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The Role of Pressure Groups and Problem Definition in Crafting Legislative Solutions to the Opioid Crisis*

*Taleed El-Sabawi***

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** Taleed El-Sabawi, JD, MS is an Assistant Professor of Law at Elon University School of Law.

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I. Introduction

The United States legislature has historically favored punitive legislative proposals to addressing problem drug use.[1] However, in addressing the current opioid crisis, legislators have been critical of past punitive approaches, [2] such as arguing that "we cannot arrest our way out of this problem."[3] Federal legislation enacted to address the opioid crisis evidences that legislators are willing to act on this rhetorical shift away from punitive approaches and have done so in a bipartisan manner.[4] Such a shift in legislative approaches is often preceded by a change in the problem definition, causal theories and aligning proposals supported by administrative agencies and organized interest groups.[5]

The rhetoric supporting recent federal legislation has evidenced an increasing acceptance of the ideas that addiction is a disease and that the opioid crisis is a public health issue.[6] Addiction has been compared to other chronic health conditions, which require long-term maintenance,[7] but the comparison has often not

1 *See generally* Taleed El-Sabawi, *Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition*. 48 U. MEM. L. REV. (forthcoming 2019).

2 *See, e.g.*, Mike Lee, *We Can Beat the Opioid Epidemic*, MIKE LEE U.S. SENATOR UTAH (May 10, 2018), https://www.lee.senate.gov/public/index.cfm/2018/5/we-can-beat-the-opioid-epidemic.

3 *Id.*

4 *See, e.g.*, Comprehensive Addiction and Recovery Act of 2016 (CARA), Pub. L. No. 114-198, 130 Stat. 695 (2016); 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016). CARA is bipartisan legislation that was passed with a 94–1 vote in the Senate and a 400–5 vote in the House. 162 CONG. REC. S1404 (daily ed. Mar. 10, 2016); 162 CONG. REC. H2373 (daily ed. May 13, 2016). CARA includes funding for education, treatment, prescriber training, overdose reversal medication, and prescription drug monitoring programs (PDMPs)—policy solutions that facially appear more aligned with a health approach. The 21st Century Cures Act built on CARA by providing an additional $1 billion of funding over two years. 21st Century Cures Act.

5 Causal theories are the stated thories of causation of a social problem and are components of causal stories. *See* DEBORAH A. STONE, POLICY PARADOX: THE ART OF POLITICAL DECISIONS MAKING 206–07 (3d ed. 2012). *See generally* El-Sabawi, *supra* note 1 (providing historic examples of how changes in problem definitions have historically preceded changes in legislative approaches in drug policy).

6 *See, e.g.*, *Portman, Whitehouse, Ayotte, Klobuchar Cheer Final Passage of Comprehensive Addiction and Recovery Act*, ROB PORTMAN U.S. SENATOR FOR OHIO (July 13, 2016) [hereinafter *Portman*], http://www.portman.senate.gov/public/index.cfm/2016/7/portman-whitehouse-ayotte-klobuchar-cheer-final-passage-of-comprehensive-addiction-and-recovery-act.

7 *Drug Abuse and Addiction: One of America's Most Challenging Public Health Problems*

extended to the social determinants of chronic conditions.[8] As such, federal legislation, like the Comprehensive Addiction and Recovery Act of 2016 (CARA) and the 21st Century Cures Act, does not fully embrace model drug policy[9] or evidence a substantive attempt to address the psychological-sociological-economic (PSE) factors that contribute to problem drug use.[10]

Since organized interest groups and federal administrative agencies have historically been influential in defining problem drug use during nationwide crisis,[11] it stands to reason that the manner in which these pressure groups defined the problem may have influenced or, at least, provided support for legislators' decisions to shy away from a criminal justice approach. These pressure groups[12] may have also affected legislators' decisions to resort to a "health" approach that did not comprehensively address demand factors or demonstrate a commitment to reforming U.S. drug policy to meet international standards of best practice.[13] To date, little scholarly analysis has been conducted on the involvement of organized interests and federal administrative agencies in defining the causes of the opioid crisis and the preferred legislative solutions.

In an effort to provide a snapshot of what such involvement

– *Addiction is a Chronic Disease*, NAT'L INST. DRUG ABUSE (June 2005), https://archives.drugabuse.gov/publications/drug-abuse-addiction-one-americas-most-challenging-public-health-problems/addiction-chronic-disease.

8 *See, e.g.*, *Portman*, *supra* note 6.

9 *See* TAMYKO YSA ET AL., GOVERNANCE OF ADDICTIONS: EUROPEAN PUBLIC POLICIES 47–48 (2014) (comparing European policies and identifying best practices).

10 *See supra* note 4, and accompanying text.

11 *See generally* DAVID F. MUSTO, AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL (Oxford Univ. Press, 3d ed. 1999) (1973). *See also* El-Sabawi, *supra* note 1.

12 For the purposes of this paper, I have defined pressure groups to include all groups that place pressure on legislators to vote for an issue in a specified manner. My definition therefore includes both organized interest groups outside of the government and administrative officials within the government.

13 *See* ALICE RAP SCIENCE FINDINGS #1–5, #40–51, ALICE RAP (n.d.) [hereinafter ALICE RAP FINDINGS], https://www.alicerap.eu/resources/documents/doc_download/387-alice-rap-science-findings-full-document-55-findings.html. ALICE RAP was a research collaboration by 200 scientists from 25 countries and more than 29 disciplines aimed at compiling evidence to inform European drug policy. *About ALICE RAP: The Project and Results*, ALICE RAP, https://www.alicerap.eu/about-alice-rap.html#a-governance-of-addictions (last visited Mar. 28, 2018). The researchers also analyzed existing drug policies in European countries and provided suggestions for how to implement best practices. *See generally* ALICE RAP FINDINGS, *supra* note 13.

may look like, this article explores the types of narratives used by pressure groups to define the opioid crisis in the congressional hearing discourse prior to the enactment of CARA. In order to do this, I analyzed 144 congressional hearing testimonies[14] discussing the opioid crisis and identified the most common narratives used to explain the causes of the opioid crisis.[15] I also identified the types of legislative proposals supported in these narratives.

Understanding the narratives used by organized interests and federal administrative agencies to define the opioid crisis offers some insight as to the narratives that were used to justify the inclusion of the provisions enacted in CARA, as narratives can be used to narrow down the available alternative legislative solutions. Organized interest groups offer the opportunity for citizens, including invested professionals, researchers, and individuals suffering from a substance use disorder, to engage in the problem definition process and influence the types of legislative proposals enacted. Gaining a better understanding of how organized interests have contributed or shaped the legislative problem definition discourse will better equip activated citizens to navigate the pluralist discourse and advocate for significant change.

14 The corpus, or population, of documents that were analyzed were compiled by conducting a search on Thomas Reuters Westlaw for congressional hearing testimony using the search terms "addict!" and "overdose!" and limiting the dates to hearings occurring in January 2014 to June 2016. I chose to limit the analysis to hearings occurring within these dates because it would capture the discourse that preceded CARA, which was passed in June 2016. I restricted the dataset to 2014 because of resource constraints. Future research will be needed to determine whether the findings of this article are time-limited. The terms addict! and overdose! were chosen because the purpose of my analysis is to capture the discourse on the social problem commonly referred to as the opioid crisis. It has been characterized by rates in overdose and an acknowledgment of the problem of addiction. I then excluded testimony, or parts of testimony, that discussed methamphetamine use, synthetic drug use, and marijuana use, as these problems were characterized differently than the opioid crisis, a difference I hope to capture in a future analysis. The results were then limited to hearings that occurred from 2014 to 2016. Both written and oral testimony were included.

