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Kenneth D. Tunnell

Eastern Kentucky University, kenneth.tunnell@eku.edu

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ABSTRACT

During the past ten years, rural Kentucky (and rural pockets of nearby states) witnessed the emergence of a new pharmaceutical drug of abuse. The powerful oxycodone, OxyContin, first manufactured in 1996 and designed for time-release pain relief, found a ready population in rural hamlets and mountain communities. Intended for patients in pain associated with terminal disease, it became a drug of abuse as it was over-prescribed and trafficked. This Justice and Safety *Research Bulletin* describes the sudden growth in the use of this new drug and its antecedents. Describing the trends in use and abuse, this Bulletin presents evidence of an epidemic created in part by organizations in both the private and public sectors. It describes the marked changes in OxyContin arrests but concludes that arrest trends likely reveal more about law enforcement than drug use. It also describes the much publicized relationship between OxyContin use and crime in Kentucky, with emphasis on the eastern part of the state and suggests that the much heralded crime increases were more rhetorical than empirical.

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Kenneth D. Tunnell
Eastern Kentucky University
467 Stratton
Richmond, KY 40475

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OxyContin and Crime in Eastern Kentucky

OxyContin (trade name), an oxycodone drug, was approved by the Food and Drug Administration (FDA) in 1995 and first marketed in 1996 by Purdue Pharma of Stamford, Connecticut. Among the most powerful analgesics currently manufactured, OxyContin is a synthetic opioid. Opioid drugs (which include opium, heroin, morphine, codeine, hydrocodone, and oxycodone) are produced from the opium poppy. Opiate agonists, such as OxyContin, provide pain relief by acting on opioid receptors in the brain, the spinal cord and directly on tissue (OxyContin Diversion and Abuse 2002). OxyContin is a single-entity product unlike most oxycodone drugs (e.g., Percodan and Percocet) which typically contain aspirin or acetaminophen. A marked improvement, OxyContin reportedly is 16 times more powerful than similar narcotics (Sappenfield 2001). Designed as an orally administered, time-release analgesic, OxyContin provides significant and sustained pain relief and, due to its addictive propensity, is listed as a Schedule II narcotic (i.e., drugs approved for medical use but that have a high potential for abuse) under the Controlled Substances Act.

OxyContin Abuse

OxyContin abuse was first noted in Maryland, the eastern part of rural Maine, eastern Ohio, the rust-belt areas of Pennsylvania and the central Appalachian region of West Virginia, Virginia and Kentucky. During the year 2000, the ten states with the highest OxyContin prescription rates (per 100,000 population) and those with problems of abuse were, in descending order: West Virginia, Alaska, Delaware, New Hampshire, Florida, Kentucky, Pennsylvania, Maine, Rhode Island and Connecticut (Hutchinson 2001). West Virginia, and

particularly its southern region, and Southeastern Kentucky have long histories of pharmaceutical abuse (DEA briefs and background 2002).

OxyContin abuse has been made possible largely by its diversion. OxyContin is illegally acquired with fraudulent prescriptions; through illegal sales; by pharmacy theft and doctor shopping; from loosely organized rings of individuals diverting and then selling it; and by way of foreign diversion and smuggling into the U.S. When OxyContin abuse dramatically increased, authorities in Pennsylvania, Florida, Ohio, Kentucky and Georgia reported swelling numbers of pharmacy robberies, burglaries and theft (OxyContin: Pharmaceutical diversion 2002).

Abuse methods vary. In some cases tablets are crushed and snorted. In others, the powder is diluted and intravenously injected. A less often used delivery style is to peel off the outer coating and chew the tablets (e.g., Sullivan 2001). These abuse techniques result in the sudden absorption of the analgesic rather than as designed -- slowly and continuously over several hours. Not surprisingly, overdoses and deaths have occurred, although despite rhetoric to the contrary, the exact number is unknown. OxyContin-related overdose deaths are difficult to disaggregate and the actual number likely will never be known with any degree of certainty. This is due in part to poly-drug use, most commonly OxyContin mixed with alcohol and other depressants. Furthermore, data does not distinguish accidental deaths from suicides. Nonetheless, all sorts of estimates -- and at times alarming ones -- have been published by the media and various office holders.

Data, however, indicate consistent increases in the number of new pharmaceutical abusers (but not solely oxycodone) and narcotic-related emergency incidents. During the 1980s, fewer than 500,000 people yearly first used prescription drugs for non-medical purposes. By

1998, the number of first-time users was at 1.6 million persons. Persons reporting at least one non-medical use of OxyContin have increased from 221,000 in 1999 to nearly two million (National Survey on Drug Use and Health 2003). Federal data indicate that emergency room visits involving oxycodone increased with the introduction of OxyContin. Between 1990 and 1996, emergency room treatment of oxycodone remained stable. After 1996, when OxyContin was first manufactured, the number of visits skyrocketed from 100 to nearly 15,000 (Clines and Meier 2001). Nonetheless, emergency rooms report that oxycodone (there is no separate category for OxyContin) is mentioned by patients in less than one percent of all cases (viz., 0.95 percent). Oxycodone ranks eighteenth with alcohol being first in frequency of mentions. Although OxyContin use and its connection to drug-related emergencies have increased, oxycodone products evidently remain far less widely used than rhetoric often suggests.

Eastern Kentucky

For decades pharmaceutical drug abuse has been a significant social problem in Central Appalachia. Prescription drugs of abuse include well-known and widely used narcotics such as Valium and Xanax and newer and more powerful analgesics such as OxyContin, Lorcet, Lortab and Vicodin, although Valium and Xanax often remain drugs of choice¹ (Kaushik 2001).

In Eastern Kentucky, news headlines and stories have documented the OxyContin problem by focusing on addictions, drug rehabilitation clinics and their scarce resources, OxyContin-fueled property crimes, pharmacy robberies, drug overdoses and deaths, and the emergence of a satellite industry selling fake Magnetic Resonance Imaging reports.

A former Hazard, Kentucky (Perry County) police chief reported that in a one year period (1999 - 2000), the number of OxyContin complaints called into his office increased

from one every three months to three or four daily. The Perry County Park became known as “Pillville” -- an indication of its open-air drug market atmosphere. The OxyContin problem in Eastern Kentucky, and specifically Hazard, was a featured and graphic *Newsweek* cover story complete with sensational rhetoric (Rosenberg 2001; cf, Blee and Billings 1999; Giardina 1999; Tunnell 2004a).²

In Kentucky, arrests for OxyContin abuse have included a former high school homecoming queen and the daughters of a reputable businessman, a circuit court judge, a local school board member, and a prosecutor. Other affluent locals include medical doctors charged with over-prescribing the analgesic (Sappenfield 2001; Sullivan 2001). One Eastern Kentucky urologist, for example, who was arrested for improperly dispensing the drug reportedly “was seeing 120 patients daily” and writing prescriptions for OxyContin (Dangers of OxyContin 2001). Five medical doctors practicing in a small pain clinic in Greenup County, Kentucky were indicted on several counts of illegally over-prescribing drugs (Mueller and Camp 2003).

Given these events, Kentucky implemented a program designed to electronically track prescription drug sales for specific pharmaceuticals, most notably, addictive analgesics (Kentucky: OxyContin traffic sparks new controls 2001). The program, Kentucky All-Schedule Prescription Electronic Reporting System (KASPER) enacted in 1998, is designed for doctors and pharmacists to monitor patients’ prescriptions, the prescriptions’ source, and frequency of refill. Law enforcement makes use of it to investigate patients, physicians, and pharmacists who, they suspect, misuse or over-prescribe pharmaceuticals. Seventeen states now have some tracking database although systems are not linked.

Constructing Kentucky's Problem

The OxyContin abuse problem became widely publicized by the media and various office holders. News coverage, in part, created a drug scare or moral panic about a new and powerful drug of abuse. During the late 1990s, OxyContin became the stuff of frequent front-page news stories. News articles consistently increased in number, as Table 1 shows.

Table 1
OxyContin Keyword Search by Year and Frequency:
1998-2005

Year	1998	1999	2000	2001	2002	2003	2004	2005
Major Papers	0	0	10	312	158	166	161	172
Magazines & Journals	0	0	3	16	10	12	20	16
Legal News	0	0	1	20	33	22	28	20
Health & Medical News	0	0	3	56	32	47	342	191
Total	0	0	17	404	233	247	551	399

Source: Lexis-Nexis Search by Keyword OxyContin.

