

# **Punishing Addiction: Criminalization as the Nation's De Facto Drug Policy**

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## **Abstract**

(133 Words)

This paper examines whether the United States *Department of Justice's* enforcement-centered drug policy aligns with the medical and behavioral realities of substance use disorder. Using public health data, criminological research, and legal analysis, it evaluates four policy objectives: reducing overdose deaths, discouraging opioid use and distribution, protecting public safety, and reducing repeat offending. Evidence from the *Centers for Disease Control and Prevention*, the *National Survey on Drug Use and Health*, and related sources indicates that overdose deaths, substance use disorders, and recidivism rates remain high despite expanded criminal enforcement and punitive sentencing practices. The analysis also examines drug-induced homicide prosecutions, mandatory minimums, and broad liability frameworks, identifying concerns related to deterrence, proportionality, and public health outcomes. Comparative evidence suggests that treatment, harm reduction, rehabilitation, and reintegration strategies may produce more effective long-term outcomes.

# **Punishing Addiction: Structural Failure in U.S. Drug Policy**

## **Background**

The DOJ's enforcement-centered framework is structurally misaligned with the medical and behavioral realities of addiction, producing outcomes that undermine the stated goals of U.S. drug policy.

Substance use disorder is widely recognized as a chronic medical condition shaped by neurological, psychological, and social factors rather than a moral failing or purely criminal behavior (*National Institute of Drug Abuse*, 2020). As a result, many countries increasingly address drug use through public health frameworks centered on treatment, harm reduction, and social reintegration rather than punitive enforcement. Harm reduction approaches seek to minimize the health and social consequences associated with drug use while improving access to treatment and reducing overdose risk (Harm Reduction International, 2022). Evidence further suggests that voluntary, patient-centered interventions are more effective than coercive or punitive approaches in promoting long-term recovery outcomes (Werb et al., 2016).

Despite substantial evidence supporting public health-oriented responses, the United States continues to rely heavily on criminal justice institutions to address addiction. Drug possession, distribution, and related conduct remain broadly criminalized, while overdose deaths increasingly lead to prosecution under *drug-induced homicide* (DIH) statutes. Within this framework, the U.S. *Department of Justice* (DOJ) plays a central role in shaping national drug policy through enforcement priorities, prosecution strategies, and sentencing practices

(Alexander, 2012). Consequently, addiction is frequently addressed as a legal and criminal issue rather than a medical condition requiring treatment.

This enforcement-centered approach has produced significant social and institutional consequences. Individuals with substance use disorders often face criminal penalties, incarceration, and long-term barriers to employment, housing, and education, all of which may contribute to continued instability and repeated system involvement. The expansion of punitive enforcement has also coincided with rising overdose mortality and increasing rates of substance use disorder, raising questions about the effectiveness of deterrence-based policy strategies.

This paper argues that the DOJ's enforcement-centered drug policy is structurally misaligned with the medical and behavioral realities of substance use disorder. Although intended to reduce drug use, overdose deaths, and threats to public safety, the current framework prioritizes enforcement outputs over public health outcomes, contributing to persistent addiction, rising mortality, and high rates of recidivism. By examining deterrence theory, institutional incentives, comparative policy models, and the unintended consequences of criminalization, this paper evaluates the extent to which punitive drug policy has failed to achieve its stated objectives.

### **Criminalization of Addiction**

The criminalization of addiction produces both individual and structural consequences that extend beyond formal punishment. Individuals with substance use disorders are frequently stigmatized and treated as offenders rather than patients, reinforcing a policy framework centered on punishment instead of treatment. This orientation is reflected in sentencing practices,

incarceration patterns, and the expanding use of drug-induced homicide (DIH) statutes, which increasingly impose severe penalties on individuals connected to overdose deaths.

At the same time, enforcement activity expanded considerably. Drug-induced homicide (DIH) arrests and overall drug arrests increased substantially between 2011 and 2021, yet these increases did not correspond with sustained reductions in opioid use or addiction rates.

| <b>Table 5. Recidivism Rates by Country</b>                                                                                                                                                                                                                                                                                                                              |                        |                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------------|
| <b>Country</b>                                                                                                                                                                                                                                                                                                                                                           | <b>Recidivism Rate</b> | <b>Definition / Timeframe</b> |
| Norway                                                                                                                                                                                                                                                                                                                                                                   | 20%                    | 2-year                        |
| UK                                                                                                                                                                                                                                                                                                                                                                       | 25–29%                 | 1–2 year                      |
| Denmark                                                                                                                                                                                                                                                                                                                                                                  | 27–63%                 | 2-year                        |
| Sweden                                                                                                                                                                                                                                                                                                                                                                   | 29–43%                 | 2–3 year                      |
| Finland                                                                                                                                                                                                                                                                                                                                                                  | 31–36%                 | 2-year                        |
| France                                                                                                                                                                                                                                                                                                                                                                   | 30–40%                 | 2–5 year                      |
| Germany                                                                                                                                                                                                                                                                                                                                                                  | 35–40%                 | 3-year                        |
| Japan                                                                                                                                                                                                                                                                                                                                                                    | 45–50%                 | 3-year                        |
| Russia                                                                                                                                                                                                                                                                                                                                                                   | 50–60%                 | 3-year                        |
| United States                                                                                                                                                                                                                                                                                                                                                            | 68–71%                 | 3–5 year rearrest             |
| <b>Note.</b> Recidivism rates are not directly comparable across countries due to differences in definitions (e.g., rearrest, reconviction, reincarceration) and follow-up periods. Data are compiled from multiple governmental and peer-reviewed sources, including the National Library of Medicine, Bureau of Justice Statistics, and international justice reports. |                        |                               |
| <b>Source:</b> <i>National Library of Medicine, National Center for Biotechnical Information, 2023.</i>                                                                                                                                                                                                                                                                  |                        |                               |

The growing prevalence of fentanyl further complicates deterrence-based approaches. As illicit opioid markets evolved, fentanyl increasingly replaced less potent opioids because of its low production costs, transport efficiency, and high potency. These market adaptations occurred alongside intensified enforcement efforts rather than being prevented by them.