15 To analyze the congressional hearing testimony, I used both qualitative and quantitative text analysis. I used QDAMiner5 for the qualitative coding and Wordstat7 for the quantitative analysis. I used content analysis methodology to create categories of causal stories and proposed solutions. Once the categories were saturated, meaning causal stories I identified fit into the categories created and no additional categories needed to be created, I identified patterns and broader themes evidenced by the categories.

I begin Part II with a discussion of how organized interest groups and federal administrative agencies are theorized to influence legislators, with a short overview of the problem definition and the role of causal stories—a type of policy narrative—in the problem definition process. In Part III, I discuss the types of causal stories that I identified in my analysis of congressional hearing testimony, contrasting these narratives with narratives that were used in the past to support criminal justice legislative approaches. Part IV concludes with suggestions on how pressure groups can utilize this political window of opportunity[16] to shift the narrative discourse from policy narratives based on causal theories of supply to causal theories that acknowledge the sociological, biological, environmental, behavioral, psychological, and economic causes of problem drug use.

II. Theories of Pressure Group Influence

Although for much of this article, I refer to organized interest groups and federal administrative agencies collectively as pressure groups, the literature analyzing their influence on legislative behavior is distinct so I review each separately.

A. Empirical Evidence of Pressure Groups' Influence on Federal Legislators

Although organized interest groups are thought to influence federal legislators through their campaign contributions, little empirical evidence exists supporting the contention that money buys groups their preferred legislative outcomes.[17] Since organized interest groups continue to spend millions of dollars funding campaigns, they must believe that the money spent is buying them something of importance. If campaign contributions are not buying legislative outcomes, they may be buying legislators' time. Investigators have

16 I am using "political window of opportunity" here to refer to a phenomenum that is originally described by Dr. John Kingdon as a "policy window," which occurs when three streams meet: the problem stream, the policy stream, and the politics stream. *See* JOHN KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 165–66 (2d ed. 1995).

17 See Beth L. Leech, *Lobbying and Influence*, *in* THE OXFORD HANDBOOK OF AMERICAN POLITICAL PARTIES AND INTEREST GROUPS 534–51 (L. Sandy Maisel & Jeffrey M. Berry eds., 2010) for a review of the literature. However, there is literature that shows that groups may contribute to legislators that are on powerful committees. *See, e.g.*, Eleanor Neff Powell & Justin Grimmer, *Money in Exile: Campaign Contributions and Committee Access*, 78 J. POL. 974, 976 (2016).

found that legislators are more likely to meet with groups that contribute to their campaigns.[18] So, although organized interest groups may not be buying votes, they may be buying legislator time and attention.[19]

Organized interest groups can use this time to define social problems using causal stories that best align with their desired outcomes.[20] Legislators are inclined to listen to organized interest groups, even if the groups have not contributed large sums of money to their campaigns, because interest groups may be privy to specialized, subject-matter-specific information.[21] This information provides legislators with policy-specific information that they can use to make informed decisions and support their positions. These interest groups subsidize the legislators' costs of acquiring this information, costs that can include time and resources.[22] Meanwhile, these groups can use their privileged position to define the problem advantageously.

B. Federal Administrative Agencies as Narrators in U.S. Drug Policy

The idea that organized interest groups use causal narratives to sway legislators may seem more intuitive or believable than the use of causal narratives by federal administrative agency officials to do the same. However, historically, in the U.S., high ranking officials in federal administrative agencies have been dominant

18 Joshua L. Kalla & David E. Broockman, *Campaign Contributions Facilitate Access to Congressional Officials: A Randomized Field Experiment*, 60 Am. J. Pol. Sci. 545, *passim* (2016).

19 *See id.* at 545.

20 These outcomes of interest may not necessarily be legislative outcomes. An organized interest group may be interested in changing the dominant problem definition, in and of itself. For example, a group of persons recovering from addiction may be invested in the adoption of the "addiction as a disease narrative"—a narrative that attributes the cause of addiction to a brain disease. Regardless of the legislative outcome, the adoption of such a narrative is a victory in and of itself, as it helps destigmatize addiction by treating it as an illness instead of a moral failing.

21 Richard L. Hall & Alan V. Deardorff, *Lobbying as Legislative Subsidy*, 100 Am. Pol. Sci. Rev. 69, 74 (2006).

22 *Id.* at 72, 74. In general, citizens' groups' reports are given more credibility than industry reports. *See* Jeffrey M. Berry, The New Liberalism: The Rising Power of Citizen Groups 127–29 (1999); William P. Browne, Cultivating Congress: Constituents, Issues, and Interests in Agricultural Policymaking 241 (1995).

players in the problem definition of drug use.[23] The causal narratives crafted by these agencies, often using data collected by the agencies, supported legislative action that limited alternative legislative solutions to those that utilized existing institutional structures. As such, these solutions were easiest to implement, unlike solutions that require multimodal approaches, agency collaboration, and the strengthening of the welfare state—even if such a multimodal approach was empirically the most successful model for combatting addiction and overdose crises.[24] These officials and the agencies that they oversee have influenced the problem definition discourse in a number of ways, including by using their positions as subject matter experts, implementers, and enforcers of legislation to increase the credibility of their definition of the problem when testifying in front of Congress.[25] As such, these agencies participate in the problem definition discourse along with organized interest groups and they may even influence the types of causal theories supported by organized interest groups.

In sum, administrative agencies influence the problem definition discourse by contributing scientific information that supports their causal story and providing accompanying rhetoric. These agencies have historically influenced the problem definition discourse, and in doing so, affected the types of legislative solutions proposed and enacted in U.S. drug policy.[26] The causal stories used by the agencies to describe the causes of drug problems have been supply-side, focusing on the availability of drugs as the cause for use, with the lack of access to drug abuse treatment coming at a distant second.[27] The legislative solution enacted to address the nation's current drug problem is a primarily health-oriented piece

23 *See generally* DAVID T. COURTWRIGHT, DARK PARADISE: A HISTORY OF OPIATE ADDICTION IN AMERICA (enl. ed. 2001) (1982); MUSTO, *supra* note 11. *See generally* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE (Jonathan Erlen & Joseph T. Spillane eds., 2004) [hereinafter Erlen & Spillane].

24 For support for this argument, compare COURTWRIGHT *supra* note 23, MUSTO, *supra* note 11, and ERLEN & SPILLANE, *supra* note 23, with ALICE RAP FINDINGS, *supra* note 13.

25 *See generally* COURTWRIGHT, *supra* note 23; MUSTO, *supra* note 11; Erlen & Spillane, *supra* note 23.

26 *See generally* Erlen & Spillane, *supra* note 23; COURTWRIGHT, *supra* note 23; MUSTO, *supra* note 11.

27 Federal administrative agencies have been historically incentivized to support supply-side policies that are criminal justice oriented. *See* El-Sabawi, *supra* note 1. *See generally* Erlen & Spillane, *supra* note 23; MUSTO, *supra* note 11.

of legislation, and suggests that the causal stories used by federal administrative agencies were more health- or medically-oriented.

III. Causal Stories, Pressure Groups, Congress, and the Opioid Crisis

A. Types of Causal Stories Used by Pressure Groups in Congressional Hearings

In order to get at least a partial view of the types of causal stories used by pressure groups to convince Congress of the causes of the opioid crisis, I reviewed a sample of federal congressional hearing testimony on substance abuse and overdoses between 2014 and 2016. I chose this time period because it preceded the enactment of CARA.

The first trend I noticed was that some narratives included an explicit reference to a cause of the problem (explicit causal theory), while others implicitly suggested the cause by supporting a particular solution (implicit causal theory). Implicit causal theories allowed the narrators to support a causal theory that aligned with a policy solution, without having to explicitly blame certain actors for causing the crisis. Even when explicit narratives were used, pressure groups demonstrated a preference for explicitly blaming groups.

