (Henderson 2001: 69-80)

Genetics is a host factor involved in the development of addiction. Others include psychological factors. Individuals with clinical depression or anxiety have a higher risk of developing addiction. This is also the case with people who come from disrupted homes or have experienced abuse. Personality factors also play a role, as addiction is more

common in people with risk taking personalities with poor impulse control, as well as in individuals with low tolerance to stress. (Henderson 2001: 22)

Environmental factors also play a role in developing an addiction. The culture and norms around the substances directly affects to the cultural acceptance and availability of substances. For example, in 1950, there were barely any substances available in college campuses, and therefore drug use in college was rare. During the mid-1960s, the rise in drug use on campus rose with the availability of the different drugs that were "trending" at the time. After the 1980s, drug availability had become so common, that grade schoolers could find easy access to drugs. (Henderson 2001: 20) Currently, with the development of social media, there has been seen a large increase in the availability and easy access to drugs to very young children. The largest issue in early use of drugs, is that these child addicts will miss out on important development of the brain in different tasks and social skills (Henderson 2001: 58).

The War on Drugs began in the belief that the cause of addiction was led only by agent factors, meaning the drugs. Although this theory has been proved to be false, the agent factors do still play a role in the development of an addiction. For many people, alcohol and drugs can be experimented on, without it leading to an addiction. This is widely seen in alcohol, as some can drink it socially, while with others it may lead to an alcohol dependency after the first experimentation. This is often due to the host and environmental factors. However, heroin and crack cocaine, as well as other highly addictive substances, can cause addiction without the support of host or environmental factors. (Henderson 2001: 17) Also, pharmaceutical opioids have been shown to cause addiction to individuals with no other factors in play. There are many different classes of drugs, which all have different effects, and therefore can cause addiction in people with different underlying mental or environmental issues. Categories of drugs include; depressants, psychostimulants, opiates, inhalants and hallucinogens.

3.3 Mental Health and Addiction

As one of the host factors that plays a role in the development of an addiction, mental health should be considered a main one. It is more common than not for people suffering

from addiction to have other psychiatric problems. The Epidemiological Catchment Area (ECA) study conducted in 1970s generated a large amount of statistical data to help understand several mental health problems. The study showed that mental health problems such as major depression, anxiety disorders or schizophrenia frequently coexist with addiction, and the chance of developing an addiction increases with the more mental health issues you have. This also is an issue as the risk to develop other mental health issues increases during addiction. (Henderson 2001: 96)

Many veterans from the Vietnam War developed issues such as chronic anxiety and tension, and some developed Post Traumatic Stress Disorder (PTSD). PTSD is a physiological reaction to a trauma, which does not subside with time, causing a permanent fearful and hyperalert state. There have been studies to suggest that mind-altering drugs can be an effective way in temporarily overriding the symptoms of PTSD. This disorder is common with war veterans and people who have suffered chronic abuse, and often these individuals suffering from PTSD, begin self-medicating with drugs, if they do not receive the mental and medical help with their symptoms. (Henderson 2001: 29-30) This was not the case for all Vietnam War veterans, as they returned from using strong drugs in the war to their homes, "rat park"-like environments, which was enough to conquer their addictions.

There have been many issues in the way the drug treatment and mental health programs have been set up. In the beginning of the 20th Century, it was very common for people suffering from both addiction and mental health problems to "slip through the cracks" as addiction treatment programs were not always equipped to deal with mental health issues, and likewise the mental health facilities would reject them due to their substance addictions. Since it is common for psychiatric disorders to coexist with addiction, and for addiction to lead to more mental health problems, the coexisting disorders have been classified into three categories, all which should have their own treatment methods.

The first category is "Substance-Induced Disorders". As the name suggests, these are symptoms and mental health issues that have been caused by the addiction. This disorder is often solely caused by the substance dependence and can therefore be treated through an addiction treatment program. Some such symptoms include

depression, anxiety, panic attacks, psychosis or alcoholic hallucinosis. There can be many symptoms simultaneously. (Henderson 2001: 97)

The second category is "Psychiatrically Complicated Addiction". This coexisting disorder is more complicated to treat, as the individuals are suffering with addiction in addition to a pre-set psychiatric issue, such as mild-to-moderate depression or anxiety disorders or individuals with a history of emotional, psychological or sexual trauma. The treatment for these types of individuals should contain an addiction treatment program, with extra support from a psychotherapy professional. These people are often more prone to relapse, which is why therapy, aftercare and follow-ups are important.

The third and most complex coexisting disorder is "Serious Persistent Mental Illness and Addiction". In this category are the individuals suffering from addiction and from chronic major psychiatric disorders. Some of these functionally impairing conditions include, major depression, bipolar disorder, schizophrenia, schizoaffective disorder and certain personality disorders. People with these conditions have been found to be extremely prone to addiction, and therefore the treatment should be focusing equally on the addiction and the mental health problem. (Henderson 2001: 98)

In the US, the War on Drugs has failed to consider addiction as a disease, which has led to mass incarceration, criminalization, homelessness and needless deaths of addicts. While the focus should have been on treatment and health care for these individuals, to help prevent health issues arising from drug use and save the money of taxpayers.

4 Health Care

On 22nd of July 1946, the World Health Organization (WHO) introduced to its constitution the following declaration:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic or social condition. (Baumrin 2012: 91)

When considering the above statement, the proper access to health care should be essential in all countries of the world. This, however, is not the case. Health care systems effectively always operate under conditions of scarcity. For this reason, different economies have different health systems, which have different motivations around their distributive justice. Justice was best defined by famous philosopher Aristotle, as "treating like cases alike and different cases differently" (Rhodes et al. 2012: 1). When discussing distributive justice, the question is, how to divide resources equally among parties who deserve and need them?

This is more complicated in situations of scarcity and conflict. Health care has many different effects on the economy and practically every area of human experience and activity. Health care has a central function of maintaining an individual's normal functioning. Individuals who have impaired functioning and/or lack access to proper health care are deprived of a large range of opportunities in life, for example, employment, relationships, aesthetic capabilities, political roles and even the capacity to think properly. The importance of having health care needs met preserves individual's ability to be fully participating citizens with the ability to participate in the political, social and economic life of their society. Therefore, health care plays an important, yet limited role in the protection equality of opportunity. (Daniels 2012: 17) The concept of equality of opportunity was best expressed by the principle of Equal Opportunity of Welfare (EOW) as follows.

> People should not be worse off than others through no fault or voluntary choice of their own. Situations where people are worse off than others because of their own sufficiently blame-worth actions or choices are not unjust, as painful or compassion eliciting as those situations may be. (Menzel 2012: 41)

There has been a wealth of evidence that richer people on average live longer and healthier lives than poor people. Even more can be found that in addition to the financial status playing a role in health inequalities, so do other racial and exclusionary practices across the socioeconomic spectrum. Even in societies with universal health care, a service providing quality medical services to all citizens regardless of their ability to pay,

the link between social status and health remain. (Daniel 2012: 19:23) Differences in health outcomes can be seen in all levels of socioeconomic status (SES). SES is an economic and sociological combines total measure, involving an individual's work experience and economic and social position in relation to others. There is evidence to suggest the more economically unequal a society is, the more unequal their health terms are. This is called the income relativity thesis. Based on this thesis, middle-income groups in societies with high income inequality are worse off in terms of health than comparably poorer groups in a society with less income inequality.

Numerous studies have shown that inequality is important at the individual level, known as the socioeconomic gradient. This can be viewed as an economic ladder, in which each step has improved health outcomes compared to the step below. It has been seen that in richer countries, people tend to have longer life expectancy. However, in these richer countries with advanced industrial economies, there is a levelling affect. This means the relationship between per capita gross domestic product and life expectancy levels off at around $8,000 to $10,000, meaning further economic advances no longer improve life expectancy. (Daniel 2012: 21) An example of this is when comparing Costa Rica with the US. Costa Rica's life expectancy exceeds that of the US, even though it has only a third of the GDP per capita of US. This is due to the importance of other factors than wealth, including culture, social organization and government policies.

Overall, there are many factors that play a role in the health of a society and its individuals, but inequality is seen in nearly all health care systems. However, the US health system has some of the largest inequalities seen in the developed countries throughout the world.

4.1 US Health System

It will become evident throughout this thesis how several different factors have attributed to the failure of the War on Drugs. One of these factors is the US Health System.

The US government spends a larger proportion of their gross domestic product (GDP) on health care than any other nation, and they spend more money per citizen on publicly funded health care than majority of the global nations. (Wolff 2012: 71) Based on this, the US should have one of the best health care systems in the world. However, this is not the case.

The US is the only modern industrial democracy and member of the Organisation for Economic Co-operation and Development (OECD) countries not to have universal health care. Instead, the US has a highly privatised health care system, which uses insurance as a tool for coverage of costs. The costs are very high, and insurance is meant to cover only the majority of an insured individual's health care costs.

Insurance in the US is often inadequate, meaning finding health coverage is very challenging and even with a high-quality insurance coverage, pursuing and settling claims can be extremely difficult and there are often stiff maximums to the limits of care insured, also insurance companies have very high prices and strict criteria. For these reasons, many millions of US citizens either lack of or have inadequate health insurance.

In a 1992 study, done by the U.S Office of Technology Assessment, it was found that half of all private and non-profit health insurers would refuse insurance coverage to an individual, whose genetic test revealed the possibility of developing a chronic disease. When considering this and the fact that from 19-50% of non-elderly Americans have some type of pre-existing health condition, it does not come as a surprise that 1 in 5 of these citizens are currently uninsured (CCIIO 2014). An insurance company spokesman explained this in the following statement.

> Insurance is sold to provide financial protection against anticipated loss. If people who know they will die at an early age are allowed by law to purchase insurance, then they are at an advantage not only over the insurer but over all the other policy holders covered by that company. As a basic principle, insurance is priced so that those at equal assumed risk pay equally for their protection. If that is not the case, the price of all insurance must change. (Pennock 2012: 390)

For several financial and geographical reasons, many US citizens have no other rights to health care, asides from evaluation and treatment by hospital emergency departments. In 1989, the Emergency Medical Treatment and Active Labor Act (EMTALA) was accepted

by the Congress without much opposition. This act was the small step the US took towards universal health care, as it ensures emergency care is given even to those patients unable to pay. This however has led to EMTALA being abused by people without possibility to afford primary care. Financially, this increased the costs of emergency care to an annual of $100 billion, which was cost-shifted to insured families, resulting in an average of $1000 higher annual premiums for insurance. (Menzel 2012: 39)

Health care reform has had an extensive amount of discussion throughout the history of the US. The issue has several vested interests involved, and therefore is highly politically charged. American democracy has a complex and historical framework, which has both constitutional and legal aspects. The health care system has had some modifications, evolvements and adaptations, and although there are still huge amounts of money being spent on it, the citizens do not seem to be equally benefiting from it.

In the US, the states with the most inequality in income distributions, also invest the least in public education, social safety nets and have the largest amount of uninsured population. The income inequalities have been widely present in studies of education spending and education outcomes, of which the results are well explained as follows.

> Income inequality explains about 40% of the variation between states in the percentage of children in the fourth grade who are below the basic reading level. Similarly, strong associations are seen for high school dropout rates. It is evident from these data that education opportunities for children in high income inequality states are quite different from those in states with more egalitarian distributions. These effects on education have immediate impact on health, increasing the likelihood of premature death during childhood and adolescence (as evidenced by the much higher death rates for infants and children in the high inequality states). Later in life, they appear in the socioeconomic gradient in health. (Daniel 2012: 22)

4.2 Mental Health Care

Mental health care services in the US have always been at a strong disadvantage even compared to primary health care services. There is a large portion of Americans without access to basic health care services throughout the states, but an even larger portion without any access to mental health services. Access to mental health services is often not covered by many insurance agencies, as there is still a long-lasting discriminatory

stigma around mental illness. Primary care physicians have reported about the struggles around finding mental health services for their patients due to several reasons, but as the most common, lack of or inadequate insurance. Since the beginning of health insurance, mental health services have been highly priced, limited or even rejected from insurance coverages.