Taken together, these patterns suggest that punitive enforcement strategies have had limited effectiveness in reducing opioid use and sales. Although deterrence remains a central justification for harsh sentencing policies, available evidence indicates that expanded

enforcement has not produced corresponding declines in addiction rates or illicit opioid availability.

This punitive approach is particularly significant given that many individuals with opioid use disorder were initially exposed to opioids through legally prescribed medications (Kolodny et al., 2015). The medical origins of many addictions complicate traditional assumptions about criminal culpability and challenge frameworks that rely primarily on deterrence and punishment.

Criminalization also generates long-term collateral consequences that may contribute to continued instability and repeated system involvement. Individuals with criminal records often encounter barriers to employment, housing, education, and healthcare access, limiting opportunities for social reintegration. These conditions are associated with higher rates of poverty, marginalization, and continued substance use, thereby reinforcing the same patterns the criminal justice system seeks to prevent.

Rather than reducing addiction-related harms, punitive responses may deepen them by increasing social exclusion while limiting access to treatment and support services. As a result, criminalization functions not only as a legal response to substance use, but also as a mechanism that can perpetuate the underlying conditions associated with addiction and recidivism.

### **Policy Feedback Loops**

The persistence of punitive drug policy in the United States cannot be understood solely as a failure of evidence-based policymaking. It also reflects institutional dynamics that reinforce enforcement-centered approaches even when public health outcomes remain poor. The current

framework is internally coherent from a bureaucratic perspective but structurally misaligned with the realities of substance use disorder.

The U.S. drug policy system operates through a policy feedback process in which enforcement activity generates measurable and politically visible outputs, including arrests, prosecutions, convictions, and sentence lengths (Pierson, 1993). Because these outputs are readily quantifiable, they are often treated as indicators of policy success regardless of whether they reduce overdose mortality, substance use, or recidivism. As a result, policy evaluation becomes increasingly disconnected from broader public health outcomes, reinforcing the continuation of existing enforcement strategies (Campbell, 2012; Enns, 2016).

This dynamic is reflected in the organizational structure of the *Department of Justice* (DOJ) and related federal law enforcement agencies. These institutions are designed to identify violations, build cases, and secure convictions. Their operational metrics are therefore tied primarily to enforcement activity rather than treatment access, recovery outcomes, or reductions in overdose deaths. Consequently, institutional incentives may favor the expansion of punitive interventions even when evidence suggests limited effectiveness in addressing addiction-related harms.

This process also reflects what organizational theorists describe as goal displacement (Merton, 1940; Blau, 1955), in which operational objectives gradually replace broader policy goals. In the context of drug policy, objectives such as reducing overdose mortality and improving public safety may become subordinated to measurable enforcement outputs, including arrest totals and high-profile prosecutions. DIH cases illustrate this tension. Although such prosecutions may demonstrate a punitive response to overdose deaths, they do little to address the underlying

causes of addiction and may discourage individuals from seeking emergency assistance during overdoses.

From this perspective, the persistence of punitive drug policy reflects not simply policy failure, but institutional continuity. The system effectively produces enforcement outputs, even when those outputs remain weakly associated with the public health outcomes the policy is intended to achieve.

### **The Limits of Deterrence in the Context of Addiction**

A central assumption underlying punitive drug policy is that individuals will modify their behavior in response to the threat of punishment. Classical deterrence theory holds that individuals are more likely to comply with the law when punishment is perceived as certain, severe, and swift (Paternoster, 2010). This framework further assumes that individuals are aware of legal consequences, capable of rational decision-making, and able to weigh long-term risks against immediate rewards.

Substance use disorder complicates these assumptions in several important ways. Repeated opioid and substance use alters neurological functioning associated with impulse control, reward processing, and risk assessment, reducing sensitivity to negative consequences while increasing the salience of immediate relief. As a result, individuals with addiction may not evaluate legal risks in the same manner as individuals without substance use disorder.

Deterrence theory also emphasizes that the certainty of punishment is generally more influential than its severity. Yet drug enforcement in the United States is characterized by substantial variability across jurisdictions, differences between state and federal prosecution, and

inconsistent sentencing practices. This uncertainty may weaken the deterrent effect of punitive sanctions because individuals cannot reliably anticipate legal consequences.

In addition, deterrence assumes that individuals prioritize long-term outcomes over immediate needs. Addiction often compresses decision-making into the present moment, particularly during withdrawal or periods of psychological dependency. Under such conditions, the possibility of future punishment may carry limited influence relative to the immediate need to avoid withdrawal symptoms or obtain relief.

