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Defining the Opioid Epidemic: Congress, Pressure Groups, and Problem Definition

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I. INTRODUCTION

The United States has a drug problem—a drug problem that is characterized by high rates of opiate overdose deaths[1] and a drug problem to which people commonly refer as the "Opioid Epidemic." The Opioid Epidemic has resulted in an increase in popular, political, and scholarly focus on the ineffectiveness of the United States' criminal justice, or punitive policy, approach[2] to problem drug use.[3] The Opioid Epidemic has also led to an increased focus on the need for U.S. policymakers to embrace a health approach[4] in addressing

1. Opioid overdose deaths have been rising for at least 16 years, with the number of deaths each year equaling a new historic high. *See Opioid Overdose*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/drugoverdose/data/index.html (last updated Aug. 9, 2018).

2. Although at times the criminal justice and punitive approach may seem interchangeable, the criminal justice approach, by my definition, also includes proposals to administer drug treatment through the criminal justice system. Some may consider such mandatory treatment punitive, while others may argue that it is still a health solution. Others would categorize it as a criminal-justice approach, as it uses the criminal justice system to administer it.

3. Throughout this paper, I use the term "problem drug use" to refer to any drug use that interferes with the ability of the user to meet his or her societal, educational, and occupational obligations. I adopt a similar conceptualization of problem drug use as Anderson et al., in that I believe problem drug use is "habitual, heavy consumption of something pleasurable." PETER ANDERSON ET AL., THE IMPACT OF ADDICTIVE SUBSTANCES AND BEHAVIOURS ON INDIVIDUAL AND SOCIETAL WELL-BEING 38 (2015).

4. Through the use of cluster analysis of components of European drug policy systems, Ysa and colleagues identified three main approaches to drug policies: a punitive approach, an assistantship approach, and a public health approach. TAMYKO YSA ET AL., GOVERNANCE OF ADDICTIONS: EUROPEAN PUBLIC POLICIES 3 (2014). The assistantship approach treats problem drug use as a disease that necessitates treatment. This is differentiated from a public health approach that emphasizes harm reduction. *See id.* at 4–5. Throughout this Article, I use the term "health approach" to characterize the U.S. drug policy system, which blends Ysa et al.'s assistantship approach with some conservative public health solutions, including education,

problem drug use,[5] an approach that emphasizes the prevention and treatment of addiction. U.S. policymakers have responded by distancing themselves from blatant punitive policies of the past and adopting health-oriented definitions of problem drug use that support health-oriented policy proposals.[6]

For example, under the Obama Administration, the Office of National Drug Control Policy ("ONDCP")[7] advocated for a health-oriented definition of problem drug use, explicitly acknowledging addiction as a chronic disease of the brain, advocating for reduced sentences for persons convicted of possession of illicit substances for personal use, and calling for a renewed focus on prevention and treatment of addiction.[8] Congress has also demonstrated a willingness

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expanding access to medication-assisted treatment ("MAT"), overdose-reversal medications, and needle-exchange programs. Unfortunately, the support for public health solutions in the U.S. is half-hearted. For example, the U.S. has alternated between federal support for and banning of needle-exchange programs. *Cf. Syringe Services Programs*, CTRS. FOR DISEASE CONTROL AND PREVENTION, https://www.cdc.gov/hiv/risk/ssps.html (last updated July 31, 2018). Even when support for federal funding for needle-exchange programs has existed, federal law only permits use of funds to staff the program and not to purchase the clean needles. *Id.*

5. The reasons that advocacy for a health approach has increased for the Opioid Epidemic when it was absent from previous epidemics is beyond the scope of this Article.

6. Admittedly the Trump administration's recent decision to rescind Obama-era policy and once again mobilize federal law enforcement agents to prosecute possessors of marijuana, even in states that have chosen to decriminalize or legalize certain recreational drug use leads one to wonder whether such receptiveness to the public health approach will continue. *See generally* Memorandum of Jefferson B. Sessions, III, U.S. Att'y Gen., Office of the Att'y Gen., to all U.S. Att'ys (Jan. 4, 2018), https://www.justice.gov/opa/press-release/file/1022196/download.

7. ONDCP is a branch of the Executive Office of the President, the primary advisor to the President on drug control policy. *Office of National Drug Control Strategy*, THE WHITE HOUSE, https://www.whitehouse.gov/ondcp/ (last visited Nov. 25, 2018).

8. *National Drug Control Strategy*, THE WHITE HOUSE, https://obamawhitehouse.archives.gov/ondcp/policy-and-research/ndcs (last visited Nov. 24, 2018). President Obama also demonstrated his support for a health approach over a criminal-justice approach by pardoning hundreds of drug users who had been incarcerated for drug possession. *See generally* Office of the Pardon Att'y, *Clemency Recipients: Pardons Granted by President Barack Obama (2009–2017)*, U.S. DEP'T

to use the health approach to address the current Opioid Epidemic by passing the Comprehensive Addiction and Recovery Act of 2016 ("CARA"), health-oriented legislation[9] that Congress drafted and enacted with nearly unanimous bipartisan support[10] and later funded with equal legislative enthusiasm.[11] In doing so, some members of Congress explicitly supported the definition of "addiction" as a brain disease, as opposed to a moral failing.[12] And defining addiction as a disease, instead of a moral failing, demands a health solution,[13] not a criminal justice solution.

OF JUSTICE, https://www.justice.gov/pardon/obama-pardons (last updated Aug. 30, 2017).

9. There are provisions in CARA, however, that do not fit squarely within the criminal justice vs. health dichotomy. For example, CARA emphasizes the need for states to develop prescription monitoring programs to identify prescribers that may be responsible for prescription drug diversion. Comprehensive Addiction and Recovery Act of 2016, Pub. L. No. 114-198, § 601, 130 Stat. 695, 732 (codified at 42 U.S.C. § 290ee-3(b)(2)(B) (2012)). Law enforcement would then have access to these prescription monitoring systems and use the intelligence it provides to criminally prosecute prescribers. *See, e.g.*, TENN. CODE ANN. § 53-10-306(a)(9) (2018). Such a supply-side solution runs counter to the demand-side focus typically accompanying a health approach.

10. CARA passed with a 92–2 vote in the Senate and a 407–5 vote in the House. *See S.524 - Comprehensive Addiction and Recovery Act of 2016: All Actions*, CONGRESS.GOV, https://www.congress.gov/bill/114th-congress/senate-bill/524/all-actions?overview=closed&q=%7B%22roll-call-vote%22%3A%22all%22%7D (last visited Nov. 25, 2018).

11. The 21st Century Cures Act built on CARA by providing an additional $1 billion of funding over two years. The 21st Century Cures Act, Pub. L. No. 114-255, § 1003(b)(2)(A), 130 Stat. 1033 (2016).

12. *See e.g.*, Press Release, Rob Portman, Portman, Whitehouse, Ayotte, Klobuchar Cheer Final Passage of Comprehensive Addiction and Recovery Act (July 30, 2016) ("This is also the first time we've treated addiction like the disease that it is, which will help put an end to the stigma that has surrounded addiction for too long."), http://www.portman.senate.gov/public/index.cfm/2016/7/portman-whitehouse-ayotte-klobuchar-cheer-final-passage-of-comprehensive-addiction-and-recovery-act.

13. I use the term "solutions" throughout this manuscript to refer to legislative or administrative policy alternatives or proposals. Although such proposals rarely solve a policy problem in its entirety, policymakers propose them with the hopes that they are at least partial solutions to the problem. *See generally* DEBORAH A. STONE, POLICY PARADOX AND POLITICAL REASON 184–206 (1988) (discussing rational choice theory). Punitive solutions are those that apply a penalty to a behavior in order to punish and deter the behavior. *See* YSA ET AL., *supra* note 4, at 3–4. In the arena

The increased public and political attention on the issue of drug use and the supportive political climate for a health approach to the Opioid Epidemic have created a window of opportunity[14] for legal scholars, professionals, researchers, and other concerned citizens to pressure legislatures and administrative agencies to shift their focus from criminal justice strategies to public health strategies. Such strategies emphasize harm reduction,[15] access to quality treatment, and the amelioration of the socio-economic risk factors that increase the likelihood of problem drug use.[16]

To effect such a policy change, however, scholars must understand the problem-definition process and the role that groups play in *redefining* a problem. Problem definition is the part of the policymaking process during which actors within the political sphere

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of drug policy, supply-side solutions are those focused on decreasing the drug supply and typically involve controlling domestic sale of the drug as well as disrupting the supply from the country of origin. *Id.* at 17. Demand-side solutions, on the other hand, decrease the demand for the drug typically through treatment and prevention efforts. *Id.*

14. Dr. Kingdon argues that, for an issue to make it to the political agenda, there must be a window of opportunity that occurs when three streams align: the problem stream, the policy stream, and the politics stream. *See generally* JOHN W. KINGDON, AGENDAS, ALTERNATIVES, AND PUBLIC POLICIES 165–95 (2d ed. 2003). The problem stream includes social issues that may or may not currently be on the public's agenda. *See generally id.* at 90–115. The policy stream includes policy proposals, or as I refer to them throughout this paper, policy solutions. *See generally id.* at 121–31. The politics stream refers to the political environment. *See generally id.* at 145–64. Often there are champions of particular problem definitions in the problem stream, or policy proposals in the policy stream, who lay in wait for all three streams to align so that they can take advantage of the window of opportunity to place their issue and/or solution on the political agenda. *See generally id.* at 175–83.

15. Harm reduction approaches focus on reducing the social, economic, and health harms of drug use, as opposed to focusing on user abstinence. YSA ET AL., *supra* note 4, at 5–6. Analysts measure success by the reduction of these harms, as opposed to abstinence of drug use. *Id.* at 5–6. For examples of harm reduction policies used by European nations, see *id.* at 34–35, 42–43.

16. The public health approach to improving access to treatment includes not only ensuring that there are enough treatment providers to provide the care, but also that the individual has transportation to get to appointments, the appointments are available during non-work hours, and the individual has the ability to pay for care. *See generally Access to Health Services*, OFFICE OF DISEASE PREVENTION & HEALTH PROMOTION, https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

characterize what causes a problem and what alternative solutions policymakers should use to address the problem.[17] A rhetorical tool that policy actors commonly use to persuade others in the problem definition process is the "causal narrative," a story that identifies the cause of the policy problem, assigns benefits and blame, and limits the alternative policy solutions.[18] Because policy actors may use different causal stories to define the same social problem, narratives battle to be accepted as the dominant causal story. It is this precise battle between narratives that is at the heart of the political policymaking process.[19] Narrators, including pressure groups, organized interest groups,[20] and administrative agencies (collectively, "pressure groups") compete for the opportunity to contribute a problem definition to the discourse.[21] Each narrator hopes that their problem definition will become the dominant problem definition,[22] because the group that dominates the problem definition discourse has the power to limit the alternative solutions available to a policy problem.[23]

Although some scholars and researchers may view the involvement of pressure groups in the policymaking process as a threat to the development of evidence-based policy, our Founding Fathers chose to design a government that permits, and even encourages, "majoritarian pluralism."[24] This mode of governing encourages policymakers to consider the preferences of groups that represent the interests of factions of its citizenry.[25] Policymaking in such a system

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17. THE POLITICS OF PROBLEM DEFINITION: SHAPING THE POLICY AGENDA 3–4 (David A. Rochefort & Roger W. Cobb eds., 1994).

18. *See* STONE, *supra* note 13, at 148–54.

19. *See id.*

20. Organized interest groups include citizen groups, trade and business associations, business corporations, professional associations, coalitions on specific issues, unions, foundations and think tanks, governmental associations, and institutions and associations of institutions.

21. Rochefort & Cobb, *supra* note 17, at 8; *see* STONE, *supra* note 13, at 153.

22. *See id.*

23. *Cf.* E. SCHATTSCHNEIDER, THE SEMISOVEREIGN PEOPLE 68 (1960) ("He who determines what politics is about runs the country, because the definition of the alternatives is the choice of conflicts, and the choice of conflicts allocates power.").

24 *Cf., e.g.*, THE FEDERALIST NO. 51 (James Madison) ("Ambition must be made to counteract ambition.").

25. Majoritarian pluralism can be traced back to James Madison's essay in *The Federalist No. 10*, in which he referred to diverse "factions" representing the interests

does not exclude experts from the policymaking process. Scholars, researchers, and professionals can affect policy change even when policymakers do not call on them individually for expert testimony. These experts can effect change by mobilizing in groups and contributing to the problem definition discourse by: pressuring groups of which they are a member to adopt a new causal narrative; swaying the public to adopt their desired causal stories; calling upon group members to pressure legislators to adopt their narrative through the use of strategically crafted emails, letters, and phone calls; and promoting their narratives at town halls or Congressional field hearings.

This Article purports to equip legal scholars, researchers, and all concerned citizens with a greater understanding of the legislative problem-definition process and the role that pressure groups play in such a process. Through the use of examples from drug policy history, this Article demonstrates how pressure groups strategically used problem definitions to shape legislative discourse and pressure Congress into supporting policy solutions that aligned with their problem definitions by, for example, sometimes attributing addiction to disease, and to deviancy at other times. By example, this Article outlines strategies that legal scholars, researchers, and concerned citizens can use to define problem drug use as a health issue caused by multiple sociological, psychological, economic, and biological factors.

Part II provides readers with an introduction to the problem-definition and policy-narrative literature, starting with a general background on its philosophical roots, and then explaining how policy actors use narratives to influence the problem definition process. Part III then provides evidence to support the claim that pressure groups affect the legislative decisionmaking process, primarily through subject-matter expertise that they provide to legislators. Part IV

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of groups of citizens. Although some scholars believe that "factions" could have referenced both parties and organized interest groups, I would argue that Madison's use of the word "parties" just a few paragraphs before his definition of factions implies that he intended for factions to refer to interest groups. *See e.g.*, Martin Gilens & Benjamin I. Page, *Testing Theories of American Politics: Elites, Interest Groups, and Average Citizens*, 12 PERSPECTIVES ON POL. 564, 566 (2014) (arguing that factions could have referenced both parties and interest groups). "By a faction," Madison writes, "I understand a number of citizens whether amounting to a majority or a minority of the whole, who are united and actuated by some common impulse of passion, or of interest, adverse to the rights of other citizens, or to the permanent and aggregate interests of the community." THE FEDERALIST NO. 10 (James Madison).

explains, by use of both hypothetical and historical examples, how groups construct narratives. This Part is by no means a complete historic account of all instances in which lobbying groups effectively used narratives to further their objectives, nor is it a complete history of drug policy in the U.S. Rather, I focus on time periods during which the health vs. criminal-justice narrative battle dominated policy discourse. Part V highlights pivotal times in early American drug policy during which pressure groups defined or redefined problem drug use as either a health problem or a criminal justice problem. Finally, Part VI concludes with lessons from our studies of pressure groups' narrative uses and outlines recommendations for problem definition strategies that legal scholars and professionals can use to further their policy objectives in drug policy debates and beyond.