There have been consistent studies made on large populations, which have confirmed the common occurrence of mental disorders. The first one of these was in the 1980s by the Epidemiological Catchment Area Study, which found that approximately 30% of the adult population had experienced some mental health disorder during the past 12 months. The results were consistent in the 1990-1992 National Comorbidity Survey and once again in the replica survey done in 2001-2003. Out of these individuals who answered the survey only one in five received treatment in the 1990-1992 survey, which improved to one in three who received treatment in the 2001-2003 survey. Research done in 1999 on the global burden of disease in the developing world and later replicated in the US showed consistent findings that mental health and substance abuse conditions create more disability than any other category of illness. (Ozar and Sabin 2012: 404). For example, major depression was found to limit well-being and function more than diabetes, arthritis, and several chronic conditions.

Before the mid-20th century, mental illnesses involving psychosis had been viewed as a serious disruption of human function, but health professionals found it difficult to impossible to treat, leading to belief of it being a hopeless condition without a cure. (Ozar and Sabin 2012: 406)

Nowadays, although still having much stigma around it, serious mental illnesses have become considered as a part of health care. As a result, there have been found different approaches to finding ways of treating it or at least providing the individual an opportunity to function better in society. In 2008, Mental Health and Addiction Equity Act was passed, resulting in widespread insurance coverage of psychiatric medications and a sign of increased acceptance around mental illnesses. This act also ensured that companies with over 50 employees should be provided the same benefits around mental health and substance abuse care, as they received on medical and surgical care. In 2010,

the National Alliance on Mental Illness came out with the following statement to define mental illness:

> Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illness are medical conditions that often result in a diminished capacity for coping with ordinary demands of life.
>
> Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder. The good news about mental illness is that recovery is possible. (Ozar and Sabin 2012: 406)

Following this, in 2014 the Medicare Improvements for Patients and Providers Act was created to reduce the co-payment for mental health treatment down from 50% to 20% (Trivedi, Swaminathan & Mor 2008). Although these laws and acts have been a great improvement from the earlier asylum and demonic exorcism "treatments", there are still many people with serious mental illnesses in the US lacking proper medical care.

In addition to these serious mental illnesses listed above, the several adverse mental health conditions, which seem to be growing among the years, are even more difficult to find mental health services for. Some of these conditions could be such as, mild to moderate depression, anxiety disorders and many other conditions that are not primarily addressed with psychiatric medications. Research shows that even though most people with a mental illness will often seek treatment, a majority of these disorders go untreated. In addition to insurance and cost issues, the average delay for those entering treatment is an average of 6-8 years for mood disorders and 9-23 years for anxiety disorders. (Ozar and Sabin 2012: 404)

Mental health services, as many other services in the US system, provide easy access for the wealthy and very well insured. The poor and the minorities, especially those living in rural areas, have had and still do have the most difficulties in finding treatment.

The American health care culture has long revolved around the pharmaceutical industry, and commonly people view illnesses that are not fixed with pharmacological treatments to be less valued as 'real' health care issues. (Ozar and Sabin 2012: 408). Children are often taught from a young age that self-management and self-control are fundamental

human skills, and they must be forward thinking, resilient and always keep a stiff upper lip. With this way of thinking, it is common to see people who need psychotherapy as weak and addicts as failures in achieving these fundamental human skills.

This "American attitude" of the "American Dream", and the functionalist perspective of inequality are some of the main issues in the US and the War on Drugs. The views around mental health and addiction, which often walk hand in hand, have most commonly been seen through the idea that these individuals with these conditions have brought them on themselves and are therefore failures of the American society. This stigma, in addition to the highly financially motivated privatised systems running the health care, housing and incarceration systems seem too often to leave these individuals with little to no chance of remaining functioning members of society. The thing is, this loss of such a large portion of citizens unable to function in society is creating its own costs, which I will begin discussing, starting with the "Opioid Crisis".

4.3 Opioid Crisis

Opiates, such as heroin and morphine, originated from a specific variety of the poppy plant. In addition to these naturally occurring opiates, people have produced synthetic opiates, often several times stronger than the original ones, such as fentanyl. Opiates are considered highly addictive, as even in small independent doses, withdrawal symptoms occur. Some effects opiates produce include pain relief, euphoria, relaxation, decreased motility of the gastrointestinal tract, constriction in pupils, provoked nausea and regulated body temperature. The withdrawals of long-term opiate use can be medically dangerous – and continue for weeks. These withdrawal symptoms include craving, muscle cramps, diarrhoea, yawning, sweating, runny nose, poor sleep and elevated body temperature.

Although opiates are not as toxic compared to alcohol, the most common medical issue with them is opiate overdoses. The tolerance for opiates builds quickly, and therefore long-term users often up the dose, until the dose is deadly. Another medical issue around opiate use is AIDS, as many addicts use dirty or shared needles to intravenously take the drug. The final, and sadly increasing medical issue with street opiate use, is that the

drugs are often "cut" with different stronger or more toxic substances, which can cause organ damage or overdose. Studies have shown that long-term opiate use can lead to chronic depression and anxiety, as well as different diseases caused by the poor nutrition and hygiene of the users. (Henderson 2001: 50-53).

Opioid overdose deaths have seen a consistent growth, contributing to decrease in life expectancy for the first time in US history (Lopez 2018). This has led to the realization of the gravity of the opioid crisis. The rise in opioid deaths can be seen in distinct waves throughout US history. The first wave started in the 1990s, with a continuous increase in prescription opioid overdose deaths until at least 1999 (CDC 2020). After this the growth stunned for a period until 2010, when the second wave begun, involving rapid increases in heroin related overdose deaths. The third and most significant wave began in 2013, with the introduction of synthetic opioids, particularly illicitly manufactured fentanyl (IMF), to the drug market. Increasing amounts of fentanyl are changing the drug market, and it can even be found in combination with heroin, cocaine, counterfeit pills and several other street drugs.

Since 1999, opioid related overdose deaths have increased nearly six times. In 2018, there were 67,367 reported drug overdose deaths in the US, out of which 46,802, meaning 69.5% were related to opioids. Out of these opioid related overdose deaths, 67% involved synthetic opioids. Although these numbers are large, they do not even represent the entire picture, as in 2018, 8% of drug overdose deaths did not list a specific drug on the death certificate, and in many deaths there are multiple drugs present, resulting in difficulties of identifying the cause of death. (CDC 2020).

In the following figure, the growth in opioid overdose death rates per 100,000 population can be seen from 1999 to 2018. The figure shows the steep rise until 2017, after which small decreases in heroin and commonly prescribed opioids are present with the steady increase in synthetic opioid deaths. (CDC 2020).

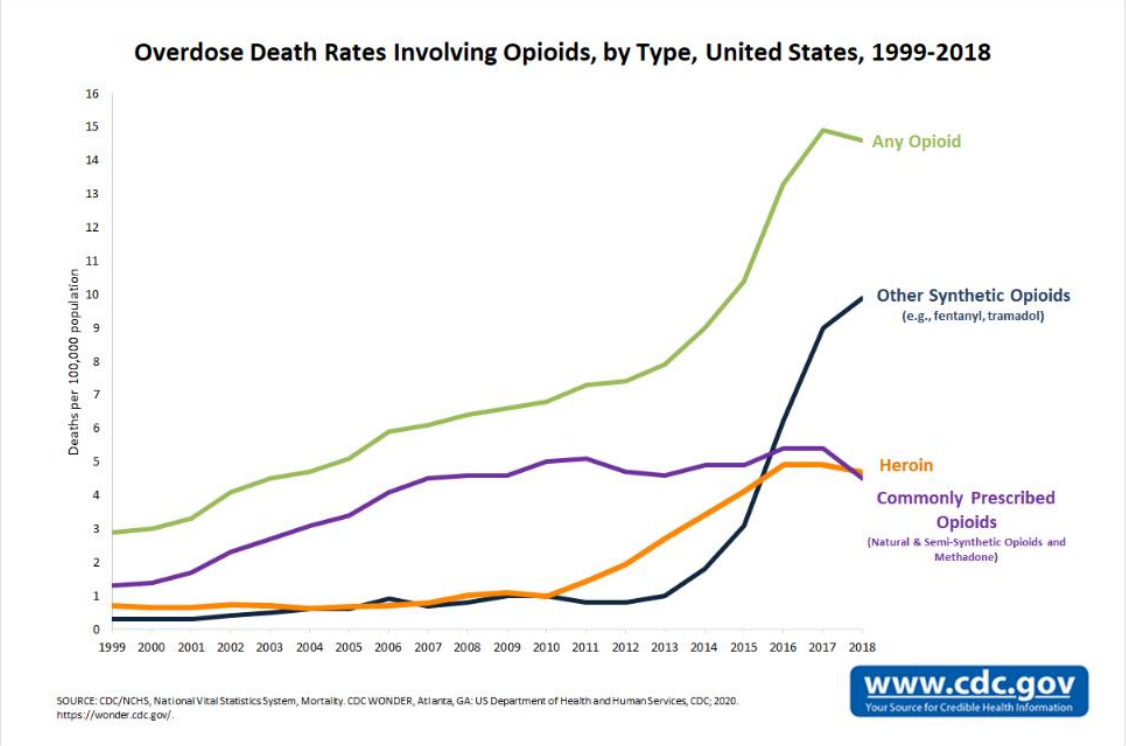


Figure 2.1. Overdose Death Rates Involving Opioids 1999-2018, Source: CDC 2020

Although the previous figure shows a decrease of prescribed opioids from 2017 to 2018, they continue to present a significant proportion of drug related overdose deaths. In 2018, 32% of the opioid overdose deaths involved prescription opioids. This co-involvement of prescription and illicit drugs has created an increasingly complex overdose epidemic in the US. Synthetic opioids, such as IMF, was involved in 23.7% of deaths also involving prescription opioids. (CDC 2020).

Since 2006, the overall national opioid prescribing rate increased steadily, peaking in 2012, with a prescribing rate of 81.3 prescriptions per 100 persons, resulting in more than 255 million prescriptions in total. The prescription rate per state varied widely in 2012, with a record of 143.8 per 100 persons in Alabama.

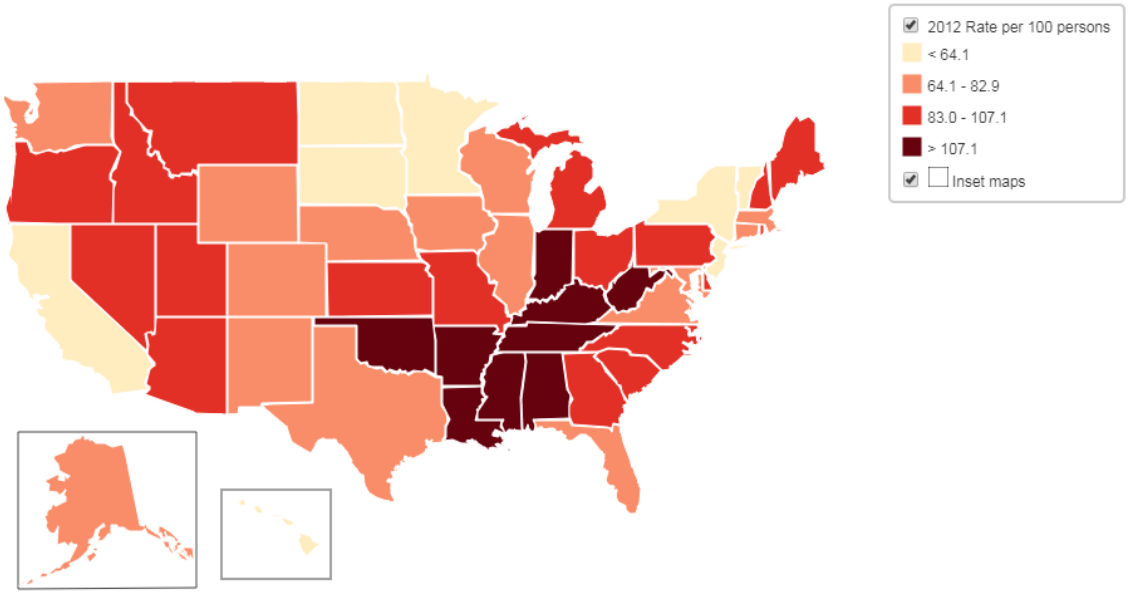


Figure 2.2. Prescription Rate per 100 Persons in US States 2012, CDC 2020

In 2018, the prescription rates had declined to the lowest rate in the recorded 13 years, of 51.4 per 100 persons, totalling in more than 168 million opioid prescriptions. Still, some counties had rates six times higher than the national rate and in 11% of counties, there was enough opioid prescriptions for each person to have one. The change from 2012 can be seen below, with Alabama still leading with 107.2 opioid prescriptions per 100 persons.