Public and private-sector officials further contributed to this moral panic about a new drug of abuse (Goode and Ben-Yehuda 1994). Similar to previous drug scares, the OxyContin problem was described using hyperbolic imagery and rhetoric. Its construction relied on sources whose claims often went unverified. For example, much public discourse on OxyContin was about its relationship to Eastern Kentucky's significantly worsening crime problem. Claims of increases in crime and increases related to specifically one variable -- OxyContin -- were widely reported as fact. Although crime data are public record, they typically were ignored by public

and private sector officials who made all sorts of sensational comments about escalating crime rates. Linking any crime increases directly to the introduction of OxyContin has not been established. Rather, the complexities of the crime problem are more enigmatic than this simple relationship suggests. Yet, consider the following:

A commonwealth attorney claimed that the Greenup County Circuit Court docket increased almost 25 percent during the year 2001 because of cases of prescription drug abuse (Gil 2002). There were dramatic increases in arrests for prescription drugs in Greenup County (and others) especially in 2001. There were increases in arrests for opium and its derivatives and synthetic narcotics. Marijuana arrests significantly declined that year. Opiate arrests jumped from 17 in the year 2000 to 134 in 2001. Likewise, synthetic narcotics arrests increased from zero in 2000 to 198 in 2001. Yet, in 2002, only five arrests were made for opiates and none for synthetic narcotics. Today's arrest numbers remain at the 2002 level. Furthermore, Greenup County has experienced decreases in crime since the introduction of OxyContin from a high of 153 per 10,000 in 1997 to a low of 70 per 10,000 in 2004. Yet, these longitudinal trends and the temporary increases in opiate arrests went ignored in reports by public officials and the media.

A Hazard, Kentucky police chief was reported as claiming that 90 percent of thefts and burglaries in that area were to get money to buy OxyContin (Alford 2001). No explanation for thefts and burglaries prior to 1996 (when OxyContin was first marketed) or for fluctuating crime rates since then were offered. For example, the year before OxyContin was manufactured, Perry County (which includes Hazard) had 303 crimes per 10,000 population. In 1996, it had 260; in 1997, 251; in 1998, 272; in 1999, 264; in 2000, an increase to 382; and in 2001 a decrease to 308.6 per 10,000 population. Crime rates then again increased to 336 per 10,000 in 2002 and

decreased in 2003 to 331 per 10,000. A less sensationalistic interpretation is that crime rates in Perry County, like nearly everywhere, fluctuate with some years experiencing increases and others decreases. Yet spatial and temporal variance -- a universal feature of crime -- went unreported. Also unreported was the reality of crime in Perry County. There and across the country, the single most frequently occurring index crime is larceny. Larceny also happens to be the least serious of all index crimes. When controlling for larceny, for example, Perry County's rate was 150.2 in 2003 -- less than half the total index rate for that year.

A closer examination of crime in the four Development Districts of Eastern Kentucky (viz., Gateway, Big Sandy, Cumberland Valley and Kentucky River) show fluctuating trends. Property crime, the crime type most commonly associated with drug abuse, has varied. In 1990, the counties of Gateway District had a property crime average of 150.3 per 10,000. The average decreased to 133.5 per 10,000 in 1994 before increasing to a high of 190.9 per 10,000 in 1997. Since then, the county average in Gateway decreased in 2004 to 142.4 per 10,000 -- lower than the 1990 average.

The situation is different in Big Sandy Development District. The average for those counties was 113.3 per 10,000 in 1990 but decreased in 1994 to 84.9 per 10,000 population. Since then, property crime rates have fluctuated with some years increasing and others decreasing but never declining to the 1994 levels. In 2003, the average was 124.9 per 10,000 but increased dramatically in 2004 to 226.4 per 10,000 population.

The counties of Cumberland Valley Development District have perhaps the most erratic property crime rates. The 1990 average for the District was 139.7 per 10,000 but declined to 133.2 the very next year. During the next few years, rates decreased and increased to 193.1 per

10,000 in 1997 but then declined steadily to 138.9 per 10,000 in 2003. Similar to Big Sandy, rates markedly increased during 2004 to 202.2 per 10,000.

Kentucky River Development District counties had an average property crime rate of 104.3 per 10,000 in 1990 which decreased to a low of 86.6 per 10,000 in 1992. Rates then steadily increased to 145.7 per 10,000 in 2000 but have decreased since then to 120.9 per 10,000 in 2004. These data do not show, contrary to published accounts, an escalating crime problem. Rather, they show what we have come to expect with crime rates -- variance. Figures 1, 2, 3, and 4 longitudinally show crime rates for these four Development Districts.