Empirical evidence further challenges the effectiveness of deterrence-based approaches in the context of addiction. Individuals with substance use disorder frequently continue using despite direct exposure to overdose deaths and other severe consequences within their social networks (Volkow, Fowler & Wang, 2004). The persistence of substance use despite immediate and potentially fatal risks raises broader questions about the extent to which legal punishment alone can meaningfully alter addiction-related behavior.

### **Unintended Consequences of Criminalization**

Beyond its limited effectiveness in reducing substance use and overdose mortality, criminalization may also produce unintended consequences that undermine public health and safety.

One significant consequence is the deterrence of help-seeking behavior during overdose emergencies. The expansion of DIH laws and related liability frameworks may create conditions in which individuals hesitate to contact emergency services due to fear of arrest or prosecution. In this context, overdose response becomes influenced not only by medical urgency but also by

perceived legal risk. Critics of DIH statutes argue that these dynamics may discourage timely intervention during overdoses and thereby increase the likelihood of preventable deaths.

Criminalization may also alter illicit drug markets in ways that increase lethality (Kleiman, 1992; Caulkins & Reuter, 2010). Enforcement pressures tend to favor substances that are more potent, easier to transport, and more difficult to detect. The increasing prevalence of fentanyl within illicit drug markets reflects these broader prohibition dynamics, as highly concentrated substances offer advantages within heavily enforced markets. As enforcement intensifies, market adaptation may contribute to the circulation of increasingly potent and unpredictable drugs.

At the individual level, criminal records create long-term barriers to social reintegration. Restrictions related to employment, housing, education, and public benefits may increase economic instability and social marginalization, conditions that are associated with continued substance use and repeated justice-system involvement. Consequently, punitive enforcement strategies may contribute to some of the same structural conditions associated with recidivism and ongoing addiction-related harms.

### **Market Adaptation and the Iron Law of Prohibition**

One of the central limitations of enforcement-centered drug policy is that illicit drug markets do not remain static in response to criminalization. Instead, illegal markets often adapt to enforcement pressures in ways that increase potency, concealment, and lethality. This dynamic is frequently described as the *“Iron Law of Prohibition,”* a principle suggesting that as enforcement intensity increases, more potent and compact substances tend to replace less concentrated forms because they are easier to transport, conceal, and distribute within heavily criminalized markets (Thornton, 1991; Beletsky & Davis, 2017).

Historical drug trends in the United States repeatedly reflect this pattern. During alcohol prohibition in the 1920s, consumption shifted away from lower-alcohol beverages such as beer toward more concentrated forms of liquor because stronger products were easier to smuggle and distribute illegally. Similar market adaptations later appeared within illicit drug markets. Powder cocaine increasingly gave way to crack cocaine in some markets due to profitability and distribution efficiency, while heroin markets eventually shifted toward synthetic opioids such as fentanyl.

The rapid expansion of fentanyl within the illicit opioid supply illustrates how prohibition dynamics may unintentionally increase overdose risk. Fentanyl is significantly more potent than heroin, requiring smaller quantities to produce equivalent effects. Because of its high potency, fentanyl is easier to transport across borders, conceal during distribution, and dilute into other substances while maintaining profitability. These characteristics make fentanyl particularly attractive within highly enforced illicit markets where reducing bulk and increasing transport efficiency carry substantial economic advantages (Ciccarone, 2017).

As enforcement efforts intensified against prescription opioids and heroin distribution networks during the 2010s, illicit opioid markets adapted rapidly. Restrictions on prescription opioid availability reduced legal access to many opioid medications, while heroin enforcement remained widespread. At the same time, fentanyl and fentanyl analogs increasingly entered the illicit supply because synthetic opioids could be produced more cheaply and transported more efficiently than plant-based heroin. Rather than eliminating opioid availability, enforcement pressures contributed to shifts toward substances that were more potent, less predictable, and substantially more lethal.

This market adaptation significantly complicated overdose prevention efforts. Unlike pharmaceutical opioids, illicit fentanyl is frequently manufactured without quality control or dosage consistency. Users often cannot determine potency or contamination levels, particularly when fentanyl is mixed into heroin, counterfeit pills, methamphetamine, or cocaine. As a result, overdose risk increases substantially even among individuals who may not knowingly intend to consume fentanyl.

The proliferation of fentanyl also challenges assumptions underlying deterrence-based enforcement policy. Traditional deterrence theory assumes that harsher penalties will reduce participation in illegal markets by increasing perceived risks. However, prohibition economics suggest that intensified enforcement may simultaneously increase the profitability of compact, high-potency substances. In this sense, enforcement pressure may unintentionally encourage the circulation of drugs that are both easier to conceal and more dangerous to consumers.

Public health researchers have increasingly argued that overdose mortality cannot be understood solely through the lens of individual decision-making or criminal behavior. Instead, overdose risk is shaped by broader structural conditions, including illicit market instability, inconsistent drug purity, barriers to treatment access, and enforcement strategies that alter supply patterns (Beletsky & Davis, 2017; Ciccarone, 2017). The emergence of fentanyl as the dominant opioid within illicit markets reflects these broader structural dynamics.

The increasing prevalence of counterfeit pharmaceutical pills further illustrates the adaptability of illicit drug markets. Counterfeit pills designed to resemble oxycodone, Xanax, or other prescription medications increasingly contain fentanyl because synthetic opioids can be manufactured at relatively low cost while generating high profits. These counterfeit products are

often visually indistinguishable from legitimate medications, increasing overdose risks among both habitual users and individuals without opioid tolerance.