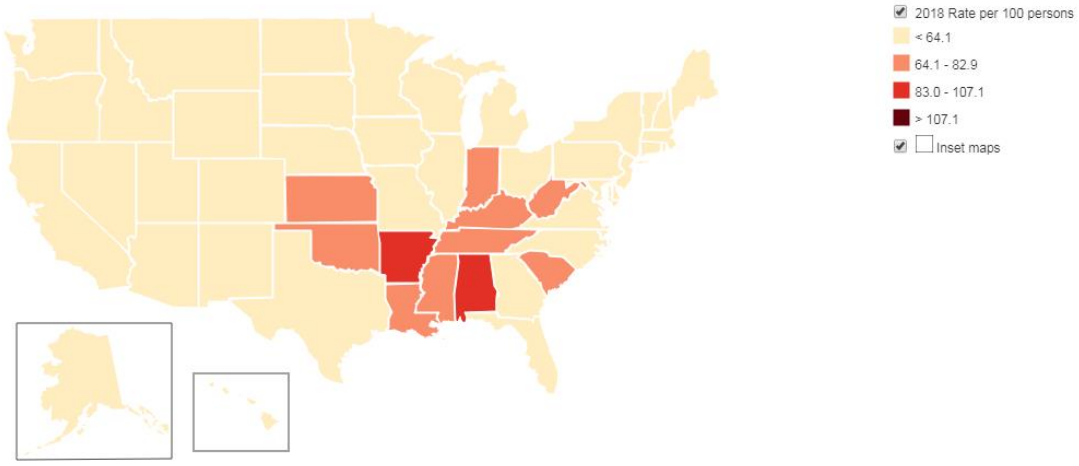


Figure 2.3 Prescription Rate per 100 Persons in US States 2018, Source: CDC, 2020

For each fatal overdose, there are several more non-fatal overdoses. Both fatal and non-fatal overdoses cause an immense emotional and economic impact. The statistics behind non-fatal overdoses are inadequate, since many are not reported. Still, research shows

the chances of an overdose increase after suffering a first non-fatal one. As overdoses are not linked to age, sex, state or county, the overdose trends are often collected through emergency department visit information. Centers for Disease Control and Prevention (CDC) created an enhanced state opioid overdose surveillance program, in which they follow the annual changes in opioid overdoses for selected states. The most current figure, shown below, shows an overall increase in 27 states, comparing sex and age group opioid overdoses, from 2018 (Q1) to 2019 (Q2), which proves the opioid crisis is still increasing. However, it shows a decrease by 12.72% in 11-24-year olds.

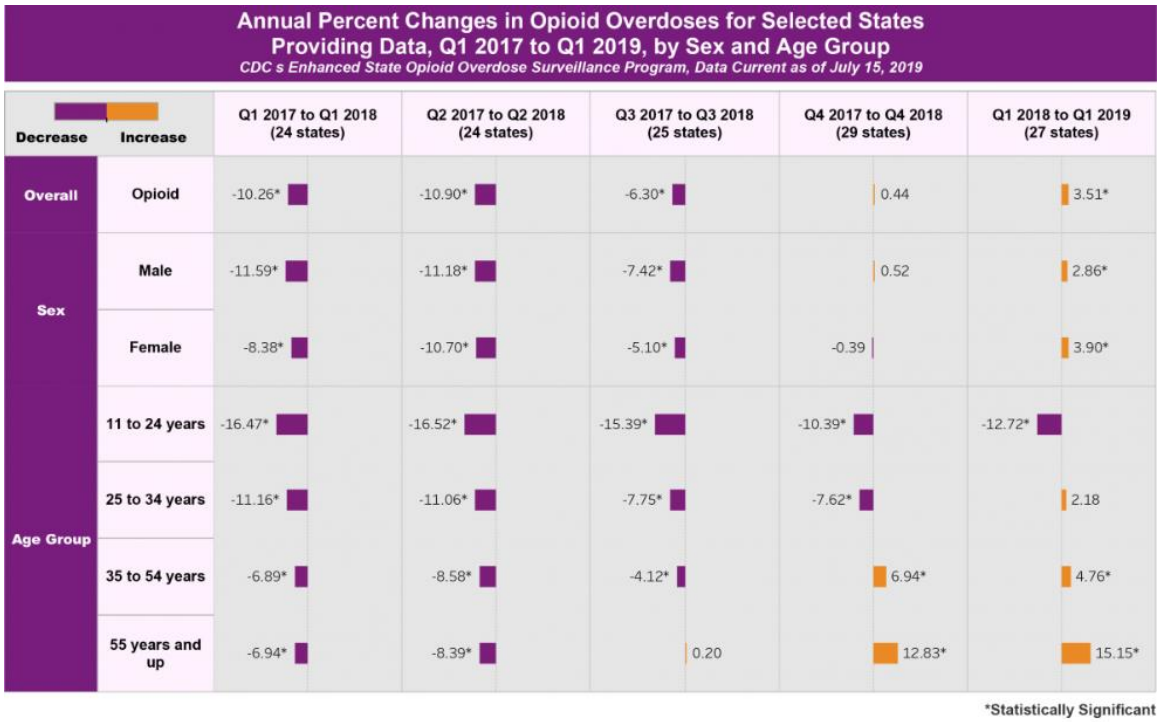


Figure 2.4. Annual Percent Changes in Opioid Overdoses, Source: CDC, 2019

5 War on Crime – Incarceration

The War on Drugs has had most of its economic impacts and costs via the US criminal justice system and the investments to law enforcement. There have been many issues with the criminal justice system in the US, as it has caused mass incarceration, high costs and increased social inequalities seen throughout all stages of the system. In this section,

I will discuss the issues of the US criminal justice system and those who profit, pay, and are impacted by the system.

5.1 Historical Background of the US Criminal Justice System

The US criminal justice system has had a long and complicated history, which has been highly tied and influenced by governmental, political, racial and financial factors. During the 18th century, it was common for authorities to "lease out" prisoners from state penitentiaries to business owners as cheap or free laborers. An example of this is business owner Joel Scott, who from 1825 leased prisoners for 55 years to produce chairs, shoes, ropes and wagons, which he sold on to accumulate more than $40,000 annually, which in our day, would be over a million dollars (Kilgore 2015: 167). In the post-slavery decades, African Americans witnessed more suffering from the local law enforcements, especially in the South, where they would be rounded up and arrested for petty charges such as loitering or vagrancy. Once arrested, state and local authorities would lease them out to the custody of farm owners, to work at these post-slavery labour camps.

In the early 1900s, with enough public outcries, many private prisons were decommissioned, putting an end to private prison leasing and labour. Most states banned contracting of prison labour by private companies by the 1930's, with Mississippi as the final state to outlaw it in 1944. (Kilgore 2015: 168).

After this period, there were some improvements made to social welfare; minimum wage and regulations for employment were created and prisons created many education, job training and addiction treatment programs to reach the goal of rehabilitating convicts back to society with opportunities to succeed. Many human rights movements in the 1960's led to more social benefits in hope to aid rural and poor communities reach equality.

With these changes, corporate profits were falling, which led to several US companies to move their manufacturing to states with fewer regulations and lower wages. In 1970, textile manufacturing was moved to the non-union states in the South with low wages

(Evans and Goldberg 2009: 9). By 1980, these states had created unions and minimum wages, leading to more industries to move their shops from large cities, offshore to Mexico and Taiwan, where environmental, health and safety standards were low and the wages mere fractions of the US minimum wages, launching the urban fiscal crisis. These large cities which lost manufacturing plants, such as Detroit and Chicago, had high African American populations, and this led to a large wave of domestic unemployment for these communities (Kilgore 2015: 20). For many, these high levels of unemployment led to more criminal activity, as it was one of the few ways left to secure an income. An increase in immigration sparked up the drug economy, which quickly opened a new criminal market of high profits. This also led to an increase in crime rates, and the development of organized crime, such as gangs and mafias.

In the 1970s, sociologists and criminologists had linked crime to issues such as lack of opportunity, poverty and inequality (Kilgore 2015: 22). However, the political rhetoric used by conservatives in the 1970s changed the public view on crime, to be unrelated to such social issues, and instead be the result of "bad choices". Due to the increase in violent crimes, the beginning of the War on Drugs and public fear and insecurity, President Nixon initiated the ongoing chaos of mass incarceration in the US. The change of views around crime led to the investments in inmate rehabilitation to decrease, and the system was changed to a philosophy of punishment and isolating prisoners from society.

There was a small pause to mass incarceration when President Carter was elected for one term. He decreased funding on law enforcement and prison expansions. However, during his time as president, the US had an economic crisis with 13% inflation and 10% unemployment rates (Kilgore 2015: 30). This was highly blamed on him and the social movements of the 1960s and early 1970s, although it most likely had more to do with the fiscal policy crisis.

After Carter, President Reagan stepped in and kicked off what has been called the "prison binge". In 1984, he invested $9.7 billion to prison construction, through the Omnibus Crime Bill. Reagan made more cuts to social welfare, criminalized many survival strategies for people on federal assistance, limiting recipients to a maximum of 5 years of benefits. (Kilgore 2015: 31). This trend continued through the following

administrations, culminating in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which cut the rights and opportunities of people with felonies, removing federal college scholarships for prisoners and cutting programs aimed to help rehabilitate convicts. By 1995, only 22% of state prisoners were enrolled to some sort of education program, a 19% drop from 1975 (Kilgore 2015: 93). 150 new prisons were built and filled in 1995 (Evans and Goldberg 2009: 6).

5.1.1 Mass Incarceration

In 1980s, crime rates had increased, then decreased for a brief period, hitting their peak in the 1990s. Since 1993, violent and property crimes had decreased each year, while the number of incarcerated continued rising.

The War on Drugs has been one of the main factors to play a role in mass incarceration, as drug arrests account for a large portion of the prison population. In 1980, drug related offenses accounted for 41,000 of incarcerations, tripling by 2000 to 500,000. During the 15-year period before 2000, drug offenses accounted for half the rise in state prison population and two thirds of the rise in federal institutions (Kilgore 2015: 69). In the 2000s, 80% of all drug related arrests were for the possession of a substance, and out of these, half were for the possession of marijuana. This means, throughout the 2000s, majority of people serving time in prisons were non-violent offenders and addicts.

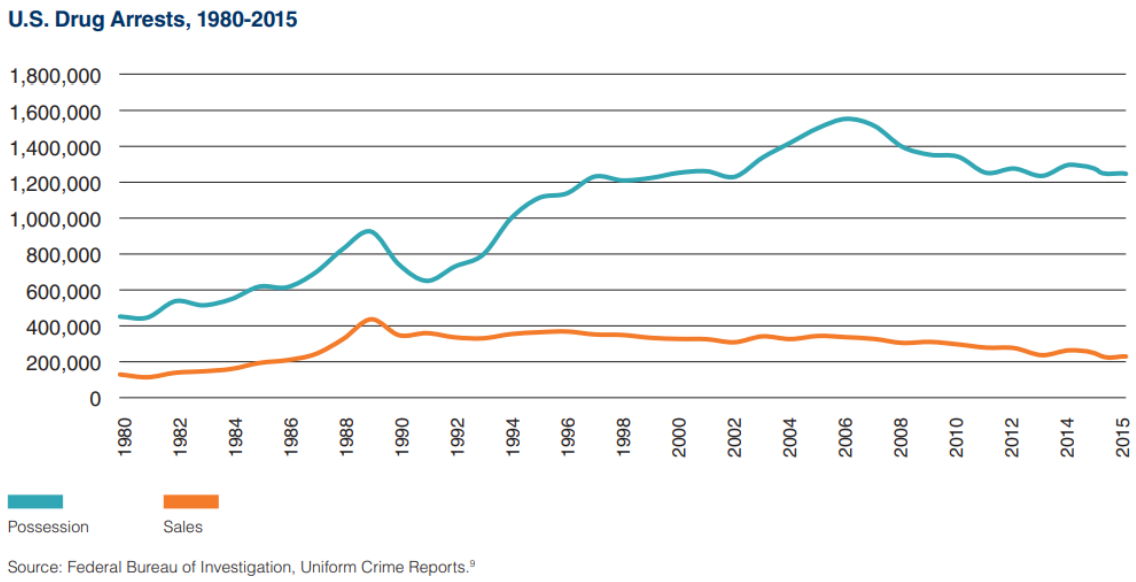


Figure 3.1. U.S. Drug Arrests 1980-2015, Source: Drug Policy Alliance, 2017

Another important factor that led to the massive increase in prison and jail population was the increase of mandatory minimums, especially for drug offenses. These minimums have caused much conflict in the criminal justice system. For example, more than 90% of all criminal cases never go to trial, as mandatory minimums set more pressure for defendants to accept plea bargains, even when innocent of the crime (Kilgore 2015: 41). The reason behind this is that often plea bargains and deals offer a shorter sentence than that if the defendant was found guilty in trial, when the mandatory minimum would be the shortest possible option for a sentence. These minimums and the three-strike laws that create longer sentences for each offence with the third one often resulting in life in prison, have expanded the use of long sentences and life-sentencing. In 2013, more than 159,000 people were serving a life sentence (Kilgore 2015: 47). Out of these people, at least 2,500 were serving life sentences for crimes they had committed as juveniles and were often sent to adult prisons, while still juveniles.