The second major trend I identified was that the criminal justice theme that dominated problem definitions in past drug crises[28] has been overtaken by a health theme that included attributing the causes of addiction to a disease and calling for health actors to be involved in addressing the crisis. Despite the prevalence of the health theme, however, the idea that drug supply caused addiction and overdoses was still ever-present.[29] Finally, only a select few testifiers acknowledged PSE factors[30] as causes of drug use, despite the empirical literature supporting their likely contribution and the emphasis placed on these causes in other developed nations.[31]

28 *See generally* COURTWRIGHT, *supra* note 23.

29 This idea will be discussed in detail in Section III(A)(2)(a), *infra*.

30 In saying psycho-social-economic factors, I am also referencing ideas of despair or lack of hope as factors that contribute to drug use and overdoses. For an overview of the despair hypothesis, see Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS PAPERS ON ECON. ACTIVITY 397, 397–98, 408, 417, 420, 427 (2017). *See also* CARL L. HART, HIGH PRICE: DRUGS, NEUROSCIENCE AND DISCOVERING MYSELF 8, 90–94 (Penguin Books Ltd. 2013).

31 *See generally Technical Reports*, ALICE RAP, http://www.alicerap.eu/resources/

1. *Implicit vs. Explicit Causal Stories*

a. Implicit Causal Stories

A subset of the hearing testimony that I analyzed did not include explicit causal theories, in that the speakers did not unequivocally state the cause of the opioid crisis, but rather, they implied the cause through their support for a particular solution and often through the types of statistics they chose to highlight. Such testimony often began with a general statement of the scope of the opioid crisis, supported by statistics, and then a call for the proposed solution to be adopted.

For example, during one hearing, the U.S. Department of Health and Human Services proposed solutions aimed at decreasing the supply and availability of prescription opioids, including providing support to states invested in prescription drug monitoring programs (PDMPs) and publishing a "best practices" for prescribing opioids without explicitly stating that over-prescription of opioid prescription pills was the cause of the opioid crisis.[32] HHS implicitly communicated that over-prescription was the cause by suggesting solutions that were aimed at decreasing the supply of prescription opioids.

Implicitly referencing the cause of the problem accomplishes more than just supporting the preferred solution. Arguably, the benefit of using such implicit causal stories is that the narrator avoids the political consequences of explicitly blaming a group, while still supporting the desired policy solution. For example, rather than

documents/cat_view/1-alice-rap-project-documents/7-reports.html (providing reports from the ALICE RAP series project) (last visited May 22, 2018). *See, e.g.*, ALICE RAP, DELIVERABLE 9.1: THE DETERMINANTS OF A REDUCTION IN OR CESSATION OF HARMFUL SUBSTANCE USE AND GAMBLING (n.d.), http://www.alicerap.eu/resources/documents/doc_download/206-deliverable-09-1-determinants-of-a-reduction-in-or-cessation-of-harmful-substance-use-and-gambling.html (discussing "the determinants of harmful substance use and gambling from across 11 disciplines within five clusters: social and cultural factors, personal factors, patterns of usage and drug knowledge, cellular and molecular factors, and multidisciplinary models.").

32 *See Examining Legislative Proposals to Combat Our Nation's Drug Abuse Crisis: Hearing Before the Subcomm. on Health of the H. Comm. on Energy and Commerce*, 114th Cong. 26–34 (2015) (prepared statement of Richard Frank, Ph.D., Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services), 2015 WL 6152905.

directly blaming prescribers for causing the opioid crisis and risking the political ramifications of accusing a relatively politically powerful group of malfeasance or negligence, use of an implicit causal story garners support for a group's preferred policy solution, without alienating prescribers.

Implicit causal stories are strategically beneficial not only because they help narrators avoid the political ramifications of finger-pointing, but also because they shift the discourse away from debating the causes of the opioid crisis to debating the efficacies of the proposed solutions.[33] The implicit cause was assumed to be the true cause, signaling that no discussion was even needed.[34] This kept actors from critiquing and, perhaps, theorizing that the causes of the opioid crisis were not only the facially obvious supply-side causal theories that were most frequently referenced, but also included fuzzier concepts of despair,[35] lack of hope, or lack of opportunity,[36] that were largely omitted from the pressure group discourse. Such a strategy shifts the discourse away from debating the causes of the opioid crisis to debating the merits of the solution. And, a simple before-and-after measurement of drug supply would be a sufficient measure of a solution's efficacy.

b. Explicit Causal Stories

In the congressional hearing testimony analyzed, explicit causal stories most often took the form of narratives rooted in *intentional* and *inadvertent* causal theories.[37] Intentional causal theories include causal theories that posit that the actor's action was intentional and that the actor intended the results.[38] Inadvertent

33 *See, e.g., id.*

34 *See, e.g., id.* (The focus on the solutions of supply, treatment for drug users, and harm reduction imply that the problem is the supply, lack of treatment, and lack of harm reduction without explicitly stating it as the cause).

35 *See generally* Case & Deaton, *supra* note 30.

36 *See* HART, *supra* note 30, at 8, 90–94.

37 Dr. Deborah Stone argues that most causal theories used in policy narratives involve two components: actions and consequences. STONE, *supra* note 5, at 208 (3d ed. 2012). Blame is assigned based on whether or not these actions and consequences were intended (or guided) or unintended (unguided). *Id.* Therefore, causal theories can include (1) unguided actions but with intended results ("mechanical cause"), (2) guided actions with intentional consequences ("intentional cause"), (3) guided actions with unintended consequences ("inadvertent cause"), or (4) a result of a "complex systems." *Id.* at 208, 214–15.

38 Intentional causes typically include an actor that acted intentionally and

causal theories are theories of causation in which the actor may have intended to commit the act, but did not intend the resulting outcome.[39]

Although most testimony *implicitly* referred to over-prescription as the cause of the problem, there were instances in which certain actors were *explicitly* blamed for causing the opioid crisis by over-prescribing prescription opioids or for causing the over-prescription of opioids. Actors that were blamed explicitly for over-prescription included the medical profession (in general), pharmaceutical opioid manufacturers, drug seekers, "bad apples" in the medical industry, and foreign drug cartels.[40]

2. *Supply-Side vs. Demand-Side Causal Narratives*

Aside from the distinction between explicit and implicit causal narratives, narratives could be further divided into supply-side and demand-side causal narratives. Supply-side causal narratives blamed the cause of the opioid crisis on the supply of opioids, while demand-side causal narratives attempted to explain why people demanded drugs.

a. Supply-Side Causal Stories

The idea that the rise of overdoses and addiction in the U.S. was caused by the increased availability of opioids was a common feature of the congressional hearing testimony reviewed.[41]

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intentionally caused the outcome in dispute. *Id.* at 209. This category includes "conspiracies," "harmful side effects that are known but ignored," "bad apples," and "blaming the victim." *Id.* at 208. These narratives explicitly blame the victim for causing the social problem that the victim is affected by. *Id.*

39 Inadvertent causal theories include "unanticipated harmful side effects of policy," "avoidable ignorance," "carelessness," and "blaming the victim." STONE, *supra* note 37. Causal theories that blame the victim within this category are softer than the intentional causal theories outlined in note 38, as the actions could have been well-intentioned but resulted in a poor outcome. *Id.* For example, if physicians, as a profession, prescribed opioids in order to treat pain as a fifth vital sign and ease the pain of the population, although their prescriptions were intentional acts, they did not intend for their patients to become addicted or overdose to the medications. *See infra* p. 390 and note 75.

40 Examples of causal stories used to assign blame will be provided in the following sub-section.

41 *See, e.g.*, *Heroin and Prescription Drug Abuse: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 113th Cong. (2014) (statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse) [hereinafter NIDA 2014], 2014 WL 1990482.