The relationship between enforcement and market adaptation does not suggest that all criminal enforcement is ineffective or unnecessary. Targeted enforcement against large-scale trafficking organizations and violent criminal enterprises remains an important component of public safety policy. However, the broader evidence suggests that punitive enforcement alone may be poorly suited to addressing the structural dynamics of modern synthetic drug markets. As enforcement intensifies, illicit markets frequently adapt in ways that increase unpredictability and lethality rather than reducing overall harm.

These patterns have important implications for future drug policy. Policies focused primarily on supply suppression may unintentionally contribute to the emergence of increasingly potent synthetic substances while failing to reduce overall demand for opioids. In contrast, approaches emphasizing treatment access, overdose prevention, harm reduction, and public health surveillance may be better positioned to reduce mortality within rapidly evolving drug markets. The rise of fentanyl, therefore, illustrates not only the persistence of opioid demand but also the broader limitations of enforcement-centered strategies in addressing contemporary addiction and overdose crises.

### **Comparative Policy Models and Institutional Alternatives**

Comparative approaches to drug policy provide additional insight into the limitations of enforcement-centered frameworks. Although non-punitive systems do not eliminate the use of incarceration entirely, several countries have adopted treatment-oriented and harm-reduction

approaches that differ substantially from the U.S. model (Hughes & Stevens, 2010). These approaches generally place greater emphasis on public health interventions, treatment access, and social reintegration rather than criminal sanctions as the primary response to substance use.

Despite important differences across countries, these systems share several common characteristics. First, addiction is addressed primarily as a public health issue rather than a criminal one. This shift reorients institutional responsibility away from law enforcement agencies and toward healthcare systems, influencing both policy priorities and implementation strategies.

Second, these approaches often emphasize continuity of care. Treatment services may be provided at multiple stages of system involvement, including during incarceration and throughout community reentry. Expanding continuity of care is particularly significant given the elevated risk of overdose following release from correctional settings.

Third, many comparative models place greater emphasis on social reintegration. Policies are designed to improve access to housing, employment, healthcare, and social support, recognizing that recovery outcomes are influenced not only by medical treatment but also by broader social and economic conditions.

The relative success of these approaches suggests that barriers to reform in the United States may reflect institutional structure as much as evidentiary disagreement. Existing drug policy systems remain deeply embedded within enforcement-oriented frameworks, making large-scale policy transformation difficult despite growing evidence supporting treatment-based and harm-reduction approaches (Global Commission on Drug Policy, 2011).

## **Toward a Rebalanced Policy Framework**

A more effective approach to drug policy would require not only discrete reforms but also a broader shift in institutional priorities. Enforcement would remain part of the policy framework, particularly in addressing large-scale trafficking and organized criminal activity. However, primary responsibility for responding to substance use disorder would increasingly shift toward public health systems and evidence-based treatment interventions.

Such a reorientation would involve several important changes. First, measures of policy effectiveness would need to extend beyond arrests, prosecutions, and conviction rates. Greater emphasis would be placed on indicators such as overdose mortality, treatment access, retention in care, and long-term recovery outcomes.

Second, resource allocation would need to reflect these priorities. Existing funding structures disproportionately favor enforcement activities relative to treatment, prevention, and harm-reduction services, limiting the capacity of public health systems to respond effectively to addiction-related harms.

Third, legal frameworks would require greater proportionality and consistency. This includes reducing reliance on strict-liability approaches and ensuring that criminal penalties more closely reflect intent and level of culpability (Kleiman, 2009; World Health Organization, 2014).

More broadly, the effectiveness of future reforms will likely depend on whether institutional structures can integrate addiction as a public health issue rather than addressing it primarily through punitive enforcement mechanisms. Without corresponding institutional change, individual policy reforms may produce only limited or temporary effects.

## Historical Development of U.S. Drug Policy

The contemporary punitive framework of U.S. drug policy developed within a broader expansion of criminal justice responses to social problems during the late twentieth century. Compared to many other advanced democracies, the United States increasingly relied on criminalization, incarceration, and adversarial legal processes as primary mechanisms of social control (Garland, 2001; Whitman, 2003). Drug policy became a central area through which this enforcement-oriented approach was institutionalized.

The passage of the *Controlled Substances Act* (CSA) in 1970 established a centralized federal framework for regulating controlled substances. During the 1970s and 1980s, concerns about crime, political emphasis on “law and order,” and broader social changes contributed to the expansion of punitive drug enforcement (Beckett, 1997; Weaver, 2010). Subsequent legislation, including the *Anti-Drug Abuse Act of 1986*, expanded mandatory minimum sentencing, increased criminal liability, and substantially strengthened federal enforcement capacity. Together, these developments reinforced a criminal justice-centered approach to drug policy.

In contrast, several European countries increasingly incorporated treatment and harm reduction into healthcare systems during the same period. The United States, however, continued to frame drug use primarily through criminal justice institutions. Differences in political structure, social welfare systems, and electoral incentives contributed to the persistence of enforcement-centered responses (Garland, 2001; Whitman, 2003).