II. PROBLEM DEFINITION & POLICY NARRATIVES

Problem-definition theory is rooted in the epistemological belief of social constructivism, which theorizes that society makes sense of the world around it through shared interpretation and meaning.[26] The "Truth," or absolute reality, may or may not exist; but rather than focusing on compiling evidence or facts that attempt to represent this absolute reality,[27] the constructivist focuses on uncovering how society interprets reality. Such an interpretation and assignment of meaning is what influences societal values, beliefs, actions, and inaction.[28] Policymaking thus becomes "a struggle over alternative realities."[29]

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26. Epistemology generally refers to theories of knowledge gathering or philosophy of knowledge. FRANK FISCHER, REFRAMING PUBLIC POLICY: DISCURSIVE POLITICS AND DELIBERATIVE PRACTICES 12 n.10 (2012).

27. Such a knowledge-seeking expedition runs counter to the mainstream scientific philosophy referred to as positivism, or its more modern counterpart postpositivism, which posits that there is an objective reality that we are trying to measure. *Id.* at 12 n.11. Within this model, the observer stands at an arm's length, with a validated measuring stick, and a statistical arsenal with the objective of proving or disproving a hypothetical truth in the form of a hypothesis. *Id.* at 118.

28. *See id.* at 123.

29. Rochefort & Cobb, *supra* note 17, at 9.

Problem-definition[30] scholars apply this knowledge-seeking theory to studying how the political process defines social problems.[31] Problem definition theorists believe that people contest and debate the problem in the political sphere based on their *perceptions* of what the problem is, but one can always contest these *perceptions*.[32] I will demonstrate this to be true in the arena of drug policy through examples of competing problem definitions at different junctures in history.

Accepting that problem definitions are contestable is not to say that they are not at all grounded in evidence. Rather, it is an acknowledgement that other factors aside from research contribute to the manner in which society defines problems, including "[c]ultural values, interest group advocacy, scientific information, and professional advice."[33] People use evidence, facts, and scientific studies to justify or support a narrative. Often, however, problem-definition narrators choose the evidence selectively, giving preference to evidence that supports their preferred causal narrative, while discounting, omitting, or ignoring conflicting evidence.[34]

Although different tools are used in the problem-definition process, I will focus on the use of policy narratives or stories, as well

30. Problem definition has different names, depending on the discipline: "problem framing" or "frames" in sociology, communication, and political science, or "policy narratives" in the narrative literature of policy studies. *Cf., e.g.*, Rochefort & Cobb, *supra* note 17. *But see, e.g.*, David A. Snow & Robert D. Benford, *Ideology, Frame Resonance and Participant Mobilization*, 1 INT'L SOC. MOVEMENT RES. 197, 197–218 (1988) (discussing aspects of social movements that some disciplines fail to analyze). Because "framing" refers to a variety of constructs, I will use "problem definition" throughout this Article to refer to the act of defining a social problem, with the caveat that different disciplines refer to the same construct by different names.

31. Social problems are a "shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge others to act in concert to affect change." Robert D. Benford & David A. Snow, *Framing Processes and Social Movements: An Overview and Assessment*, 26 ANNUAL REV. OF SOCIOLOGY 611, 615 (2000). A social problem differs from a policy problem because a social problem does not become a policy problem until it "gains attention and legitimacy" and lends itself to an "official programmatic response." Rochefort & Cobb, *supra* note 17, at 8.

32. *Id.*

33. *Id.* at 4.

34. *See generally id.* at 15–24; STONE, *supra* note 13, at 133–37.

as the use of synecdoche in these narratives.[35] Policy narratives "are a way of structuring and communicating our understanding of the world."[36] They resemble fictional narratives in that they have characters, a plotline, an ending, and a relatively consistent structure.[37] Unlike fictional narratives, however, policy narratives require a higher standard of believability, and society judges them as real depending on how believable or credible they appear to be.[38] Narrators can gain credibility through the use of experts or with scientific evidence.[39] Believability, however, depends on the degree to which the narrative resonates with cultural and societal norms,[40] the familiarity of the plotline,[41] and the degree to which the character descriptions coincide with the audiences' perceptions of that character from their life experiences and encounters.[42] Many of these recycled plotlines apply to different social problems over time, especially because familiar policy narratives tend to be more convincing to legislatures, administrative officials, and the public.[43] These policy narratives are important in that they affect perceptions of the trade-offs between policy alternatives[44] and the content of legislation.

The causal story is a common type of narrative in the policymaking sphere. Causal stories describe the cause of the problem,

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35. There is disagreement in the policy narrative literature on whether policy narratives and policy stories are the same construct. *See, e.g.*, SHAUL R. SHENHAV, ANALYZING SOCIAL NARRATIVES 20–36 (2015) (analyzing "stories" as constituent parts of "narratives"). However, I use the terms interchangeably in this Article.

36. Elizabeth A. Shanahan, Michael D. Jones & Mark K. McBeth, *Policy Narratives and Policy Processes*, 39 POL'Y STUD. J. 535, 539 (2011).

37. STONE, *supra* note 13, at 109. *See also generally* SHENHAV, *supra* note 35 (outlining the structure and use of social narratives).

38. FISCHER, *supra* note 26, at 177–78.

39. *Id.*; *see also* ANNE LARASON SCHNEIDER & HELEN INGRAM, POLICY DESIGN FOR DEMOCRACY 34–38 (1997) (analyzing the virtues and vices of "policy science").

40. *See generally* Isaac William Martin, *Redistributing Toward the Rich: Strategic Policy Crafting in the Campaign to Repeal the Sixteenth Amendment, 1938–1958*, 116 AM. J. SOC. 1 (2010) (explaining the use of policy crafting and reviewing sociological theory in connection with the politics of redistribution).

41. For examples of common plotlines, see STONE, *supra* note 13, at 166–72.

42. FISCHER, *supra* note 26, at 177.

43. *See* STONE, *supra* note 13, at 166–72.

44. Martin, *supra* note 40, at 6–7.

assign blame, and suggest burden and benefit allocations depending in part on the blame assignment and the social construction of the target population[45] that the policy solution affects.[46]

These stories often identify the actors of the story as either heroes or villains, innocent or guilty, or strong or weak, and they describe the cause of the phenomenon as action or inaction by these characters.[47] Narrators in the policymaking discourse then use the causal stories, or causal narratives, as tools of persuasion.

The narrators, or storytellers, in the policymaking process can include, but are not limited to, the president, administrative officials, legislators, judges, and organized interest groups. The president uses the bully pulpit to communicate causal narratives that justify his focus on an issue in his presidential agenda and to garner public support for his initiatives.[48] Administrative agency officials use causal stories to convince the president and the legislature that a social issue within their subject-matter expertise is a policy problem that the president and Congress should prioritize.[49] Administrative officials also use causal stories to justify rules and regulations that they promulgate in carrying out their duties of enforcement and implementation of legislation.[50]

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45. In general, "the social construction of target populations refers to the cultural characterizations or popular images of the persons or groups whose behavior and well-being are affected by public policy." Anne Schneider & Helen Ingram, *Social Construction of Target Populations: Implications for Politics and Policy*, 87 AM. POL. SCI. REV. 334, 334 (1993).

46. *See* STONE, *supra* note 13, at 154–65; Schneider & Ingram, *supra* note 45.

47. Anne L. Schneider, Helen Ingram & Peter deLeon, *Social Construction and Policy Design*, *in* THEORIES OF THE POLICY PROCESS 105, 105 (Paul A. Sabatier & Christopher M. Weible eds., 3d ed. 2014); STONE, *supra* note 13, at 109.

48. Presidents have a long, documented history of using causal narratives, as well as other rhetorical devices, to mobilize the public to support efforts to address the nation's drug problems. Often they have used such rhetoric to increase election or re-election prospects. *See generally, e.g.*, ANDREW B. WHITFORD & JEFF YATES, PRESIDENTIAL RHETORIC AND THE PUBLIC AGENDA: CONSTRUCTING THE WAR ON DRUGS (2009) (detailing how presidents use narratives and rhetoric to further their policy goals).

49. See *infra* Section III.B for examples of narrative use by the Narcotics Bureau to justify the war on drugs and the need to continue its efforts in addressing the drug problem using a law enforcement approach.

50. For example, from the 1970s to the 1990s, the Social Security Administration supported the causal narrative that addiction was a disorder that resulted in a disability. *See* Max Selver, Note, *Disability Benefits and Addiction:*

Legislators also use causal stories to persuade colleagues to adopt certain legislative solutions and garner constituent support on issues and proposals.[51] Organized interest groups use causal stories to persuade legislators and administrative officials both to adopt legislative and regulatory proposals that benefit their members.[52] Even judges use causal stories to justify their interpretations of the law.[53] Although multiple actors are involved in the narrative discourse, I focus in this Article on the manner in which pressure groups participate in the legislative narrative discourse and affect legislative solutions. In order to do so, I begin by presenting evidence that supports the contention that pressure groups influence legislative decision-making and then theorize how they use narratives to do so.

III. PRESSURE GROUPS & LEGISLATIVE INFLUENCE

Organized interest groups battle for legislators' time[54] and attention so that they can have the opportunity to define problems that affect their members.[55] Administrative agencies also engage in the

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Resolving an Uncertain Burden, 91 N.Y.U. L. REV. 954, 988 (2016). This interpretation allowed individuals with addiction to qualify for Social Security Income benefits. *Id.*

51. For example, in advocating for the passage of CARA, Senator Robert Portman defined addiction as a chronic disease of the brain. *See* Portman, *supra* note 12.

52. *See, e.g.*, Section IV.D (discussing how the Parents Group's use of causal narratives to shift government focus and resources to protecting their children from the temptations of marijuana).

53. *See, e.g.*, Daniel Polisar & Aaron Wildavsky, *From Individuals to System Blame: A Cultural Analysis of Historical Change in the Law of Torts*, 1 J. OF POL'Y HIST. 129, 131–40 (1989) (chronicling how judges defined the problems presented in tort litigation differently over time to accommodating changing public and cultural views on who should be blamed and benefited by tort litigation).

54. *See generally* Joshua L. Kalla & David E. Broockman, *Campaign Contributions Facilitate Access to Congressional Officials: A Randomized Field Experiment*, 60 AM. J. POL. SCI. 545 (2016).

55. FRANK R. BAUMGARTNER ET AL., LOBBYING AND POLICY CHANGE: WHO WINS, WHO LOSES, AND WHY 9–15 (2009); SCHNEIDER & INGRAM, *supra* note 39, at 3–5 ("Criticisms of government in the United States center around *governance*—the capacity of a democracy to produce public policy that meets the expectations of society . . . ."). *See also generally, e.g.*, JOHN MARK HANSEN, GAINING ACCESS:

legislative problem-definition process by issuing government reports that outline the cause and scope of public problems[56] and by testifying in front of Congress.[57] By defining the problem, pressure groups can influence legislative outcomes.[58] Although throughout this paper I often refer to both organized interests and administrative agencies collectively as pressure groups, I will review the evidence for organized interest group and administrative agency influence on legislative decision-making separately, because the political science literature often treats these two groups separately in their analysis.

CONGRESS AND THE FARM LOBBY 1919–1981, at 227 (1991); Richard L. Hasen, *Lobbying, Rent-Seeking, and the Constitution*, 64 STAN. L. REV. 191, 219 (2012).

56. In the arena of drug policy, government reports have been very influential in focusing the public's attention on the nation's drug problem and enumerating the magnitude of the problem, usually through reports of increases in the number of persons using illicit substances, persons addicted to illicit substances, or persons overdosing from illicit substances. In Gozenbach's analysis of 15 years of American drug policy, the attention cycle for each episode of nationwide problem drug use began with a federal agency releasing a report publicizing an increase in drug use, after which the media began covering the nation's drug problem, and then public concern over the nation's drug problem also increased. WILLIAM J. GONZENBACH, THE MEDIA, THE PRESIDENT, AND PUBLIC OPINION: A LONGITUDINAL ANALYSIS OF THE DRUG ISSUE, 1984–1991, at 93–100 (1996). Public attention would fade, however, even if the problem drug use remained at the same rate. *Id.* It was not until a government agency released another report that the media, and then the public, would once again pay attention to problem drug use. *Id.* The order in which this occurred suggests that government reports shape the media's perception of drug problems.

57. Harry Anslinger was famous for his fiery testimony in front of Congress on drug issues while he was director of the Narcotics Bureau; he preached fire and brimstone for the deviants who used and sold drugs, and lawmakers deferred to his judgment. *See generally* DAVID T. COURTWRIGHT, DARK PARADISE: A HISTORY OF OPIATE ADDICTION IN AMERICA 61–77 (2001) (discussing 19th century popular attitudes toward opium users and their attendant social troubles); *id.* at 138 ("Anslinger initially endorsed the psychopathy view [of drug addicts]."). *See also id.* at 156 (describing Anslinger's congressional testimony and Capitol Hill politicking related to federal criminal drug laws then under consideration); DAVID F. MUSTO, THE AMERICAN DISEASE: ORIGINS OF NARCOTIC CONTROL 225 (3d ed. 1999).

58. *Cf.* SCHNEIDER & INGRAM, *supra* note 39, at 172 ("There are many other examples of how members of Congress have sidestepped public debates over values by adopting narrow, scientific definitions of problems."); Mark K. McBeth et al., *The Intersection of Narrative Policy Analysis and Policy Change Theory*, 35 POL'Y STUD. J. 87, 87–104 (2007).

A. Organized Interests' Influence on Legislators

Researchers have long hypothesized that organized interests influence legislative decision-making by providing legislators with financial contributions.[59] Politicians need such campaign funds to pay for advertisements, among other costs, that increase the likelihood that voters will elect the candidate.[60] It reasonably follows that legislators may pay special attention to interest groups that donate to their campaign.[61] As logical as such a deduction may be, the empirical literature, to date, has not been able to find a consistent relationship between campaign contributions and policy outcomes.[62] Researchers, however, have found that legislators are more likely to meet with groups that donate to their campaign.[63] This indicates that what groups might be buying with their campaign contributions is not necessarily a legislative outcome, but a legislator's time.[64] Getting some focused time and attention from a legislator allows the group to use that time

59. *See, e.g.*, Stephen Ansolabehere & James M. Snyder, Jr., *Money and Institutional Power*, 77 TEX. L. REV. 1673, 1673–78 (1999); Brandice Canes-Wrone, *From Mass Preferences to Policy*, 18 ANN. REV. POL. SCI. 147, 152, 155–56 (2015); Eleanor Neff Powell & Justin Grimmer, *Money in Exile: Campaign Contributions and Committee Access*, 78 J. POL. 974, 976 (2016);.

60. Kalla & Broockman, *supra* note 54, at 546.

61. *See* Benjamin I. Page, Larry M. Bartels & Jason Seawright, *Democracy and the Policy Preferences of the Wealthy*, 11 PERSP. ON POL. 51, 66–68 (2013) (describing wealthy individuals' engagement of the political process and how their participation influences outcomes). Scholars have also hypothesized that legislators pay special attention to campaign contributors that donate to other legislators' campaigns in the hopes that these donors will donate funds to their campaign in the future. Kalla & Broockman, *supra* note 54, at 546.