Figure 1
Property Crime Rates Per 10,000 Population, Gateway District 1990-2004

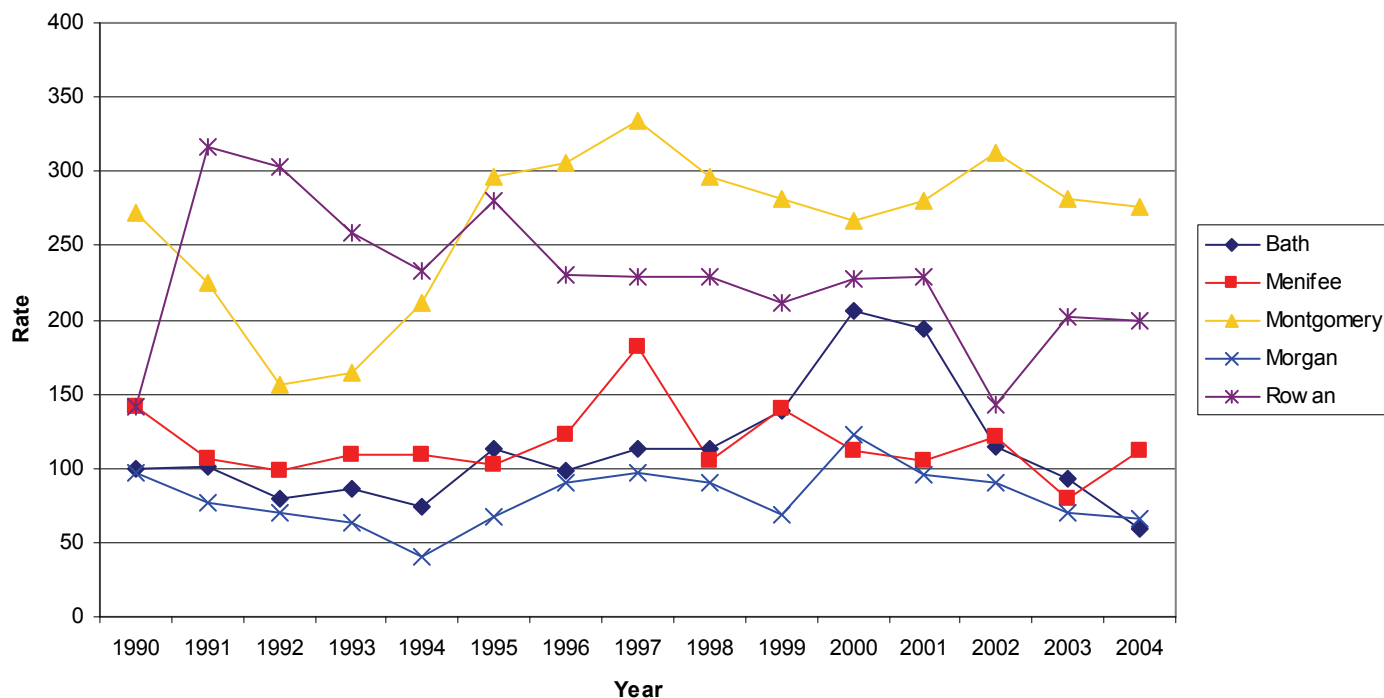


Figure 2
Property Crimes Per 10,000 Population, Big Sandy District 1990-2004

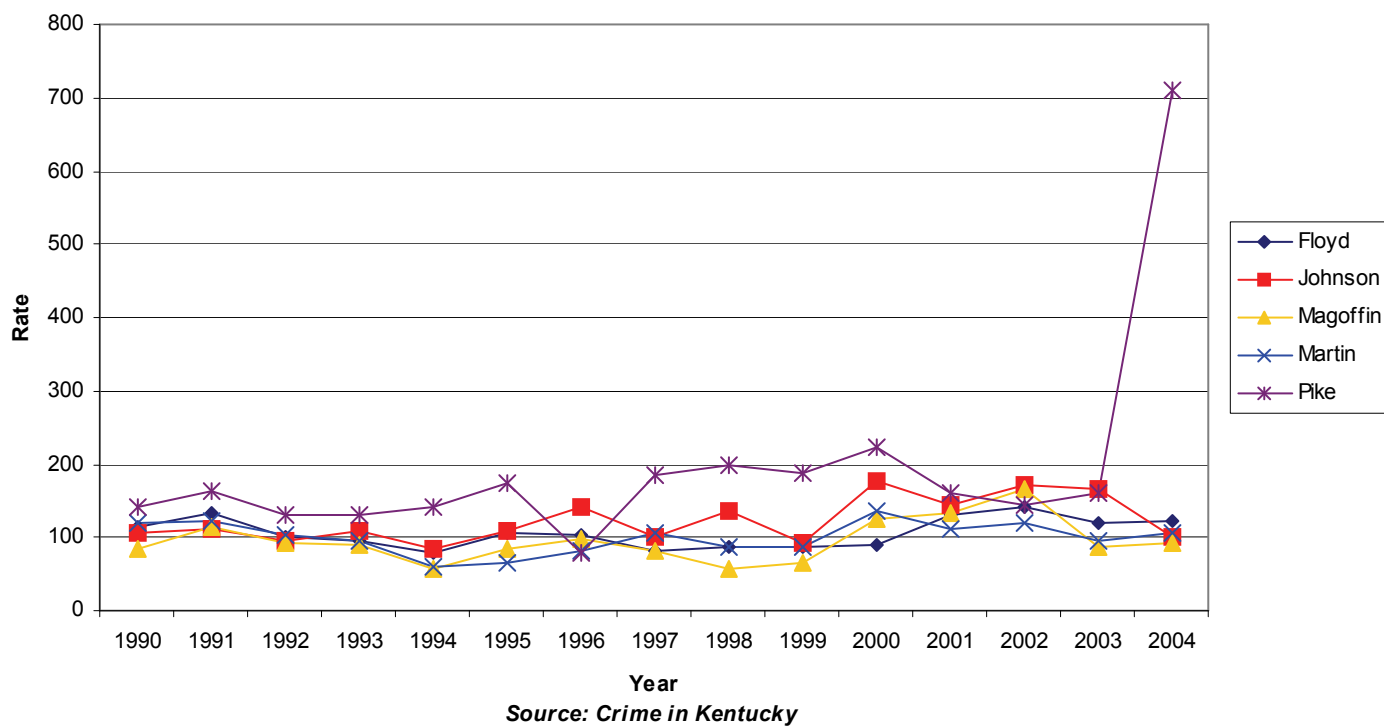


Figure 3
Property Crime Per 10,000 Population Cumberland Valley District, 1990-2004

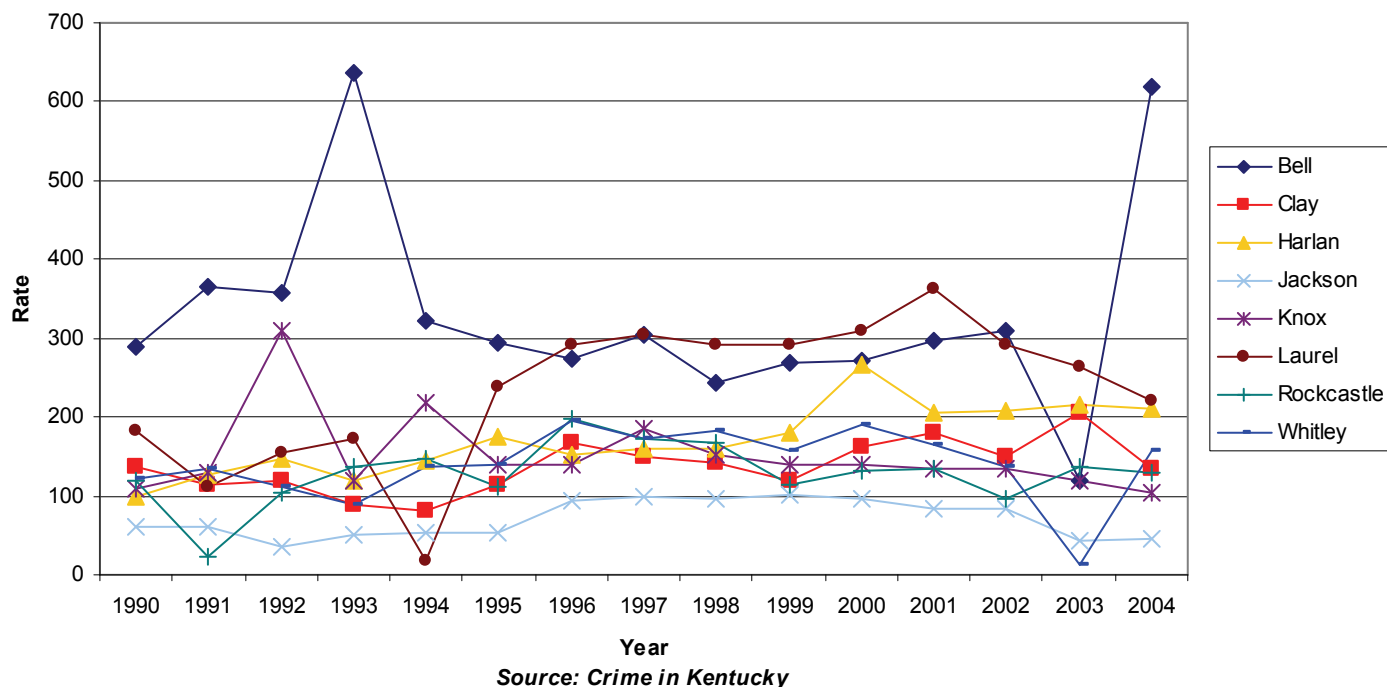
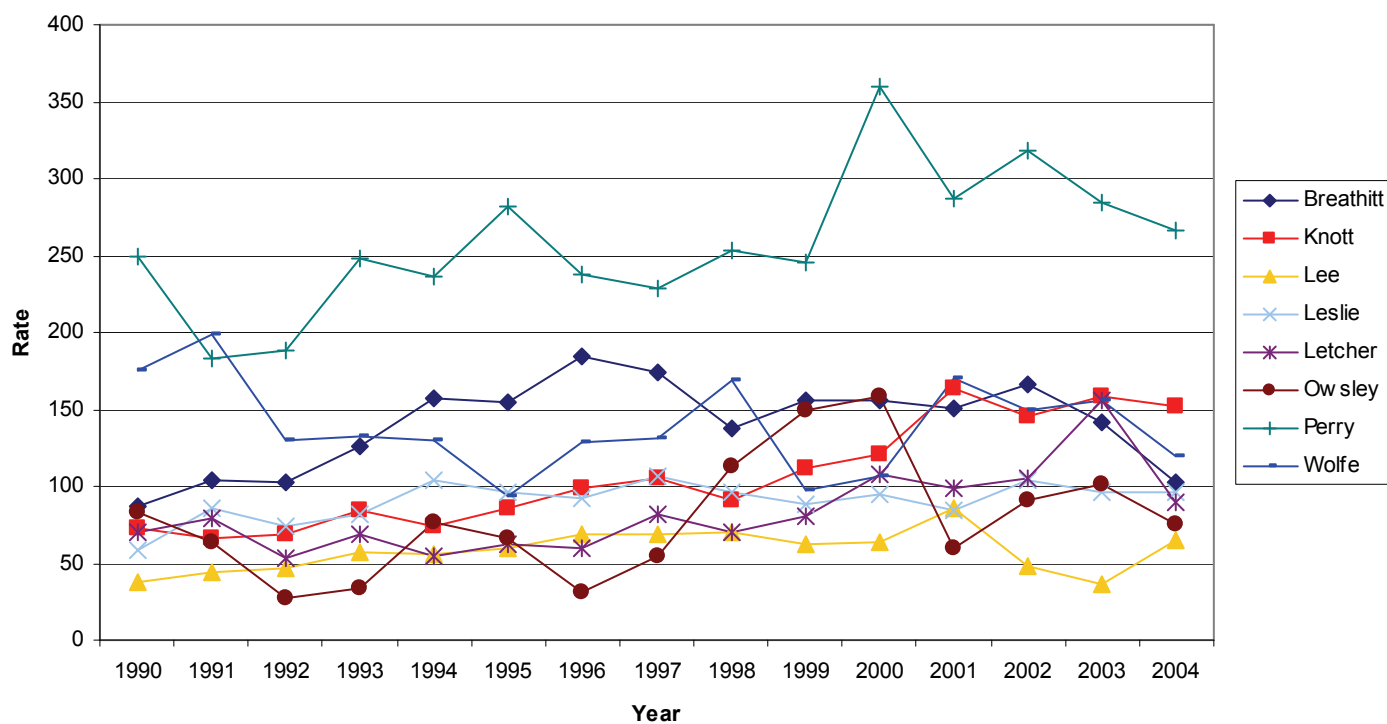


Figure 4
Property Crime Per 10,000 Population, KY River District 1990-2004



Unlike the erratic property crime rates in Eastern Kentucky, violent crime has steadily decreased. Each Development District had a lower violent crime rate in 2004 than in 1990. For example, Gateway's 1990 violent crime rate was 32 per 10,000; its 2004 rate was 14.06 per 10,000. Big Sandy's violent crime rate was 17.68 per 10,000 in 1990; in 2004, the district had a rate of 14.5 per 10,000. Cumberland Valley had a rate of 22.9 per 10,000 in 1990 and 2004 rate of 11.2 per 10,000 population. Kentucky River's violent crime rate was 30.1 in 1990 and half that rate in 2004 of 15.7 per 10,000. Figures 5, 6, 7, and 8 show the longitudinal trends in violent crime for these four Development Districts.