The opioid crisis further exposed the limitations of this framework. During the 1980s and 1990s, opioid prescribing increased substantially, particularly following the introduction of OxyContin

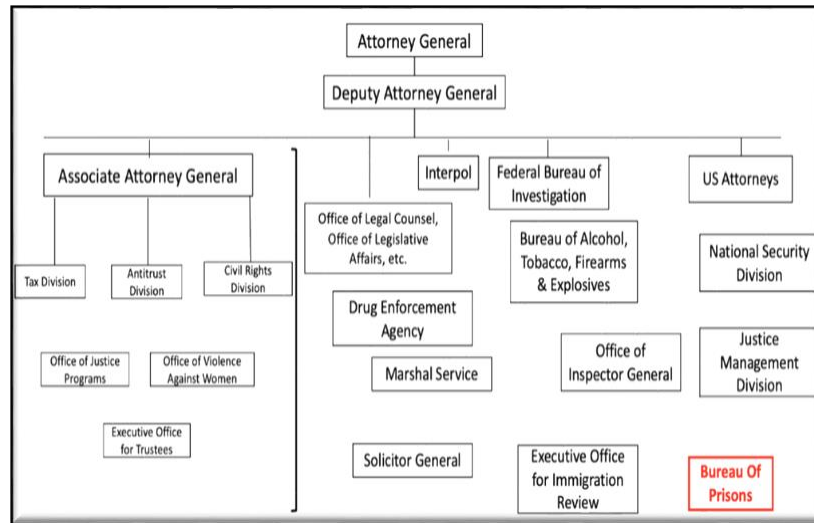
in 1996 (Rosenblum et al., 2008). As dependency and overdose mortality increased, enforcement strategies expanded alongside, rather than being replaced by, treatment-oriented responses. Although early enforcement efforts focused primarily on pharmaceutical companies and high-level traffickers, prosecutions increasingly extended to lower-level participants, including individuals with substance use disorders and those connected to overdose incidents through expansive interpretations of distribution and causation statutes.

This historical development reflects more than just policy continuity. It demonstrates how institutional and political structures reinforced punitive approaches even as evidence increasingly supported public health-oriented alternatives. As a result, U.S. drug policy evolved within systems designed primarily around enforcement rather than treatment, contributing to the structural tensions that continue to shape contemporary responses to addiction.

### **Department of Justice Structure**

The DOJ oversees federal law enforcement agencies involved in drug enforcement, including the *Federal Bureau of Investigation* (FBI), *Drug Enforcement Administration* (DEA), *Bureau of Prisons* (BOP), and the *U.S. Marshals Service* (Congressional Research Service, 2020).

**Figure 1. DOJ Organizational Chart**



The organizational structure of these agencies reflects an enforcement-centered approach to drug policy. Institutional performance is typically measured through outputs such as investigations, arrests, prosecutions, and convictions rather than broader public health indicators. As a result, the DOJ framework reinforces punitive responses to substance use disorder while providing comparatively limited institutional emphasis on treatment, prevention, or harm-reduction outcomes.

## Department of Justice Goals

### Goal 1: Reduce Overdose Deaths

Reducing overdose mortality is one of the central objectives of contemporary U.S. drug policy. However, overdose deaths have continued to increase despite decades of intensified enforcement. Although the *Centers for Disease Control and Prevention* (CDC) provides important national surveillance data, overdose reporting often lags by approximately one year, limiting the ability of policymakers to respond rapidly to changing conditions.

According to CDC (2023) estimates, approximately 109,000 overdose deaths occurred during the 12-month period between April 2021 and April 2022, with fentanyl involved in a substantial majority of cases. More broadly, overdose mortality has increased across successive decades despite expanded enforcement efforts and increasingly punitive legal responses.

| <b>Table 1. Number of Overdose Deaths in each Decade</b> |                        |                     |                        |
|----------------------------------------------------------|------------------------|---------------------|------------------------|
| A                                                        | B                      | C                   | D                      |
| <b>Year</b>                                              | <b>Overdose deaths</b> | <b>Year</b>         | <b>Overdose deaths</b> |
| 1970                                                     | 7,101                  | 2000                | 17,415                 |
| 1979                                                     | 2,544                  | 2009                | 37,004                 |
| <b>% Change</b>                                          | <b>-64%</b>            | <b>% Change</b>     | <b>112%</b>            |
| <b>Total Deaths</b>                                      | <b>61,446</b>          | <b>Total Deaths</b> | <b>287,238</b>         |
| 1980                                                     | 2,492                  | 2010                | 38,329                 |
| 1989                                                     | 5,035                  | 2019                | 70,630                 |
| <b>% Change</b>                                          | <b>102%</b>            | <b>% Change</b>     | <b>84%</b>             |
| <b>Total Deaths</b>                                      | <b>35,760</b>          | <b>Total Deaths</b> | <b>536,478</b>         |
| 1990                                                     | 4,506                  | 2020                | 91,799                 |
| 1999                                                     | 16,849                 | 2023*               | 112,000                |
| <b>% Change</b>                                          | <b>274%</b>            | <b>% Change</b>     | <b>22%</b>             |
| <b>Total Deaths</b>                                      | <b>83,099</b>          | <b>Total Deaths</b> | <b>310,789</b>         |
| *Total count not currently available                     |                        |                     |                        |
| <i>Source: CDC Mortality files 1970-2023</i>             |                        |                     |                        |

The 1970s remain the only decade in recent U.S. history in which overdose deaths declined overall. Following the enactment of the Controlled Substances Act (CSA) and the establishment of the DEA, federal drug policy increasingly emphasized criminal enforcement as its primary strategy. Yet overdose mortality rose substantially during subsequent decades, including significant increases during the 1980s, 1990s, and 2000s. By the 2010s, overdose deaths exceeded the combined totals of previous decades, and annual deaths surpassed 100,000 during the early 2020s.