Jails are also a large chunk of the incarcerated population. Nearly every US cities and counties have their own jails and they have been constantly consuming large amounts of local budgets as the jail populations have risen. In 1985, the daily average jail population was 256,615. This figure doubled in 1990 to 405,320 and peaked in 2007 with 776,523 people in jail on average in a day. In 2013, the daily jail population had declined by a little to 731,000. However, in that year approximately 12 million people spent time in jail, equalling to 1 in 20 US adults. (Kilgore 2015: 106). The reasons for this immense amount of people spending time in jail were numerous. Among the most common were, high bails, people waiting in jail for resolution to their cases, awaiting trial or money bonds. Also, some people convicted of misdemeanours or low-level felonies could end up serving their entire sentences in jail.

Around 95% of those in prison will eventually be returned to their communities. However, with the removal of rehabilitation as a goal, along with the programs aimed at giving inmates education, job training, enhanced social skills and treatment for substance addiction have left many prisoners with worse situations than before they were incarcerated. In 2005, more than two thirds of those who left prison were arrested again within 5 years (Kilgore 2015: 91).

Before 1980, parole and probation officers were trained as social workers to assist in the rehabilitation out of prison. After the rehabilitation model changed, these officers took a function closer to law enforcement, in surveillance and control. This control and the expanded use of "technical violations" led to several ways to end up back in prison. Some of these included, missing scheduled meeting with parole officer, failing to tell parole officer of change in employment or residence, failing to disclose parole status to an employer or landlord, being in the company of someone with a criminal history, being in a prohibited area and failing a drug test, even for those whose crimes did not involve drugs. For the situation of addicts who were sent to prison for possession and lacked treatment for their substance abuse during their incarceration, it was more common than not, to end up back in prison for failing a drug test. In 1999, more than a third of those entering prison were for parole violations, out of which two thirds were technical violations (Kilgore 2015: 94). There were later minor modifications to parole conditions, so that in 2012, the figure of people entering prison for parole violations dropped to 27%.

The worst peak of mass incarceration had passed by 2009. Around this time, the US prison population declined slightly for the first time since 1970. It rose slightly again in 2012, but due to economic and political trends of "decarceration" fell by 0.6% in 2013. Public opinion began to shift away from the support of mass incarceration and especially in victimless crimes such as prostitution and drug possession. Critics have even included mainstream politicians, conservative libertarians and some business leaders. However, this did not decrease the proportion of drug arrests for possession. In 2015, for drug possession alone, approximately 87,000 people were held in jail, majority of whom had not been to trial, about 46,000 were incarcerated in state prisons and one quarter of the 3.8 million people on probation and one third of the 870,000 on parole, had drug law violation as their most serious offense. (Drug Policy Alliance 2017).

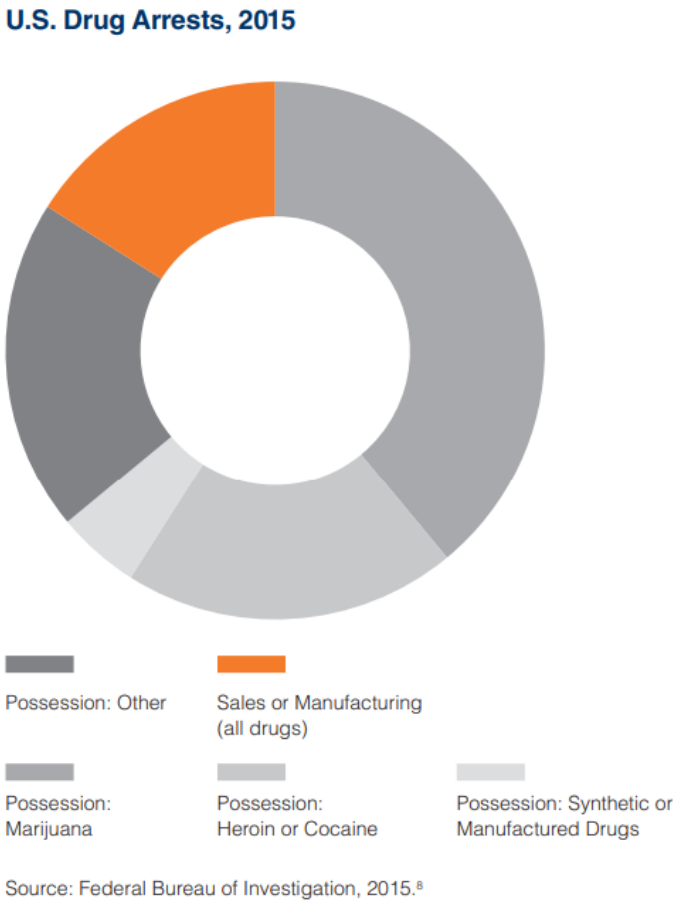


Figure 3.2. U.S. Drug Arrests 2015, Source: Drug Policy Alliance 2017

5.2 Economic Impacts of the US Criminal Justice System

Mass incarceration was an integral part of the globalization of capital. After the Cold War, relations between labour and capital changed on the international scale leading to the prison industrial complex to become an essential component of the US economy. However, this was also affecting domestic economic decline, increased racial and class disparities, the growth of the international drug economy, all leading to the prison industry growth. This industry has the interests of the government, politicians and private businesses gaining profit and social control from it.

The economic impacts of the US Criminal Justice system are linked to nearly all aspects of the War on Drugs in one way or another. The most negatively affected by the system are often the middle-to-lower class citizens, and especially those in rural communities. However, in addition to these people most directly affected by the War on Drugs and

therefore the US healthcare, mass incarceration and homelessness, the "average" citizens are often the ones paying for this through their taxes.

5.2.1 Prison Expenditures – Who profit and who pay?

Most US citizens are paying from their tax dollars to all aspects of the criminal justice process, such as law enforcement, judicial systems, building the prisons and jails, staff salaries, bills for energy, equipment, maintenance, supplies, bond repayments, and several more. (Kilgore 2015: 114). Almost all funding around operating prisons comes from tax revenues and to build them, loans or bonds are taken to finance the process, whose repayments and high interest rates also are paid by taxes. Another source of tax revenue are local businesses in the states or counties in which the prisons are being built, which can also be negatively affected by the competition of cheap prison labour.

In addition to the tax revenues, prisoners and their families are a large source of income to the prison industry. Many prisoners are required to pay for possible court expenses, basic necessities, such as medical care, toilet paper and use of the law library, and in some jails, such as Berks County Jail in Pennsylvania, inmates are charges $10 per day (Evans and Goldberg 2009: 13). In addition to these, there are several other services with high costs for prisoners or their families, such as phone calls. A 2012 national survey found that some states charge $14 for a 15-minute phone call (Kilgore 2015: 143).

The federal government's law enforcement budget tripled from 1969 to 1973, with the federal aid to state and local law enforcement growing from $60 million to $800 million (Kilgore 2015: 29). Local expenditure on the criminal justice system grew from $21 billion in 1982 to $109 billion in 2006, while within this time frame local corrections had an even larger increase from $3 billion in 1983 to $18 billion in 2002 (Kilgore 2015: 113). In 2010, the average cost of keeping a prisoner for a year varied across states, from $60,076 in New York to $26,498 in West Virginia (Kilgore 2015: 183).

Less direct financial sources for this industry have come from the decrease in investment to the federal and state social welfare system. Some of the programs hardest hit by Reagan administration funding cuts were those designed to help the poor. This led to even higher poverty rates, especially in urban communities of colour, who ended up in

the most complex crossfires of the racialized policing of the War on Drugs, violent gangs, expansion of drug trade, and the demise of jobs, social services, and welfare support. The Reagan administration also cut funding for public housing and housing subsidies by 50% (Kilgore 2015: 139). The declines in welfare benefits continued for years, with 48 states having lowered welfare payment levels from 1996 to 2010.

The total costs of drug possession criminalization are difficult to calculate, as there are so many additional costs of incarceration, supervision and court processing which vary across states. Jeffrey Miron, a Harvard economist, had his 2010 report published by the Cato Institute. He estimated the cost of policing low-level drug possession offenses to exceed $4.28 billion each year, which grows with all additional costs per state (Drug Policy Alliance, 2017). He also found that California spends more than a billion dollars on drug-related taxpayer expenditures, and Florida and Georgia hundreds of millions.

The source of money coming into the prison industrial system is quite straightforward; however, where all this money is going is more complex. There is a large supply chain when it comes to the construction and operations of the prisons and jails, as well as the law enforcement and judicial systems. However, there are also large companies and private corporations, politicians and investors benefiting from the investment, labour and politics behind the US Criminal Law systems.

Expanding and sustaining mass incarceration has several costly activities. The first process is to build the infrastructure. This is where steps in architects, engineers, contractors, mechanics, and other companies or individuals who profit from the build. A report by IBISWorld found that corrections constructions from 2001 to 2012 cost on average $2.8 billion per year. California reported in a comparative study, an average of $200 million for each prison built during this time. This translates to $92,000 per bed, which at the time was nearly the national average selling price of a house, $115,000. (Kilgore 2015: 184)

Once the infrastructure is built, wages and salaries become a major operating cost, generally consuming at least half of expenditure in corrections. Some staff include guards, counsellors, administrators, case managers, cooks, accountants, maintenance people, doctors, and drivers, among others. Since 1979, the employment figure for

corrections has nearly tripled, with approximately 2.4 million people nationwide employed in the justice system (Kilgore 2015: 186).

The other major operating costs include supplying goods and services to the prisoners. Some essentials include food, clothing, water and medical supplies, and there are stores where prisoners can buy "non-essentials" such as hygiene items, supplemental food and clothing. Most prisons also have a range of recreational equipment, such as televisions, sports equipment and telephones. In this area, is where some businesses and corporations have found they can have a growing source of profits. Bob Barker Industries is one of these companies. They produce a wide range of goods to prison staff and prisoners, with about $100 million a year in total sales (Kilgore 2015: 189).

Since prisons and jails have begun outsourcing, they have created more business opportunities. One of the most conflicting, yet major services outsourced is health care. One of the largest prison medical providers with approximately $1.5 billion in annual revenue is Corizon Correctional Healthcare (Kilgore 2015: 190). In 2012, the company paid almost $1.8 million to settle claims by Vermont prisoners from 2007-2011 for gross abuse and neglect. This was only one of several lawsuits and protests that have been lodged against them. Kerry Korpi, from the American Federation of State, County and Municipal Employees (AFSCME), stated the following on private health care in prisons; "Private correctional health care companies have a track record of cost cutting that puts both inmates and staff at risk. These companies' goal is profit, not public safety" (Kilgore 2015: 190).

Another highly criticized source of profit for a small number of companies is from contracting cheap prison labour. One of the largest prison labour contractors is The Bureau of Federal Prison Industries (Unicor). In 2013, Unicor employed around 13,000 laborers. Incarcerated workers who are under contract to a private company must be registered with the Prison Industries Enhancement Certification Program, which ensures such workers are receiving legal minimum wage among other regulations. In 2013, only 4,735 prisoners were under this contract, which leaves it safe to say with the number of prisoners under just Unicor, these contracts are not well followed. (Kilgore 2015: 192). These companies profiting from prison labour often end up causing issues to small local businesses, as they may sell similar products, but with the cheap production done in

prison, the prices can cause too much competition to the local businesses paying over minimum wage for production. This has led to such cases as the U.S Technologies company which sold its electronics plant in Texas, leaving 150 workers unemployed, only to reopen it 6 weeks later in a nearby prison (Evans and Goldberg 2009: 14).