62. *See generally* Beth L. Leech, *Lobbying and Influence*, *in* THE OXFORD HANDBOOK OF AMERICAN POLITICAL PARTIES AND INTEREST GROUPS 534, 534–51 (L. Sandy Maisel & Jeffrey M. Berry eds., 2010). Political scientists also hypothesize that organized interests are influential because they have information on the preferences of their members and can mobilize their members to vote for a legislator. *Id.* at 545–46. However, the empirical evidence justifying such a claim is weak. *See e.g.*, *id.* at 546 (finding that interest groups used arguments that were "electoral in nature" only 3% of the time).

63. Kalla & Broockman, *supra* note 54, at 546.

64. *See id.* at 547.

to define policy problems and try to narrow policy solutions.[65] In sum, the body of research suggests that, although campaign finance *may* influence legislative outcomes, it does not provide a reliable predictor of how or why interest groups seek to influence legislators' decision-making processes.

Interests groups, however, have other resources that they can provide to legislators, aside from dollars and votes—resources that may allow them to otherwise influence legislative decision-making. Interest groups offer subject-matter expertise and specialized information that allow legislators to make informed decisions on issues without incurring direct information costs themselves.[66] Additionally, advocacy or citizens groups can publish reports on an issue that the public and media find trustworthy and convincing.[67] If such a report aligns with a legislator's narrative on an issue, the report provides external validity to his or her claims.[68] It is when groups offer this "legislative subsidy" that they are in a prime position to use their research and subject matter expertise to justify a particular problem definition.[69]

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65. *Id.* Leech also notes that interest groups may use their influence to affect which issues get on the political agenda. Leech, *supra* note 62, at 546. For a legislative outcome to be possible, an issue must first get on the political agenda and be deemed worthy of attention by legislators. *Id.* at 549. Conversely, then, by preventing issues from ever getting on the political agenda in the first place, groups can block legislation from being introduced on the issue. *See id.* It is difficult to measure how many issues do not make it on the agenda and why they do not make it on the agenda, so most research on interest group influence has focused on counting yes or no votes on legislation that has made it through the many hurdles necessary to reach a floor vote. *Id.* at 546.

66. Richard L. Hall & Alan V. Deardorff, *Lobbying as Legislative Subsidy*, 100 AM. POL. SCI. REV. 69, 69, 71 (2006).

67. The public and media do not have as easy access to industry reports as they do citizens' groups' reports. *Cf.* JEFFREY M. BERRY, THE NEW LIBERALISM: THE RISING POWER OF CITIZEN GROUPS 121–27, 133–42 (1999) (discussing the overrepresentation of citizens' interest groups in nightly television news coverage as a function of the research reports that they generate and the incentives they have to create them); WILLIAM P. BROWNE, CULTIVATING CONGRESS: CONSTITUENTS, ISSUES, AND INTERESTS IN AGRICULTURAL POLICYMAKING 110–11 (1995) (describing congressional constituents as the "primary informants" of policy problems).

68. *See* Hall & Deardorff, *supra* note 66, at 72.

69. Hall & Deardorff coined the term "legislative subsidy" to refer to the specialized information that organized interest groups can provide to legislators, so

B. Administrative Agency Influence on Legislators

Federal, state, and local administrative agencies are another source of specialized information for legislators. These agencies are often privy to data and statistics that measure the type, scope, and cause of a problem.[70] Since legislatures charge administrative agencies with the implementation and enforcement of legislation, the agencies' technical expertise on the logistics of policy implementation can be valuable in ensuring that legislators minimize the unintended consequences of legislative proposals. [71] Further, administrative agency officials are powerful allies for organized interest groups in successfully redefining a policy issue.[72]

Historically, federal administrative agencies have been especially influential in defining problem drug use and focusing the national attention on America's drug problem via agency reports on problem drug use.[73] Federal administrative agencies, like the Substance Abuse and Mental Health Services Agency ("SAMHSA") and the Center for Disease Control and Prevention ("CDC"), collect yearly data on variables that government researchers consider to be

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that legislators do not have to expend costs in acquiring this information themselves. *Id.* at 72–76.

70. *Cf.* United States v. Nova Scotia Food Prods. Corp., 568 F.2d 240 (2d Cir. 1977) (holding that agencies must disclose scientific research they use in rulemaking so interested parties have an opportunity to comment on it or provide their own to address specific policy concerns).

71. While it is true that, traditionally, only federal agencies were the sole enforcers of federal law, with the expansion of Congressional delegation of authority and duties to the federal bureaucracy has come the subsequent delegation of enforcement to state and local governments. *Cf.* Mark K. McBeth et al., *The Intersection of Narrative Policy Analysis and Policy Change Theory*, 35 POL'Y STUD. J. 87, 93 (2007) (describing joint efforts of the National Park Service and the Montana State Livestock Department to control bison population). Typically, this occurs through the use of conditional federal funding for state programs. *Cf. generally* BRIAN T. YEH, CONG. RESEARCH SERV., R44797, THE FEDERAL GOVERNMENT'S AUTHORITY TO IMPOSE CONDITIONS ON GRANT FUNDS (2017).

72. BAUMGARTNER ET AL., *supra* note 55, at 13–15 (finding that support for a narrative by high ranking governmental officials in either the legislature or the administration best predicted whether or not a problem was successfully redefined). See also Part IV where I demonstrate how parents' groups partnered with NIDA to affect the definition of problem drug use in the late 1970s and 1980s.

73. *See supra* notes 4–7.

measures of problem drug use.[74] These data allow these agencies to monitor any changes in the variables from year to year and alert Congress of any increases in rates of use, addiction, or overdose deaths.[75]

Although the inclination is to treat such reports as objective research, it is important to acknowledge that agencies have a stake in results that they publish. On one hand, highlighting the severity of a problem through numbers and statistics increases focus on the agency's problem of interest and supports requests for additional funding allocations to that agency. On the other hand, continually having increasing rates of death or addiction can demonstrate that the agency is ineffectively handling the problem. For example, the Bureau of Narcotics, the predecessor to the federal Drug Enforcement Agency ("DEA"), knowingly overestimated the number of persons addicted to illicit drugs to justify continued budget allocations and ensure the Bureau's survival.[76] To demonstrate that it was effective and producing results, however, the Bureau of Narcotics balanced its reports of escalating problems with reports of decreases in addiction or, more often, increases in the number of arrests of drug traffickers and users.[77]

This is not to say that doctoring statistics is the only way agencies have influenced narratives in drug policy. Agencies can steer the narrative discourse simply by making decisions on what to count and how to define the categories that they are counting.[78] For example, agencies must decide questions of categorical inclusion like, when counting the number of persons abusing prescription opioids, should

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74. *See, e.g.*, U.S. Dep't of Health & Human Servs., *SAMHSA Data and Dissemination*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/data/ (last visited Nov. 27, 2018).

75. *See, e.g.*, JONAKI BOSE ET AL., SAMSHA, U.S. DEP'T OF HEALTH & HUMAN SERVS., KEY SUBSTANCE USE AND MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2015 NATIONAL SURVEY ON DRUG USE AND HEALTH (2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf.

76. *See* COURTWRIGHT, *supra* note 57, at xii.

77. *Id.*; *see also id.* at 155–57; Joseph F. Spillane, *Building a Drug Control Regime, 1919–1930*, *in* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 25, 32, 43–47 (Jonathon Erlen & Joseph F. Spillane eds., 2004) [hereinafter Spillane, *Drug Control Regime*].

78. STONE, *supra* note 13, at 133–37.

the law consider doubling the prescribed dose of one's own prescription to eliminate pain a form of problem drug use?[79] What criteria should policymakers use to determine whether an accidental overdose caused death relative to an intentional suicide by overdose? Decisions on each of these measurement questions cannot only result in the over- or undercounting of a problem but can change the meaning of the results and how policymakers define the problem.[80] Further, since the rational decision-making model of policy prefers measurable policy outcomes, policy actors may prefer policy solutions that produce outcomes that can be easily measured using pre-existing measurement tools[81] over policy solutions that produce outcomes that cannot be as easily measured, due to the outcomes' complexity or the lack of a widely implemented measurement tool.[82] In deciding what to measure, what to report, or how to report it to legislators, administrative agencies influence the narrative discourse. Additionally, they influence the discourse by explicitly supporting some narratives over others.

In conclusion, evidence exists in the empirical literature to support the claim that both organized interest groups and administrative agencies can influence the manner in which lawmakers define a problem, and that such problem definition can limit the policy

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79. *See, e.g.*, Arthur Hughes et al., *Prescription Drug Use and Misuse in the United States*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Sept. 2016), https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR2-2015/NSDUH-FFR2-2015.htm (demonstrating that measuring a phenomenon involves decisions about how to define and categorize, which in turn affect the results).

80. *Id.*

81. For example, since the CDC monitors overdose deaths, increasing the availability of Naloxone, an overdose-reversal medication, is a policy solution whose outcome can be easily measured by counting the number of overdoses before implementing the policy solution and then determining if a decrease follows implementation. *See CDC WONDER Database*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://wonder.cdc.gov/ (last visited Nov. 27, 2018) (database for monitoring overdose deaths); *Opioid Overdose Reversal with Naloxone (Narcan, Evzio)*, NAT'L INST. ON DRUG ABUSE (2018), https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio (last updated Nov. 27, 2018) (providing information on naloxone).

82. For example, if the lack of hope for a better future is what causes overdose epidemics, it is much more difficult to measure "hope." Further, no annual administrative agency survey even attempts to measure "hope."

alternatives available for inclusion into legislation. The next Part outlines how groups construct narratives, and how that may differ based on their motivations for doing so.

IV. HOW GROUPS CONSTRUCT NARRATIVES

The narrative-generation process is not always a conscious endeavor. *Why* a group constructs a narrative in the first place, however, influences *how* a group constructs its narrative. Is the group constructing a narrative to achieve or avoid a policy solution? Are they constructing a narrative to garner widespread acceptance of a particular causal theory? Or are they developing a narrative to ensure that a specific population benefits from or carries the burden of the policy solution? Since a group can begin the narrative-construction process by choosing its characters, cause, or desired solution, the group's objective influences its decision as to which component to focus its attention. The order in which groups select these components varies, and choices at each juncture affect the alternatives that are available for the remaining story elements. If the group makes certain choices purposefully, then it can narrow the available alternatives to those that align with the narrators' interests.

A. Designing a Narrative to Further a Solution

A narrator may begin the narrative-crafting process by first choosing a desired solution. For example, the National Organization for the Reform of Marijuana Laws ("NORML"), a group that advocates for the legalization of marijuana,[83] could hypothetically see the Opioid Epidemic and the shift in public support for decriminalization[84] as a window of opportunity through which to

83. *See generally* THE NAT'L ORG. FOR THE REFORM OF MARIJUANA LAWS, http://norml.org/ (last visited Nov. 27, 2018).

84. In February of 2017, Representative Thomas Garrett introduced the Ending Federal Marijuana Prohibition Act of 2017. H.R. 1227, 115th Cong. (2017). In August of 2017, Senator Cory Booker proposed the Marijuana Justice Act of 2017, which would amend the Controlled Substances Act to remove marijuana from the schedule list. S. 1689, 115th Cong. (2017). There has also been a movement at the state level to decriminalize and legalize marijuana. *See generally State Medical Marijuana Laws*, NAT'L CONFERENCE OF LEGISLATURES (Nov. 8, 2018), http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx.

pursue its agenda.[85] As such, if NORML constructed a policy narrative to define the Opioid Epidemic, they could start the narrative-formation process by choosing their desired solution (marijuana legalization) and then developing a cause of the Opioid Epidemic that at least makes medical marijuana legalization a likely solution. Perhaps NORML might argue that the Opioid Epidemic resulted from physicians relying on opioid prescription pain pills as the primary treatment for chronic pain because opioids were the only treatment option available in their medical arsenal.[86] The lack of alternative treatment options resulted in the over prescription of "highly addictive"[87] opioid prescription pain pills.[88] Legalizing marijuana for medicinal use offers a solution to the problem, as NORML might define it, because patients can use marijuana as an alternative pain treatment to "overly addictive"[89] and overdose-causing prescription pain pills. Evidence indeed supports

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Furthermore, a majority of Americans (61%) support the legalization of marijuana. Hanna Hartig & Abigail Geiger, *About Six-in-Ten Americans Support Marijuana Legalization*, PEW RESEARCH CTR. (Oct. 8, 2018), http://www.pewresearch.org/fact-tank/2018/01/05/americans-support-marijuana-legalization/. These factors suggest that the politics stream in Kingdon's model may be aligned for the solution of marijuana legalization. *Cf.* KINGDON, *supra* note 14 at 146–49 (discussing how the "national mood" in a given moment can spur policy change).

85. *See supra* note 20.

86. NORML advances such a narrative when contributing to the public discourse. *See Relationship Between Marijuana and Opioids*, THE NAT'L ORG. FOR THE REFORM OF MARIJUANA LAWS, http://norml.org/marijuana/fact-sheets/item/relationship-between-marijuana-and-opioids (last visited Nov. 27, 2018).

87. I use quotation marks here to indicate that I refer to the pervasive opinion that opioid prescription pain pills are highly addictive and am in no way indicating that such a claim is supported by the weight of the evidence.

88. There is empirical support for these claims. *See generally, e.g.*, Lauren S. Penney et al., *Provider and Patient Perspectives on Opioids and Alternative Treatments for Managing Chronic Pain: A Qualitative Study*, 17 BMC FAM. PRAC. 164 (2016).

89. *See Relationship Between Marijuana and Opioids*, *supra* note 86 (attributing a decrease in opioid prescription rates to state implementation of medical marijuana laws). Although some have called opioid prescription pain pills "extremely" addictive, the rate of iatrogenic addiction—addiction caused by medical mistake—is often overestimated because addiction, abuse, misuse, and dependence are all treated as if they are the same construct when they are in fact very different. *See, e.g.*, Nora D. Volkow & A. Thomas McLellan, *Opioid Abuse in Chronic Pain — Misconceptions and Mitigation Strategies*, 374 NEW ENG. J. OF MED. 1253, 1259 (2016).

these hypothetical claims, and would thus lend credibility to NORML's narrative. For instance, physicians have cited the lack of alternative pain treatment options for chronic pain patients as an issue in care.[90] Additionally, empirical research has shown that cannabis can effectively treat pain for some patients.[91]

This is not the only causal theory with empirical support. For example, despair,[92] unemployment,[93] or self-medication[94] could also serve as causes of the Opioid Epidemic in an effective narrative. If NORML focused on these other causes in their causal story, however, marijuana legalization no longer neatly addresses the policy problem. By starting with their desired solution, NORML members can limit the list of causes to those that call for legalization of at least some forms of marijuana use. Similarly, they would limit the characters or target population of their narrative to persons with chronic pain, thus excluding persons with problem drug use who do not have a chronic pain diagnosis.[95] The consequences of such a limitation on the target

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90. *See, e.g.*, Howard L. Fields, *The Doctor's Dilemma: Opiate Analgesics and Chronic Pain*, 69 NEURON 591, 592–93 (2011).

91. *See, e.g.*, Kevin P. Hill et al., *Cannabis and Pain: A Clinical Review*, 2.1 CANNABIS & CANNABINOID RES. 96, 99–102 (2017).