These trends raise questions regarding the effectiveness of deterrence-based enforcement strategies in reducing overdose mortality. Despite expanded arrests, prosecutions, and sentencing severity, illicit drug markets adapted in ways that increased both potency and lethality, particularly with the growing prevalence of fentanyl. At the same time, addiction rates and overdose deaths continued to rise alongside intensified enforcement measures.

Changes in enforcement priorities also complicate the deterrence rationale underlying punitive drug policy. While earlier federal efforts focused more heavily on large-scale trafficking organizations, contemporary prosecutions increasingly involve lower-level participants and individuals prosecuted under DIH statutes. Critics argue that these approaches impose severe penalties without clear evidence of corresponding reductions in overdose mortality or improvements in public safety.

The increase in overdose deaths during the COVID-19 pandemic further highlighted the limitations of existing policy frameworks. Between 2019 and 2022, overdose mortality rose sharply despite continued enforcement activity. Taken together, these patterns suggest that enforcement-centered approaches have had limited success in achieving the stated goal of reducing overdose deaths.

## **Goal 2: Discourage Opioid Sale and Use**

A central objective of punitive drug policy is deterrence: the assumption that severe legal penalties will reduce participation in illicit drug markets and discourage opioid use (Caulkins & Reuter, 2010). In addition to criminal enforcement, federal and state governments have implemented prescribing regulations, prescription monitoring programs, public education campaigns, and expanded naloxone access in an effort to reduce opioid-related harms.

Despite these measures, access to evidence-based treatment for substance use disorder remains limited. Although *medications for opioid use disorder* (MOUD) are available in some correctional and community settings, treatment access remains inconsistent and unevenly distributed. As a result, the broader policy framework continues to rely heavily on punitive enforcement despite growing evidence supporting treatment-oriented approaches.

Empirical trends raise questions regarding the effectiveness of deterrence-based strategies in reducing opioid use. According to data from the *National Survey on Drug Use and Health* (NSDUH), rates of opioid addiction increased substantially between 2000 and 2023 despite expanded enforcement activity and increasingly severe penalties.

| <b>Table 3. Population Adjusted Rates of Addiction</b>                     |                             |                            |                            |                                      |
|----------------------------------------------------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------------|
| <b>Year</b>                                                                | <b># of People Addicted</b> | <b>% Chg. in addiction</b> | <b>% Chg in Population</b> | <b>Population Adjusted Addiction</b> |
| 2000                                                                       | 14,000,000                  |                            |                            |                                      |
| 2009                                                                       | 21,800,000                  | 56%                        | 9%                         | <b>51%</b>                           |
| 2010                                                                       | 22,600,000                  | 4%                         | 1%                         | <b>3%</b>                            |
| 2019                                                                       | 57,200,000                  | 153%                       | 6%                         | <b>144%</b>                          |
| 2020                                                                       | 59,300,000                  | 16%                        | 0%                         | <b>16%</b>                           |
| 2022                                                                       | 68,700,000                  | 16%                        | 1%                         | <b>15%</b>                           |
| 2023                                                                       | 70,300,000                  | 2%                         | 0.50%                      | <b>1.50%</b>                         |
| 2024                                                                       | 74,000,000                  | 5%                         | 0.50%                      | <b>4.50%</b>                         |
| <b>Source:</b> <i>National Survey on Drug Use &amp; Health (2000-2023)</i> |                             |                            |                            |                                      |

Heroin use followed a similar pattern between 2011 and 2022, including notable increases during periods of heightened social and economic stress, such as the COVID-19 pandemic. These trends suggest that broader social, psychological, and pharmacological factors may play a greater role in shaping drug use patterns than legal deterrence alone.

| <b>Table 4. Nationwide Annual Heroin Usage</b> |              |             |
|------------------------------------------------|--------------|-------------|
| <b>Year</b>                                    | <b>Users</b> | <b>%Chg</b> |
| 2011                                           | 620,000      |             |
| 2012                                           | 669,000      | 7.90%       |
| 2013                                           | 681,000      | 1.80%       |

|                                                                                                                                                                                             |                  |                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|----------------|
| 2014                                                                                                                                                                                        | 914,000          | 34.20%         |
| 2015                                                                                                                                                                                        | 828,000          | <b>-9.40%</b>  |
| 2016                                                                                                                                                                                        | 948,000          | 14.50%         |
| 2017                                                                                                                                                                                        | 886,000          | <b>-6.50%</b>  |
| 2018                                                                                                                                                                                        | 808,000          | <b>-8.80%</b>  |
| 2019                                                                                                                                                                                        | 745,000          | <b>-7.80%</b>  |
| 2020                                                                                                                                                                                        | 902,000          | 21.10%         |
| 2021                                                                                                                                                                                        | 1,099,000        | 21.80%         |
| 2022                                                                                                                                                                                        | 1,200,000        | 9.20%          |
| 2023                                                                                                                                                                                        | 1000000*         | <b>-16.70%</b> |
| 2024                                                                                                                                                                                        | Not yet released | -              |
| <b>Total =</b>                                                                                                                                                                              |                  | <b>61.30%</b>  |
| *The decline in 2023 reflects the national shifts toward fentanyl, not a true decrease in opioid use overall.                                                                               |                  |                |
| <b>Source:</b> <i>The National Center for Drug Abuse Statistics.</i><br><a href="https://drugabusestatistics.org/heroin-statistics/">https://drugabusestatistics.org/heroin-statistics/</a> |                  |                |

### Goal 3: Protect the Public

Protecting public safety is a central justification for punitive drug policy. Evaluating this objective requires consideration not only of crime reduction and overdose prevention, but also of the broader social and economic consequences associated with large-scale incarceration and enforcement-centered interventions.