5.2.2 Private Prisons

The Prison Industry Enhancement Certification Program mentioned earlier, was established by Congress in 1979. This program re-introduced the private sectors involvement in employing prison labour and operating corrections facilities. One of the first corporations to open their private facility was The Corrections Corporation of America (CCA). They won a contract to run an immigration detention centre in Texas in 1983, and the co-founder stated the company was founded on the principle that you can sell prisons, "just like you were selling cars, or real estate or hamburgers" (Kilgore 2015: 168).

The number of prisoners in the private sector prisons had increased by around 1600% from 1990 to 2009, which was a far higher rate than the prisoner increases in the public sector prisons. By 2013, CCA owned and controlled 53 corrections and detention facilities, in addition to managing 13 government owned facilities, which in total came to approximately 86,000 prisoners. Their total revenue on this year was $1.69 billion. During the same year, another private corrections corporation GEO Group managed and/or owned 66 corrections and detention facilities adding up to 72,744 beds. Their total revenue in 2013 was $1.52 billion. Overall, the private prison industry earned around $5.47 billion in 2013. (Kilgore 2015: 169)

In 2011, a report by the Justice Policy Institute on the time period of 2003 to 2010 found that CCA hired 179 lobbyists from 32 states and spent $1.55 million to back up political candidates with harsher sentencing laws and pro-private prison campaigns (Kilgore 2015: 174). In the same report GEO Group had spent $2.4 million in supporting similar political candidates and deployed 63 lobbyists in 16 states.

The financial effectiveness of private prisons to states and counties has had ambiguous results, although it is clear these corporations have had significant profits. However, the private prisons have been involved in several scandals and cases of abuse.

5.3 The "Criminals"

Approximately a third of US prisoners are non-violent offenders. In California, the top three most common charges are first, the possession of a controlled substance, second, possession of a controlled substance for sale, and third, robbery. Violent crimes were not even in the top 10 charges. (Evans and Goldberg 2009: 10). Many criminals are poor people committing non-violent crimes out of economic need.

The incarcerated population is largely determined by race, class and gender. Large sectors of them come from low-income urban and rural communities. Capital flight during the 1970's, caused high domestic unemployment, and increased poverty in many of these communities. In addition to the cuts in social welfare, local government had set in new policies that ended up criminalizing the poor, and the increased fines and fees in the criminal justice system, further causing issues in lower income classes. There were also several welfare regulations made to criminalize people on welfare by banning informational work, such as babysitting, contract house cleaning or selling second-hand clothes. These people were forced to supplement their income to survive with these "illegal" activities.

There were many critics and people against these changes, such as US attorney general Nicholas Katzenbach, who in 1967 concluded; "The most significant action that can be taken against crime is action designed to eliminate slums and ghettos, to improve education, to provide jobs, to make sure that every American is given the opportunities and freedom that will enable him to assume his responsibilities" (Kilgore 2015: 25).

After these events had happened, activists and human rights advocates had similar arguments on the topic, such as Angela Y. Davis, when she stated the following.

> Imprisonment has become the response of first resort to far too many of the social problems that burden people who are ensconced in poverty. These problems often are veiled by being conveniently grouped together under the category "crime" and by the automatic attribution of criminal behaviour to people of colour.
>
> Homelessness, unemployment, drug addiction, mental illness, and illiteracy are only a few of the problems that disappear from public view when the human beings contending with them are relegated to cages. Prisons thus perform a feat of magic. Rather, the people who continually vote for new prison bonds and tacitly assent to a proliferating network of prisons and jails have been tricked into believing in the magic of imprisonment. But prisons do not disappear problems— they disappear human beings. The practice of disappearing vast numbers of people from poor, immigrant, and racially marginalized communities has become big business. (Kilgore 2015: 23)

In 2012, a national advocacy group for mental health, the Treatment Advocacy Center reported that more than 350,000 people in prisons and jails had a serious mental illness (Kilgore 2015: 108). The systematic cutbacks in mental health services has resulted in mentally ill individuals to be locked up, during a mental health crisis, as police have no other place to take them. These individuals are more likely to experience violence in jails and more likely to end up in solitary confinement. The poor and especially homeless, are most likely to be taken to jail for a mental health crisis, as they have no private place to work on their issues. This result in these people disproportionately often ending up with several minor charges, such as loitering or disturbing peace.

In addition to the cutbacks in mental health services, another important service scaled down was drug treatment programs. This results in many addicts ending up in a continuous loop of incarceration for charges such, as possession of drugs, drug paraphernalia and being drunk and disorderly. As discussed under mental health and addiction, the most victimized by the lack of programs and mass incarceration are those with dual diagnosis.

Another targeted community in the mass incarceration of US, not combined by geographical location, as much as a community with mutual experiences who have faced common oppression, which is the lesbian, gay, bisexual, transgender and queer (LGBTQ) community. A national survey done in 2012 reported 40% of homeless youth, to identify themselves as LGBTQ. Due to these high rates in homelessness, they have been especially vulnerable to incarceration. Out of this community, transgender people have the largest connection to the poverty and incarceration loop. Based on a survey done in

2011, homelessness was almost double and poverty four times the national average for transgender people, and one in six transgender people have been incarcerated at some time. With black transgender people, 47% have been incarcerated. (Kilgore 2015: 148).

5.3.1 Racial Disparity

One of the most targeted groups in the era of mass incarceration are the African Americans. In addition, other disproportionately incarcerated groups are Latinos and Native Americans. In 1985, white people compromised 47% of the national jail population, while black people compromised 36% of it, while making up only 13% of the US population (Kilgore 2015: 14). By 1990, black people comprised 41% of jail population (Kilgore 2015: 106). This could suggest to a growing number of crimes in the black community; however, this was at the time when crime rates were falling. In 1970, the prison population contained about 30% people of colour, while in 2012, the proportion of people of colour in the prison population was 70%. Many studies and reports have been conducted on the inequality and racial disparity the African American and other coloured communities face within every step of the US criminal justice system.

In the 2000s, African American and Latino communities were impoverished due to the high rates of unemployment, declining education systems and cutbacks to social services. During this time many college campuses had become the hotbeds for drug trade and use; however, policing and violent raids disproportionately targeted these communities.

A study done for Human Rights Watch in 2009, came to the conclusion that statistics repeatedly showed that while white people were at least equally as likely to buy, sell or use prohibited drugs, people of colour were far more likely to be prosecuted and incarcerated for drug offenses (Kilgore 2015: 69). A national survey was done by the American Civil Liberties Union (ACLU), which showed that black and white people use marijuana at similar rates, however black people are four to five times more likely to be arrested for marijuana possession.

Clear racial disparity does not only show in the arrests of the African American communities, but also the sentencing process. As early as 1991, a federal commission

found that white defendants more frequently found ways around the mandatory minimums or had reduced charges to avoid offences with mandatory minimums, concluding that the use of mandatory minimum "appears to be related to the race of the defendant" (Kilgore 2015: 48). Further studies were done, which came to similar conclusions.

A study by Tushar Kansal for the Sentencing Project in 2005 reviewed several studies on racial disparity in sentencing conducted between 1980 and 2000 came to the following conclusions.

1. Young Black and Latino males are subject to particularly harsh sentencing compared to other offender populations, especially if they are unemployed;

2. Black and Latino defendants typically receive longer sentences than whites for taking a case to trial instead of accepting a plea bargain;

3. People of color also are less likely to receive substantial sentence reductions for cooperating with government prosecutors, i.e., serving as an informer, or snitch;

4. Black defendants convicted of harming white victims suffer harsher penalties than Blacks who commit crimes against other Blacks or white defendants who harm whites;

5. and Black and Latino defendants tend to be sentenced more severely than comparably situated white defendants for less serious crimes, especially drug and property crimes. (Kilgore 2015: 54)

Since then, several newer studies have surfaced with similar findings on the disparities in the application of specific harsh sentencing measures. For example, African Americans make up 47% of those serving life, out of which 77% have committed their crimes as juveniles. In Louisiana, African Americans compose 91% of those sentenced to life without parole for nonviolent offenses. (Kilgore 2015: 54). In addition, when it comes to death penalty, roughly a third of those executed during the first two decades of resumption of capital punishment were African Americans. Also, racial disparity is seen in bail levels. The Pretrial Justice Institute in Maryland concluded that African Americans' bail average is 35% and Latinos' bail 15% higher than the bail for white people with similar charges. (Kilgore 2015: 107)

6 Criminalization of Poverty – Homelessness

As seen throughout the analysis on the different roles playing in the War on Drugs and the US economy, the communities and people most affected are highly defined by race, class, mental health and overall socioeconomic status. The individuals most impacted are those at the bottom of the economic pyramid, the poor and the homeless.

Regardless of race, poor people are most likely to be incarcerated. The US prison population can be seen to represent the poorest and most marginalized members of the working class, although they are also more likely to be unemployed and uneducated. In 1982, sociologists came up with the "broken window" approach, which at the time of escalating crime rates, suggested that small crimes, such as vandalism and defacing public property were the first steps to more serious criminal activity. This led to police departments arresting more people for minor violations, such as loitering and public drunkenness. This was followed by increased regulations and laws against several survival activities common with the poor, such as, selling goods and services on the street and sleeping and urinating in public.

There have long been laws to govern the public behaviour of the homeless, controlling their location and activities. Legal scholars, judges and practicing attorneys have been long debating the issues around framing poverty itself as a crime. Although some changes have been made, the false stigma around the homeless in mainstream society has caused difficulty in developing the situation. Some stigmas around the homeless do bare some truth, such as mental illness and substance abuse have been researched, to be the most common individual factors for causing homelessness, but these also seem to be common impacts caused by homeless, causing a sort of "chicken-egg riddle" as to which comes first.

Scientists and analysists have long researched the causes and impacts of poverty on the individual level, as well as economic level. Many scientists have found common structural factors causing poverty and homelessness, such as economic trends, unemployment rates, deindustrialization, rising rents, racism, sexism, homophobia and many more (Howard 2013: 178).

6.1 Economic and Political Causes and Impacts of Poverty

The stigmas around the homeless population was (and still is) a large factor in the changes to the policies and programs made by the government. Homelessness was increasingly believed to be caused by the individual alone, and their laziness, lack of religiosity, poor socialization or alcohol and substance abuse. The new policies were focused around reforming the individual's behaviour, morality or character. These beliefs and stigmas around homelessness gained popular opinions throughout the voting public on how politicians and governments should not provide aid to them, for it is against the American visions of work ethic and economic self-sufficiency (Howard 2013: 5). Another influence on the new policy decisions were the geographic and cultural boundaries between the nation's urban populations and the homeless, routinely abandoning many urban homeless in accordance with the political realities.

In the 1960s, sociologists and scientists had begun merging their findings on the causes and impacts of homelessness with the goals of social service providers to find possible solutions for developing services to aid the homeless. President Lyndon Johnson enacted a 'War on Poverty' with aimed to end poverty by addressing not only the symptoms, but also the causes. City officials in several states began increasing programs such as mental health services, medical care, job training, shelter facilities and employment assistance. Almost instantly, these programs proved successful, enduring and positively affected several homeless individuals lives (Howard 2013: 177). In addition to aiding many residents, the federal urban programs by the Office of Economic Opportunity had also brought money to the cities in which they operated.

In the 1970's, the urban fiscal crisis led to an increased need in social welfare, launching the welfare crisis, in which the number of residents receiving welfare assistance rose dramatically from 531,000 in 1965 to 1.25 million in 1972 (Howard 2013: 177). The urban fiscal crisis and welfare crisis ended up fuelling each other, costing the economy and its residents. Due to these, there were substantial federal reductions in social programs. In the 1970s, with the beginning of the War on Drugs, mass incarceration and governmental and public stigmas around homelessness, criminals and drugs, the urban landscape was proving to be less hospitable in many respects for the homeless and poor, than during the Great Depression.