92. In 2015, Case & Deaton noticed that the areas that had the highest overdose rates also had high rates of deaths due to alcohol and suicide. Anne Case & Angus Deaton, *Mortality and Morbidity in the 21st Century*, BROOKINGS INST. (Mar. 23, 2017), https://www.brookings.edu/bpea-articles/mortality-and-morbidity-in-the-21st-century/. These three deaths of despair were highly correlated with "an accumulation of pain, distress, and social dysfunction in the lives of working class whites that took hold as the blue-collar economic heyday of the early 1970s ended, and continued through the 2008 financial crisis and the subsequent slow recovery." *Id.*

93. Economically deprived areas with high unemployment rates often have high addiction rates. *See generally* Katherine McLean, *"There's Nothing Here": Deindustrialization as Risk Environment for Overdose*, 29 INT'L J. OF DRUG POL'Y 19, 20, 22 (2016) (reporting that prescription opioid abuse has become more prevalent in smaller suburban and rural communities).

94. Recent studies have shown that opioid misuse is higher for individuals who report untreated pain as well as untreated chronic mental illness, including depression. *See e.g.*, Penney, *supra* note 88.

95. Although popular discourse makes it appear as if persons who overdose from opioid addiction are most likely persons who received an opioid prescription from a doctor for long-term treatment of chronic pain, the empirical evidence to date does not support this contention. *See, e.g.*, Michael A. Yokell et al., *Presentation of*

population is that the policy solutions implemented would benefit chronic pain patients, but they would not benefit members of the target population who are not chronic pain patients. NORML, however, would have come closer to accomplishing its objective by pushing for the legalization of marijuana incrementally, a political feat much easier to accomplish than marijuana legalization wholesale.[96]

In sum, for pressure groups that are invested in the legislative adoption of a pet policy solution, beginning by identifying where they want their narrative to end allows them to reverse-engineer a story that guides the discourse to their desired solution.

B. Devising a Narrative to Avoid a Solution

Rather than starting the narrative-crafting process with a desired solution, narrators can also choose the elements of their narrative based on a desire to eliminate undesirable solutions. For example, prescription opioid drug manufacturers, whom some actors have blamed for causing the opioid epidemic,[97] could hypothetically support a causal narrative that Chinese manufacturers have flooded the streets with counterfeit OxyContin and fentanyl, which then caused a spike in overdoses. Indeed, there is evidence that counterfeit opioids from

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Prescription and Nonprescription Opioid Overdoses to US Emergency Departments, 174 JAMA INTERNAL MED. 2034, 2036 (2014) (finding that less than 13% of patients admitted to U.S. emergency rooms for opioid overdoses had a pain diagnosis).

96. For an example of attempts to incrementally legalize marijuana, see, for example, Joel Ebert, *With Assist from House Speaker Beth Harwell, Medical Cannabis Bill Advances in House Subcommittee*, TENNESSEAN (Feb. 27, 2018), https://www.tennessean.com/story/news/politics/2018/02/27/medical-marijuana-law-tennessee-politics-tn-house/378069002/.

97. Prescription opioid manufacturers have been blamed for intentionally downplaying the addictiveness of their products, insisting that their medications last for 12 hours while possessing evidence that it only lasts for 8 hours. *See* Alana Semuels, *Are Pharmaceutical Companies to Blame for the Opioid Epidemic?*, THE ATLANTIC (June 2, 2017), https://www.theatlantic.com/business/archive/2017/06/lawsuit-pharmaceutical-companies-opioids/529020/. They have also been blamed for failing to intervene, even though they knew or should have known that their medication was likely being diverted. *See, e.g.*, Press Release, Mike DeWine, Ohio Att'y Gen., Attorney General DeWine Files Lawsuit Against Opioid Distributors for Practices Fueling Opioid Diversion (Feb. 26, 2018), http://www.ohioattorneygeneral.gov/Media/News-Releases/February-2018/Attorney-General-DeWine-Files-Lawsuit-Against-Opio.

China have increased the illicit drug supply in the U.S.,[98] but other factors that this narrative ignores have also played a role in the increased supply and demand of illicit opioids.[99] By supporting this causal narrative, U.S. drug manufacturers could shift the blame to China, making it more likely that any proposed regulations will punish China instead of American pharmaceutical companies.[100]

C. Devising a Narrative to Support a Causal Theory

Although the first two strategies that this Article outlines emphasize devising a narrative around a solution, some narrators devise their narrative with a cause as the focal point. For example, narrators, like advocacy groups that represent persons in recovery from

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98. Ryan Lucas, *Justice Department Indicts 2 Chinese Nationals in Synthetic Opioid Case*, NAT'L PUB. RADIO (Oct. 17, 2017, 2:14 PM), https://www.npr.org/2017/10/17/558330881/justice-department-indicts-2-chinese-nationals-in-synthetic-opioid-case; Sui-Lee Wee & Javier C. Hernandez, *Despite Trump's Pleas, China's Online Opioid Bazaar Is Booming*, N.Y. TIMES (Nov. 8, 2017), https://www.nytimes.com/2017/11/08/world/asia/china-opioid-trump.html.

99. *Cf. supra* notes 62–64 and accompanying text (discussing lobbying and campaign contributions).

100. Such a problem definition has consequences beyond those that the narrators desire because it encourages punitive solutions. It could, for example, shift the focus to international interdiction strategies that involve agencies in charge of foreign affairs. In the past, some presidents have supported the definition of problem drug use in a manner that blames other countries, particularly other countries that are less powerful than the U.S. *Cf., e.g.*, WHITFORD & YATES, *supra* note 48, at 83 (describing 1988 presidential hopeful Michael Dukakis's campaign statement that, if he was elected, America "won't be doing business with drug-running Panamanian dictators anymore" as an "attack" on his opponent George H.W. Bush's diplomatic efforts as Vice President under Ronald Reagan). As commander-in-chief, the president could then take actions against these countries, showing the electorate that he is simultaneously involved in foreign affairs and punishing the "bad guys." One could foresee President Trump supporting such a narrative, as it adds credibility to his desires to punish China and supports his preferred policy solution of building a wall at the American-Mexican border to further prevent the smuggling of drugs from international sources. *See, e.g.*, Matthew Hall, *US Turns to Trump Targets—UN, China and Mexico—for Help in Opioid Crisis*, THE GUARDIAN (Jan. 7, 2018, 6:00 AM), https://www.theguardian.com/us-news/2018/jan/07/us-. American pharmaceutical companies, however, may or may not have intended each of these consequences when they devised their hypothetical narrative. These consequences could be a result of such a narrative all the same.

addiction, may devise their narratives by starting with the causal story that addiction is chronic brain disease. These advocacy groups may be invested in popularizing the causal story that addiction is a disease because it refutes the stigmatizing causal story that weak character causes addiction. Further, the chronic-disease analogy communicates that addiction can recur due to the nature of the disease itself, which necessarily means that a person's moral character is irrelevant. These groups may support such a causal story even if they are aware of evidence that socio-economic factors also contribute to problem drug use, because they believe that the "addiction is a disease" causal story is most powerful in combatting social stigma. Even if the "addiction is a disease" causal story does not align with the best policy results, it has utility in and of itself.[101]

D. Devising a Narrative to Benefit or Burden a Target Population

Rather than focusing the narrative-design process around achieving or avoiding a solution or a cause, narrators can also begin crafting a narrative by choosing the target population, or characters, that they would like to see receive benefit or blame. Problem drug use affects many populations.[102] Listing all members of a target population can be not only an exhaustive and likely impossible endeavor, but it may also confuse the narrative's intended audience, which may have limited attention and resources. Therefore, in choosing the characters for their narratives, narrators often choose the segment or segments of a heterogeneous population that they are most interested in benefiting or burdening.[103]

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101. *See generally, e.g.*, Julie A. Warren, *Defining the Opioid Crisis and the Limited Role of the Criminal Justice System in Resolving It*, 48 U. MEM. L. REV. 1203 (2018).

102. *See, e.g.*, CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2016 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES (2017) (Table 6.51A, "Illicit Drug Use Disorder in Past Year Among Persons Aged 18 or Older, by Age First Used Marijuana and Demographic Characteristics: Numbers in Thousands, 2015 and 2016"), https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf.

103. *See* SCHNEIDER & INGRAM, *supra* note 39, at 84–89 (describing "target populations" as a "crucial" component of causal stories and policy effectiveness).

For example, pressure groups can focus on the rural populations of overdose victims,[104] downplaying or ignoring the inner-city victims, or they could describe opioid-overdose victims as White, not Black, or as middle- and upper-class, not poor.[105] These portrayals only partially represent the target population of overdose victims, as there are many poor Black and Hispanic city-dwellers who suffer overdoses.[106] Yet, in describing the target population, narrators can choose to focus on only one sub-population as if it represents the entire target population. Doing so often communicates that this sub-population is the only part of the population that "should" benefit from the policy solution. This

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104. Moreover, by limiting the focus to overdose victims, narrators include only recreational drug users and hardcore chronic users who overdose, not those who do not overdose.

105. By focusing on a sub-population, narrators can better control the images and associations that are triggered by the narrative. *Cf.* STONE, *supra* note 13, at 179 (recounting American Medical Association efforts to organize physicians against the adoption of Medicaid and Medicare). Similarly, when pressure groups use anecdotes that describe problem drug use by focusing on an individual who uses, pressure groups can choose to focus on that individual's membership in one group, while ignoring their membership in other groups. Society categorizes persons into populations or groups of actors. Any one actor can be a member of multiple populations at a time. For example, an overdose victim can be a physician, a father, and a substance user. As such, each population of actors is comprised of sub-populations of actors (e.g. fathers who are substance users; doctors who are substance users). And each of these sub-populations is socially constructed to represent different images in the listeners' mind. The image of a father is quite different from that of a doctor. Pressure groups can choose to focus on actors' membership in one population over others, as if that population membership defines the actor. *See* SCHNEIDER & INGRAM, *supra* note 39, at 84–89; *cf.* STONE, *supra* note 13, at 170 ("A person may have needs and problems *as* a woman (gender), a black (race), a small business owner (class), and a parent (family status). Numerous political organizations clamor to represent her and her kind to make her identify her interests in common with them.").

106. *See* Keith Humphreys, *Opioid Abuse Started As a Rural Epidemic. It's Now a National One.*, WASH. POST (July 31, 2017), https://www.washingtonpost.com/news/wonk/wp/2017/07/31/opioid-abuse-started-as-a-rural-epidemic-its-now-a-national-one/; *Opioid Overdose Deaths by Race/Ethnicity*, THE HENRY J. KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity/ (last visited Nov. 30, 2018); Haeyoun Park & Matthew Bloch, *How the Epidemic of Drug Overdose Deaths Rippled Across America*, N.Y. TIMES (Jan. 19, 2016), https://www.nytimes.com/interactive/2016/01/07/us/drug-overdose-deaths-in-the-us.html.

is an example of employing a literary technique called "synecdoche."[107]

Choosing a sub-population of the target population on which to focus has consequences for the policy-making process. Policy solutions tailored for one sub-population may not be effective for other sub-populations because the causes of problem drug use in each sub-population may be different. For example, the causes of marijuana use among teenagers may be different from the causes of opioid prescription pain pill abuse by middle-aged White men.[108] The policy solutions that address problem drug use in these sub-populations would likely be different as well. A holistic problem definition would acknowledge the various categories of persons whom problem drug use affects, acknowledge the multiple causes, and devise an array of solutions that would address each. Given that drug-policy resources in the U.S. are both finite and rarely enough to address problem drug use in a single sub-population, policymakers make choices as to how to define who benefits or who bears the burden.[109]

Pressure groups can also affect legislators' decisions as to which sub-population to benefit or burden using such narratives. In the late 1970s and 80s, addiction treatment providers warned Congress that persons addicted to cocaine and crack were flooding their clinics.[110] Yet parents' advocacy groups[111] ("Parents Groups") insisted

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107. STONE, *supra* note 13, at 116–17. Such a technique is useful because populations have already been socially constructed as having certain attributes and characteristics, including whether that group is deserving of public assistance. *See infra* note 122; *see also infra* text accompanying notes 122–129.

108. See, for example, Comprehensive Addiction and Recovery Act, Pub. L. No. 114-198, § 201(d), 130 Stat. 695, 715 (2016), which provides research grants, in part, to researchers identifying "unique circumstances" facing teenagers and young adults struggling with drug use.

109. *See* STONE, *supra* note 13, at 203–05.

110. MICHAEL MASSING, THE FIX 166–68 (2000).

111. The Parents Movement arose in the late 1970s out of a greater counter-revolution to what parents viewed was the corruption of societal values by the popular media that glorified sex and recreational drug use. *See generally id.* at 143–54. Parents pointed to parental defiance and recreational drug use as indicators that they were losing control of their children. *Id.* at 168–69. The increase in marijuana use by middle class youth and suburban college students added to their concern, as well as legislative proposals in Congress to decriminalize marijuana. *See generally* MARSHA MANATT, NAT'L INST. ON DRUG ABUSE, PARENTS, PEERS, AND POT (1979),

that the federal government should stop focusing on the "black crack problem"[112] or reducing the number of "heroin addicts,"[113] but should focus instead on teenagers who were experimenting with marijuana.[114] In defining the drug problem, these Parents Groups focused on youth as the target population because they wanted youth to benefit from the policy solutions. However, Parents Groups defined drug users, or "druggies" as they referred to them, as part of the problem. Parents Groups blamed druggies for using peer pressure to convince teenagers to use and, in some cases, supply teens with drugs.[115]

To the dismay of Parents Groups at the time, there was little to no scientific or medical evidence to support their claims that marijuana was a gateway drug that would lead to a host of evils.[116] In attempting to locate such evidence, Marsha Schuchard, an English teacher and co-founder of the Parents' Resource Institute for Drug Education ("PRIDE"), contacted Director Robert DuPont of the National Institute on Drug Abuse ("NIDA") to ask him for help finding such evidence.[117] In DuPont, Schuchard found an ally and supporter of her narrative. DuPont even inquired whether Schuchard would be willing to author a NIDA publication that explained to parents how to prevent teenage drug use.[118] She agreed and published two papers with NIDA.[119] Although NIDA asked her to refrain from drawing medical or scientific conclusions about marijuana due to her lack of medical or

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https://files.eric.ed.gov/fulltext/ED185485.pdf; *see also generally* MARSHA MANATT, NAT'L INST. ON DRUG ABUSE, PARENTS, PEERS, AND POT II: PARENTS IN ACTION (1983), https://files.eric.ed.gov/fulltext/ED247498.pdf.

112. MASSING, *supra* note 110, at 185 (quoting Keith Schuchard, co-founder of Parents' Resource Institute for Drug Education ("PRIDE"), a prominent parents group).

113. *Id.* at 146 (quoting Marsha Schuchard).

114. *Id.* PRIDE's argument to convince policy-makers to focus on marijuana use was that intensive heroin use accounted for 1% of the population, while teenage gateway drug use affected all of the nation's children. *Id.*

115. *Id.* at 145–46.

116. The National Commission on Marihuana and Drug Abuse had explicitly stated that there was no scientific evidence that marijuana was a gateway drug. *Id.* at 151.

117. *Id.* at 144.

118. *Id.* at 145.

