Competing Issue Publics in the Opioid Epidemic: Implications for Public Policy

Elizabeth Pérez-Chiqués, Patricia Strach and Katie Zuber

Public perception matters for policy outcomes. Most research finds that, in contrast to past drug waves, the public views the contemporary opioid epidemic as a medical rather than criminal justice issue, although a smaller body of research suggests that criminal justice frameworks persist. We know less, however, about how issue publics with direct experience—who are more likely to take action and have the ear of policy makers—understand it. How do people involved in the ecosystem of drug use and policy understand the opioid epidemic, and what are the implications for policy and policy change? We identify the competing issue publics that people with experience represent by the frameworks they draw from and the perceptions they hold. Through in-depth interviews and participant observation, we, too, find that people with direct experience more often use language of the medical framework than the criminal justice framework. Yet underlying the seemingly strong surface-level support for the medical framework, the criminal justice approach remains in place. Within the issue publics critical for policy debates, individuals apply the medical framework selectively to people proximate to them, or they are ambivalent, holding multiple frames (including criminal justice) at once, even among those outside the criminal justice field. Further, our research reinforces how even the medical framework is compatible with many punitive elements. The hidden persistence of a punitive framework allows differential treatment for specific populations today and paves the way for dramatic policy change, potentially in the future. Our research has implications for public perception and policy change more broadly.

In an area behind the rocks where there are lots of needles, Narcan [the drug that reverses opioid overdoses], crack vials, and garbage, George [not his real name] leaves a Narcan bag hanging from a tree, so the folks who use there will have it. We walk down the pathway in a hurry to wrap up. George reminds some other people who use about Narcan and what to say when they call 9-1-1. "Don't say it's an overdose," he starts. "Say they aren't breathing, and they are not responsive." One of the men asks why, and George explains that emergency responders will take a long time if they think it's an overdose. The man nods as if to say, "Ah, yes, of course." (participant observation with harm reduction personnel, July 2023)

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Narcan? It's a pain in the ass. Reviving them just to continue their crime spree. From the police perspective, you're keeping them alive just to continue burglarizing people. Some local police departments publicize Narcan reversals but not here. (participant observation with emergency services personnel, July 2019)

As opioid overdose deaths rose in the 2000s, scholars have shown how public opinion, media stories, and policy about opioids have relied on a medical framework. Rather than thinking of illicit opioid use as a crime requiring a criminal justice solution, as was the case during the previous heroin, crack cocaine, and methamphetamine drug waves, opioid use during the contemporary wave has increasingly been seen as a disease needing a medical solution: an *opioid epidemic*. Yet for all the attention to the medical framework, another body of literature suggests continuity with the criminal justice framework. Opioid use remains highly stigmatized, and public opinion, media coverage, and policy solutions for marginalized communities often remain negative and punitive. Further, the criminal justice infrastructure remains, even if it is currently targeted toward different individuals. Given the contradictory findings, we ask: How do people involved in the ecosystem of drug use and policy understand the opioid epidemic, and what are the implications for policy and policy change?

We chose to look at people with direct professional or personal experience because scholars argue that the perceptions that matter most may not be those associated with the general public but instead with a segment of the population that pays greater attention to an issue: what is referred to as an *issue public*. Issue publics are more knowledgeable, more likely to take action, and more likely to have the ear of policy makers on a specific issue. Because they are the public to whom policy makers are often responsive, it is important to examine how the broad group with direct experience understands the opioid epidemic.

To do so, we engaged in multiyear in-depth fieldwork, including interviews and participant observation, with 124 individuals with direct experience with the opioid epidemic, encompassing local officials, criminal justice personnel, service providers, community members, as well as people who use drugs (PWUD) and their families. We transcribed and analyzed our data inductively. We categorized the competing issue publics that individuals in our sample represent based not by their membership in any of these groups but by the frameworks they draw from—criminal justice, medical, structural, selective, or ambivalence—and the perceptions they hold.