Another change increasing homelessness during this period, was the shifting tax laws, such as those around Single Resident Occupancy (SRO) hotels, in which the city instituted a tax abatement called the "J-51" program, in which tax incentives were offered to those who converted the SRO properties to middle-income and luxury apartments, which were promoted due to the rising real estate values. These SRO hotels were some of the only private housing options for the homeless, with the room prices less than $50 a week. During the same period, mental health policies were experiencing changes in policies as well. States created policies around the deinstitutionalization of the mentally ill, resulting in state officials and mental health providers gaining rights to abandon many mentally ill individuals. This led to an increased amount of formerly hospitalized mental health patients ending up homeless on the streets. (Howard 2013: 183). All these changes by the states and the cities led to an increased "new" homeless population on the streets. Political leaders faced criticism by each other and outsiders, and continuously deflected the blame of the situation on others and evaded responsibility, instead of developing any solutions for the crisis.

During the Reagan presidency, the hostility toward government-funded programs to aid the homeless increased and supporters called for lower taxes and reduced government spending, resulting in even more limitations and cuts to social welfare, and federal officials began to call for greater personal responsibility. Reagan often shared the idea that the poor were homeless by choice, or lack of motivation. Even with pressures from the courts to provide adequate services to the homeless, the federal government outweighed the efforts and further slashed social programs, low-income housing and basic nutrition programs, leaving the poor in crisis and even more homeless flooding the streets.

With the increasing amount of visible homelessness, protest groups began to lobby for the rights of the homeless and used media attention to pressure the Reagan administration to address the issue. In 1986, Reagan approved the Homeless Assistance Act, allocating federal support to homeless assistance programs to educate homeless youth and provide assistance to the mentally ill homeless. The programs topped $1.67 billion in congressional funding by 2009 (Howard 2013: 221).

An issue which has caused much controversy from all sides of the political as well as economic spectrum has been the views on "worthy", such as unemployed but educated homeless and "unworthy", such as mentally ill or substance abusing homeless, and on how much help should be provided to each. Since the late 1980s, a popularly understood and used reply to providing shelters for the homeless has been "not in my backyard", which also applied to drug rehabilitation centres, foster care facilities and such facilities dealing with possibly the mentally ill, substance abusers, or other "problematic" people.

By 2009, a survey done on 235 cities by the National Law Center on Homeless and Poverty and the National Coalition found that 17% of cities prohibited "camping", while 33% prohibited it in certain public places. They also found that 30% of cities prohibited sitting or lying down in public places, also 47% prohibited loitering in public areas, while 17% citywide (Kilgore 2015: 109). Some jurisdictions even made sharing food in public illegal. For many homeless people, living in a car was the only "safer" living option, which was also made illegal in many states starting in California. This led to many homeless people to move to concentrated areas where camping is legal. However, these places are common for forceful policing, where police sweep the areas, arresting individuals for countless minor factions, destroying personal property and confiscating among other things essential medications.

These homeless people arrested are often completely broke, which is a large issue when it comes to the increasing use of fines and fees as additional punishment. In 2009, in North Carolina the state legislature passed fees, which were required to be paid, even if not found guilty for the crime. These included a "general court fee and a "facility fee" which summed up around $125.50 to $132.50. Other states passed their own fees, such as Louisiana with a $300 fee to "judicial expense fund", and Washington with a $600 legal financial obligation for each felony conviction, and a mandatory DNA sample fee of $100. Annual interest on money owed is also set in many states, such as 12% in Washington. In 2010, a survey done in 15 large-population states found that 14 of them, used "poverty penalties", which meant extra charges were added to unpaid debts. All states had jurisdiction to incarcerate those who failed to pay and 7 revoked voting rights until debt was paid. (Kilgore 2015: 110).

In addition to court fees and fines, outsourcing probation to private firms has resulted in instances where these firms do not offer a real probation program, but instead collect fines on behalf of the local government and top off the monthly fees with their own service charges. In instances where the individual is unable to pay, they are threatened with incarceration.

6.2 The Homeless Population

The homeless population has been difficult to follow throughout the years, as the numbers of homeless on the streets vary nearly daily. A single-night survey in 2009 found approximately one-third of the 643,000 homeless counted, lived unsheltered outside of an emergency shelter. Among the unsheltered, reports estimated as many as 110,000 youth living outdoors. From 2007 to 2009, the number of sheltered homeless families increased by 13% adding up to approximately 240,000 family members. Another commonality in the homeless population are military veterans, often suffering from PTSD, traumatic brain injury or sexual abuse issues, which among these 2009 studies were found to make up approximately 107,000 of the homeless. (Howard 2013: 220)

During the 1960s, one of the programs set to help the homeless was the Manhattan Bowery Project in New York. In this program the link between homelessness and serious medical conditions became apparent, as nearly two thirds of the homeless involved suffered from pulmonary disorders, 23% from liver disease, nearly 40% were diagnosed with personality disorders and one third were diagnosed with schizophrenia (Howard 2013: 176). After the deinstitutionalization of mentally ill patients in 1965, and the city's unwillingness to develop more supplemental programs, the proportion of mentally ill increased within the homeless population even more. Another "chicken and egg" puzzle can be seen between the homeless and those with a mental disorder. Although many people on the streets have prior to their situation had a mental disorder, many can also gain them through the hardships of living on the streets.

By the late 1970s, more people of colour and women emerged in homeless population, diversifying it. By the early 1980s, an estimate of two thirds of the homeless population were African American, most likely partially caused by the urban fiscal crisis and the

welfare crisis. Urban African Americans and Latinos often lacked access to education and employment, leaving them dependent on social services. Now, there are also rising numbers of homeless students and youth in the streets.

7 The War on Drugs in US Economy

The War on Drugs has impacted and been impacted by countless aspects of the US economy, such as those discussed above. Powerful interests in politics, business and finance have been benefited from these systems and "wars", and they tend to be high up in the economic ladder and play roles in many of the policies made around the working class. The people affected most negatively seem to be quite consistent throughout: mainly poor, uneducated, unemployed and/or people of colour. The War on Drugs, and all which follows costs the US citizens and businesses in tax dollars. The US economy is highly motivated around the idea "all for themselves", which can thin the line between the working and homeless class.

This ideology of Americans has many issues, as many workers are often living paycheck to paycheck, and the chances of ending up in the situation of the homeless and unemployed is not that far off. Especially in times of economic disaster, such as the current COVID-19 pandemic, unemployment rates skyrocket and politicians seem unwilling to hand out much assistance to those in crisis.

Since 1971, the US War on Drugs has cost over $1 trillion. This amount includes such things as spending on law enforcement, drug enforcement agencies and other drug policies and efforts to control drug supply. In addition, the US spends an estimate of $3.3 billion annually in incarcerating people charged with drug offenses. (Pearl 2018).

A commonly overlooked cost of the War on Drugs has also been on the environment. Illicit unregulated drug production has been associated with pollution as toxic chemicals are disposed without regulations sending them to local waterways and environments. Also, the law enforcement has played a part in spraying drug crops with toxic chemicals in several protected areas and national parks, even despite aerial spraying being banned in these areas. (Campbell, 2019)

7.1 Supply-Side War

Throughout the 40 years of the War on Drugs, the demand for drugs has only grown. Although the laws punish and criminalize the demand side, the harshest punishments are set for the supply of the drugs, resulting in a supply-side war. Statistics have shown that the demand for drugs is price inelastic, meaning it is not dependent on the price of the drugs (Powell, 2013). This gives the suppliers more room to increase prices, cut the product with other agents, such as fentanyl in to heroin, to make production cheaper, and the high profits are often used to develop technologies to smuggle drugs or buy more weapons and tools to fight law enforcement.

The US War on Drugs has a direct link to the Mexican economy as well, since many drugs are smuggled through Mexico to the US. This has been seen in the statistics around Mexican drug-related deaths, increasing from 2,300 in 2007 to 11,000 in 2010. The change during this period was the Mexican government's decision to step up the enforcement efforts. The growing amount of drug-related deaths can also be seen throughout the US, and especially in states close to the borders. (Powell, 2013).

When considering a successful supply-side war, the goal should be to decrease quantity without increasing price, as with higher prices, drug dealers gain more revenue from the War on Drugs, making it more beneficial for the criminals involved with the supply, and more dangerous for the law enforcement opposing it. Overall, the War on Drugs has caused drug dealers and smugglers to gain high profits and power over the drug economy, which will always be a large market, especially with the rising amounts of drug use in the US, and the lack of knowledge and awareness around addiction.

7.2 Solutions to the US Drug Crisis

There are many issues contributing the drug crisis in the US, and the War on Drugs has ended up as one of them. Even with so much research around addiction and the Rat Park experiment debunking the prior rat experiment playing a role in the War on Drugs, the concept of locking addicts up and isolating them from society should be the worst

option to dealing with the drug crisis. This can even be seen with the current opioid crisis and the increase in drug use during the War on Drugs.

Ethan Nadelmann, head of the Drug Policy Alliance summed up his views on the War on Drugs well, by saying;

> If we're lucky, our grandchildren will recall the global war on drugs of the late 20th and early 21st centuries as some bizarre mania, the true challenge is learning to live with drugs so that they cause the least harm. An effective strategy needs to establish realistic objectives and criteria for evaluating success or failure, and must focus on reducing the death, disease, crime and suffering associated with both drug use and drug policies. (O'Connor, 2014)

When considering solutions to the drug crisis, the goal would be to treat the symptoms of drug addiction, while also focusing on fixing the sources of addiction, which in the US, would mean serious changes in policy, regulations and laws. In addition to policies against drugs, the policies of health care, especially mental health services, as well as incarceration and homelessness should be reviewed and considered through more research on the issues, instead of through the lenses of capitalism and private profit.

In addition to these, there should be serious intervention on the stigmas, beliefs and fears around addiction, homelessness and incarceration, as no changes can be made, while most of the public responds "not in my backyard" for all change aspiring facilities and services. This would probably be one of the hardest changes to be made, as there is a long history in the US of labelling people as "worthy" and "unworthy" based on their ability to contribute to society, without even giving then the opportunity to succeed.

7.2.1 Programs and Services

There are many programs and services that have proved to work in helping alleviate the symptoms and causes of drug addiction. Many have either worked earlier and been removed by the authorities in the US or have proved successful in other countries.

An effective way of reducing the stigma, as well as increasing knowledge around drug addiction would be to improve education on drugs. The current method of educating youth about drugs is via promotion of abstinence. As seen with a similar approach around

sex education, teaching abstinence instead of safe sex education leads to an increased amount of teenage pregnancy and sexually transmitted diseases (Stanger-Hall and Hall, 2011). The same applies to drug education. Education curricula should provide access to drug education programs such as Safety First, which is based on the philosophy of harm reduction and aims to foster open dialogue about drugs and drug-related risks. The goal of this program would be for health teachers to add this program to the education curriculum for 9th and 10th grade classrooms (Drug Policy Alliance, 2020). In addition to such high school programs, drug safety education should be made accessible to all who need it, including addicts, families affected by addiction, prisoners, youth without access to proper education and so on. It would be important to increase education around drugs and addiction to lower the stigma and promote safety for those who choose to use them. Education programs should also extend to prisons and jails once again for both addiction and job training to offer the incarcerated population chances for rehabilitation back into society.

A service that has proved success in other countries is supervised consumption sites. Supervised consumption sites are controlled settings for people with pre-obtained drugs to enter a sterile room with clean needles and sanitized products and inject themselves under the supervision of trained medical professionals. In addition to having a safe setting to consume the narcotic, the users would be provided health care, counselling, drug treatment and referrals to health and social services (Drug Policy Alliance, 2020). Drug Policy Alliance has been a front-runner in trying to implement these centres nationwide, but the fear and stigma around drug use has prevented them.

When considering treatment for addiction, an important change that should be made is more low-barrier access to drug treatments and therapies. As discussed earlier, the waiting times to receive treatment and therapy are long and tedious. In the US Opioid Treatment Programs (OTP) are the only federally licensed accesses to methadone, which is an opioid addiction treatment medicine that prevents withdrawal symptoms without creating the opioid "high" (Drug Policy Alliance, 2020). These programs often have long lines and are located in only a few places, which causes difficulty for those living in rural areas with transportation, as the patients receiving the medication are required to attend the programs up to six days a week. Another opioid treatment medicine is Buprenorphine, with similar qualities to Methadone. Buprenorphine prescriptions are

rarely given, as the doctors and health care providers are required an advanced training and waiver from the government to prescribe the medication. A large change with the accessibility of these medications should be made to make treatment of an addiction more possible.