Historically, supply-side causal narratives emphasized the trafficking of illicit psychoactive substances with blame explicitly assigned to foreign and local criminal enterprises.[42] The 2014–2016 supply-side causal narratives differed from the blatant supply-side narratives of the past because the 2014–2016 narratives involved health actors, the health system, and health terminology.[43] For example, while street gangs and Colombian cartels may have been blamed for supplying the crack cocaine responsible for the crack cocaine drug crisis in the late 1980s and early 1990s,[44] doctors, pharmacists, pharmacies, and drug manufacturers were often blamed for supplying the opioid crisis.[45] While internal systems at the Federal Bureau of Investigation or the Drug Enforcement Administration may have been touted as the solutions to past drug epidemics, prescription monitoring systems were proposed to identify bad apples in the healthcare system,[46] as well as to improve quality of care.[47] The use of health or medical terminology and actors makes the narratives used appear as if the opioid crisis is being defined as a public health issue. However, the causal narratives are classic supply-side narratives attributing the cause of addiction and overdoses to availability of the substance; and they imply that the supply must be limited because the prevalence of the supply itself causes rises of overdose and addiction. Meanwhile, the public health approach to drug policy has been characterized, at least internationally, by solutions that focus on reducing the harms

42 For historic examples, see MUSTO, *supra* note 11; COURTWRIGHT, *supra* note 23.

43 By health terminology, I am referring to the characterization of addiction or overdoses as adverse health consequences or side effects to medication, for example. *See, e.g.*, *Opioid Abuse Among Older Americans: Hearing Before the S. Spec. Committee on Aging*, 114th Cong. (2016) (statement of Katherine Neuhausen, M.D., MPH, Assistant Professor, Department of Family Medicine and Population Health and Associate Director, Office of Health Innovation, Virigna Commonwealth University) [hereinafter *Opioid Abuse Among Older Americans*), 2016 WL 370153.

44 *See* COURTWRIGHT, *supra* note 23 at 180.

45 *See, e.g.*, *Opioid Abuse Among Older Americans*, *supra* note 43.

46 *See, e.g.*, *Heroin/Prescription Drug Abuse: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Louis J. Milione, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration) [hereinafter DEA 2016], 2016 WL 319839.

47 *See VA Opioid Prescription Policy, Practice, and Procedures: Hearing Before the S. Comm. on Veterans' Affairs*, 114th Cong. 12–17 (2015) (prepared statement of John D. Daigh, Jr., M.D., C.P.A., Assistant Inspector General for Healthcare Inspections, Office of Inspector General, U.S. Department of Veterans Affairs) [hereinafter Daigh, *VA Opioid Prescription Policy*], 2015 WL 1348883.

of use and addressing the reasons for users' demand for the drug.

The most dominant supply-side causal narratives in the 2014–2016 legislative discourse can be grouped as follows: (1) narratives that blamed the cause of the opioid crisis on over-prescription of prescription opioids, (2) those that blamed "bad apples" for diverting prescription opioids to the streets for financial gain, and (3) those that blamed the opioid crisis on international supply of heroin and synthetic drugs.

i. Over-Prescription as a Cause of the Opioid Crisis

Variations of causal stories that attributed the cause of the opioid crisis to physician over-prescribing included: (1) The pills themselves were highly addictive,[48] even for those that used the prescriptions as directed;[49] and (2) Opioids were over-prescribed and left-over prescriptions[50] were diverted to the black market or misused by family members and friends.[51] Some narrators explicitly blamed physicians for over-prescribing,[52] and others blamed "bad apples"[53] in the medical industry, pharmacists, physicians, pharmacies, drug manufacturers, and doctor shoppers, for diverting opioids for financial gain.[54] Some narrators avoided blaming groups of actors directly and, instead, spoke generally about over-prescription or prescription drug availability as a problem.[55]

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48 *See, e.g.*, *Opioid Abuse in America: Facing the Epidemic and Examining Solutions: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions*, 114th Cong. 25–27 (2015) (prepared statement of Eric Spofford, Chief Executive Officer, Granite House, Derry, NH; New Freedom Academy, Canterbury, NH), 2015 WL 8158091.

49 *See, e.g.*, *Opioid Abuse Among Older Americans*, *supra* note 43.

50 The term *left-over prescriptions* refers to instances in which the patient does not use the entire amount prescribed and thus some prescription pills are "left over." *See, e.g.*, *Opioid Crisis: Field Hearing Before the S. Comm. on Homeland Sec. and Governmental Affairs*, 114th Cong. 61–69 (2016) (prepared statement of Tim Westlake, M.D., Vice Chairman, State of Wisconsin Medical Examining Board and Chairman, Controlled Substances Committee) [hereinafter *Heroin and Prescription Opioids in Wisconsin*], 2016 WL 1572172.

51 *See, e.g.*, DEA 2016, *supra* note 47.

52 *See, e.g.*, *Opioid Abuse Among Older Americans*, *supra* note 43.

53 Blaming the "bad apples" is a common causal narrative strategy. *See* STONE, *supra* note 5, at 208–11.

54 *See, e.g.*, *Heroin and Prescription Opioids in Wisconsin*, *supra* note 50, at 64.

55 *See, e.g.*, *Examining the Opioid Epidemic: Challenges and Opportunities: Hearing Before the S. Comm. on Fin.*, 114th Cong. 42 (2016) (prepared statement of David Hart, Assistant Attorney-in-Charge, Health Fraud Unit/Consumer Protection

For example, the Acting Deputy Administrator of the DEA argued:

> Another factor that contributes to the increase of prescription drug diversion is the availability of these drugs in the household. In many cases, dispensed controlled substances remain in household medicine cabinets well after medication therapy has been completed, thus providing easy access to non-medical users, accidental ingestion, or illegal distribution for profit.[56]

By referring to the availability of prescription pain pills in the household, the DEA could reference the consequences of over-prescription (left-over prescriptions) as the cause of the problem, without discussing the prescribers' acts of over-prescribing. Criminal justice agencies, like the DEA, also blamed the "bad apples" in the medical industry directly, for intentionally diverting and profiting from the diversions.[57] Blaming the bad apples has its political advantages because it allows the blamed group to claim that it is not the group as a whole that is "bad," but rather, a few bad seeds that can be weeded out.[58] It signals to prescribers that their competence and character were not at issue and assuaged

Section, Oregon Department of Justice), 2016 WL 706631 ("Oregon, like the rest of the nation, has continued to struggle with overprescribing and misuse of prescription opioids."). In some cases, the speaker spoke of how PDMPs decreased the availability of prescription opioids and overdoses. *See, e.g.*, *Heroin/Prescription Drug Abuse: Hearing Before the S Comm. on the Judiciary*, 114th Cong. (2016) (statement of Nora D. Volkow, M.D., Director, National Institute on Drug Abuse), 2016 WL 319843. These cases focused on the solution of curbing over-prescription rather than the cause of over-prescription itself. *See, e.g.*, *id.*; *Opioid Crisis: Field Hearing Before the Comm. on S. Homeland Sec. and Governmental Affairs*, 114th Cong. 151–156 (2016) (prepared statement of Carole S. Rendon, Acting U.S. Attorney, Northern District of Ohio, United States Attorney's Office, U.S. Department of Justice), 2016 WL 1608495.

56 *Controlled Substances Quota Process: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 114th Cong. (2015) (statement of Joseph T. Rannazzisi, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration) [hereinafter DEA 2015], 2015 WL 1643509.

57 *See, e.g.*, *id.*

58 *See* STONE, *supra* note 5, at 206–28, for a general discussion about the uses of the "bad apple" narrative in the policy process.

any fears that prescribers, as a group, would be punished for the actions of outliers. Further, supporting such a narrative justified the involvement of criminal justice agencies like Department of Justice and the DEA[59] and enabled them to request funding to support their role in addressing the opioid crisis.[60] With the decrease in support for criminal justice solutions to addressing drug problems, agencies like the DEA must continue to justify their expenditures and budget requests. Going along with the health framing, but insisting that there are still "bad guys" within the medical industry causing the problem at issue, allows agencies like the DEA to carve out a role as a "fixer" of the problem and in doing so ensure their continued relevance.[61]

Since medical professionals, particularly physicians' groups and nurses' associations, are generally positively socially constructed[62] and relatively politically powerful,[63] it is not surprising that some pressure groups did not expressly blame prescribers directly for causing the crisis. These groups focused instead on suggesting solutions, including PDMPs and promulgating physician guidelines, both of which were described as tools that could be used to help practitioners do their jobs better,[64] as opposed to punishment

59 *See* DEA 2015, *supra* note 56.