Figure 5
Violent Crime Per 10,000 Population Gateway District 1990-2004

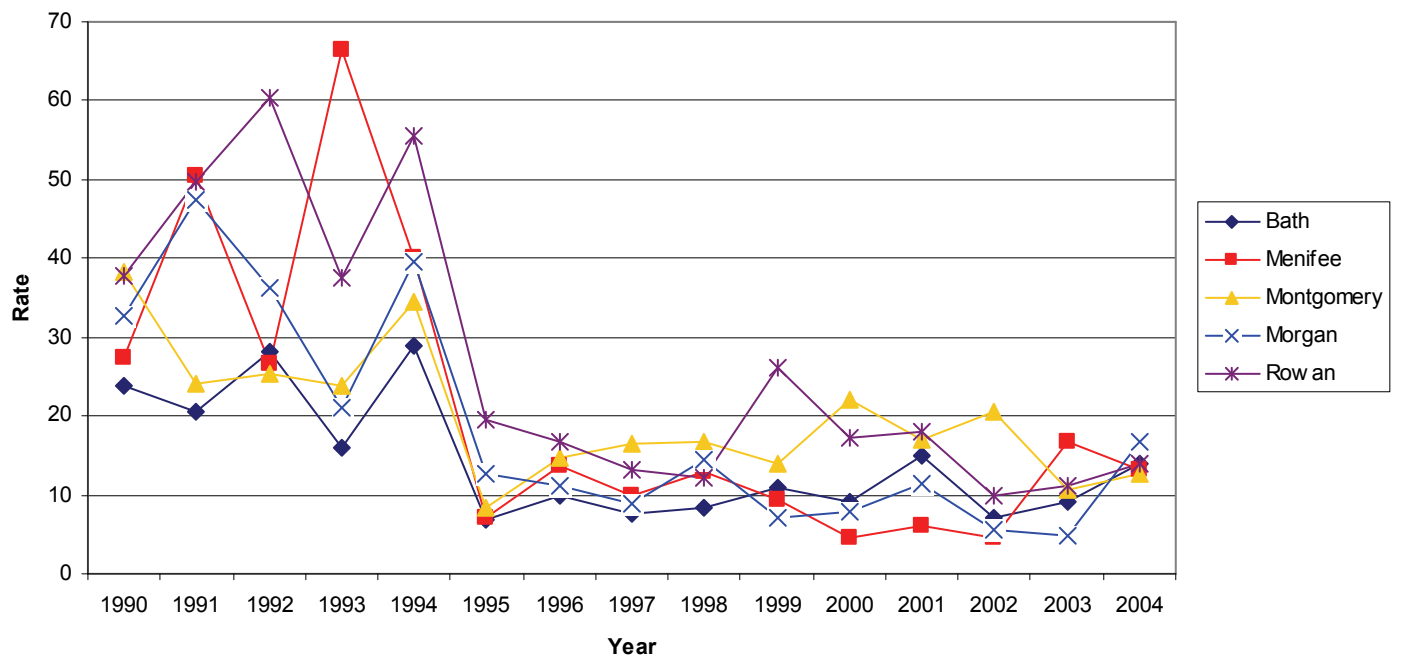


Figure 6
Violent Crime, Per 10,000 Population, Big Sandy District 1990-2004

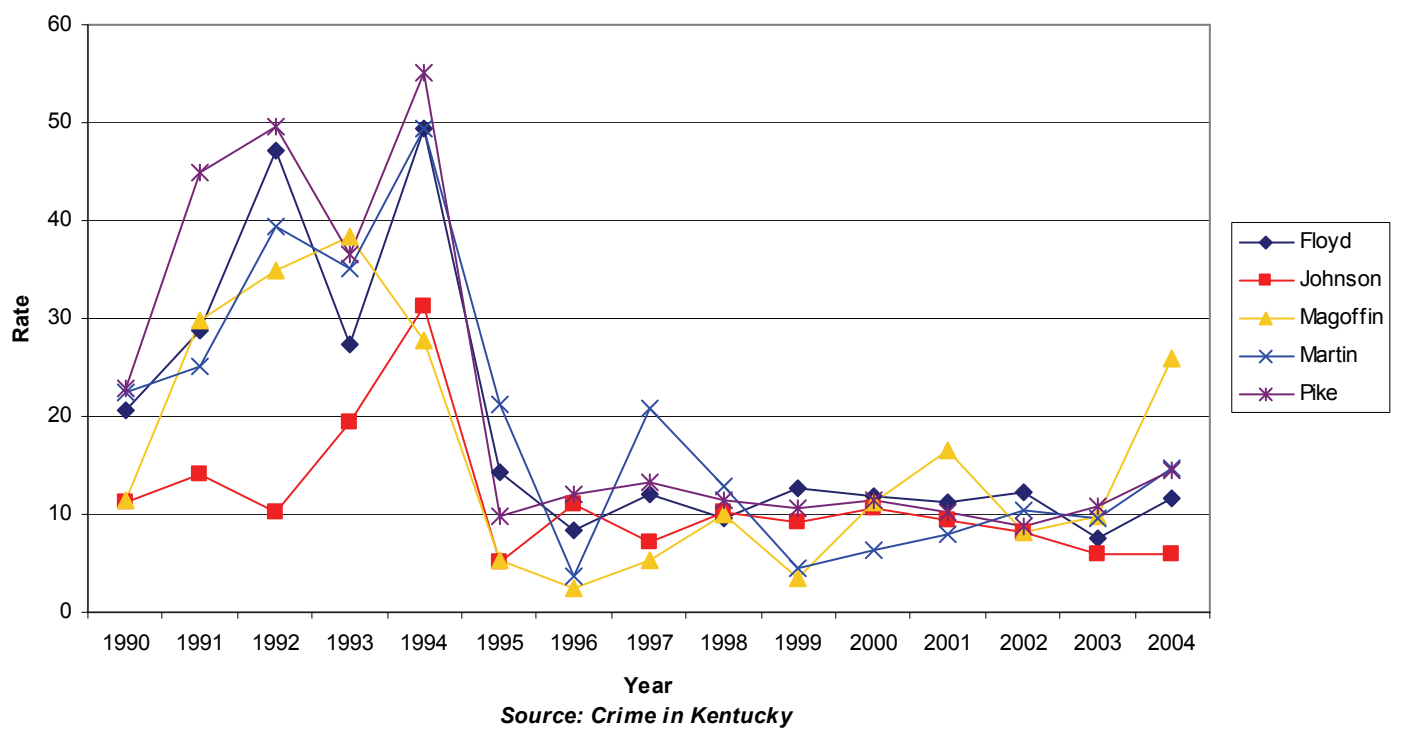


Figure 7
Violent Crime Per 10,000 Population, Cumberland Valley District, 1990-2004