Like much existing research, we find individuals with direct experience more often talk about opioid use using the language of the medical framework. Yet looking more closely at what they say reveals the persistence of the criminal justice approach, as the excerpts at the beginning of this article illustrate. Individuals did not always apply the medical framework universally to people who use opioids; instead, some applied it selectively to people proximate to them, such as their family or community, while drawing on the criminal justice framework for others. Likewise, individuals did not always have consistent frameworks: some were ambivalent and drew on multiple frames.

Our data further reinforce how the medical framework is compatible with many punitive elements. Even individuals who consistently hold beliefs that drug use is a disease and treatment is the solution may support burdens on drug treatment that are not found for other health conditions. In short, individuals with direct experience employ selective and ambivalence frames that are compatible with the criminal justice framework or a punitive version of the medical framework, even when their direct experience is outside the criminal justice field. Because they are engaged and have direct experience, the people in our sample represent the ceiling of what is politically possible in terms of policy making. Even people who are closest and potentially most sympathetic, such as family members, employ frames compatible with the criminal justice approach.

Underlying seemingly great surface-level support for the medical framework within the issue publics critical for policy debates, the criminal justice and punitive approaches—through the criminal justice, selective, ambivalence, and a punitive version of the medical framework—remain, thereby limiting the possibilities for what is politically possible in policy making. Beyond the specific frameworks we identify and the specific policy issue we examine here, our research has implications for studying public perception and policy change more broadly. Dramatic retrenchment can seem unexplainable when there is broad public support for a policy or population, but hidden frameworks allow differential treatment for particular populations within policies, such as drug policy, and potentially pave the way for significant policy change in the future when these frameworks reemerge because they were never fully replaced by alternative ones.

Public Perceptions of Drug Use and Policy

Public perceptions matter for policy outcomes. Public opinion researchers demonstrate that the effect of public opinion on public policy is both frequent and substantial (Burstein 2003; Page and Shapiro 1983), and public policy scholars show that public understandings shape how policy makers respond to issues (Baumgartner and Jones 1993; Nelson 1984; Schneider and Ingram 1993; Stone 2002). Researchers studying the opioid epidemic overwhelmingly tell a story of support for the medical framework, although some research offers caution around

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characterizations of broad backing for the medical framework, suggesting support for the criminal justice framework instead.

To better understand these contradictory findings, we focus on how individuals engaged in the ecosystem of drug use and policy—broadly defined as the interconnected issue publics that sometimes collaborate but often compete with one another to influence public policy—understand the opioid epidemic. By focusing on issue publics, we examine those groups of people who are the most attentive to, knowledgeable about, and likely to influence policies impacting the opioid epidemic.

Support for the Medical Framework

In one body of research, political and other social scientists have shown how media, public opinion, and policy use the medical framework for the contemporary opioid epidemic (Kim, Morgan, and Nyhan 2020; Mendoza, Rivera, and Hansen 2019; Netherland and Hansen 2016; 2017; Shachar et al. 2020). This framework is employed due to perceived race (Daniels, Netherland, and Lyons 2018; de Benedictis-Kessner and Hankinson 2024; Gollust and Miller 2020; Kim, Morgan, and Nyhan 2020; Shachar et al. 2020; Wood and Elliott 2019), class (Hansen and Roberts 2012; McElrath and McEvoy 2001; but see Wood and Elliott 2019), geographic location (Hansen and Roberts 2012), and blameworthiness of opioid users (de Benedictis-Kessner and Hankinson 2024; Haeder, Sylvester, and Callaghan 2021; Mendoza, Rivera, and Hansen 2019).