60 Office of the Press Secretary, The White House, *FACT SHEET: President Obama Proposes $1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic* (Feb. 2, 2016), https://obamawhitehouse.archives.gov/the-press-office/2016/02/02/president-obama-proposes-11-billion-new-funding-address-prescription.

61 For a more detailed accounting of the changing narratives of criminal justice actors in response to the opioid crisis, see Taleed El-Sabawi, *Carrots, Sticks and Problem Drug Use: The Law Enforcement Lobby's Contribution to the Policy Discourse on Drug Use & the Opioid Crisis*, OHIO ST. L.J. (forthcoming 2019).

62 Individual actors are organized by society into groups. *See* ANNE LARASON SCHNEIDER & HELEN INGRAM, POLICY DESIGN FOR DEMOCRACY 107–09 (1997). These groups are ascribed certain characteristics, often resulting in the group as being either negatively or positively construed. *Id.* These constructions do more than determine the social value of members of the groups, but also have political consequences in the policymaking process. *See id.*

63 *See id.*

64 *See, e.g.*, *VA Opioid Prescription Policy, Practice and Procedures: Hearing Before the S. Comm. on Veterans' Affairs*, 114th Cong. 6–10 (2015) (prepared statement of Carolyn Clancy, M.D., Interim Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs) [hereinafter Clancy, *VA Opioid Prescription Policy*] (Veterans Administration's explanation of the benefits of a PDMP), 2015 WL 1348882.

for misdeeds.

Some narratives did directly blame prescribers as a group for over-prescribing.[65] Oftentimes, those most critical of the medical profession came from within it. For example, two physician testifiers, one representing the Wisconsin Medical Board, and the other representing the Phoenix House, a well-known treatment facility, blamed prescribers for causing the opioid crisis,[66] but communicated prescribers' good intentions and lack of malice, emphasizing that they had meant to help, not harm.[67] They argued that although their actions may have been intentional (prescribing opioids), the consequences of their actions (addiction, overdoses, and diversion) were unintended.

Aside from deflecting blame by arguing that the consequences of their acts were unintended, prescribers tried to shift blame by using (1) narratives that argued that "bad apples" were responsible for over-prescribing and diversion, (2) narratives that attempted to shift the focus to another point in the causal chain, and (3) narratives that blamed the system's emphasis on treating pain for all patients seeking care.

For example, some physicians that testified embraced the bad apple strategy in order to deflect blame from the profession as a whole.[68] Such a causal narrative strategy allowed the profession as a group to shift the blame to the greedy and malicious doctor

65 *See Examining the True Costs of Alcohol and Drug Abuse in Native Communities: Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. (2015), 18–22 (prepared statement of Hon. Melanie Benjamin, Chief Executive, Mille Lacs Band of Ojibwe Indians) [hereinafter *Drug Abuse in Native Communities*], 2015 WL 4572873; *Heroin and Prescription Opioids in Wisconsin, supra* note 50; *Opioid Use Among Seniors: Hearing Before the S. Spec. Comm. on Aging*, 114th Cong. (2016) (statement of Jerome Adams, M.D., MPH, Commissioner, Indiana State Department of Health), 2016 WL 739340.

66 *Heroin and Prescription Opioids in Wisconsin, supra* note 50; *Heroin and Prescription Drug Abuse: Hearing Before the Caucus on Int'l Narcotics Control of the S. Comm'ns. and Temp. Comms.*, 113th Cong. (2014) (statement of Andrew Kolodny, M.D., Chief Medical Officer, Phoenix House Foundation) [hereinafter Statement of Kolodny], 2014 WL 1990484. *See, e.g.*, *Heroin and Prescription Opioids in Wisconsin, supra* note 50, at 62 ("To speak frankly, there can be no doubt that the sources of the supply of opioids stem from the ease of availability of prescription opioids due to over-prescription by doctors themselves. We physicians need to own our part in the problem.").

67 *See, e.g.*, Statement of Kolodny, *supra* note 66, at *2 ("Doctors didn't start overprescribing opioids out of malicious intent. For most of us it was a desire to treat pain more compassionately that led to overprescribing.").

68 *See, e.g.*, *Heroin and Prescription Opioids in Wisconsin, supra* note 50.

dealers, the "bad guys." Blame was also shifted from physicians to "doctor shoppers,"[69] persons who went from doctor to doctor drug-seeking. Although doctor shoppers may have been individuals with opioid use disorder that were drug-seeking, the DEA frequently characterized "doctor shoppers" as part of pharmaceutical diversion schemes, grouping them with the likes of "prescription forgery rings, and practitioners and pharmacists who knowingly divert controlled substance pharmaceuticals."[70] Persons with opioid use disorders that were seeking opioids were more often referred to as drug seekers, and although drug seekers were also blamed for "doctor shopping," they were not portrayed as the "bad guys." They were described more so as persons who needed to be identified and offered help. They were portrayed as persons who were ill and needed treatment as opposed to "bad apples."[71]

Another narrative strategy used to deflect blame away from prescribers was to redirect focus to another point in the causal chain. For example, some prescribers argued that opioid pain pill manufacturers, like Purdue, misrepresented the safety of their products.[72] Prescribers argued that they relied on the misrepresentations provided to them by companies like Purdue when deciding how to treat patients with chronic pain.[73] The Food and Drug Administration was also blamed for allowing companies like Purdue to market their drugs for chronic pain, despite the lack of evidence for its efficacy.[74]

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69 *See, e.g.*, *America's Heroin and Opioid Abuse Epidemic: Hearing Before the H. Comm. on Oversight and Gov't Reform*, 114th Cong. 24–34 (2016) (written statement of Louis J. Milione, Deputy Assistant Administrator, Office of Diversion Control, Drug Enforcement Administration), 2016 WL 1106485.

70 *Id.* at 28, 30.

71 *See, e.g.*, DEA 2016, *supra* note 46. Even the DEA refrained from portraying drug users as criminals, opting to refer to them instead as "our family members, friends, neighbors, and colleagues." *Id.* at *1.

72 *See Examining Heroin and Opiate Abuse in Southwestern Pennsylvania: Hearing Before the Subcomm. on Health Care of the S. Comm. on Fin.*, 114th Cong. 39–41 (2015) (prepared statement of A. Jack Kabazie, M.D., System Director, Division of Pain Medicine, Allegheny Health Network) [hereinafter *Opiate Abuse in Southwestern Pennsylvania*], 2015 WL 5999232; Statement of Kolodny, *supra* note 66.

73 *See, e.g.*, Statement of Kolodny, *supra* note 66.

74 One narrator blamed not only Purdue Pharma but also the FDA's improper enforcement of "the Federal Food, Drug and Cosmetic Act (FD&C Act) in 1996, when Purdue Pharma released OxyContin. The FD&C Act prohibits drug companies from promoting products for conditions where evidence of safety and efficacy is lacking. Instead of enforcing the FD&C Act, FDA allowed

Finally, prescribers blamed the system as a whole for pressuring them to address pain at every visit by treating pain as the fifth vital sign.[75] This emphasis was institutionalized with system-wide quality measures that tied physicians' performance ratings with patient reports of whether or not their pain was adequately addressed.[76] Further, this emphasis persisted despite the lack of tools, aside from prescription opioids, available to prescribers to address pain.[77]

b. Demand-Side Causal Stories

In the 2014–2016 legislative discourse analyzed, demand-side causal stories, or causal stories that attributed the cause of the opioid crisis to users' demand for drugs, focused on the lack of access to treatment and the biological mechanisms of addiction. The idea that socio-economic, psychological, or sociological circumstances caused or even contributed to the opioid crisis was largely lacking from the congressional hearing testimony. Despite recent and past research that acknowledges the roles of depression,[78] joblessness,[79]

Purdue Pharma to promote OxyContin to family doctors for treatment of common aches and pains and to launch a campaign of misinformation about opioid risks and benefits." *Id.* at *3.