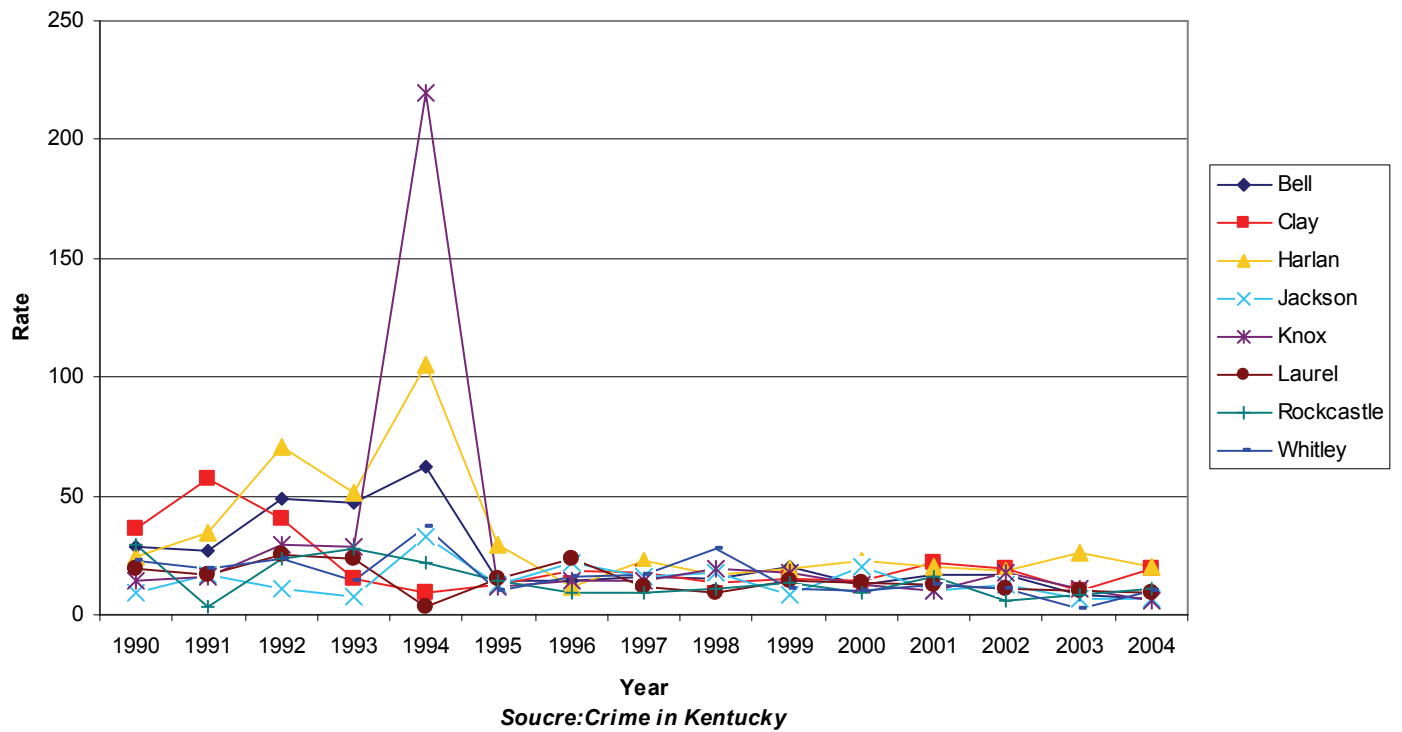
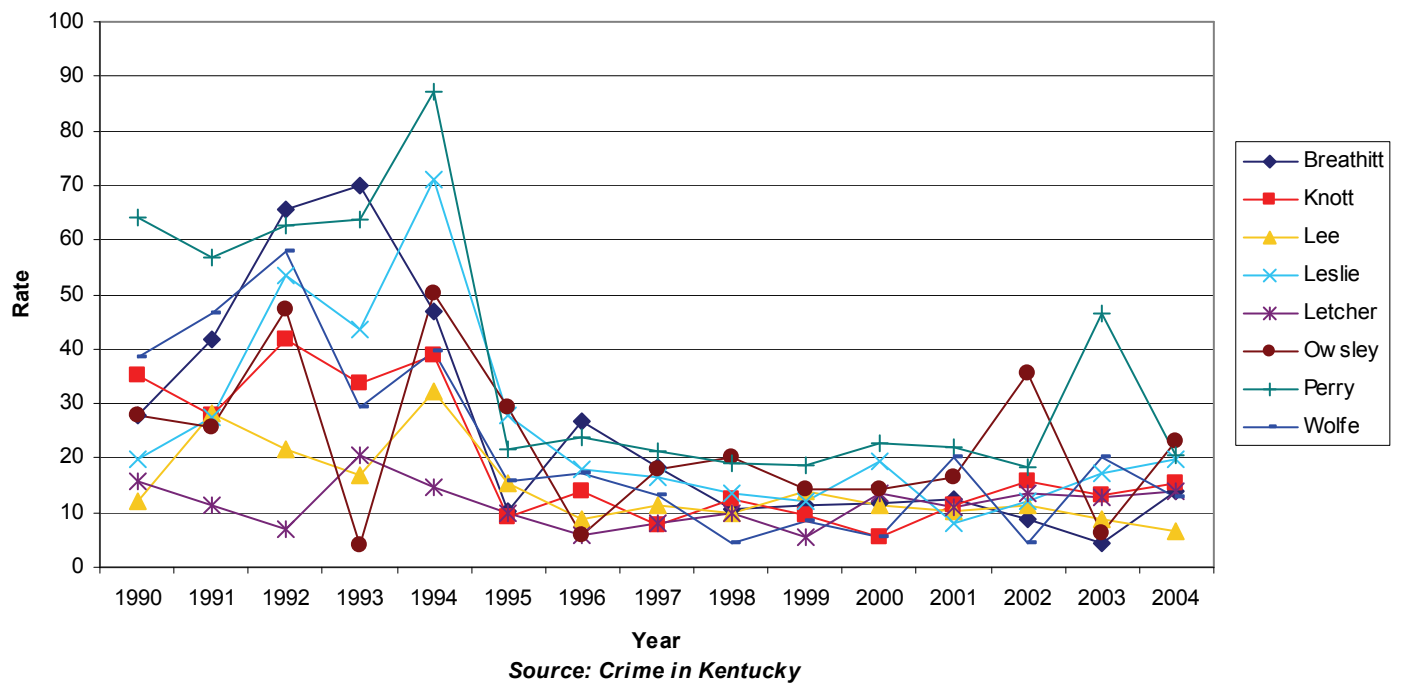


Figure 8
Violent Crime Per 10,000 Population, KY River District, 1990-2004



Like Eastern Kentucky counties, state-wide numbers have fluctuated with lower rates in 2004 than in 1994. In fact, state wide, crime has declined since 1996. Violent crime has decreased by 24.5 percent since 1996. Property crime has decreased by more than eight percent since 1996 although it increased by one percent from 2003 to 2004 (as is reflected in the Development Districts' 2004 numbers). The data simply do not support linking any crime increases (or decreases) directly to the introduction of OxyContin.

Beyond the state and region, the *Boston Herald* reported that “[OxyContin] is seen as fueling a crime wave around the country, particularly in poor areas” (Lasalandra 2003). According to this story, a national crime epidemic is associated with the use of this one drug. Yet, the fact is, no such crime wave exists. Crime rates in the United States for years have steadily decreased. Property crime (the type most commonly associated with drug abuse) decreased from a high of 5,140 per 100,000 population in 1991 to 3,624 per 100,000. Property crime rates declined 23.4 percent from 1995 to 2004, stabilizing in 2002. Violent crime rates have steadily declined, dropping 32 percent from 1995 to 2004, reaching the lowest levels on record. The percentage of households experiencing any type of criminal victimization has steadily decreased as has the raw number of households experiencing any crime (Uniform Crime Report 2004; Sourcebook of Criminal Justice Statistics 2004).

Furthermore, longitudinal data from 1988 to the present show that the ten states with the highest per capita OxyContin use have lower property and violent crime rates than the ten states with the lowest per capita OxyContin use. Not only is a national crime wave a fabrication, those very states with the highest OxyContin use per capita have experienced declining crime rates since OxyContin was first marketed, although differences between these two groups of states are

narrowing and are not statistically significant.

Even Kentucky's recently elected governor weighed in by publishing that ". . . OxyContin problems [are] overwhelm[ing] the law enforcement communities . . . Substance abuse is increasingly linked to violent crimes . . . Over the past eight years, crime has increased in Kentucky" (Fletcher and Pence 2003: 33 & 37). Yet, rather than discussing Kentucky's dynamic crime rates (based on population), the fact that crime in Kentucky did not increase during that period, or that violent crime rates were lower in 2003 (and 2004) than in 1996, the realities of crime and public perceptions of it were skewed as this publication reported the scary number of crimes occurring each minute.

OxyContin Arrests in Eastern Kentucky

Rhetoric evidently is more newsworthy than the realities of crime and drug abuse. For example, one Kentucky State Police Captain reportedly claimed that "with drugs such as cocaine and marijuana, police could occasionally work their way to Mr. Big." But, regarding OxyContin and other narcotics, the Captain stated that "each day brings a new kingpin depending on who got their prescription filled" (Johnson 2003: A8). This is a poor analogy. A prescription translates to about 30 pills -- hardly a "kingpin's" normal inventory. Yet such rhetoric is accepted by the media and reported uncritically to an alarmed public.