In the current opioid epidemic, media stories focus on the medical framework over the criminal justice framework. In an early study of media, McGinty et al. (2015) find the opioid epidemic is portrayed as being caused by illicit drug dealing and the solution is criminal justice policies, but the emphasis on law enforcement decreased while the emphasis on prevention has increased over time. In a follow-up study, McGinty et al. (2019) find that treatment, harm reduction, and prevention were the most common solutions mentioned. Wu (2023) also shows a shift in coverage over time—from articles blaming PWUD and suggesting punitive measures to a focus on medical professionals overprescribing and solutions that included treatment. In a comparison of media frames for the current opioid drug wave to earlier frames about crack cocaine, Shachar et al. (2020) find that articles on opioids most commonly used the word "health" and showed concern for PWUD, whereas articles on crack cocaine most commonly used the words "police," "law enforcement," and "crime." Studies also show sympathetic medical portrayals of opioid use in local media (Mendoza, Rivera, and Hansen 2019), Canadian media (Webster, Rice, and Sud 2020), and obituaries (Adams and Buchbinder 2022), which contrast with crack cocaine portrayals because of the racial composition of the users of this drug (Alexander 2020).

Consistent with the medical framework, public opinion research has shown that Americans more often see pharmaceutical companies and overprescribing by doctors as responsible for the opioid epidemic, and they support a public health response over a criminal justice one. Sun et al. (2023) find that respondents blamed opioid-related deaths on pharmaceutical companies, a lack of drug treatment programs, doctors, and the people who take opioids for opioid-related deaths, and they also thought that pharmaceutical companies, doctors, and people who use opioids—not law enforcement—were responsible for fixing it (see also Barry et al. 2016). Cook and Brownstein (2019) find overwhelming support for a treatment-based approach to the opioid epidemic and that attribution of responsibility shifts depending on whether opioid use is prescription-based (doctors) or illicit heroin (individual users). Pyra et al. (2022) find majority support for policies expanding Medicaid to fund drug treatment, making naloxone (Narcan) available, and providing mandatory treatment. Still, support generally and for specific constituencies in particular is affected by ideology and perceptions of drug users, especially racial resentment (Cook and Brownstein 2019; de Benedictis-Kessner and Hankinson 2024; Sylvester, Haeder, and Callaghan 2022).

Empirical research has established the relationship between how people understand opioid use and the policies to address it (de Benedictis-Kessner and Hankinson 2024; Shachar et al. 2020). Kelly, Dow, and Westerhoff (2010) show that referring to PWUD—where drug use is not restricted to opioids—with criminal-justice language as "substance abusers" makes PWUD more culpable, eliciting less sympathy and making them more deserving of punishment; in contrast, referring to PWUD using medical language as having a "substance-use disorder" makes them less responsible for it, thereby eliciting more sympathy and seeing them as more deserving of treatment. Perhaps as a result of media stories and public opinion that draw on a medical framework for opioids, public policy has changed too. Kim, Morgan, and Nyhan (2020) find that members of Congress were more likely to introduce treatment-oriented bills during the current opioid drug wave and more likely to introduce punitive bills during the previous crack cocaine drug wave, with differences by party (Weiss and Zoorob 2021). Netherland and Hansen (2016) find that policies to address opioid drug use shifted the targets of law enforcement from PWUD to the doctors and pharmacies that prescribe the drugs.

Support for the Criminal Justice Framework

Although a great deal of literature finds broad support for the medical framework, a smaller body of research finds continuity with the criminal justice framework instead;

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both persistent negative attitudes (stigma) toward PWUD (including opioids) and the drug policy infrastructure—that relies on punitive criminal justice solutions more than therapeutic health ones—remain in place. Stigma is still a real issue for people who use opioids (Perry, Pescosolido, and Krendl 2020), and people who use opioids face greater stigma and even dehumanization compared to other stigmatized groups (Sumnall et al. 2020). Survey research (Lin et al. 2022; Perry, Pescosolido, and Krendl 2020) shows both general stigma in attitudes about people who use opioids (untrustworthy, dangerous, not competent) and enacted stigma about respondents' own desire not to work with or have a person who uses opioids marry into their family. In a study of social media posts, Russell et al. (2020) find that a sizable minority (39%) questioned the media's focus on the opioid epidemic, thought it diverted attention from other social problems, and believed individuals made deliberate choices to use opioids. Stigma toward people who use opioids is associated with higher support for punitive criminal justice policies and lower support for health-oriented ones (Adams et al. 2021; Kennedy-Hendricks et al. 2017; Perry, Pescosolido, and Krendl 2020; Tsai et al. 2019; Wakeman and Rich 2018).