Another service which could help decrease opioid overdose deaths involves services where users are provided kits and strips to check their drugs for synthetic opioids, such as fentanyl checking strips. Other programs and services that have made a substantial difference in the prevention of overdose and diseases such as HIV include clean needle programs, to prevent sharing dirty needles and take-home naloxone kits, which is the overdose reversal drug. The accessibility of clean needles and naloxone should be easy for all users, so that their safety is ensured.

Finally, overall rehabilitation programs should be more accessible to all those willing and wanting to quit their addiction. Rehabilitation programs should not include prices that are above the essential costs, so that those in poor and rural areas could also be given the opportunity to gain counselling, education, cleansing from withdrawals in a safe environment, or receiving opioid treatment medications and in some cases learning basic functioning, which has been lost during the addiction.

7.2.2 Politics and Policies

As seen throughout the thesis, politics has played a large role in creating, upholding and demolishing the policies and stigmas around addiction, health care, incarceration and homelessness. That said, politics could also help change the policies and views around these issues.

First off, the US health system could be reformed to help in the prevention, treatment and medication of addiction. There should be policies in place, aiming to decrease the inequalities of access to primary health care, and especially to mental health services. With adequate access to health and mental health services, there could be a massive drop in cases of dual diagnosis, as those with mental illness would receive proper treatment and therapy and where needed medication to help them receive the opportunity to function at their full potential. This could also help decrease the amount

of incarcerated and homeless mentally ill individuals, since they make up such a large portion of both. With proper medical care, the amount of addiction, and overdoses could save the US economy in overall costs now spent on incarcerating and providing emergency care to this population. In addition, the economy could benefit from the people who are given the opportunity to function normally, with adequate health.

Secondly, there should be changes in policies around incarceration, such as the removal of private companies which profit from those incarcerated. Instead, the profits gained from the labour of prisoners should be spent on their education, drug treatment and job training programs, for them to gain opportunities to be rehabilitated back into society as a functioning member, instead of ending up in a loop of incarceration, addiction and poverty.

Thirdly, there should be policies made to bring back adequate social benefits and programs to help the poor and homeless. Such could include creating housing for the homeless, in which everyone has an opportunity for privacy, unlike current shelters that have a record of theft, rape and other brutal assaults. Also, there should be policies made to decriminalize poverty, and remove punitive policing of homeless communities, including civil asset forfeiture, excessive fines and other such administrative penalties. Also, social benefits and services should be easier to access, especially for those without housing and employment. This could increase the chances of rehabilitating those less fortunate back into benefactors to the US economy.

7.2.3 Laws and Regulations

For the most effective and permanent changes in the US drug crisis, there are several laws and regulations that should be changed. Overall, the War on Drugs should be abolished, with new goals set to stop the demand of drugs more intently than the supply, as it has been proven throughout the past 50 years that even with drugs criminalized, the demand has only increased (Drug Policy Alliance, 2017). This new "war" on the demand of drugs would include ways to improve the lives of those affected by addiction and find ways to prevent addiction through the opportunity's individuals are given.

Decriminalisation and legalisation have been tried in different countries with successful outcomes, but the stigma around drug use has and will probably prevent such drastic changes to happen in the US any time soon. There are steppingstones to these two changes however, which the US could adapt to their laws and regulations before choosing decriminalisation or full legalisation. Such could include eliminating federal and state criminal penalties, and collateral sanctions for drug use.

7.2.3.1 Decriminalization

Decriminalization of drugs would mean removing the criminal penalties for drug use, including eliminating crimes such as drug use and possession, possession of equipment used to introduce drugs into the human body and low-level drug sales. Decriminalizing the use of drugs would prioritize the health and safety of the people who use drugs and remove stigma around drug use encouraging more people to seek treatment and help.

Data from the US and other countries have shown that treating drug abuse as a health issue is a more successful model for the health and safety of communities, instead of treating them as criminals (Drug Policy Alliance, 2020). Decriminalization would have several positive impacts such as reducing the number of people incarcerated and arrested, which would in turn decrease the amounts of people affected by a criminal record, and also would therefore decrease racial, ethnic and income-based disparities caused by the current criminal justice system. Decriminalizing possession would transform current law enforcement structures and direct their resources towards preventing serious and violent crimes, which in turn would improve the relationship between communities and law enforcement agencies. With health care, it could improve the cost-effectiveness of public health resources as people with drug problems could be more encouraged to seek treatment before issues get bad enough to land them in emergency care. This in turn, would improve the outcomes of treatment, as the users could seek help easier, and gain more support from families, as addiction could be seen more as a health problem, than a criminal problem, which it is.

Portugal was the first country to adopt a full decriminalization policy in 2001. Prior to this, there had been an escalation of problematic drug use, especially with unsafe

injections, causing Portugal to have the highest rate of drug related AIDS in the European Union in 1999, and therefore had dramatically increasing amounts of drug-related deaths (Drug Policy Alliance, 2017). In response, Portuguese legislators eliminated criminal penalties for low-level possession and consumption of all drugs and addressing these possessions through the public health system instead of the criminal justice system. The criminal justice system still processes illegal violations such as drug trafficking and non-drug offenses. The decriminalization policy included several expansions addressing problematic drug use, including major expansions of treatment and harm reduction services, methadone maintenance and other health interventions, access to sterile syringes and eliminating majority of the barriers to access these vital services.

Portuguese policymakers created a working infrastructure in which the resources saved from the criminal justice system were deployed to creating more in-depth health care systems and creating a more encouraging opportunity for those dependent on drugs to seek treatment. They also created a system for those found with small amounts of drugs to be summoned to appear before a local "dissuasion commission". This commission operates independently from the criminal justice system and involves one legal arena official and two health or social arena officials, who determine the extent of the individual's addiction. The commission can decide between three outcomes depending on the situation, either referring the individual to a voluntary treatment program or impose a fine of administrative sanction or in more than 80% of cases, when not deemed a problematic user, they are let go on a provisional suspension, in which if they are not found in possession for the following six months, the matter is dropped. Even if the individual fails to enter treatment, fails a drug test or continues drug use, they are not incarcerated.

With nearly 20 years of this decriminalization policy effective, researchers have found several promising outcomes throughout the years. Overall illicit drug use rates have mostly remained the same, but 'past month' drug use has decreased since 2001, and Portugal's drug use rates are below the European average. Problematic drug use, adolescent drug use and injection drug use have all decreased since 2003 (Drug Policy Alliance, 2017). New cases of HIV diagnoses saw a dramatic drop from 1,575 cases in 2000 to 78 in 2013, and new AIDS cases dropped from 626 in 2000 to 74 in 2014. Another dramatic drop was seen in drug overdose deaths, which fell from 80 in 2001 to

16 in 2012. Also, the number of people in drug treatment increased more than 60% from 1998 to 2011, which is even more impressive considering that Portugal's treatment programs are voluntary and not compulsory.

A study done in Portugal in 2015, reported the per capita social cost of drug misuse decreased about 18% from 2000 to 2010, which was estimated to be due mainly of reductions in legal system costs but also a reduction of health-related costs.

In the criminal justice system, there were large changes, reflected in these reduced costs. The annual number of arrests for drug offenses declined by more than 60% following decriminalization. Another large decrease was seen in the percentage of people incarcerated for drug law violations which fell from 44% in 1999 to 24% in 2013, which was not only due to a decrease cases of possession, but for all drug offenses.

Several of the issues and fears expressed by critics of decriminalization have been not come to pass in Portugal. These include a decrease drug prices leading to more drug use, which was not the case, as drug prices remained the same. Another common fear was that decriminalization of drugs would lead to more crime and drug dependence, which the results have shown not to be the case. The clear declines in illegal drug use before and after decriminalization can be seen in the figure below.

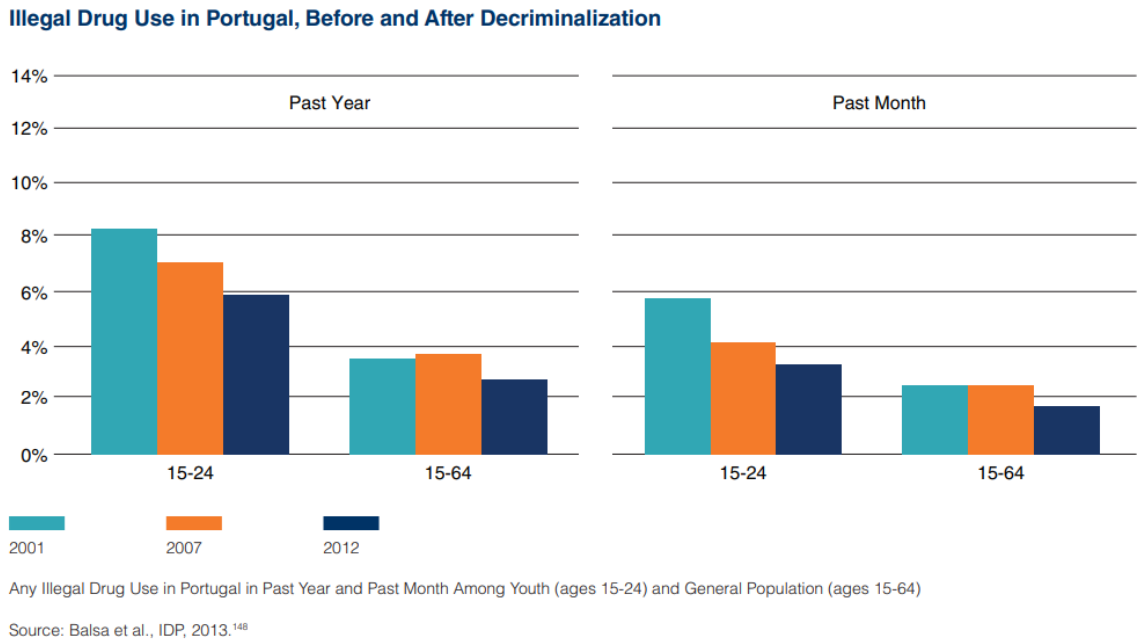


Figure 3.1. Illegal Drug Use in Portugal, Source: Drug Policy Alliance, 2017

Other countries have taken partial decriminalization policies to action. The Czech Republic has long had policies in which small amounts of personal drug possession was not criminalized. People found with drugs up to certain quantities faced administrative sanctions, which could include a fine. In addition, Czech Republic has integrated many harm reduction and treatment elements such as syringe access programs and low-threshold opioid substitution treatments, which are among the most expansive in Europe. The results of these partial decriminalization policies have been seen in net societal benefits, and a decrease in drug use among Czech youth and young adults.

Another country with long-standing partial decriminalization policies is the Netherlands. The government officials have instructed prosecution for either civil or criminal penalties not to apply to possession of roughly a single dose or less of any drug. The policies have had effective outcomes. Rates of addiction and problematic drug use are lower than in most of Western Europe, and they have a significantly lower heroin overdose rate and less injection drug use.

Due to the several positive studies and research done on decriminalization and its policies, there have been countless calls by national and international organizations for alternatives to the US criminalization. Some of these include the World Health Organization, the American Public Health Organization, the Global Commission on Drug Policy, the American Civil Liberties Union, Human Rights Watch, among many more.

7.2.3.2 Legalization

In decriminalization, although still a war on supply, the demand is decreased since treatment and help is more accessible. Although decriminalization has several positive effects on the economy, taxpayers and the people affected by drug use, it does not remove the power and profits away from the supply side of the drug economy. In other words, the criminals producing, trafficking and supplying the drugs are still benefiting from the drug demand. This poses several health risks for the users as they get their drugs from criminals with more interests in the profits than the health outcomes the users experience. For this reason, drugs have high risks of being cut with alternative

substances increasing risks of overdose and infection, and drug users are rarely aware of how 'clean' or 'dirty' their drug is.

The next step should be the legalization of drugs. Legalization would in addition to eliminating criminal penalties for possession, remove or at least significantly reduce the black market and criminal networks associated with the drug trade and shift the production and sales of drugs to the state. This has been seen with the legalization of alcohol, tobacco and in some countries and states marijuana. Legalization of drugs would include creating regulations and controls of legal production and sales of drugs to adults. The regulations often include limits on use and sales, quality controls, licensing requirements, consumer protections, taxation and advertising restrictions.