The financial costs of the current system are substantial. The federal Bureau of Prisons reported expenditures exceeding \$8.8 billion in 2024, while broader national estimates place the total costs of incarceration—including policing, courts, and correctional systems—at hundreds of billions of dollars annually. These estimates do not fully capture indirect economic effects associated with workforce exclusion, reduced earnings, and long-term barriers to reintegration following incarceration.

The social consequences of incarceration also extend beyond individuals directly involved in the criminal justice system. Families of incarcerated individuals often experience financial

instability, increased caregiving burdens, and disruptions related to housing, employment, and education. Research further indicates that incarceration is associated with adverse mental and physical health outcomes among family members and children (Lee et al., 2014).

Despite these costs, evidence regarding the long-term public safety benefits of extended incarceration remains mixed. Durlauf & Nagin (2011) argue that increases in sentence length produce diminishing deterrent effects, particularly when compared with policies emphasizing certainty of punishment or prevention-oriented interventions.

At the same time, substance use disorder remains widespread while treatment access remains limited. According to the Substance Abuse and Mental Health Services Administration (SAMHSA, 2022, 2023), millions of Americans meet the criteria for substance use disorder, yet only a minority receive treatment. Access to harm-reduction interventions—including naloxone distribution and syringe service programs—also remains uneven across jurisdictions despite evidence that such interventions reduce overdose mortality and infectious disease transmission.

Recent sentencing reforms, including portions of the First Step Act, have modestly reduced incarceration for some nonviolent offenses. However, many drug-related prosecutions, including DIH cases, remain subject to lengthy sentencing structures that continue to emphasize punitive responses.

Taken together, these patterns raise broader questions regarding whether enforcement-centered drug policy has produced proportional public safety benefits relative to its economic, social, and public health costs. Although punitive approaches remain central to U.S. drug policy, evidence suggests that large-scale incarceration alone has had limited effectiveness in addressing

addiction-related harms while generating substantial collateral consequences for individuals, families, and communities.

#### **Goal 4: Punish the Offender**

Substance use disorder is widely recognized within public health and medical literature as a chronic and treatable condition rather than a form of moral deviance or personal weakness (Leshner, 1997; American Society of Addiction Medicine, 2011; NIDA, 2020). Public health organizations have consistently emphasized that effective responses to addiction require treatment, prevention, and harm-reduction strategies in addition to, or in place of, punitive interventions (World Health Organization, 2014; Department of Health and Human Services, 2016).

One of the principal justifications for incarceration is the assumption that punishment discourages future offending. More broadly, correctional systems are often expected to promote rehabilitation and reduce recidivism. However, evidence regarding the effectiveness of long-term punitive incarceration in achieving these objectives remains mixed.

Beginning in the 1970s, U.S. criminal justice policy increasingly emphasized punishment and mandatory sentencing while placing comparatively less emphasis on rehabilitation and treatment-based interventions. This shift contributed to substantial prison population growth alongside expanded use of lengthy incarceration for drug-related offenses.

Recidivism data raise important questions regarding the effectiveness of this approach. Estimates indicate that a substantial proportion of individuals released from U.S. correctional facilities are rearrested or reincarcerated within several years of release. Comparative studies further suggest

that some countries emphasizing rehabilitation and reintegration—including Norway, Denmark, and Sweden—report lower recidivism rates than the United States (Yukhnenko, Sridhar & Fazel, 2023).

Although cross-national comparisons should be interpreted with caution due to differences in legal systems, reporting practices, and sentencing structures, these patterns suggest that punitive sentencing alone may be limited in reducing repeat offending. Research further indicates that stable housing, employment access, treatment availability, and continuity of care are important predictors of successful reintegration following incarceration.

Taken together, these findings suggest that enforcement-centered approaches emphasizing lengthy punishment may not consistently achieve the broader goals of rehabilitation or long-term reductions in recidivism. Individuals with substance use disorders frequently reenter communities facing many of the same social, economic, and treatment barriers that existed prior to incarceration, potentially contributing to repeated system involvement over time.

### **Retribution vs. Restorative Justice**

Retributive theories of punishment have historically played a central role in criminal justice systems. Under retributive frameworks, punishment is justified primarily as a response to wrongdoing, with emphasis placed on proportionality, accountability, and moral responsibility (Hegel, 1991/1821). Contemporary punitive drug policy reflects many of these assumptions by emphasizing criminal sanctions as the principal response to substance use and related offenses.

Critics of retributive approaches argue that punishment-centered systems may be limited in their ability to address the underlying conditions associated with addiction, including trauma, mental

illness, poverty, and social instability. Behavioral and criminological research further suggests that punitive responses alone do not necessarily reduce recidivism or promote long-term rehabilitation (Alper, 2018).