Stigma persists even among physicians and people with personal experience. In a survey of primary care physicians, Kennedy-Hendricks et al. (2016) find that physicians most often place responsibility for prescription opioid-use disorder on the individuals with the disorder. Further, more than three-quarters of physicians were unwilling to have a person with prescription opioid-use disorder marry into their family or to work closely with them, both measures of social stigma. In a nationally representative survey of Americans, Kennedy-Hendricks et al. (2017) find that individuals with personal experience themselves or with close family members with personal experience were as or more likely to express stigma toward people with prescription opioid use disorder (but see Adams et al. 2021; Russell et al., 2020). Lin et al. (2022) find that people who had personal experience with a friend or family member who used opioids showed less stigma toward people who used opioids in their past but greater stigma toward those who currently used opioids.

Further, qualitative research on media portrayals, public opinion, and public policy has found marginal support for the medical framework within a broader context of support for the criminal justice approach. McLean (2017) finds a shift in the framing of opioid drug use from a criminal justice to a health issue in news sources, but criminal justice solutions do not disappear. Instead, they are redeployed as tactics for some populations (e.g., drug dealers, urban drug users) when treatment and harm reduction for PWUD grew more common. Although Netherland and Hansen's research (2016; 2017) is often cited to show how opioid use is perceived under the medical framework, their study finds that more positive, humanizing portrayals happen only for *some* populations—notably non-urban, middle-class, and white communities. Daniels, Netherland, and Lyons (2018, 342) conclude that racialized and gendered media portrayals are "a necessary precursor for the 'gentler' approach to treatment and harm reduction in contrast to the punitive, law enforcement responses when a drug epidemic is located in communities of color."

In contrast to research that finds broad support for the medical framework, scholars examining marginalized urban populations find that the criminal justice framework remains dominant. For these populations, there is either little media attention or framing of drug use as a criminal justice problem—with a focus on drug sales, crime, and violence—rather than a health one. In a comparison of buprenorphine, used recently to treat opioid addiction, and methadone, used to treat heroin addiction for decades, Hansen and Roberts (2012, 82) argue that methadone was a "governmental intervention to lower black and Latino urban crime," whereas buprenorphine is a health policy response for "less stigmatized white consumers assumed to be at lower risk of diverting or misusing it." Marie Gottschalk (2023, 365) argues that federal, state, and local governments "have redeployed punitive tools from previous wars on drugs and created some new ones," casting "doubt on claims that the country pivoted toward public health and harm reduction strategies" (see also Wu 2023). People of color are more likely to be punished for drug law violations, to face higher conviction rates, and to receive longer sentences (Alexander 2020; Beckett, Nyrop, and Pfingst 2006; Ghandnoosh and Barry 2023; Human Rights Watch 2000; PEW 2023). The persistence of stigma toward people who use opioids and the inclusion of criminal justice approaches at least for some populations in media portrayals, public perception, and policies suggest that the criminal justice framework persists.

Issue Publics

Yet for all the attention to competing public perceptions of the opioid epidemic, political scientists show that the perceptions that matter most may not be those of the general public but a subpopulation for whom the issue is "close to home" (Converse 2006, 10–11): what they call "issue publics." Unlike the general public, who have "top of the head" beliefs about issues (Zaller 1992), issue publics have direct experience and, as a result, are more knowledgeable, more likely to take action, and more likely to have an influence on public policy.