119. *Id.* at 152 (discussing MANATT, PARENTS, PEERS, AND POT, *supra* note 111).

scientific training, Schuchard ignored these requests.[120] Despite her lack of credentials and the lack of evidence supporting her statements, her publications were the most requested NIDA publications.[121]

NIDA's stamp of approval gave the Parents Groups' narrative credibility, and the Parents Groups' narrative benefited from the believability that came with focusing on a target population that was already socially constructed as needing protection and deserving of policy benefits.[122] Even before Schuchard's NIDA publications became available for request, however, the members of the Parents Groups argued that they were experts because they were parents. For example, in 1980, when testifying in front of Congress on the potential health issues that might arise from decriminalizing marijuana, a Parent Group member explained:

> The most important credential I can give you to substantiate my testimony is that I am a mother, not a doctor, not a scientist. I am here to protect my children.

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120. *Id.*

121. *Id.* at 153.

122. Schneider and Ingram theorize that target populations are categorized by society into two groups: those deserving of public assistance and those who are undeserving. SCHNEIDER & INGRAM, *supra* note 39, at 108. A group's deservingness is then moderated by the groups political power to create four types of target populations: Advantaged, Contenders, Dependents and Deviants. *Id.* Advantaged groups are groups that society has determined are most deserving and are groups with the great deal of political power. *Id.* They include businesses, the middle class, senior citizens, military, scientists, and family farmers. *Id.* The Contenders also wield political power but are viewed as undeserving. *Id.* They include gun owners, the rich, CEO's, and savings and loans companies. *Id.* Politically, it would be unwise to punish these groups because of their political power, but it would be equally unpopular with citizens if policy solutions benefited these groups. Dependents are politically weak but are constructed as deserving and include mothers, children, persons with disabilities, and the ill. *Id.* at 109. Because of their social construction, it is not difficult to construct narratives that call for these groups to benefit. For such a narrative to be successful, it requires the mobilization of large amounts of constituents or the endorsement of politically stronger groups. Lastly, the Deviants are constructed as undeserving and lack political power. *Id.* at 109–10. They include criminals and most often hardcore drug users. *Id.* at 109. The construction of individuals who use drugs may be changing, however, as they become constructed as persons with a disease of the brain.

> I am also here to protect my neighbor's children and the children of this nation.[123]

According to policy scholar Michael Massing, by the end of the Congressional hearing, the possibility of marijuana decriminalization was dead.[124] Massing credits the Parents Groups with more than just the defeat of marijuana decriminalization. In his view, the Anti-Drug Abuse Act of 1986, which re-established mandatory minimum sentences for drug possession, embodied the "parent model of drug abuse."[125]

PRIDE and other Parents Groups demonstrate how pressure groups can design a policy narrative based on the desire to benefit a target population. They first centered the narrative composition on youth as the target population, and they secondarily sought facts to establish that there was a problem and that the cause of the problem was marijuana. They utilized their narrative to form coalitions with school boards, school principals, the Parents Teachers Association ("PTA"), and local churches.[126] Maybe most importantly, they found a high-ranking administrative agency official to support their narrative.[127]

It is important to note, however, that the Parents Groups' success in focusing the nation's attention on the sub-population of youth was costly to the remaining population addicted to illicit substances, as the latter were more likely to end up in the emergency room than in treatment.[128] And the government's refusal to pay attention to the growing number of crack-cocaine users contributed to the magnitude of the crack-cocaine epidemic that would hit hard in the late 1980s to early 90s.[129]

In conclusion, this Section demonstrates theoretically how narrators can use narratives to limit the alternative legislative solutions

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123. MASSING, *supra* note 110, at 153 (quoting housewife-turned-anti-marijuana activist Joyce Nalepka).

124. *Id.*

125. *Id.* at 184.

126. *Id.* at 151.

127. They later aligned themselves with Nancy Reagan and played a big role in the First Lady's anti-drug campaign. *Id.* at 187–90.

128. *Id.* at 153–54, 189–90.

129. *Id.* at 190.

available in the policy discourse and assign benefits and burdens to target populations. In structuring their causal narratives, narrators can achieve their desired legislative solutions by strategically choosing a solution, cause, or target population on which to focus. The order in which they choose these elements depends on their goals. Narrators then use these narratives in the problem-definition discourse to persuade policymakers.

Although there are often multiple problem definitions vying to be the most dominant, only a few become accepted as the "true" definitions of the problem. The longer that people accept a problem definition as true, the more likely it is that the definition becomes permanently institutionalized.[130] Lawmakers create institutions that implement and enforce policy around the solutions that accompany the problem definition. The next Part demonstrates that, once lawmakers create such institutions, it becomes even more difficult to redefine a problem because these institutions are invested in maintaining the status quo definition.[131] As drug policy history demonstrates, however, it is not impossible to redefine policy problems, especially as cultural and societal norms evolve and the composition and power of interest groups change.[132] The Opioid Epidemic arguably created a juncture at which the cultural and political environment offer a window

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130. By "institutionalized," I refer to both the behavioral constraints placed on governmental and societal actions, *see* DOUGLASS C. NORTH, INSTITUTIONS, INSTITUTIONAL CHANGE AND ECONOMIC PERFORMANCE 17–26 (1990), as well as the governmental structure that makes, implements, and enforces the rules and regulations based on these behavioral patterns and societal constraints.

131. BAUMGARTNER ET AL., *supra* note 55, at 26. For example, as I demonstrate in Part V, the adoption of a deviance narrative, and implementation of punitive legislation to address the deviance, has resulted in the allocation of money and resources to federal, state, and local authorities that enforce the legislation. If activists were successful in redefining problem drug use as a health issue, the need for such an enforcement would decrease, as would the number of law enforcement officials needed and the funding allocated to these institutions. With the allocation of federal funds to the private prison system in the 1980s, private prisons as well as law enforcement unions are heavily incentivized to lobby to maintain the status quo. *Cf.* KENNETH J. MEIER, THE POLITICS OF SIN: DRUGS, ALCOHOL, AND PUBLIC POLICY 108–09 (1994) (depicting state agencies' incentives and opportunities to shape policy).

132. *See, e.g.*, BAUMGARTNER ET AL., *supra* note 55, at 176 (noting that, out of 98 policy issues studied, researchers found four policy issues that had been redefined—three of which were only partial redefinitions).

of opportunity for pressure groups to *redefine* problem drug use as a public health issue. Therefore, exploring historic examples of pressure-group problem definitions during windows of opportunity for change may provide us with a better understanding of how to successfully redefine problem drug use at the current juncture. As renowned drug policy historian David Musto wrote in reference to the crack-cocaine epidemic in the late 1980s:

> How can we understand this epidemic? It is important for us to know the history of drug abuse in America if we are to make wise decisions concerning drug abuse now and in the future. . . . When we are in the middle of a drug crisis, however, we tend to forget this history and assume that we must face our drug onslaught with no guideposts. Unaware of how we have overcome past drug problems, we are liable to panic.[133]

V. THE USE OF HEALTH VS. DEVIANCY NARRATIVES IN DRUG POLICY HISTORY

Comparing the policymaking process for different pieces of legislation over time is a difficult endeavor. The factors that affect the legislative process, including cultural norms, political institutions, ideologies, and political circumstances, especially vary when comparing legislative events that occur decades apart. These evolving factors not only influence the likelihood of legislative enactment of a policy solution, but also influence the types of causal narratives that groups use and the way in which they define a problem.[134]

Conceding such differences, there is still value in analyzing the types of narratives that groups have used over time to define a policy problem, even if it is not for the purpose of proving that pressure groups' narratives per se *caused* a legislative outcome. First, political institutions prefer the status quo, making it more difficult to redefine a problem the more engrained it becomes.[135] Studying the past use of narratives to define a problem helps shed light on how such a past may have influenced how we define a problem today. Second, groups often

133. MUSTO, *supra* note 57, at *ix*.

134. *See* STONE, *supra* note 13, at 153.

135. *See generally* BAUMGARTNER ET AL., *supra* note 55, at 29–45.

recycle causal narratives, as familiar narratives can be more believable than unfamiliar narratives and may elicit less scrutiny.[136] Studying the use of narratives at different junctions of drug policy history helps us identify the most recycled stories in drug policy. Third, examining how groups strategically crafted narratives to align with their interests illuminates how future groups wishing to influence the problem-definition process can use problem definition strategies. It also demonstrates how such groups can form alliances around their narratives. Finally, the following Section also illustrates the powerful role that administrative agency officials can play in defining problem drug use.

A. The Opiate Epidemic & The Opioid Epidemic

At times, society has attributed problem drug use to a disease or disorder. At other times, narratives blame deviancy or a character flaw causing problem drug use. Although the policy idea that addiction is a disease or a health issue may seem new to the policy discourse, because of its recent resurgence, it emerged in political discourse as early as the 1800s. Since the "addiction is a disease" narrative developed during this time period, this analysis begins there.

Examining narrative use to describe an opiate crisis in the mid- to late 19th century to help illuminate causal stories that could define the 21st century Opioid Epidemic may seem futile, or even downright silly. Not only was daily life vastly different in the 1800s, but so were the federal government's structure and powers. Although the federal government's powers have grown significantly since the 19th century, the political parties have evolved, the internal structures of Congress have changed, and the number of pressure groups involved in the political process has greatly increased, some definite similarities exist between the late-19th century opiate crisis and the current Opioid Epidemic. The target population of both epidemics included a sub-population of iatrogenic addicts, persons who become addicted to a habit-forming drug due to a medical error. This sub-population of iatrogenic addicts includes middle- to upper-class Whites—members

136. STONE, *supra* note 13, 148–54.

of the public that, during both time periods, people viewed as the mainstream and not associated with the deviant underworld.[137]

Aside from the similarities in composition of the target populations during both epidemics, physicians and pharmacists also risked blame for causing the 19th century opiate crisis—a causal story that called for the punishment and regulation of physicians and pharmacists. The Harrison Narcotics Act of 1914, discussed further below, is arguably the prescription monitoring program of the early 20th century.[138] Both require reporting, recordkeeping, and the monitoring of physician and pharmacist prescribing practices.[139] Adoption of both implies that these professionals need oversight, as law enforcement agencies used records from both monitoring systems to punish physicians and pharmacists that appeared to be overprescribing habit-forming medications.[140] During both epidemics, representatives in Congress made statements supporting the causal narrative that iatrogenic addiction was a disease that necessitated treatment.[141] Lastly, in both cases, drug manufacturers, pharmacists, and physicians were active in the problem definition process despite these groups' lobbying not being a constant feature of American drug policy.[142]

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137. *Cf.* COURTWRIGHT, *supra* note 57, at 71–72 (describing the atmosphere of New York opium dens, where, despite smokers' cravings, fistfights and thefts rarely took place); *cf. also* SCHNEIDER & INGRAM, *supra* note 39, at 106–08 (discussing the social construction of ethnic groups).

138. Prescription monitoring programs are policy solutions that involve the state-wide monitoring of habit-forming drug dispensing. *See* Diversion Control Div., *State Prescription Drug Monitoring Programs*, U.S. DRUG ENF'T ADMIN., https://www.deadiversion.usdoj.gov/faq/rx_monitor.htm (last visited Nov. 30, 2018). Although prescription monitoring programs are sometimes framed as tools to help medical professional identify patients that may be drug-seeking, law enforcement can access the data to aid them in identifying and prosecuting physicians and pharmacists that are diverting prescription medication. *Id.*

139. *Compare* Harrison Narcotics Act of 1914, Pub. L. No. 63-223, 38 Stat. 785 (1914) (repealed 1970), *with* Diversion Control Div., *supra* note 138.

140. See generally MUSTO, *supra* note 57, at 54–68, for a historic account persecution of physicians and pharmacists under the Harrison Tax Act; *accord supra* note 138.

141. *Cf. supra* note 86 (describing how NORML might leverage this narrative).

142. For example, medical professionals and the pharmaceutical industry did not consistently lobby on alcohol and drug abuse issues between 1998 and 2017. *See Alcohol and Drug Abuse*, CTR. FOR RESPONSIVE POLS.,

Due to these similarities, analyzing the types of narratives that defined the problem of addiction during this early epidemic may prove more useful than one would have initially predicted.

B. Defining the Nation's First Opiate Epidemic

1. Sub-Populations of the Target Population

By the late 1800s, an opiate epidemic plagued the nation.[143] By the end of the 19th century, an estimated 150,000 to 250,000 persons had become addicted to drugs.[144] The public began to vocalize their fear of habit-forming drugs, especially when it came to drug use by Chinese immigrants and Southern Blacks.[145] The majority viewed these marginalized populations' drug use as a direct threat to White safety.[146] Further, "opium dens," public places where smokers met to smoke socially, encouraged undesirable social mixing.[147] As the narrative went, these sub-populations became addicted to opiates and cocaine because their weak moral characters predisposed them to using drugs for their euphoric effect.[148] Once they became drug users, they

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https://www.opensecrets.org/lobby/issuesum.php?id=ALC (last visited Nov. 30, 2018).

143. The estimated number of opiate addicts in the 19th century was between 150,000 to 200,000. STEPHEN KANDALL, SUBSTANCE AND SHADOW: WOMEN AND ADDICTION IN THE UNITED STATES 15 (1999). For reference, the U.S. population was 62,979,766. *1890 Fast Facts History*, U.S. CENSUS BUREAU, https://www.census.gov/history/www/through_the_decades/fast_facts/1890_fast_facts.html (last visited Nov. 30, 2018).

144. *See generally* COURTWRIGHT, *supra* note 57, at 28–34 (discussing late-19th and early 20th century efforts to quantify the number of addicts in the United States).

145. *Id.* at 62–81.

146. *Id.*

147. *See* Joseph F. Spillane, *The Road to the Harrison Narcotics Act: Drugs and Their Control, 1875–1918*, *in* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 1, 7–8 (Jonathon Erlen & Joseph F. Spillane eds., 2004) [hereinafter Spillane, *Drugs and Their Control*].

148. For a summary of the discourse, see generally, for example, Rebecca Carroll, *Under the Influence: Harry Anslinger's Role in Shaping America's Drug Policy*, *in* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE, 61, 61–91 (Jonathon Erlen & Joseph F. Spillane eds., 2004) [hereinafter Carroll, *Anslinger's Role*].

posed even more of a threat to society because the drugs increased their sexual proclivity, criminal behavior, and, in the case of Blacks, their physical strength.[149] The public viewed such a deviant sub-population of drug users as deserving of punishment,[150] and as a result, these marginalized populations that were politically weak became most likely to bear the burden of punitive policy solutions aimed at decreasing drug use.[151]

On the other hand, society "tolerated" iatrogenic addicts,[152] due in part to their membership in the "'acceptable' segment of the mainstream population."[153] Most iatrogenic addicts were wives and mothers, two categories of persons that may be politically weak, but are often socially constructed as deserving of policy benefits.[154] Another factor that made iatrogenic addicts more socially tolerable was the way in which physicians' groups, pharmacists' associations, and drug manufacturers, which included both patent medicine

149. *See* COURTWRIGHT, *supra* note 57, at 94–98; MUSTO, *supra* note 57, at 7.

150. Carroll, *Anslinger's Role*, *supra* note 148, at 62–64, 77–81.

151. *See generally* SCHNEIDER & INGRAM, *supra* note 39, at 109–10 (outlining policy solutions often used for politically weak deviant target populations).