The taxation revenue from illegal drugs can regulate a secure direct income to the economy, as is now seen with alcohol and tobacco. The increased revenues to the government could be then used to treating the causes and symptoms of drug abuse, such as financing the health care systems to have more resources and accessibility to all who need it. Also, with power removed from the drug trade black market, the amounts of overdoses caused by fentanyl contaminations could decrease significantly.

The most common criticism of legalization would be that it would result in significant increases in drug use, as has been seen with currently legal drugs, such as alcohol, which have been regarded as economic burdens to society (Ritter, 2019). In addition, moral arguments include that use of currently illegal drugs should not be acceptable in society, as it would send the wrong message. These critics are quite alike to those around decriminalization, which were debunked. However, with no current fully legalized countries, it is hard to estimate how complete legalization would affect the economy.

Some countries have however taken steps towards the legalization of certain drugs. Marijuana has been legalized for medical use in several countries across the world and an increasing amount of countries and US states have taken steps towards legalizing recreational marijuana. The first country to legalize recreational marijuana was Uruguay in South America, in 2013. The second and largest country to legalize marijuana for recreational use was Canada in 2018. Legalizing marijuana is still such a new

development that there is not yet much statistical data on its impacts on crime, youth and consumption.

In the US in 2016, around 9% of the population aged 12 or older were current users of marijuana, which is less than in most years between 2002 and 2010 and has remained quite consistent since 2011. Marijuana use disorders within the year occurred in 1.5% of the population in 2016, but no deaths have ever been linked directly to marijuana use (CDC, 2020).

There are impressive results in tax revenues gained from the marijuana industry, as an example below shows Colorado, in which the taxes from legalized marijuana have reached $266.5 million in 2018, on an upward trend.

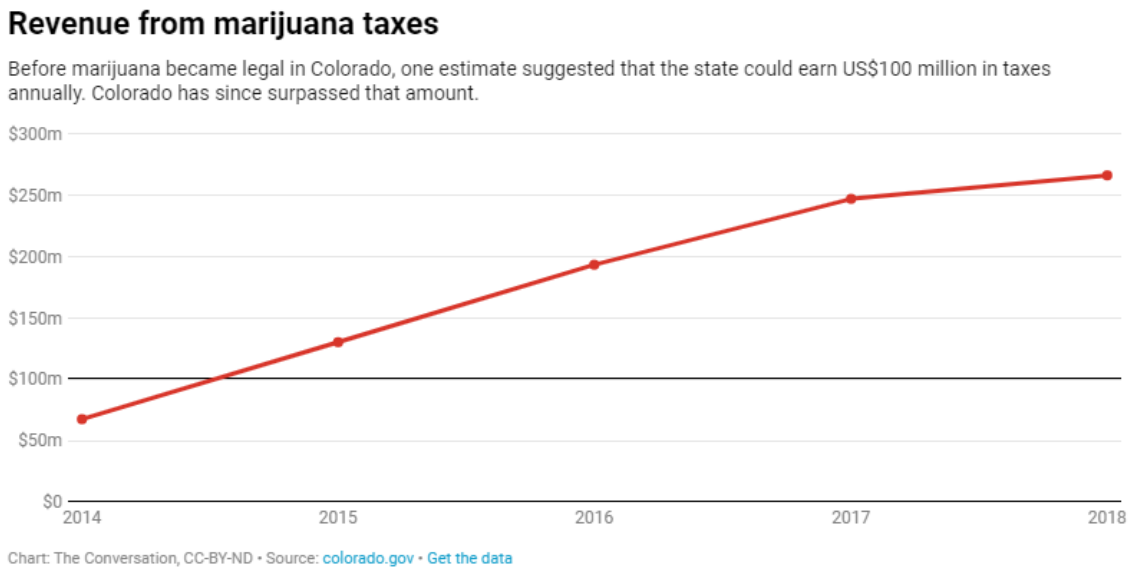


Figure 4.1. Revenue from marijuana taxes, Vittert 2019

It has been estimated that the US economy could save roughly $7.7 billion annually via marijuana legalization, from averted enforcement costs. Additionally, sales of marijuana could yield $6 billion tax revenue, making a positive net total of $13.7 billion. With this, more than 650,000 students annually could be sent to public universities. (Pearl 2018.)

Switzerland was the first country to legalize the supply and use of heroin under medical supervision. This was in response to the rapid rise in injecting heroin during the 1970s and 80s, reaching approximately 500 new HIV cases per million people, which at the time was the highest proportion in Western Europe. In 1975, Switzerland tried the common policy of criminalizing drug users, which failed, leading to a steep rise in the number of people who injected drugs from less than 4,000 in 1975 to 30,000 in 1992. (Campbell, 2018.) The crisis led to many changed policies in hopes to solve the injecting phenomenon, which had become highly visible in the streets.

As a response Switzerland introduced the Swiss Heroin-assisted treatment (HAT) model in the mid-1990s, opening their first HAT clinic in 1994. The model of the clinic was based around prescribing a supply of pure heroin and clean supplies, which were to be used in a supervised safe and hygienic venue. Once the first HAT clinic had passed its three-year national trial and had decreased drug use deaths in this period, leading to the government launching a large-scale expansion to the trial, with aims to accommodating 15% of the nation's heroin users. The results were astounding, with a steep decrease in the amount of deaths since the launch of the initial program in 1994.

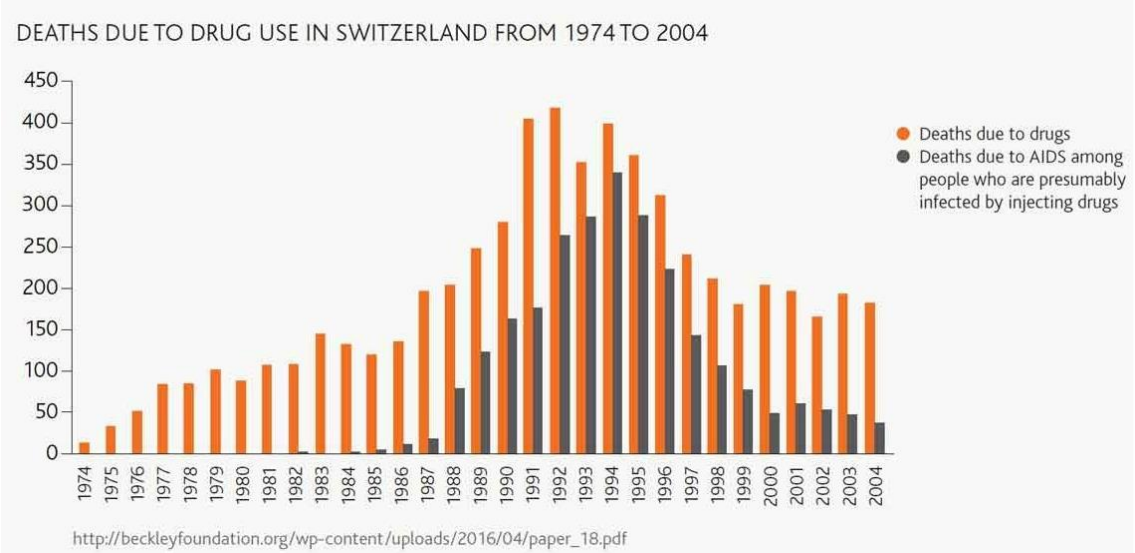


Figure 5.1. Summary of Impacts, Source: Campbell 2018

These positive outcomes have inspired changes in the law and regulatory infrastructure of Switzerland, from changing focus from criminal justice to public health and service

investments. Some other impacts of the HAT model involved a reduction in consumption of illicit heroin and cocaine, health outcomes improved for HAT participants, a large reduction in criminal activity among HAT participants, new heroin users decreased and participation in other treatments such as for methadone increased. (Campbell, 2018.)

Other countries have adapted the Swiss HAT model, such as Germany, Netherlands and Canada, and have seen similar results. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reviewed the programs in 2012 and concluded the following statements on the HAT treatment.

> "HAT can lead to the "substantially improved" health and well-being of [participants]; "major reductions" in their continued use of illicit heroin; "major disengagement from criminal activities", such as acquisitive crime to fund their drug use, and "marked improvements in social functioning" (e.g. stable housing, higher employment rate)."
>
> "If an analysis of cost utility takes into account all relevant parameters, especially related to criminal behaviour, [HAT] saves money'."
>
> "While [HAT] may be a useful addition to our treatment "toolbox" for opioid users, it is not a solution for the heroin problem … But for those among whom the benefit is observed, there are major gains for themselves, their families and society." (Campbell, 2018.)

Although the Swiss HAT model does not fully legalize recreational heroin use, it does legalize the medical use of heroin. With such a strong and addictive drug, the recreational legalization might do more harm than the medical legalization of it. However, the medical legalization of heroin has already shown indisputable evidence of the positive effects for both the addicts and the cost-effectiveness it has brought to the countries' economies from applying it.

8 Conclusion

The War on Drugs has had several impacts in the US economy. There have been clear profits for a few larger players, such as private prisons, private health care providers

and other companies and individuals gaining from the incarceration and prison labour processes. Another positive economic impact the war on drugs has had is around the companies and individuals such as lawyers and those involved in the construction process of the prisons and jails, those employed in the prison industry and those who sell their goods and services to the staff and incarcerated. Even with these however, there is a structure of profit, where those running and managing the prison have high revenues, while the staff such as prison guards often have low wages.

The negative impacts on the US economy are far broader and have several aspects. These aspects include financial, social, political, health, and structural impacts to the economy, which are negative. The negative financial impacts are tied to the costs of illegal drugs and addiction, costs of the criminal justice system and costs of human loss. These are all mainly paid by the individuals affected and by the US taxpayers. The negative social impacts include the racial divide, the wage gap divide and an overall lack of empathy and relativity in the US citizens causing several large divides throughout the population. Politics has also played a large role in the launch and policies created around the War on Drugs and has continued to be impacted by those who will pay politicians to uphold the systems from which they profit. This has led to an increasing lack of trust in the government and politicians in the US. The health impacts are clear when analysing the amount of drug abuse, illnesses related to addiction, such as mental illness, and the overall overdose deaths of the opioid crisis. The lack of health care access seems only to intensify these problems. Finally, the structural impacts of the War on Drugs have been severe. The War on Drugs has given politicians and governments more opportunities to criminalize and neglect those at the bottom of the US economic ladder, simultaneously upholding the public stigmas around poverty and addiction.

The War on Drugs has caused a lot of suffering to poor minorities, and in turn it has cost the US taxpayers a lot of money. The data and statistics gathered throughout this thesis have shown that the original goal of the War on Drugs, which was to decrease drug use, has not been achieved, instead only increasing drug use and drug overdoses and related health issues, due to the false theory of addiction. From this information alone, it should be clear that the War on Drugs needs to end, and the focus should be changed from law enforcement to health care and rehabilitation, to make an impact on

drug use and addiction. Another important focus should be on de-stigmatizing addiction and poverty, which would very likely be the most difficult part of the changes needed, as the functionalist perspective of having opportunity to financially succeed, no matter the starting point, has been engraved in many Americans' ideology, "the American Dream".

The reality is that many Americans lack the opportunities of adequate health, leading to self-medication by drugs. Criminalizing these people will only remove and isolate them from society causing even more harm to them and their future opportunities. Even investing in rehabilitation and clean needle programs will only be like putting a band aid on a broken leg: it may help the bleeding, but the underlying issue must be addressed.

Throughout history, addiction has been researched and studied, and the Rat Park experiment was an important experiment in increasing the understanding of addiction and how the War on Drugs has only replicated the caged rat situation for humans. Although there are several factors in addiction, the host and environmental factors are the factors which need to be addressed. I believe these could be best addressed through increased access and opportunities for education and health care, especially mental health services. Also aiding the poor communities and giving them other ways to financially remain afloat should be an important priority. Knowing human nature, which primally revolves around survival, anyone with an enough desperate situation would likely commit a crime to provide food and shelter to themselves or their families, which is why helping those with desperate financial situations would also work positively in reducing crimes.

It is sad to say that I believe we are still far from the day when the American public realizes the economic and human costs of the War on Drugs. The political rhetoric and fake news have caused several issues in the US to keep facts hidden from the public, not least in the ways that many have not realized their tax dollars are being used for a vicious loop of corporate profit being gained from the unfortunate. Overall, even though a few have profited immense amounts from the War on Drugs, for majority of the American citizens and the US economy, it has been a colossal failure.

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