75 *See, e.g.*, Daigh, *VA Opioid Prescription Policy*, *supra* note 47, at 12 ("Adequate management of pain has become a tenant of the compassionate delivery of health care. Subjective pain levels are now considered to be the fifth vital sign in medicine in addition to body temperature, pulse rate, respiration rate, and blood pressure.").

76 *See, e.g.*, *Opiate Abuse in Southwestern Pennsylvania*, *supra* note 72, at 39–40 ("Physicians who have compensation or employment tied to patient satisfaction scores may feel pressure to prescribe opioids in response to patient pain complaints.").

77 *See, e.g.*, *Addressing Trauma and Mental Health Challenges in Indian Country: Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. 30–35 (2016) (prepared statement of Kathryn R. Eagle-Williams, M.D., CEO/Quality Care Director, Elbowoods Memorial Health Center, Mandan, Hidatsa and Arikara Nation), 2016 WL 4527182 (discussing the lack of tools to address mental health issues in Native American communities, including the use of opiates "to mask mental illness.").

78 *See* Katherine McLean, *"There's Nothing Here": Deindustrialization as Risk Environment for Overdose*, 29 INT'L J. DRUG POL'Y 19, 24–25 (2016).

79 *Id.* at 24.

lack of social connectedness,[80] neighborhood sociocultural factors,[81] and lack of hope (for the betterment of life's circumstances)[82] in influencing addiction and overdose, reference to such causes was largely ignored in the 2014–2016 hearing testimony.

The narratives that cited the lack of access to treatment as a cause of the opioid crisis were often ambiguous. Most implied that access to treatment was a problem without referring to the lack of treatment as a cause of the opioid crisis, but rather proposing solutions that include expanding funding provided to treatment systems.[83] These narratives generally called for an increase in funding.[84]

Another subset of narratives cited the lack of "evidence-based" or "quality" treatment as a problem contributing to the opioid crisis. These narratives were frequently coupled with solutions proposing increased access to medication assisted treatment (MAT).[85] In other words, there seemed to be a common association of MAT with evidence-based or quality treatment. Not all MAT was treated equally, with some narrators supporting certain types of MAT over others.[86] Many of these narrators were careful to acknowledge

80 *See generally* Amary Mey et al., *What's the Attraction? Social Connectedness as a Driver of Recreational Drug Use*, 23 J. SUBSTANCE USE 327 (2018); Theophile Niyonsenga et al., *Social Support, Attachment, and Chronic Stress as Correlates of Latina Mother and Daughter Drug Use Behaviors*, 21 AM. J. ADDICTIONS 157 (2012); John Oetzel et al., *Social Support and Social Undermining as Correlates for Alcohol, Drug, and Mental Disorders in American Indian Women Presenting for Primary Care at an Indian Health Service Hospital*, 12 J. HEALTH COMM. 187 (2007).

81 COMM. ON OPPORTUNITIES IN DRUG ABUSE RESEARCH, INST. OF MED., PATHWAYS OF ADDICTION: OPPORTUNITIES IN DRUG ABUSE RESEARCH 126–27 (1996) (discussing sociocultural and environmental factors in certain communities that affect drug use and abuse).

82 *See generally* HART, *supra* note 30.

83 *See, e.g.*, *Opioid Abuse Among Older Americans*, *supra* note 43; *Heroin/Prescription Drug Abuse: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Linda E. Hurley, Chief Operating Officer and Director, Clinical Services, CODAC Behavioral Healthcare, Inc.), 2016 WL 319842.

84 *See, e.g.*, *America's Growing Heroin Epidemic: Hearing Before the Subcomm. on Crime, Terrorism, Homeland Sec., and Investigations of the S. Comm. on the Judiciary*, 114th Cong. 60–68, 64 (2015) (prepared statement ofNancy G. Parr, Commonwealth's Attorney, City of Chesapeake, Va.) 2015 WL 4538567 ("There are too few treatment programs. There are too few affordable treatment programs. There is insufficient funding for valid treatment programs. There is a stigma related to seeking treatment. Money addresses the first three problems and education can address the fourth.").

85 *See, e.g.*, NIDA 2014, *supra* note 41.

86 Some groups voiced concern over the addictiveness of methadone, the

that MAT could and should be combined with psychotherapeutic treatment and that MAT was not for everyone.[87] However, the need to expand the number of treatment providers that were legally able to provide MAT was frequently mentioned.[88]

Although overdose reversal medications (ORMs) do not technically reduce the demand for drugs, I considered any narrative referencing the lack of access to ORMs as demand causal narratives, because ORMs are harm-reduction methods that are meant to be followed up with treatment for the underlying substance abuse.[89] Lack of access to ORMs was not necessarily cited as a major cause of the opioid crisis; however, lack of access to ORMs was cited as a factor that contributed to the scope of the problem.[90] Further, even if the causal narratives used did not cite to a lack of access to ORMs as the dominant cause, many referred to increasing access to ORMs

potential for its abuse, and the possibility of diversion. *See, e.g.*, *Drug Abuse in Native Communities*, *supra* note 65.

87 *See, e.g.*, NIDA 2014, *supra* note 41.

88 *See, e.g.*, *Opioid Abuse Among Older Americans*, *supra* note 43; *Opioid Abuse in America: Facing the Epidemic and Examining Solutions: Hearing Before the S. Comm. on Health, Educ., Labor, and Pensions*, 114th Cong. 8–15 (2015) (prepared statement of Leana Wen, M.D., Health Department Commissioner, Baltimore, MD), 2015 WL 8489722; Statement of Kolodny, *supra* note 66.

89 *Naloxone for Opioid Overdose: Life-Saving Science*, NAT'L INST. FOR DRUG ABUSE, https://www.drugabuse.gov/publications/naloxone-opioid-overdose-life-saving-science/naloxone-opioid-overdose-life-saving-science (last updated Mar. 2017).

90 *See, e.g.*, *Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations for 2016, Part 6: Hearing Before the Subcomm. on the Dep'ts of Labor, Health and Human Servs., Educ., and Related Agencies of the H. Comm. on Appropriations*, 114th Cong. 568–72 (2016) (prepared statement of Whitney O'Neill Englander, Government Relations Manager, Harm Reduction Coalition), 2015 WL 1967922; *Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 114th Cong. 15–24 (2015) (prepared statement of Fred Wells Brason, II, President and Chief Executive Officer, Project Lazarus), 2015 WL 1384265; *Examining the True Costs of Alcohol and Drug Abuse in Native Communities: Hearing Before the S. Comm. on Indian Affairs*, 114th Cong. 11–16 (2015) (prepared statement of Mirtha Beadle, Director, Office of Tribal Affairs and Policy Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), 2015 WL 4572876; *What Is the Federal Government Doing to Combat the Opioid Abuse Epidemic?: Hearing Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 114th Cong. 58–70 (2015) (prepared statement of Douglas C. Throckmorton, M.D., Deputy Director, Center for Drug Evaluation and Research, Food and Drug Administration), 2015 WL 1967893.

when proposing solutions to the problem.[91]

Finally, some causal stories did mention the lack of patient education as a contributing factor to the opioid crisis or referenced the need to educate patients on the risks of opioid prescriptions in an effort to decrease their demand for the drugs.[92]