152. Even so, individuals who became addicted to opiates were often ashamed by their habit and tried to hide it from their loved ones, indicating that there was still societal disapproval of use even for this class of users. KANDALL, *supra* note 143, at 3.

153. *See id.* at 41; *cf.* SCHNEIDER & INGRAM, *supra* note 39, at 108–10 (analyzing types of potential target populations).

154. Spillane, *Drugs and Their Control*, *supra* note 147, at 5–6.

manufacturers[155] and self-proclaimed "ethical drug companies"[156] (collectively, the "medical industry"), legitimized these addicts' use.[157]

As the next Section demonstrates, the medical industry's financial stake in maintaining a customer base within this sub-population incentivized the industry to support policy narratives that benefited this subgroup. At the same time, the industry had no financial incentives to protect the marginalized sub-population of users. The social construction of these distinct subgroups of drug addicts, taken with the medical industry's financial interest in retaining iatrogenic addict customers, ensured that these sub-populations would be the center of two different policy narratives.

2. The Medical Industry's Desired Policy Solution

The medical industry had significant financial interest in ensuring that opiates and cocaine remained licit for medicinal purposes, because, throughout the 1800s, physicians and pharmacists

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155. Patent medicine manufacturers produced over-the-counter medicines and tonics, many of which contained morphine, alcohol, and cocaine. Spillane, *Drugs and Their Control*, *supra* note 147, at 4. They were unregulated until the Pure Food and Drug Act of 1906, which required patent medicine companies to list out potentially harmful ingredients on its labels. KANDALL, *supra* note 143, at 23. Prior to the Act, patent medicine manufacturers lobbied long and hard to remain unregulated. *Id.* Patent medicines did not require a doctor's prescription and could even be purchased via mail order catalogue for rural Americans who did not have easy access to a pharmacy. *Id.* at 16. The companies that manufactured patent medicines advertised heavily in the common periodicals of the time with remedies for a litany of ailments. *Id.* at 41. They marketed directly to consumers, highlighting the benefits for self-medication and downplaying the need for physicians to play the intermediary between the drug manufacturer and the consumer. Spillane, *Drugs and Their Control*, *supra* note 147, at 4.

156. Ethical drug companies distinguished themselves from patent-medicine manufacturers by refusing to market directly to consumers. *Id.* at 4. Instead, they marketed to physicians and pharmacies. *Id.* They also published studies of the benefits of their medications in their own scholarly journals. *Id.* at 3.

157. *Id.* at 5–10; *see also generally* COURTWRIGHT, *supra* note 57, at 42–53.

prescribed opiates[158] more often than any other medication.[159] Cocaine's medicinal benefits were not widely publicized until the 1880s, but once people learned about them, they also soon hailed cocaine as a wonder drug that doctors even used to treat opiate addiction.[160] At a time when medicine was not very sophisticated, opiates, and then cocaine, offered physicians a treatment that worked and increased the physicians' effectiveness in the eyes of their patients.[161] Pharmacists also utilized opiates and cocaine in a variety of ways. Some pharmacists filled physician prescriptions, some prescribed opiates and cocaine, some used opiates and cocaine in creating their own elixirs, and some sold over-the-counter patent medicine.[162] Both opiates and cocaine were common ingredients in patent medicine.[163] While ethical drug companies also wanted to continue producing these drugs, banning these substances would arguably affect patent medicine manufacturers more than ethical drug

158. The types of opiates used included opium, morphine and heroin. *See generally* KANDALL, *supra* note 143, at 10–42. Morphine is a derivative of the opium poppy that was isolated in 1817. *Id.* The introduction of the hypodermic needle in 1856 made morphine much more accessible. *See* MICHAEL P. ROTH, CRIME AND PUNISHMENT: A HISTORY OF THE CRIMINAL JUSTICE SYSTEM 146–47 (2d ed. 2011); Spillane, *Drugs and Their Control*, *supra* note 147, at 9. Heroin was invented in 1874 but was not widely marketed until 1898. Spillane, *Drugs and Their Control*, *supra* note 147, at 9.

159. More specifically, morphine was commonly prescribed for a variety of ailments. *See generally* COURTWRIGHT, *supra* note 57, at 35–60. At the time morphine was invented, it was one of the few tools that physicians had at their disposal that was actually effective. *Id.* at 46–48. After heroin was invented and popularized by the German pharmaceutical company Bayer, it was also prescribed, especially when it was marketed as less addictive than morphine. Spillane, *Drugs and Their Control*, *supra* note 147, at 9. The number of ailments that heroin treated, however, was fewer than that of morphine, so the number of persons who became iatrogenically addicted to heroin was much lower than morphine addicts. COURTWRIGHT, *supra* note 57, at 91.

160. KANDALL, *supra* note 143, at 33; MUSTO, *supra* note 57, at 7.

161. *See generally* COURTWRIGHT, *supra* note 57, at 42–60.

162. As a profession, pharmacists' political strength was weakened by the competing interest among sub-specialties. There were disagreements within the profession as to whether or not they should fight for the ability to prescribe medication, dispense refills to medications, develop their own medications, and sell patent medications. Spillane, *Drugs and Their Control*, *supra* note 147, at 4–5; KANDALL, *supra* note 143, at 19–23; MUSTO, *supra* note 57, at 14–15.

163. Spillane, *Drugs and Their Control*, *supra* note 147, at 4.

companies because patent medicine manufacturers relied heavily on these drugs as active ingredients in most of their medications—active ingredients that they did not disclose to their customers until the law forced them to do so.[164]

Because of the medicinal uses of opium, morphine, heroin, and cocaine, drug manufacturers, pharmacists, and physicians actively lobbied in developing early U.S. drug policy. Aside from their immediate interest in protecting their access to these "habit forming drugs,"[165] these groups were likely lobbying to secure their position within the medical industry. Although Congress largely did not regulate the medical industry, physicians, drug manufacturers, and pharmacists knew it would only be a matter of time before the federal government started regulating it, and each group wanted to make sure that they influenced the legislation that defined which group would have the authority to make, distribute, and sell medication to consumers.[166]

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164. *See generally* John P. Swann, *The FDA and the Practice of Pharmacy: Prescription Drug Regulation Before 1968*, *in* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 145, 145–66 (Jonathon Erlen & Joseph F. Spillane eds., 2004); Rudolph J.R. Peritz, *"Nervine" and Knavery: The Life and Times of Dr. Miles Medical Company (2007)*, *in* ANTITRUST STORIES 61 (Eleanor M. Fox & Daniel A. Crane eds., 2007).

165. "Habit forming drugs" was a phrase used in the 19th and early 20th century to refer to what we now call "narcotics." *See, e.g.*, COURTWRIGHT, *supra* note 57, at 135–36.

166. Physicians and pharmacists were concerned with which group would be given exclusive control over prescribing and dispensing of medication. Spillane, *Drugs and Their Control*, *supra* note 147, at 5–17; MUSTO, *supra* note 57, at 13–21. Both physicians' and pharmacists' groups were in the process of establishing training standards, licensure requirements, and scope of practice for their respective professions. *See* MUSTO, *supra* note 57, at 13. They were also vying for the right to be the exclusive prescribers or dispensers of medication. *See id.*

At the time, physicians' and pharmacists' scope of practice overlapped. Some pharmacists wrote prescriptions or at least refills for patients without a doctor's prescriptions. *See id.* at 18. Some pharmacists dispensed drugs directly to patients, without physician oversight. *Id.* at 19. Further, pharmacists were trying to internally determine their own scope of practice as it related to drug manufacturing and sales, overlapping at times with patent medicine manufacturers. Some pharmacists sold patent medicines in their drug stores, while some denounced patent medicine as snake oils. *See id.* at 14–15. And still other pharmacists created their own elixirs, competing in a sense with the patent medicine companies. *Id.* at 15.

3. Building a Coalition and Designing a Shared Narrative

Although each of these groups were interested in establishing exclusivity over at least one part of the manufacturing or distribution process, their immediate collective need to keep opiates and cocaine accessible for medicinal use led them to develop a coalition to lobby Congress on anti-narcotic legislation. There was growing professional and public awareness that opiates and cocaine were addictive. By the end of the 19th century, for example, it was difficult for physicians and pharmacists to deny that opiates and cocaine caused addiction.[167] To succeed at convincing Congress to adopt their proposed solution, the medical industry needed to devise a causal story that resonated with public sentiment and accounted for the population of iatrogenic addicts. The American Medical Association ("AMA") and the American Pharmacists Association ("APhA") had already acknowledged that the drugs at issue caused addiction.[168] However, they defined addiction as a disease that developed as an unfortunate side effect to an effective medical treatment.[169] Physicians had discretion to decide whether the risk of addiction was worth the benefit of the treatment.[170] Since addiction was a disease, it logically followed

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Pharmacists were not the only competition or threat to the patent medicine manufacturers. Physicians by and large opposed patent medicine, especially because patent-medicine manufacturers marketed directly to patients and advocated self-medication over consulting with a physician. *See* Spillane, *Drugs and Their Control*, *supra* note 147, at 3–5. Ethical drug manufacturers saw patent-medicine manufacturers not only as competition, but as a threat to the credibility of the drug manufacturing industry. *See id.* at 4. Ethical drug companies marketed only to physicians and thought it abhorrent that the patent-medicine manufacturers marketed directly to consumers. *Id.* at 3–4. Although one would imagine that physicians would be allied with ethical drug companies as a result, physicians viewed ethical drug companies with suspicion, as their business model was evolving to one dominated by the corporate structure and one that abandoned the traditional model of developing drugs based on physician demand. *See id.* at 3. Physicians feared becoming slaves to ethical drug companies. *Id.* In sum, although the medical industry allied on some issues, each group within it was simultaneously struggling to establish its exclusivity in the medical market.

167. MUSTO, *supra* note 57, at 5. Historian David Musto describes physicians' acceptance of the addictiveness of morphine as "[e]ventual[]" and "gradual." *Id.*

168. *See id.* at 14–18.

169. *Id.* at 18–22.

170. *See id.*

that physicians should have license to use methods such as medication-assisted therapies to treat it.[171] This definition of legitimacy gave both professions the added benefit of establishing themselves as the decision-maker of its legitimacy.

Such a narrative explained iatrogenic addiction and provided a solution that allowed for the continued medicinal use of opiates and cocaine. It did not offer a solution that addressed non-iatrogenic addiction, however, which affected primarily lower-class Whites, opium smokers, Chinese immigrants, and Blacks.[172] To address non-iatrogenic addiction, physicians and pharmacists created classifications for legitimate and illegitimate drug use.[173] Illegitimate drug use, or use of drugs obtained without physician approval, purportedly had no therapeutic benefit, and addicts used these drugs to produce euphoric effects.[174] Under the prevailing view, any addiction that illegitimate drug use caused resulted from the users' flawed character and desires to over-indulge in hedonistic behavior.[175]

The medical profession continued to make this distinction between the causes of addiction despite the fact that their leading biological theory of addiction did not support such a differentiation. The leading medical theory explaining the biological cause of addiction, at this time, was the antibody theory, which theorized that addiction was caused by antibodies forming in the blood that prevented the user from refraining from drug use.[176] Such a causal theory does not distinguish between whether or not the user was exposed to the drug iatrogenically or "illegitimately." Therefore, theoretically, this medical theory of addiction that the medical community used to justify a medical approach to treating addiction could have just as easily been applied to non-iatrogenic addicts. Despite this discrepancy, physicians and pharmacists continued to offer differing causal theories for legitimate and illegitimate drug use.

Not only should practitioners have facially applied the medical theory of addiction to iatrogenic and non-iatrogenic habitual drug use

171. *See id.*
172. *See generally* COURTWRIGHT, *supra* note 57, at 85–109.
173. Spillane, *Drugs and Their Control*, *supra* note 147, at 5–10.
174. *Id.*
175. *See* MUSTO, *supra* note 57, at 14–23.
176. *Id.* at 147.

equally, but there was no empirical support for the contention that marginalized populations' drug use made them social deviants.[177] Since non-iatrogenic, habitual drug users were from socio-economic classes that society relegated to hard labor in the workforce, these addicts may have been self-medicating for the pain and discomforts of life, just like their White counterparts.[178] Despite the contradictions and lack of evidence, policymakers may have found the medical profession's causal stories more believable because their representations of the target populations were consistent with the stereotypical images the public had associated with them. Further, the APhA and the AMA drew on their credentials as experts, which would add to their narrative's credibility.[179] In sum, distinguishing between legitimate and illegitimate use allowed the medical industry to develop different causal stories for iatrogenic and non-iatrogenic addicts that accounted for public sentiment and the differing social views that the public held regarding the various sub-populations of addicts.

4. From Storytelling to Legislating

State and local governments had already begun to pass laws that regulated the sale or distribution of habit forming drugs, focusing on

177. If anything, the evidence showed that individuals who committed crimes prior to their drug use just continued committing crime after their drug use. *See* MUSTO, *supra* note 57, at 7.

178. Iatrogenic addicts, on the other hand, were mostly Southern White women who had been prescribed morphine by their doctors to alleviate pain and discomfort of daily life as a housewife. COURTWRIGHT, *supra* note 57, at 36; KANDALL, *supra* note 143, at 14–19. Some scholars believe that morphine use in the Civil War created a great many iatrogenic addicts. *See, e.g.*, KANDALL, *supra* note 143, at 19–20. Historian David Courtwright disputes this claim and argues quite convincingly that although Civil War soldiers may have been introduced to morphine and gotten a "taste" for it while fighting in the war, their dosages were quite controlled and it was unlikely that doctor prescribing practices to soldiers during the war resulted in the creation of many iatrogenic addicts. COURTWRIGHT, *supra* note 57, at 54–55. Middle and upper class White women, however, were most likely to seek the care of a physician for ailments and were therefore the most likely to be prescribed opiates. *Id.* at 35–53.

179. *See generally* FISCHER, *supra* note 26, at 177–78 (discussing the use of professional expertise to add to the credibility of the claims made in a narrative).

controlling marginalized populations' drug use.[180] As a response, the APhA proposed a model state law that regulated the dispensing of opiates and cocaine but allowed for physicians and licensed pharmacists to prescribe the substance for medicinal use.[181] The APhA also advocated for the medical maintenance of individuals who had become addicted.[182] Effectively, the APhA argued that addiction was a health issue for iatrogenic addicts. The APhA's model state law also addressed the problem of "illegitimate drug use"—namely the use of smoking opium, which both the APhA and AMA agreed had no medicinal value.[183] The APhA argued that the states should prohibit smoking opium and that the federal government should prohibit importation.[184] Further, the APhA argued that the entire underclass of non-iatrogenic addicts, "drug fiend[s]" or "'the demi-monde, known criminals[,] or those whose occupations are shady' should be totally prohibited" from accessing habit-forming drugs.[185]

The banning of smoking opium would not affect retail pharmacists' bottom lines because they sold very little of the substance.[186] The prohibitions also would not affect physicians' current or future clientele, as non-iatrogenic addicts generally came from socio-economic classes that made them undesirable patients.[187] Additionally, since Chinese immigrants primarily used smoking opium, society would view prohibiting it as a moral victory.[188] With no organized interest group lobbying for the protection of smoking opium, the drug's association with the criminal underclass, and the calls from administrative agency officials to regulate the drug, it was

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180. Spillane, *Drugs and Their Control*, *supra* note 147, at 10–14; MUSTO, *supra* note 57, at 13–21.