Other unsettling instances include the reporting of "Oxyfest," the biggest drug raid in Kentucky history that netted 201 alleged OxyContin dealers in a two day Federal and State law enforcement crackdown ("Police arrest 201 in OxyContin crackdown" 2001). One U.S. Attorney General, justifying the arrests, claimed that during the previous year, OxyContin had caused 59 deaths in Kentucky alone (Alford 2001; "Raids in Kentucky aim at Deadly New

Drug” 2001). Purdue Pharma dismissed his estimates as “inflammatory.” Although published widely, the Attorney General’s claims are not empirically supported.

Beyond the published claims about the OxyContin - crime connection, there were and are all sorts of reports on high levels of OxyContin use and arrests. As was noted previously, some claim that OxyContin cases are dominating law enforcement and court dockets. Yet data indicate that law enforcement attention to OxyContin was short-lived -- only during the year 2001 -- despite rhetoric to the contrary.

Arrest trends are consistent across the Eastern Kentucky region. The drug category that includes oxycodone, “Opium or Cocaine and their Derivatives,” includes any derivative of the poppy plant such as opium, cocaine, morphine, heroin, methadone, and hydrocodone. Arrests for that drug category have varied widely across the past decade and a half. At the beginning of the 1990s, arrest rates for the region averaged about eight per 10,000 population. Arrest rates dropped, however, to about two and a half per 10,000 in 1995. Afterwards, arrest rates never reached their 1990 level until the year 2001 when the regional average jumped to 29 arrests per 10,000. The very next year, they markedly dropped off to 3.72 per 10,000. They remain at nearly that level today. Figures 9, 10, 11 and 12 show longitudinal drug arrests for the four Eastern Kentucky Development Districts.

Figure 9
Drug Arrests Per 10,000 Population, Gateway District, 1990-2004

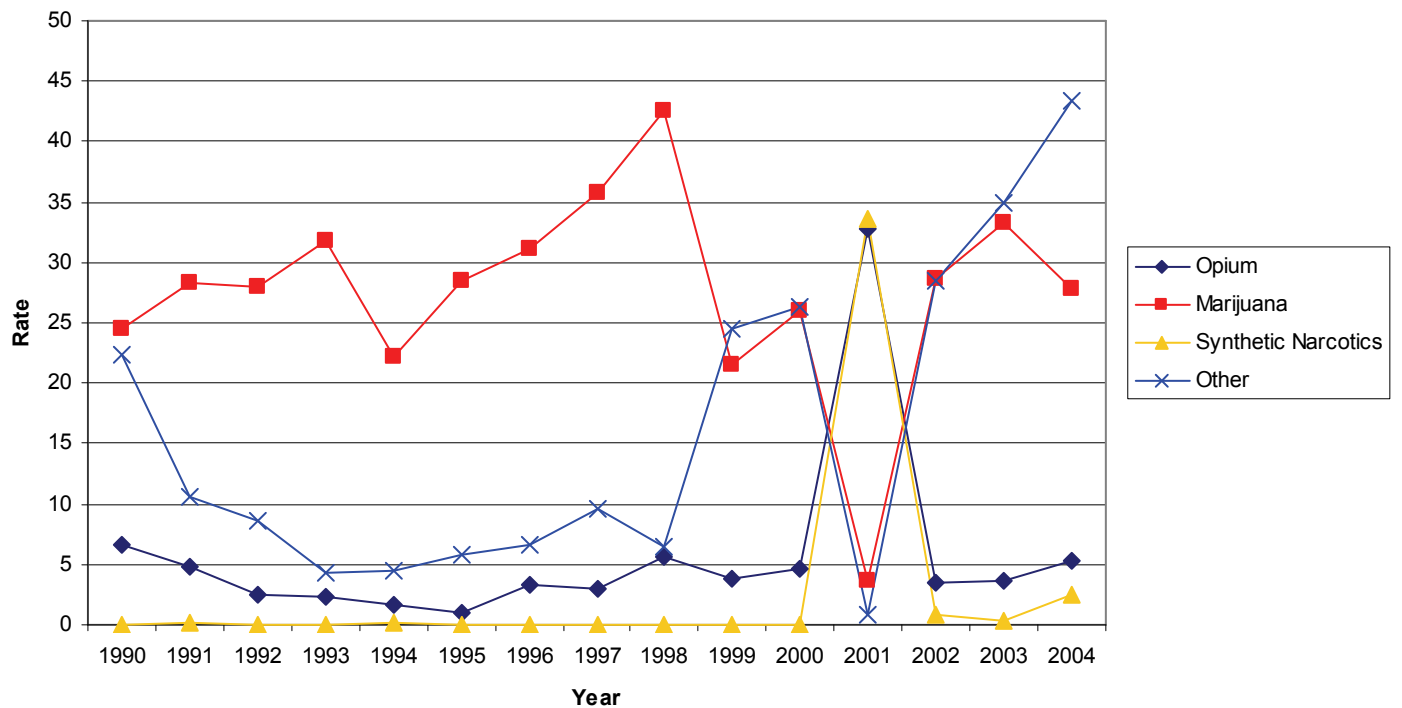
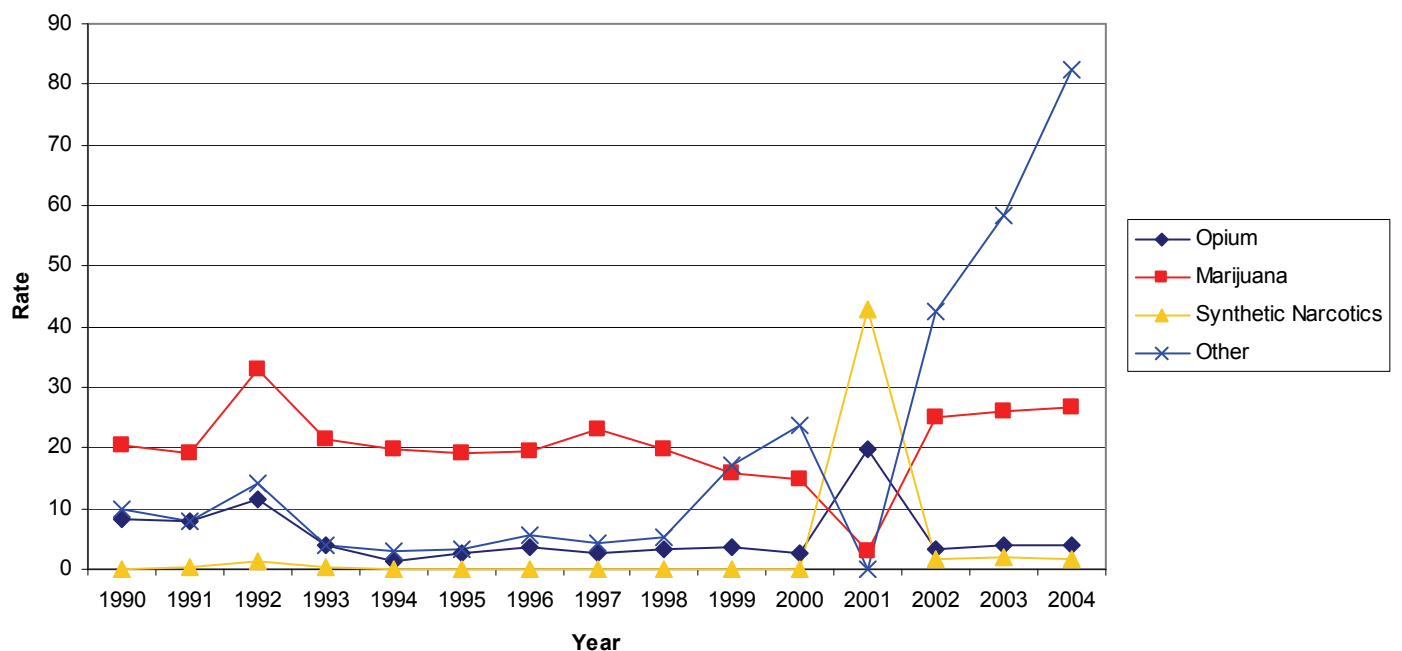


Figure 10
Drug Arrests Per 10,000 Population, Big Sandy District, 1990-2004



Source: Crime in Kentucky

Figure 11
Drug Arrests Per 10,000 Population, Cumberland Valley District, 1990-2004