B. Summary of Findings

While CARA evidenced a rare instance in U.S. drug policy in which health solutions dominated legislation, the causal narratives used and the solutions adopted appeared more of a departure from the U.S.'s past approaches to drug policy than they actually were. The types of causal stories used by pressure groups in hearing testimony equally favored supply-side causal theories and ambiguous calls for increasing the access to treatment; the solutions offered focused on decreasing the supply of opioids, most often through reducing the prescription of opioids overall via prescriber education and PDMPs. Although health actors may have been called to implement the proposals and health-related terminology may have been used, at their core, these solutions are supply-side solutions. The actors in the causal stories were different but the storylines remained similar. The drug dealers of the 1980s and 1990s were changed to physicians

91 *See, e.g.*, Clancy, *VA Opioid Prescription Policy*, *supra* note 64; *Drug Enforcement Administration: Hearing Before the Subcomm. on Crime, Terrorism, Homeland Sec., and Investigations of the H. Comm. on the Judiciary*, 113th Cong. 12–18 (2014) (prepared statement of Hon. Michele M. Leonhart, Administrator, Drug Enforcement Administration), 2014 WL 4643550; *Examining the Policies and Priorities of the U.S. Department of Health and Human Services: Hearing Before the H. Comm. on Educ. and the Workforce*, 114th Cong. 12–28 (2016) (prepared statement of Hon. Sylvia Matthews Burwell, Secretary, U.S. Department of Health and Human Services), 2016 WL 1023258. Increasing access to ORMs included training or calling for the training of first responders to administer ORMs. *See, e.g.*, *Border Security–2015, Volume 2 of 2: Hearing Before the S. Comm. on Homeland Sec. and Gov't Affairs*, 114th Cong. 1568–1578 (2015) (prepared statement of Hon. R. Gil Kerlikowske, Comm'r, U.S. Customs and Border Protection, U.S. Department of Homeland Security), 2015 WL 5317597; *Deadly Synthetic Drugs and Poison Peddlers: Hearing Before the S. Comm. on the Judiciary*, 114th Cong. (2016) (statement of Sullivan K. Smith, MD, FACEP, Medical Director, Emergency Department Cookeville Regional Medical Center, Cookeville, Tenn.), 2016 WL 3165409.

92 *See, e.g.*, *VA Accountability: Assessing Actions Taken in Response to Subcommittee Oversight: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 113th Cong. 33–39 (2014) (prepared statement of Robert Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans' Affairs), 2014 WL 768554.

or prescribers. Prescription drug companies and pill mills were substituted in for the international drug cartels.[93] There appeared to be a general consensus that it was the availability of opioids that caused the nation's drug problems—the underlying assumption that the mere availability of psychoactive substances would create a new class of drug users.

Although the focus of the narratives and the aligning solutions were supply-oriented, and not evidence of a demand-side focus found in more progressive drug policy, these supply-side solutions were not the same criminal justice-oriented solutions of the past.[94] And such a shift is at least a symbolic victory, as it evidences an understanding that the U.S.'s historic approach is not effective. However, the types of causal stories used to describe the opioid crisis and aligned solutions are piecemeal at best, superficial at worst, and only bring the U.S. marginally closer to embracing the most evidence-based drug policy regimes.

Moreover, the discourse focused more so on which policy solutions to enact, as opposed to fully engaging in a discussion of what caused the opioid crisis in the first place. In much of the testimony, it was accepted as a given that over-prescription caused the opioid crisis and, as such, over-prescription needed to be curtailed. While the need to cut down on opioid prescriptions and to simultaneously better fund substance abuse treatment centers are worthwhile endeavors, unless the U.S. fully engages in a discussion of what causes a person to misuse prescription pain medication or illicit drugs, the billions of dollars of funding allocated to addressing the opioid crisis will not produce the desired results, nor will they have any lasting effect on stymieing future drug crises.

Had their motivation been collectively to redefine problem drug use in a manner most aligned with best practices in drug policy, pressure groups might have focused on demand-side approaches that emphasize a public health orientation, or even better yet, an emphasis on improving the well-being of the drug user so that he is less likely to use.

IV. Concluding Thoughts

In this article, I have reviewed the ways in which pressure

93 *See, e.g.*, DEA 2016, *supra* note 46, at *3. Mexican cartels were also referenced as contributors to the opioid crisis, but the cartels were blamed far less frequently than health actors. *See, e.g.*, *id.*

94 El-Sabawi, *supra* note 1, at 3–4.

groups can use causal stories to influence the types of policy solutions available to legislators seeking to address the policy problem, specifically the current opioid crisis. To lend credence to the theoretical literature cited, I analyzed congressional hearing testimony given by pressure groups testifying on problem drug use prior to the passage of CARA, health-oriented federal legislation aimed at addressing the drug crisis. Since the types of causal theories used to describe a policy problem are posited to align with the types of solutions adopted, I expected to see health-oriented causal stories dominating the criminal justice-oriented causal stories commonly used to justify past U.S. drug policy.[95]

Pressure groups did indeed utilize a health-oriented approach to characterize the opioid crisis. The causal stories used painted the issue as one that was caused by health actors and one that should be solved using the health system. The transition from a criminal justice orientation to a health orientation shifted the blame from the drug user's character to forces outside of the user's control, like outside actors and biological predispositions. In doing so, the hearing testimony often portrayed drug users as persons in need of medical help as opposed to criminal punishment. This shift away from what European scholars have termed the "moral paradigm" approach and toward an assistentialism approach is laudable, as it makes treatment more likely than incarceration.[96]

Such a framing, however, remains decades behind our European counterparts who have surpassed the assistentialism approach to embrace a public health approach and have progressed beyond the public health approach to advocate for a well-being approach.[97] Preceding CARA's enactment, the bipartisan support for addressing problem drug use and the more positive social construction of the target population of drug users[98] offered

95 *See generally id.* (providing overview of some of these criminal justice oriented causal stories and policies).

96 The "moral paradigm" approach was influenced by puritan ideology; the dominant causal narrative attributed addiction to the individual's lack of self-control and overall character weakness, and drug users were characterized as "sinful" and "vicious." *See* YSA ET AL., *supra* note 9, at 3–4. The assistentialism approach is characterized by a belief that drug users are in need of saving and that the healthcare professional is the individual best suited for doing the saving; the dominant causal narrative attributed addiction to disease. *See id.* at 4.

97 *See* ALICE RAP FINDINGS, *supra* note 13, at #4, 8, 42, 45, 48, 49.

98 *See* Taleed El-Sabawi, *What Motivates Legislators to Act: Problem Definition & the*

advocates a policy window of opportunity[99] for which drug policy advocates could redefine problem drug use. Such an opportunity to re-characterize a policy problem is rare and the manner in which pressure groups choose to do so affects not only the current opioid crisis, but also has long-lasting effects on the path of drug policy in the future.[100]

Rather than take full advantage of this opportunity to re-characterize problem drug use in a way that aligned with best practices in drug policy, actors testifying before Congress were focused on the immediate need to decrease the availability of opioids, attributing the cause of the problem to the supply of opioids and proposing solutions to help decrease the supply. Given the over-use of prescription opioids in the last decade, it is not surprising that over-prescription was often cited as the main cause of the opioid crisis and that it was regularly accompanied by solutions aimed at decreasing the number of prescriptions. Despite the short-term benefits of supply control, as a long-term focus of drug policy, supply control-oriented drug policy, as opposed to demand control, is not a feature of the leading European drug policy model[101] and has not been successful in controlling drug use in the U.S. historically.[102]

Admittedly, some pressure groups involved in the causal narrative discourse may have been most interested in supporting narratives that protected its members from blame and punishment, as opposed to strategically utilizing this window of opportunity to decrease problem drug use in the long term. However, even drug policy and health advocates that were concerned primarily with improving the rates of addiction and overdose did not take advantage of the opportunity to redefine drug use in a manner that made most likely the adoption of a *drug policy system* that would deliver the best

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Opioid Epidemic, a Case Study, 15 IND. HEALTH L. REV. 188, 211–12 (2018) (discussing the social construction of target populations in general and as applied to populations of drug users throughout history).