181. MUSTO, *supra* note 57, at 17–18 (citing the APhA's Committee on the Acquirement of the Drug Habit, which made recommendations for model laws to be passed by the states to decrease the likelihood of addiction).

182. *Id.* at 18 (citing the APhA's Committee on the Acquirement of the Drug Habit).

183. Spillane, *Drugs and Their Control*, *supra* note 147, at 5–10; MUSTO, *supra* note 57, at 17.

184. MUSTO, *supra* note 57, at 14–23.

185. *Id.* at 20 (citing the APhA's Committee on the Acquirement of the Drug Habit).

186. *Id.* at 17.

187. *See* COURTWRIGHT, *supra* note 57, at 39–40.

188. MUSTO, *supra* note 57, at 4, 17.

of no surprise that smoking opium was the first drug that Congress prohibited.[189] Criminalization is a common solution for a policy problem that caused by deviant behavior.[190]

The medical industry continued its lobbying with its sights set on Washington. The APhA, with representatives from the AMA and drug manufacturers, formed a coalition, the National Drug Trade Conference ("NDTC"), to lobby on antinarcotic legislation at the federal level.[191] Formalizing this coalition allowed these groups to present a united front in defining problem drug use. In 1913, members of Congress proposed legislation, the Harrison Narcotics Act, to tax the sales of certain habit-forming drugs.[192] By the time the NDTC finished negotiating with Congress, the bill preserved the AMA and APhA's ability to prescribe and dispense medication containing habit-forming drugs as long as it was for a legitimate medical purpose.[193] The legislation also required the registration of sellers, recordkeeping, and reporting of sales to the Bureau of Internal Revenue ("BIR").[194]

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189. Municipalities with large concentrations of Chinese immigrants were the first to pass laws outlawing the smoking of opium, demonstrating the racialization of certain drug use. *Cf.* COURTWRIGHT, *supra* note 57, at 52–53 (describing municipal efforts to restrict the availability of narcotics). In 1909, the federal government followed suit by passing the Smoking Opium Exclusion Act, which banned the smoking, sale and possession of smoking opium. *See* MUSTO, *supra* note 57, at 3–4. It did not, however, regulate medications containing opium. Members of the Executive had been pressuring Congress to pass some legislation regulating opium use to support the U.S.'s condemnation of China for their role in exporting opium. *Id.* The U.S.'s leadership involvement in the 1909 Shanghai Opium Conference, which was convened to address Chinese exportation of opium, and the 1912 International Opium Convention at which the U.S. became a signatory of a treaty pledging to assist in controlling sale of opiates, necessitated the need for the U.S. to pass legislation addressing opiate sales or risk appearing hypocritical. *Id.* at 33.

190. *See* SCHNEIDER & INGRAM, *supra* note 39, at 109–10.

191. MUSTO, *supra* note 57, at 54–55.

192. Harrison Narcotics Act of 1914, Pub. L. No. 63-223, 38 Stat. 785 (1914) (repealed 1970).

193. MUSTO, *supra* note 57, at 54.

194. *Id.* at 35, 59–60. The National Association of Retail Druggists, the National Association of Medicinal Products, and The American Association of Pharmaceutical Chemists, the latter two of the three which were drug manufacturers, also lobbied on anti-narcotic legislation. *Id.* at 55. Each of these groups also used narratives that stressed the medicinal value of habit forming drugs and argued that addiction could be controlled by decreasing illegitimate, or non-medical use. *See*

Due in part to the participation of physicians, drug manufacturers, and pharmacists in the problem-definition discourse,[195] the use and possession of morphine, heroin, and cocaine remained licit for medicinal purposes throughout the early 1900s.[196] The medical community benefited from strategically crafting a narrative that defined iatrogenic addiction as a disease that they were best equipped to treat, especially since, at the time, this sub-population of drug addicts were desirable consumers.[197] In essence, the medical industry lobbied Congress to keep these substances licit for medicinal purposes, while advocating for the punishment of marginalized populations' illicit or recreational use.

In conclusion, examination of the types of causal narratives that the medical industry used to describe problem drug use while drug use was licit at the federal level provides us with some insight as to how some pressure groups could influence the problem-definition discourse. In using these causal narratives, the medical industry advocated for a health definition for at least some target populations, while advocating for a criminal justice approach for others. The previous analysis also demonstrates how groups, aided by political and societal factors,[198] can use causal narratives to pressure Congress into action or inaction. The next Section demonstrates how administrative

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generally id. (containing examples of arguments used by these drug manufacturers in promoting their objectives).

195. Of course, it was not only interest group lobbying that prevented the regulation of opiates during this era. The acceptance of opiate use by the public as well as the lack of federal regulation of domestic issue in general also played a role. *See generally* COURTWRIGHT, *supra* note 57, at 42–60.

196. *See* COURTWRIGHT, *supra* note 57, at 2.

197. *Id.* They were desirable mainly because of their class and their ability to pay for treatment and medications.

198. It is important to note that, during this era, the federal bureaucracy was small and Congress had left much of the regulation of social problems to the local governments. *See* THEDA SKOCPOL, SOCIAL POLICY IN THE UNITED STATES: FUTURE POSSIBILITIES IN HISTORICAL PERSPECTIVE 11–13 (1995). The federal government had not yet established its power to police under the interstate commerce clause. *See* Wickard v. Filburn, 317 U.S. 111, 128–29 (1942) (holding, nearly thirty years after enactment of the Harrison Narcotics Act, that Congress has broad power under the Constitution to regulate economic activity). Thus, the general political atmosphere would have favored less federal interference and regulation and greater inertia would have been needed to propel Congress to outlaw drug use in its entirety.

agencies took advantage of a window of political opportunity to capitalize on changes in the public mood to redefine problem drug use in a way that has dominated for almost a century.

5. The Role of Administrative Agencies in the Retreat from the Health Frame

Aside from the State Department's early interest in regulating opium as a way to participate in worldwide initiatives to prevent the exportation and trafficking of China's opium, federal administrative agencies did not concern themselves with early efforts to define problem drug use. After the passage of the Harrison Narcotics Act in 1914, however, the stakes changed.

Congress directed the BIR, under Cornell Levis Nutt's direction, to enforce the Harrison Narcotics Act.[199] Nutt and his colleagues masterfully capitalized on the nation's fear of deviants to ensure that Congress generously funded their department.[200] American troops had just fought the first World War and were fearful of the "others" that threatened to disrupt the semblance of American life that they had left behind.[201] Americans did not tolerate addicts whose inability to contribute to the war effort made them appear un-American.[202] Further, a growing group of reformers during the Prohibition Era viewed both alcohol and drugs as vices that the law should prohibit.[203] Nutt and his colleagues, whom the president appointed to the Treasury Department's Special Narcotic Committee, capitalized on the public mood by publishing a report that estimated 1

199. *See* Spillane, *Drug Control Regime*, *supra* note 77, at 25. Although there were early efforts by BIR Commissioner Daniel C. Roper to define addiction as a medical issue, including his assistance in drafting the France Bill, the window of opportunity ended as the Republicans gained control of Congress. *Id.* at 26–27. Further, the lack of support by his own bureau quelled any hope for BIR support of a public health solution to addiction. *Id.* at 27. Once Roper retired, Cornell Levis Nutt stepped up the rhetoric in defining addiction as a criminal justice issue, ensuring a law enforcement approach. *Id.* at 29–30.

200. *See id.* at 31–32.

201. *See* MUSTO, *supra* note 57, at 133–34.

202. *Id.*

203. *Cf.* U.S. CONST. amend. XVIII (prohibiting the "manufacture, sale, and transportation" of alcohol and empowering Congress and the States to enforce the prohibition), *repealed by* U.S. CONST. amend XXI.

million addicts in the U.S. by 1919, a figure that they actively disseminated to the press.[204] This figure added to public fear of this target population and justified the need for the creation of the Narcotic Division of the Treasury Department's Prohibition Unit, a division of the BIR that Congress created at the end of 1919.[205] (Of course, even the BIR later admitted that the figure of 1 million was an overestimation.)[206]

The figure justified the creation of the Narcotics Division, a division that the BIR needed to coordinate their massive efforts to not only collect taxes and maintain a record of drug sales, but also control physicians' uses of these medicinal substances—an interpretation of the Harrison Narcotics Act that many physicians and pharmacists thought conflicted with Congressional intent.[207] The BIR believed that the law prohibited the prescription of narcotics to any addict, even for medication maintenance treatment. The BIR arrested thousands of physicians and heckled pharmacists over claims that they were prescribing and dispensing habit-forming drugs in quantities that exceeded legitimate medical treatment.[208] It issued regulations giving itself authority beyond that which the Harrison Narcotics Act expressly outlined, most of which the Supreme Court upheld as constitutional.[209]

Facing the full force of the BIR, the AMA repudiated their initial support for medication-maintenance treatment in 1920.[210] Physicians were targeted for arrest and administrative agencies blamed physicians in congressional hearing testimony for causing the addiction epidemic.[211] The political costs for continuing to advocate for narcotic prescription was high, and the payoff was rather low. By the early 1900s, the population of iatrogenic users that consisted of middle- and upper-class Whites, had dwindled.[212] Physician self-

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204. Spillane, *Drug Control Regime*, *supra* note 77, at 30–31.

205. *Id.*

206. *Id.*

207. *Id.*; MUSTO, *supra* note 57, at 121–22.

208. *See generally* MUSTO, *supra* note 57, at 121–50.

209. *See generally id.* at 121–34. The Supreme Court responded by first curtailing the BIR's authority and then adding its stamp of approval. *See id.*

210. *Cf.* at 153 ("The dominant public attitude by 1920 was strong and fearful: to maintain an addiction was to maintain or create a menacing personality.").

211. *Id.* at 134–39.

212. *See generally* COURTWRIGHT, *supra* note 57, at 110–23.

education and self-regulation led to a change in physician prescribing practices of opiates and cocaine.[213] Further, medical treatment had evolved with new treatments replacing opiates and cocaine.[214] The growing acceptance of the germ theory of disease, as well as vast improvements in sanitation, decreased the need for drug use.[215] Non-iatrogenic heroin users, comprised of mostly young urban men who were associated with the criminal underworld—addicts that neither society nor the medical industry viewed with the same compassion as model patients—began to replace iatrogenic addicts.[216] They were a target population that the AMA had no incentive to protect.

So the AMA, which had grown in size and strength, abandoned the claims that addiction was a disease and distanced itself from treatment of addiction.[217] Many of its new members were general practitioners who were more conservative than their predecessors and most concerned with federal government intrusion into the practice of medicine and the threat of socialized medicine. [218] Further, disagreement grew within the medical community over whether addiction was indeed a disease. In 1919, researchers falsified the hypothesis underlying antibody theory, the leading justification for the "addiction is a disease" narrative, further convincing many physicians to abandon their claim that addiction was a disease.[219] Additionally, physicians were becoming disenchanted by claims that addiction was curable after studies debunked a series of treatments that purportedly cured addiction.[220] A growing number of physicians began advocating for addict incarceration to protect both society from the addict and the addict from himself.[221]

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213. *See generally id.* at 110–37.

214. *Id.*

215. *Id.*

216. *Id.*

217. MUSTO, *supra* note 57, at 200–01.

218. *See* Spillane, *Drug Control Regime*, *supra* note 77, at 27.

219. *See* MUSTO, *supra* note 57, at 76, 83. Although the antibody theory was falsified in 1919, even at the height of its support, the theory never had any substantial evidence or proof supporting it. Spillane, *Drug Control Regime*, *supra* note 77, at 27–28.

220. MUSTO, *supra* note 57, at 82.

221. COURTWRIGHT, *supra* note 57, at 134–37.

When Senator Joseph I. France introduced a bill in the summer of 1919, which defined addiction as a health issue, called for the use of Public Health Service ("PHS") hospitals to offer treatment for addiction, and requested a federal matching funds for all addiction treatment programs, the AMA withdrew their support for maintenance treatment and medical treatment for addiction.[222] The AMA was growing increasingly concerned about the possibility of "government medicine," or a nationalized health system, and the idea that federally funded institutions would provide addiction treatment represented to the AMA just another example of the federal government's increasing involvement in providing healthcare.[223] The AMA further distanced itself from conversations of addiction, going so far as to repudiate their previous claims that addiction was a disease.[224] Addiction was not a disease, claimed the AMA, but a manifestation of repressed psychological issues.[225]

The PHS had no desire to take responsibility for treating addicts, so they endorsed the AMA narrative and expanded on it, claiming that addiction was actually a personality disorder, a type of psychopathy, one that not only predisposed addicts to drug use but also to criminal and anti-social behavior.[226] There was no cure for psychopathy, so the PHS advocated for the use of the criminal justice system to handle this population.[227] Such a narrative ensured that PHS hospitals would not have to act as treatment centers for the nation's population of drug users, a policy solution that they were trying to avoid.

With physicians and pharmacists under the watchful eye of the BIR, and the drug manufacturing industry undergoing a fundamental transformation,[228] the coalition of interest groups that supported the

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222. Spillane, *Drug Control Regime*, *supra* note 77, at 27.

223. *Id.*

224. *See* MUSTO, *supra* note 57, at 83.

225. *See* Spillane, *Drug Control Regime*, *supra* note 77, at 28; MUSTO, *supra* note 57, at 83.

226. *See* Spillane, *Drug Control Regime*, *supra* note 77, at 28.

227. *See id.*

228. Ethical drug companies evolved as they took on corporate structure and invested more in the research and development of new medications that they could then market to physicians using their own research journals. *Spillane, Drugs and Their Control*, *supra* note 147, at 3. They no longer relied on physicians' demand to

"addiction is a disease" narrative was no longer interested in continuing to support such a narrative. The strength with which the BIR entered the problem-definition discourse and the shift in public sentiment required these groups to adjust their narrative or their involvement in drug-policy discourse. This era marked the end of the dominance of the "addiction is a disease" narrative and the beginning of the addiction-as-deviance narrative's dominance. Various narrators would use the deviance narrative over the next thirty years to justify the creation of additional federal law enforcement agencies that were invested in portraying the addict as a criminal.

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dictate what drugs to make and instead focused on creating new drugs and then inducing demand by marketing the drug to physicians. *Id.* Moreover, as physicians changed their prescribing practices, and the demand for opiates and cocaine decreased, it is likely that the profit stream from these medications was already decreasing for drug manufacturers. Further, with the public's growing awareness of the risks of morphine, heroin, and cocaine, reformers' calls for prohibition of alcohol and drugs, and physicians' vocal criticism of drug manufacturers incorporating—thereby callously prioritizing profits over patient well-being—continuing to embrace the narrative that addiction was a mere side effect of a medical treatment would have been politically risky. Congress signaled its disapproval of drug manufacturers' role in the opiate epidemic by refraining from holding hearings on the amendments to the Harrison Narcotics Act to prevent the drug manufacturers, amongst other organized interests, from watering down the amendments proposed. MUSTO, *supra* note 57, at 136. Further, although losing the revenue from opiate and cocaine sales would not be pleasant, outlawing the use of opiates and cocaine would also eliminate the greatest source of revenue for ethical drug companies' largest competitors: the patent-medicine manufacturers. Patent-medicine manufacturers were already experiencing political and financial turmoil. *See* Spillane, *Drugs and Their Control*, *supra* note 147, at 4–5. They were busy staving off attacks from ethical drug companies and physicians. *Id.* Physicians lobbied for the regulation of patent-medicine manufacturers, which they accused of undermining physician authority by marketing directly to consumers and claiming that public had the tools necessary to treat their own illnesses by purchasing medication directly from the patent medicine manufacturers. *Id.* The passage of the Pure Food and Drug Act of 1906 marked the beginning of the end of the reign of the patent-drug companies, as they now had to label their medication with any potentially harmful ingredients, including cocaine, alcohol and morphine. *See* Swann, *supra* note 164, at 149–50. The requirement that manufacturers disclose the use of opium, morphine, heroin, alcohol, or cocaine caused their sales to drop by a third. MUSTO, *supra* note 57, at 22.