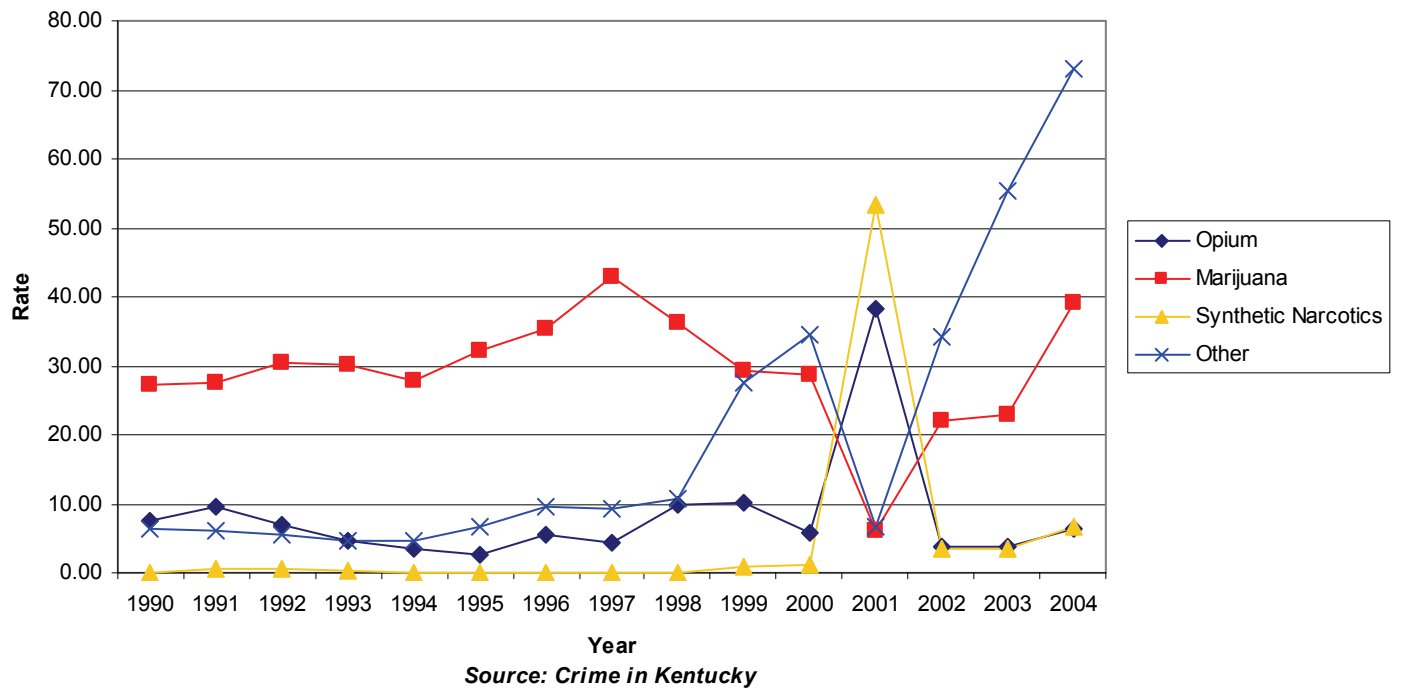
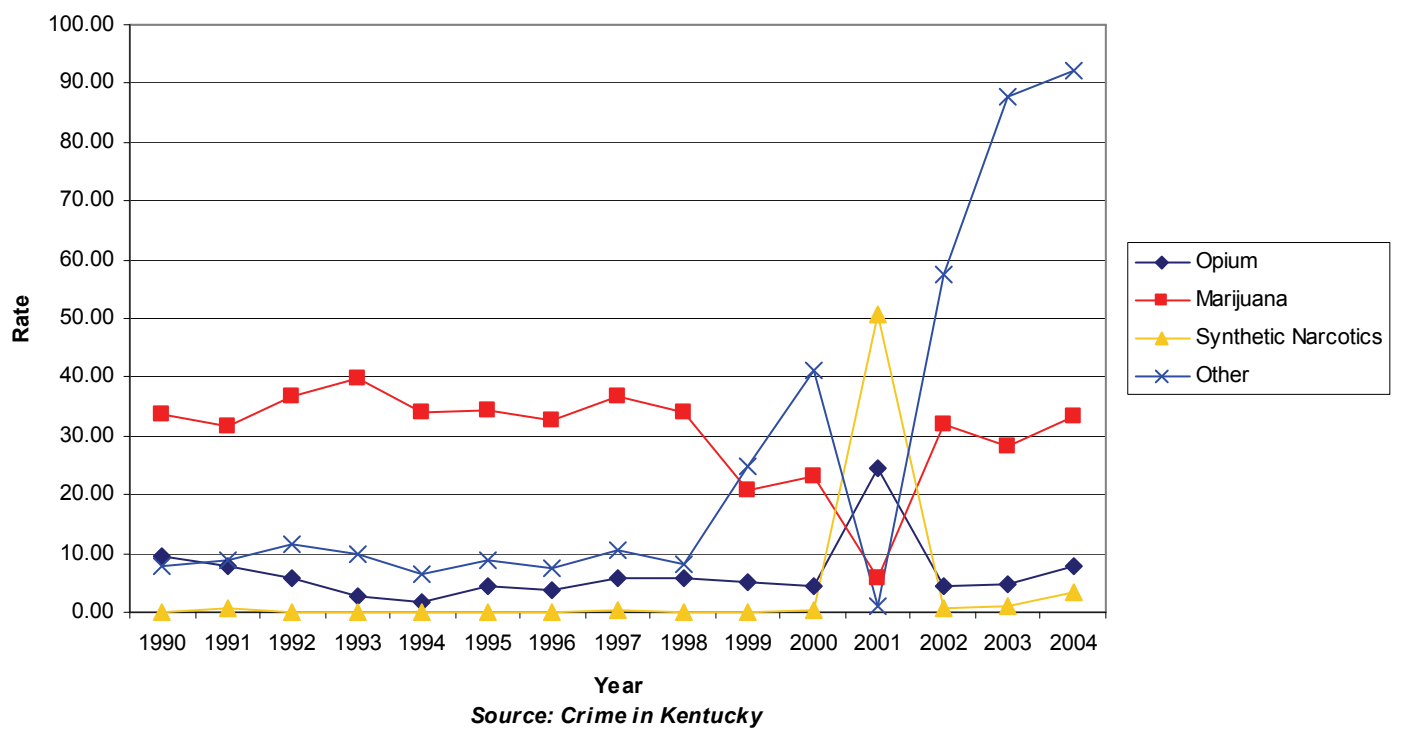


Figure 12
Drug Arrests Per 10,000 Population, KY River District, 1990-2004



Likewise, regional arrests for synthetic narcotics which can cause addiction (e.g., methadone, Demerol, Darvocet) in 1990 averaged .0425 per 10,000. In 1995, there were no reported arrests in Eastern Kentucky for synthetic narcotics. The next few years witnessed arrest rates of less than one per 10,000. In 2001, however, the region's average arrest rate markedly increased to 45 per 10,000 population. But, just as sharply, rates dropped off the very next year to a regional average of 1.65 per 10,000. They remain at about that level today.

Across the past decade and a half, marijuana arrest rates were several times higher than rates for any other drug category. That is, until the year 2001. Just as opium and synthetic arrests significantly increased, regional marijuana arrests plummeted from 23.16 per 10,000 (in 2000) to 4.6 in 2001. The very next year, regional marijuana arrest rates jumped back to almost 27 per 10,000. Regional averages remain at about that level today.

Regional arrest rates for the category "Other Dangerous Non-Narcotic Drugs" which includes stimulants, hallucinogens, and depressants were in double digits for the years 1999 and 2000, averaging over 31 per 10,000. Like marijuana, arrests for this category significantly declined during 2001 to a low of 2.09 per 10,000. But, unlike rates for opiates and synthetic narcotics, arrest rates for this drug category increased markedly the very next year and have remained high -- in fact higher than any other drug type. The regional arrest average was nearly 73 per 10,000 in 2004.

Given all the rhetoric about OxyContin abuse, trafficking, doctor shopping, prescription fraud and on and on, these data likely are surprising. If indeed the problem were as dire as published accounts have led us to believe, then arrests should have remained somewhat consistent with 2001 levels. But, as the data show, arrests sharply increased for only one year --

2001 -- the very year that the OxyContin problem received so much attention from media and public officials. Ironically, the local newspaper, *The Lexington Herald Leader*, gave the OxyContin story front page news coverage during 2003, a year when arrests for the drug category that includes OxyContin were at about four per 10,000 population.

Law enforcement likely responded to a socially constructed crisis, then when attention (and perhaps, funding and other resources) waned, returned to policing marijuana and the more serious drug of abuse -- methamphetamine (which is part of the Other Dangerous Non-Narcotic Drug category). Since then arrests for all other drugs have been much higher than for OxyContin and other opiates. Yet, media coverage of methamphetamine has not equaled that given to OxyContin and other narcotics.