Restorative justice offers an alternative framework that emphasizes repair, accountability, and reintegration rather than punishment alone (Zehr, 2015; Van Ness & Strong, 2015). Rather than focusing exclusively on what punishment is deserved, restorative approaches examine the broader harms associated with an offense and seek to facilitate dialogue, accountability, and community reintegration where appropriate.

In the context of substance use disorder, restorative approaches may also encourage greater attention to treatment access, continuity of care, and the social conditions associated with recovery. These models recognize that addiction-related harms are often shaped by broader structural and interpersonal factors that punitive systems alone may be poorly equipped to address.

Advocates of restorative justice do not necessarily reject all forms of criminal accountability or incarceration. Instead, restorative frameworks generally emphasize responses that balance public safety with rehabilitation, treatment, and reintegration. Although restorative approaches vary substantially across jurisdictions, comparative evidence suggests that systems placing greater emphasis on rehabilitation and reintegration may experience lower rates of recidivism and repeated system involvement.

Within the context of U.S. drug policy, the contrast between retributive and restorative approaches reflects broader questions regarding the purposes of punishment and the extent to

which enforcement-centered strategies can address the long-term social and public health dimensions of addiction.

### **Implications for Policy Reform**

The evidence reviewed throughout this paper suggests that enforcement-centered drug policy has had limited effectiveness in reducing overdose mortality, discouraging opioid use, or lowering recidivism rates. At the same time, punitive approaches have generated substantial social, economic, and public health costs. These findings support the need for policy reforms that more closely align criminal justice responses with the medical and behavioral realities of substance use disorder.

First, access to evidence-based treatment should be substantially expanded, particularly *medications for opioid use disorder* (MOUD). Research consistently demonstrates that MOUD reduces overdose mortality, improves treatment retention, and decreases illicit opioid use (Wakeman & Barnett, 2018; NASEM, 2019). Expanding treatment availability within correctional facilities and ensuring continuity of care during community reentry may be especially important in reducing overdose risk following incarceration.

Second, harm-reduction interventions should be more broadly implemented. Naloxone distribution, syringe service programs, drug-checking technologies, and related interventions have been associated with reductions in overdose mortality and infectious disease transmission (NASEM, 2019; CDC, 2024). Expanding access to these services may reduce immediate harms while improving engagement with treatment systems.

Third, sentencing frameworks related to drug offenses warrant reevaluation. Critics of mandatory minimum sentencing and DIH statutes argue that these approaches may impose severe penalties in situations involving limited intent or ambiguous culpability (Burris et al., 2019). Expanding judicial discretion and aligning sentencing practices more closely with proportionality principles may reduce excessive punishment while preserving accountability for serious trafficking offenses.

Fourth, diversion programs and treatment-oriented alternatives to incarceration should be expanded where appropriate. Comparative evidence suggests that approaches emphasizing treatment, rehabilitation, and community reintegration may reduce repeated system involvement more effectively than incarceration alone (Greenwald, 2009; Hughes & Stevens, 2010).

Finally, resource allocation should more closely reflect public health priorities. Current funding structures continue to devote substantial resources to enforcement activities despite evidence supporting the effectiveness of treatment, prevention, housing assistance, and community-based interventions in addressing addiction-related harms

Taken together, these reforms reflect a broader shift away from viewing addiction primarily through punitive legal frameworks and toward approaches that integrate public health, treatment access, and long-term reintegration. Although no single intervention is likely to resolve the opioid crisis independently, evidence suggests that policies emphasizing treatment and harm reduction may be better aligned with the underlying dynamics of substance use disorder than enforcement-centered strategies alone.

## **Conclusion**

This paper has argued that the U.S. Department of Justice’s enforcement-centered approach to drug policy is structurally misaligned with the medical and behavioral realities of substance use disorder. Despite decades of expanded criminal enforcement, overdose mortality has increased, substance use disorders remain widespread, and recidivism rates continue to remain high. At the same time, punitive policies have generated substantial social, economic, and public health costs.

The findings presented throughout this analysis suggest that deterrence-based approaches alone have had limited effectiveness in reducing opioid use, overdose deaths, or repeated system involvement. Enforcement strategies emphasizing mandatory sentencing, drug-induced homicide (DIH) prosecutions, and broad criminal liability frameworks have expanded punitive intervention without corresponding evidence of sustained improvements in public health outcomes.

Comparative evidence further indicates that systems placing greater emphasis on treatment access, harm reduction, rehabilitation, and reintegration may achieve more favorable long-term outcomes. Although enforcement remains an important component of drug policy, addiction-related harms appear more effectively addressed through approaches integrating public health and social support systems alongside targeted criminal enforcement.

These findings have broader implications for criminal justice policy. Treating addiction primarily through punitive legal frameworks may contribute to continued cycles of incarceration, social instability, and repeated system involvement while limiting access to treatment and recovery support. More balanced approaches emphasizing proportionality, treatment access, harm reduction, and continuity of care may better align institutional responses with the underlying dynamics of substance use disorder.

No single policy intervention is likely to eliminate addiction or overdose mortality entirely.

However, the evidence reviewed in this paper suggests that continued reliance on punishment as the dominant response to addiction is unlikely to achieve the long-term public health and public safety goals that current drug policy seeks to advance.

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