6. Attempts to Battle Narratives with Numbers

The most politically active federal law enforcement agency in the problem-definition discourse was the Federal Bureau of Narcotics ("FBN"), founded in 1930 with Harry J. Anslinger as its first commissioner.[229] Anslinger came from the Prohibition Bureau prior to its dismantling, and he was determined to not let his new bureau suffer the same fate as the Prohibition Bureau.[230] Luckily for Anslinger, he was a master story-teller who specialized in creating believable narratives that resonated with public sentiment. He supported his policy narratives with half-truths, questionable statistics, and harrowing tales of the perils of drugs use.[231] He was also very adept at using the media to garner support for his narratives and regulatory proposals.[232] As faulty as his evidence may have been, he was convincing, and, throughout his thirty-two-year tenure, Congress often deferred to his judgment when considering legislative proposals to address problem drug use.[233] For much of his career, Anslinger argued that drug use was a sign of deviance and that the only suitable solution for such deviancy was stricter and harsher penalties for drug users and drug traffickers.[234] "'The addict,' he claimed, 'is like a typhoid carrier; he will spread crime and disease wherever he goes. He will spread addiction.'"[235] The policy solutions that aligned with such a narrative included the confinement of the addict to protect society. This causal story eliminated the possibility of medical-maintenance or medical-assisted therapies as a policy solution, which Anslinger was also clear to explicitly denounce.[236] "The idea of the government poisoning its citizens with narcotics is nonsense. Why don't they set

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229. Carroll, *Anslinger's Role*, *supra* note 148, at 61.

230. *Id.* at 64.

231. *Id.* at 66.

232. *Id.* at 70–73.

233. *Id.* at 61, 66.

234. *Id.* at 61.

235. Rebecca Carroll, *The Narcotic Act Triggers the Great Nondebate: Treatment Loses to Punishment*, *in* FEDERAL DRUG CONTROL: THE EVOLUTION OF POLICY AND PRACTICE 101, 129 (Jonathon Erlen & Joseph F. Spillane eds., 2004) (quoting Aslinger from a 1959 interview on the *Monitor* television show) [hereinafter Carroll, *The Great Nondebate*].

236. *Id.* at 127.

up bar rooms for alcoholics . . . ? Why not furnish everybody with what they want, bullets, or department stores for kleptomaniacs, and so on."[237]

Anslinger presented anecdotes and "fabricated horror stories connecting drug use with violent crime" as testimony in several congressional hearings, and they "weighed heavily" in Congress's decision to enact major narcotics legislation, including the Boggs Act of 1951 and the Narcotic Control Act of 1956 ("NCA").[238] By 1956, Anslinger had accomplished his goals of persuading Congress to pass legislation requiring stiff mandatory minimum sentencing for possession and drug sale.[239] The NCA even allowed for the jury to recommend the death penalty for a conviction of drug sales to a minor.[240] As rhetoric expert Dr. Rebecca Carroll put it, "After twenty-six years, Anslinger was the recognized authority on narcotics. By controlling the discussion on narcotics, Anslinger controlled the policy on narcotics."[241]

Not until mandatory minimums became a reality did organized interest groups make a concentrated effort to publicly challenge the legitimacy of the United States' criminal-justice approach to the nation's drug problems or attempt to redefine the problem of addiction as a medical disease. The American Bar Association ("ABA") and the AMA led the way in the attempt to redefine addiction as a health issue by testifying at congressional hearings and forming a formal, joint committee to study narcotic drugs.[242] The ABA-AMA Committee hoped that their research would add credence to their criticisms of the United States' criminal-justice approach to addiction and would open up a dialogue between the Committee, the Narcotics Bureau, and

237. *Id.* (quoting Aslinger from a 1959 interview on the *Monitor* television show) (internal quotation marks omitted).

238. *Id.* at 66.

239. Narcotic Control Act of 1956, Pub. L. No. 728, § 103, 70 Stat. 567, 568–69 (1956).

240. *Id.* § 107.

241. Caroll, *The Great Nondebate*, *supra* note 235, at 112.

242. *Id.* at 112–13.

Congress regarding alternative legislative solutions for the drug problem.[243]

Instead, it enraged Anslinger, who wrote them letters dismissing the evidence in their 1958 Interim Report[244] as inconsistent and lacking in factual accuracy.[245] Anslinger refused the Committee's multiple requests to meet and used the media to communicate his disgust for the Interim Report.[246] Later that year, the FBN released official Comments on the Narcotic Drug Interim Report of the ABA-AMA, a compilation of previously published and new articles that supported the FBN's narratives—none of which directly addressed the claims made in the Interim Report.[247] The FBN, under Anslinger's direction, did what it did best: battle the evidence with narratives. The ABA-AMA released their final report in 1961, which they titled "Drug Addiction, Crime or Disease?"[248] However, as Rufus King, one of the authors of the report, later wrote in his book *The Drug Hang-Up*, "ABA-AMA, No Match for HJA."[249]

Although the ABA-AMA tried to redefine addiction as a disease, they did not have a high-ranking government official supporting their narrative. Rather, a high ranking administrative officer who had established himself as a narcotics expert directly

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243. The Committee was especially interested in exploring the expansion of medication-assisted treatments. *See id.* at 113–14 (contrasting the health and criminal approaches to addiction and drug-related crimes).

244. The report summarized the two approaches to addressing problem drug use: the punitive approach and the health approach. *See generally* DRUG ADDICTION: CRIME OF DISEASE? INTERIM AND FINAL REPORTS OF THE JOINT COMM. OF THE AM. BAR ASS'N AND THE AM. MED. ASSS'N ON NARCOTIC DRUGS (1961) [hereinafter ABA-AMA], http://bit.ly/2Q8MGw7. It advocated that the federal government fund an experimental pilot program that prescribed opioids on an outpatient basis as treatment for addiction. *Id.* at 11. The report included a detailed appendix outlining Britain's approach to treating addiction, a harm reduction approach that favored MAT. *Id.* at 121–53.

245. Carroll, *The Great Nondebate*, *supra* note 235, at 116.

246. *Id.* at 115–16.

247. *See generally* ADVISORY COMM. TO THE FED. BUREAU OF NARCOTICS, COMMENTS ON NARCOTIC DRUGS: INTERIM REPORT OF THE JOINT COMMITTEE OF THE AMERICAN BAR ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION ON NARCOTIC DRUGS (1959); *see also* Caroll, *The Great Nondebate*, *supra* note 235, at 120.

248. ABA-AMA, *supra* note 244, at 159–66.

249. Carroll, *The Great Nondebate*, *supra* note 235, at 130.

opposed their narrative.[250] Aside from not having the necessary support from an official—support that Baumgartner, et al., argue is an important predictor of successful problem redefinition[251]—the ABA-AMA made an erroneous assumption: gathering scientific or empirical evidence to support claims and arguments was necessary to refute the dominant deviance narrative. Essentially, they brought facts to a battle of narratives.

After all, Anslinger's dominance in the drug policy discourse did not result from his use of "facts" or scientific evidence to support his arguments. Anslinger invested his energy in telling a compelling narrative that resonated with his audience and legislators who were interested in assuaging their constituents' fears. His narratives were consistent, his description of the target population elicited images that made his solutions more persuasive, and he artfully utilized the media to communicate his narrative. The ABA-AMA Committee, on the other hand, did not produce enough copies of the Interim Report for mass circulation, and they ran out of copies soon after it was published.[252] Initially, they printed enough copies to provide copies to the FBN and some ABA and AMA members for review, but the Committee wanted to make sure that the Interim Report was factually accurate and approved by the Board before copies got into the hands of the media, libraries, schools, and even all of the members of the ABA and AMA.[253] This decision allowed Anslinger to control the discourse by criticizing the Interim Report in the media, when few had the opportunity to read the Interim Report for themselves.[254] Further, Anslinger insisted that the FBN widely circulate its Comments to the Interim Report as soon as it published them in 1958, making sure to send copies to the media,[255] while the ABA-AMA Interim Report did

250. *See generally* Carroll, *Anslinger's Role*, *supra* note 148.

251. *Cf.* BAUMGARTNER ET AL., *supra* note 55, at 77–78 (describing challenges that advocates face when they lack a champion in a legislative body, or there is an opponent in the legislative body).

252. *See* Caroll, *The Great Nondebate*, *supra* note 235, at 116–18.

253. *Id.* at 117–18.

254. *See id.* at 120–29.

255. *Id.* at 120. King argued that the FBN purposely made their publication appear similar to the Interim Report by printing it on the same colored paper and formatting the cover similarly in an effort to confuse readers into thinking that they were reading the Interim Report and not the comments to it. *Id.* at 122–24.

not become widely distributed until 1961 as an attachment to the Final Report.[256] By the time the report was available, the public had already made their judgments. Anslinger understood that the key to success was to ensure that the FBN narrative dominated, while the ABA-AMA was more concerned with ensuring that they had their facts straight—even if it meant delaying its reports' entrances into the discourse. As well-researched as the Interim and Final Reports may have been, policymakers dismissed them even before they became widely available to the public, and with their dismissal, the efforts to redefine "addiction" as a disease died. In the policymaking process, evidence is only one input into the decision-making process and, in this case, it was no substitute for a well-crafted narrative.

VI. LESSONS LEARNED: CONCLUDING REMARKS

As legal scholars, we devote many of our printed words to analyzing legislation that has been enacted or proposed. We propose "better" legislative proposals or argue that current proposals or enacted legislation are inadequate. Little legal scholarship analyzes or suggests *how* to enact model legislative solutions. In the academy, we place so much emphasis on the numbers, the facts, and the evidence, as if the side with the best evidence and the most publications in the highest-ranked journals wins. If one's goal is to contribute to the policymaking process, however, to help policymakers reform our ineffective and costly criminal-justice approach to problem drug use and replace it with any one of the model health-oriented drug policies that many developed nations have effectively implemented, then compiling more evidence will not help us reach our objective. The existence of evidence alone does not change policy. The AMA and ABA had sufficient evidence to support their policy position, yet Harry Anslinger silenced them with his narrative. Arguably, the AMA was more successful in achieving their objectives in the late 1800s and early 1900s, when they had little evidence to support their narrative that addiction was a disease, than they were when they had a well-researched and documented report in the late 1950s. As groups like the Parents Groups of the 1970s and 1980s have shown us, power lies in the narrative.

256. *Id.* at 125.

Although narratives may trump evidence, there is still strength in numbers in the sense that more voices in unison are stronger than a single voice. The coalitions that have formed around common narratives throughout drug-policy history have shown us that the more narrators that tell the same story, the more likely that the narrative will dominate the policy discourse. In each instance groups had choices or alternatives as to how they wanted to craft their narrative, yet each compelling narrative had some commonalities. They each drew from cultural norms and beliefs in order to make their narratives believable. Their descriptions of their characters coincided with their populations' social construction. And their causal theory aligned with the population they wished to benefit and the solution they supported. Not only did these groups have commonalities in their narrative structure, they also shared an understanding of the power of narratives in the policy-making process. They used their narratives to persuade other groups, legislators, and even high-ranking administrative officials to support their causal explanations and their policy proposals.

Concerned citizens, including legal scholars, have at their disposal several strategies that they can use to take advantage of the current window of opportunity that bi-partisan and public support for the addiction-as-a-disease narrative has created. Since a plethora of evidence supporting the efficacy of a health-oriented approach already exists,[257] proponents of the public-health approach can focus their efforts on affecting the policymaking process by using some of the strategies that this Article outlines. Namely, proponents can begin by (1) identifying preferred public health solutions, (2) strategically crafting a compelling policy narrative that aligns with the desired public health solutions and accounts for cultural norms and beliefs, (3) forming coalitions with other proponents that support the narrative and its aligning solutions, and (4) using the narrative to persuade high-ranking government officials in both the executive and the legislature to support public-health solutions.

Moreover, advocates for the public-health approach will need to broaden the problem definition of the Opioid Epidemic specifically, and problem drug use in general, to address sufficiently current and

257. *See generally* COURTWRIGHT, *supra* note 57, at 165–74 (describing federal health-related efforts to curb drug use and addiction in the 1960s and 70s); MASSING, *supra* note 110, at 271–75; MUSTO, *supra* note 57, 230–43; YSA ET AL., *supra* note 4, at 42–43 (describing EU member nations' efforts to combat drug addiction).

future problem drug use. For example, as with other health outcomes, the social determinants of health influence addiction and overdose death rates.[258] If advocates support a policy narrative that attributes problem drug use, at least in part, to social, economic, and environmental factors, a multi-modal public health oriented solution will have a greater likelihood for political success. Such a narrative does not negate the "addiction is a disease" narrative, but rather builds on it to focus on both treatment and establishing a system of supports that ensures the greatest likelihood for lifelong treatment success. Advocates can add to the credibility of such a narrative by pointing to the evidence that demonstrates that such multi-modal approaches are not only more effective, but are also more cost-effective in the long term.[259]

Since legal professionals and legal scholars are already predisposed to seeking policy change through the judicial system, this Article has focused on another avenue by which legal scholars and professionals can contribute to the problem-definition discourse and influence policy outcomes—the legislative process. Although this manuscript focuses on affecting the legislative process, narrators can apply the problem definition strategies it presents to the implementation *and* interpretation phases of policy-making. Moreover, although this discussion focuses on the issue of problem drug use, pressure groups can apply these strategies to other issues, like gun violence, for which groups desire to redefine the problem and effect policy change.

For a multi-modal public health approach to become a legislative staple in American policy, advocates of such an approach must learn from the failures and successes of past organized interest groups and focus on building a dominant and compelling narrative to supplement existing scientific evidence and seek support for such a narrative from coalitions and high-ranking government officials. After

258. *Cf.* ANDERSON ET AL., *supra* note 3, at 203 (discussing the correlation between socioeconomic status and harms from problem drug use).

259. *See generally* YSA ET AL., *supra* note 4 (providing recent experiences and efforts from Europe).

all, it is not the evidence, but the problem *redefinition* and its accompanying narratives that drive policy change.[260]

260. David A. Rochefort & Roger W. Cobb, *Preface to* THE POLITICS OF PROBLEM DEFINITION: SHAPING THE POLICY AGENDA vii (David A. Rochefort & Roger W. Cobb eds., 1994); STONE, *supra* note 13, 160–65.

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