Explanations

OxyContin abuse is a highly localized problem requiring specific interpretations. Probable explanations for OxyContin abuse within rural eastern Kentucky include the following: prescription drug use is a culturally entrenched phenomenon in Eastern Kentucky; Kentucky leads the nation in prescription drug use in part due to the state having the fourth highest cancer rate in the nation; Kentucky has an above-average older population that uses prescription drugs; Kentucky's higher levels of chronic illnesses and debilitating diseases contribute to increasing numbers of pharmaceutical prescriptions and addictions; prescription fraud largely has been ignored by medical, academic and legal communities; OxyContin is a very powerful drug whose design makes it easy to abuse; and Purdue Pharma aggressively promoted OxyContin. This last explanation is particularly telling.

Over the first five years of manufacture, OxyContin sales totaled \$2 billion --

considerably higher than the company's projected \$350 million ("Painkiller's sales far exceeded levels anticipated by maker"). According to the *Wall Street Journal*, sales and marketing projections for OxyContin took shape during 1995 when Purdue planned on committing 70 percent of its sales force's time to OxyContin immediately after its introduction into the market ("Painkiller's sales far exceeded levels anticipated by maker"). After five years, the sales force was expected to devote 40 percent of its time to OxyContin. But, by Spring 2002, Purdue Pharma's sales force was spending 80 percent of its time promoting it. Marketing strategies specifically targeted medical doctors known for prescribing large numbers of painkillers. Sales representatives personally called on hospital committees responsible for deciding which drugs to use (Camp 2003c). In all fairness, such promotional measures evidently are the norm within the pharmaceutical industry. Purdue's efforts, however, paid off in a big way. According to the DEA, OxyContin retail sales are now greater than for any other brand-name controlled pharmaceutical (Ambien, a sleeping pill, ranks second and Xanax eighth) (OxyContin diversion and abuse 2002).

Yet a drug panic emerged about OxyContin specifically despite the steady increase in sales of other pharmaceuticals. For example, Ambien sales increased 31 percent from 2000 to 2001; Duragesic, an analgesic patch that slowly releases "strong medicine for strong pain," had a 50 percent sales increase; Adderall, an amphetamine regularly prescribed for attention deficit disorders increased in sales 66 percent; Meridia, a drug used for "weight maintenance," increased its sales by 45 percent; and Vicoprofen, a non-single entity hydrocodone, increased in sales by 20 percent during this same period. Since 1990, hydrocodone national consumption has increased by 300 percent (Drug Enforcement Administration, Office of Diversion Control).

Media attention, though, was nearly singly focused on OxyContin.

Another explanation for high levels of OxyContin in Eastern Kentucky is the dual role of the DEA. Other than enforcing federal drug laws, the DEA is responsible for determining manufacturing quotas for legal, prescription drugs including powerful analgesics. The Controlled Substances Act mandates that the DEA prevent, detect and investigate the diversion of legally manufactured controlled substances all while ensuring that there are adequate supplies to meet legitimate medical needs. The agency recently authorized sharp increases in production of specific addictive analgesics. The 2003 quota for hydrocodone, for example, was 14 percent higher than 2002 and 75 percent higher than a decade ago (Camp 2003a). Oxycodone production, authorized by the DEA, has increased 1,200 percent since 1993 (Diversion Control Program).

Both corporate and government policies and practices, particularly the DEA's charge, have contributed to the growth of OxyContin use and abuse in a number of states, most notably those in central Appalachia and specifically in Eastern Kentucky. The pharmaceutical industry (along with government support and policy) likewise contributed to the problem. Data show that parts of Eastern Kentucky ranked highest nationally in per capita narcotics distribution. Although distributed legally, some drugs are diverted into illegal black markets. And, an axiom about narcotic dispersal is that the more drugs legally bought and sold in a particular area, the more that will be illegally diverted (Johnson 2003a; 2003b).

Although Eastern Kentucky's counties led the nation, narcotics distribution increased nationally during the late 1990s as chronic pain was treated more aggressively than previously (Johnson 2003a). The American Pain Society, for example, representing 3,500 pain specialists,

during its 2002 annual convention, endorsed the use of OxyContin for severe cases of osteoarthritis (Tanner 2002). A year before, medical doctors adopted a new and aggressive approach to treating pain by recognizing it as a vital sign. This means that physicians measure and manage pain as any other vital sign, blood pressure, for example. Congress, during the 2000 session, declared the first years of the 21st century as the “Decade of Pain Control and Research” (Kalb 2001: 45). It seems that even these progressive measures by Congress and the medical community may have contributed, at least indirectly, to a drug abuse and diversion problem.

Conclusion

Like all social problems, the origins of OxyContin abuse are located in social events that require social explanations. Kentucky’s problem with OxyContin abuse has particular social antecedents. They include: Purdue’s sales and marketing strategies, Congress’ declaration of the “decade of pain,” the medical community treating pain differently (as a vital sign), the DEA granting increases in manufacturing, and a history of pharmaceutical use and abuse in rural Kentucky. On the other hand, the OxyContin epidemic’s relationship to crime in Kentucky evidently is a socially constructed one with little empirical support. Likewise, increased OxyContin use is not affecting drug arrest rates, given that arrests increased significantly in 2001 but decreased just as sharply in 2002 (where rates remain today).

Whenever drug scares emerge, such as this most recent one with OxyContin, the role of the mass media and its focus on a drug at a particular point and time must be questioned. Questions also must be raised about how the public comes to accept their stories. Table 1, as discussed earlier, illustrates the incredible growth in news stories given to OxyContin from zero

news or health articles in 1998 (and 1999) to a high of 404 stories in 2001, to little more than half that number in 2003 and increasing to a new high of 551 in 2004. Such news saturation about one particular phenomenon contributes to the public acceptance of that news as fact. The *Lexington Herald-Leader*, the major newspaper serving the bluegrass and the eastern Kentucky regions, ran a 12 part series titled, "Prescription for Pain," between January 19 and February 16, 2003 (and a Sunday December 7 insert of 20 pages) that detailed the OxyContin problem and its alleged connection to worsening crime trends. The coverage detailed narcotics abuse and arrests in Kentucky. Yet, it inaccurately presented OxyContin as the most significant factor for explaining crime fluctuations and increasing drug arrests; it wrongly characterized crime and arrest trends in Eastern Kentucky. These and other nebulous characterizations were unnecessary, some might say, irresponsible, since crime and arrest data are freely accessible to the public.

The OxyContin-crime panic, like others, is a socially constructed occurrence. Scares usually result in an extreme reaction to a perceived drug problem that may not necessarily correspond to its actual social or individual harm. A panic may arise regardless of a drug's pervasiveness or increases and decreases in its use. Drug scares, it has been noted, "are independent phenomena, not necessarily related to actual trends or patterns in drug use or trafficking" (Brownstein 1995: 55). Drug scares, as moral panics, are symbolic crusades that involve particular interest groups or agencies that lead the way in labeling the drug as dangerous. In some cases those groups and agencies benefit from such. This historically has been the case as public officials, often aided by media outlets, make less than honest claims for greater crime fighting resources and social control initiatives. The OxyContin-crime propagated relationship evidently is only the latest in this long history.

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Notes

1. Lorcet and Lortab are brand names for the drug Vicodin, a non-single entity hydrocodone. An analgesic for moderately severe pain, Vicodin is an addictive drug.

2. Two sentences from the *Newsweek* article are illustrative: "Hazard has a long tradition of self-medication. Moonshine and marijuana, grown in its fertile soil, have long helped blot out depression, boredom, even physical pain . . . OxyContin seemed like the most potent antidote yet to the local despair" (Rosenberg 2001: 49). What Rosenberg fails to acknowledge is that moonshine is made and marijuana grown largely as revenue-producing export products. Granted, these drugs are used locally, but Hazard, Kentucky is "wet" and spirits are legally bought and sold.

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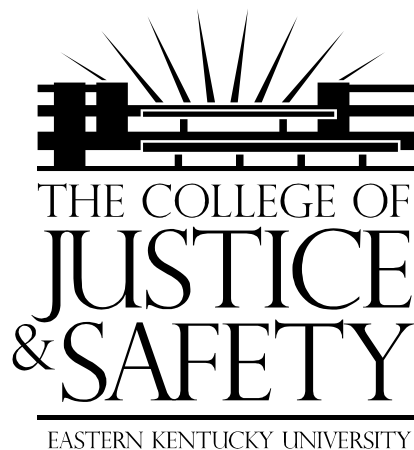
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**Dr. Allen Ault
Dean, College of Justice and Safety

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College of Justice & Safety

457 Stratton Building

Eastern Kentucky University

521 Lancaster Avenue

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