99 *See supra* text accompanying note 16.

100 *See generally* FRANK R. BAUMGARTNER ET AL., LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY (2009) (providing an analysis of group efforts to define policy issues and noting the rarity of successful problem re-definition).

101 YSA ET AL., *supra* note 9, at 47–48. *None* of the trendsetting countries in drug policy prioritize supply reduction, whether it be through efforts to arrest and penalize high traffic offenders, prevent the importation of drugs, or to monitor drug diversion from pharmacies and physicians. *See id.* at 47–68.

102 COURTWRIGHT, *supra* note 23, at 132, 159–60.

long-term results.

Although cloaked in medical and health terminology, many of the causal stories used by pressure groups emphasized the supply, or availability, of prescription opioids as the cause of the crisis and substituted actors in the medical industry for the street drug dealers of past narratives. Despite references to biological or genetic factors or lack of access to health services, the psychological, sociological, economic, and health factors that greatly impact drug use[103] were essentially ignored. Of course, greater funding for drug treatment is greatly needed, as is the expansion of access to MAT, two solutions that were identified by pressure groups. However, without building the structure that is found in model drug policy systems and without establishing coordination between agencies that address not only treatment but also the triggers and social determinants of drug use, the money allocated to address the opioid crisis will not address the root causes of problem drug use.

Undeniably, the U.S. does not have the social safety net that is the hallmark of many European countries with model drug policies. For example, many of the countries with the best drug policies also have universal healthcare systems, as well as more generous welfare systems.[104] Therefore, some may argue that European countries had the infrastructure and the policy experience to approach drug use as a public health problem or a well-being problem. Even conceding these claims, however, the U.S. does have a shadow or privatized welfare state[105] that it can draw on and private actors within it that it can coordinate with in order to mimic European drug policy without overhauling its social welfare system. Aside from coordinating with the private sector, U.S. policymakers could work with state and local

103 *See* Laura Stoll & Peter Anderson, *Well-being as a Framework for Understanding Addictive Substances*, *in* THE IMPACT OF ADDICTIVE SUBSTANCES AND BEHAVIOURS ON INDIVIDUAL AND SOCIETAL WELL-BEING 53, 58–64 (Peter Anderson et al. eds., 2015) (discussing the link between factors that comprise a person's well-being and various addictions). *See generally* Robert C. Pope et al., *The Social Determinants of Substance Abuse in African American Baby Boomers: Effects of Family, Media Images, and Environment*, 21 J. TRANSCULTURAL NURSING 246 (2010). *See also* Petra Meier et al., *Project Area 3: Determinants of Addiction*, ALICE RAP, http://www.alicerap.eu/about-alice-rap/areas-a-workpackages/area-3-determinants-of-addiction.html (last visited Mar. 23, 2018).

104 *See generally* YSA ET AL., *supra* note 9.

105 *See, e.g.*, MARIE GOTTSCHALK, THE SHADOW WELFARE STATE: LABOR, BUSINESS, AND THE POLITICS OF HEALTH CARE IN THE UNITED STATES 1–2 (2000).

governments, as well as with existing federal programs, to offer coordinated services and rehabilitation programs for drug users or persons at risk for drug use. Federal funding to address the opioid crisis can be allocated not only to fund treatment, but also to assist with housing, job training, and trauma treatment, thereby increasing drug users' quality of life and decreasing their demand for drugs.

However, without framing drug use as a problem caused by demand—as a problem which is rooted in psychological, social, economic, and behavioral factors—the wrap-around solutions needed to treat and prevent drug use are not even on the table for discussion. Such a holistic causal definition is necessary to make policy alternatives available that embrace multimodal policies, involving the medical, public health, social services, criminal justice, housing sector, rehabilitation services, and job training and reintegration programs that are key features of trendsetting drug policy models adopted in other developed countries. These policy frameworks not only address current drug crises but also prevent future crises by ensuring a continuum of care that extends beyond the walls of traditional treatment and confinement—progressing to the adoption of what European scholars have called the "well-being paradigm," whose end outcome is to improve drug users' well-being.[106]

Pressure groups that have the time and attention of legislators looking to adopt a problem definition for the opioid crisis are in prime positions to popularize such demand causal stories. And, although it is common for scholars and concerned citizens to consider organized interests as corrupt players in politics, they offer both groups access to the problem definition process. After all, organized interests include professional organizations and citizens' groups, groups that are open to legal scholars and concerned citizens alike to join, to participate in, and to influence.

In conclusion, pressure groups' adoption of a health approach to defining the opioid crisis was notable, but far from the redefinition needed to effectuate true drug policy reform. If policy actors are interested in both addressing current drug misuse and preventing future increases in misuse and overdose deaths, the causal stories that they use to describe the cause of drug use must be more than

106 ALICE RAP, Description and Analysis of Addiction Governance Practices Understanding Changes in Governance Practice 129 (2014), https://www.alicerap.eu/resources/documents/cat_view/1-alice-rap-project-documents/7-technical-reports.html?start=10.

superficially health-oriented. Concerned actors must dig deeper and ask not only why is there an increase in the drug supply, but ask instead, why is there an increase in demand for drugs? Dr. Andrew Weil provides a thought-provoking answer to this question that can challenge the dominant causal theories used to explain the opioid crisis. He writes,

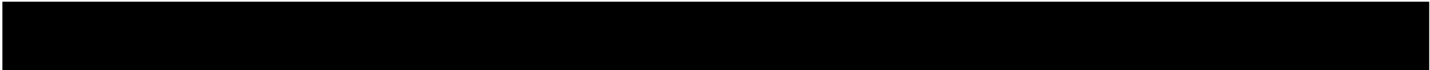
> To come up with a valid explanation, we simply must suspend our value judgments about kinds of drugs and admit (however painful it might be) that the glass of beer on a hot afternoon and the bottle of wine with a fine meal are no different in kind from the joint of marijuana or the snort of cocaine; nor is the evening devoted to cocktails essentially different from the day devoted to mescaline. All are examples of the same phenomenon: the use of chemical agents to induce alterations in consciousness.[107]

He goes on to theorize that people use drugs because they wish to change their consciousness, and their inner need to change consciousness is mostly unaffected by whether or not the drugs are legal.[108] If Dr. Weil is correct and people do demand and use drugs to alter their consciousness—if the need and desire to alter one's consciousness is so deep that legality of the drug is inconsequential—then maybe rather than focusing on decreasing the supply of drugs, drug policy advocates are best advised to ask why chronic and long-term drug users feel such an overwhelming desire to alter their consciousness, or put another way, to escape their reality. Do they have an underlying and untreated mental health issue for which drug use provides relief? Are their living circumstances so abysmal that a drug-induced state is their best escape? Or, are they genetically predisposed to addiction or have underlying altered brain structure from use? These questions are by no means exhaustive and do not address all of the potential causes for a user's demand for a drug. However, asking such questions leads us to identifying causes that align with policy proposals that can change the path of drug policy from a supply orientation to a demand orientation. Pressure groups'

107 Andrew Weil, *Why People Take Drugs*, *in* THE AMERICAN DRUG SCENE: READINGS IN A GLOBAL CONTEXT 72–80, 73 (James A. Inciardi & Karen McElrath eds., Oxford Univ. Press, 7th ed. 2015) (1972).

108 *Id.* at 73–74, 80.

use of a health-oriented frame is a step in the right direction, as long as we acknowledge that it is a small step, and move forward with the intent of taking advantage of future windows of political opportunity to advance not only a health frame but a public health frame, or even a well-being frame, that places the demand of the user at the heart of its narrative.



Northeastern University
School of Law