Issue publics are groups of people who pay close attention to issues that directly affect them (Bolsen and Leeper 2013; Converse 2006; Hutchings 2003). Although the world of politics and public policy often seems "remote and abstract," research demonstrates that people tend to mobilize around issues that are "close to home" or close to their "immediate world" (Converse 2006, 10-11). Such

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action may take the form of collecting information on the actions of their representatives, thereby holding public officials democratically accountable (Hutchings 2003); acquiring (and recalling) political news and information (Bolsen and Leeper 2013; Holbrook et al. 2005; Iyengar et al. 2008; Price and Zaller 1993); evaluating and voting for particular candidates (Hutchings 2021; Krosnick 1988; McGraw, Lodge and Stroh 1990); and writing letters, making phone calls, and supporting advocacy organizations (Krosnick and Telhami 1995; Miller and Krosnik 2004). Given the intensity of their beliefs, the attitudes and opinions of issue members are not easily swayed by political elites. Because such attitudes are "hard core," "well crystallized," and "perfectly stable over time" (Converse 2006, 49; Visser, Bizer, and Krosnick 2006), issue publics (more so than the public as a whole) elicit a response from government officials. Such findings help explain why politicians might support policies that otherwise do not enjoy majority support in part to please issue public constituencies.

Yet the little research that exists about people with direct experience of the opioid epidemic is mixed on their support for the medical or criminal justice frameworks. In a study of commenters on Facebook, Daniels, Netherland, and Lyons (2018), for example, find that people with close personal or professional proximity to drug use were more likely to express concern about the spread of the epidemic, endorse a disease model of addiction, and advocate for therapeutic treatment. It is not clear, however, that people with direct experience are always more sympathetic or supportive of the medical framework. Some survey research discussed earlier (Kennedy-Hendricks et al. 2016; 2017; Lin et al. 2022) finds that people with direct experience as health care providers or family members were *more* likely to express stigma toward PWUD, especially those in active use, suggesting that people with firsthand experience may have more complicated understandings of drug use than simply adhering to the medical framework or the criminal justice framework alone.

Methods

To understand how people involved in the ecosystem of drug use and policy understand the opioid epidemic and its implications for policy and policy change, we draw from interviews with 142 individuals with direct professional or personal experience, including state and local officials, criminal justice personnel, medical and health service providers, community members, as well as PWUD and their families. Interviews were stratified by geography (rural, suburban, urban). Most interviews were conducted in person in New York State by the authors between November 2017 and April 2022, with some completed via Zoom due to distance or COVID-19 travel restrictions. Interviews (30 minutes–2 hours) were recorded with consent or documented via handwritten notes and then transcribed, uploaded to Atlas.ti, and coded; 124 interviews addressed a specific understanding of drug use.

Additionally, we draw on field notes from participant observation at 23 sites, including health services facilities, public forums, and neighborhood outreach programs, conducted between 2017 and 2023. Participant observation provided vital "metadata," essential for interpreting interview transcripts (Bateson 2025; Fuji 2010; Soss 2015).

Following initial coding, the analytic sample included 23 officials and government agency employees, 21 individuals who work in the criminal justice system, 62 health services providers, 7 community members, and 11 PWUD and their families (see appendix A for details on exclusion criteria and appendix D for a comprehensive list of interviewees in the final sample). These descriptive categories reflect the respondents' primary roles or expertise, although many occupied multiple positions. The sample is skewed toward health services providers and underrepresents law enforcement, many of whom spoke to us on background only.

We conducted open-ended interviews addressing challenges, what worked or did not, and what interviewees wanted policy makers to understand (see appendix B). Because our data come from in-depth conversations with people with direct experience (i.e., the issue publics), they are more than "top of the head" responses to questions asked of the general public.

Analytic Strategy

We analyzed the 124 interviews identified in the initial round of coding using interpretive methods that treat meaning as emergent through interpretation. People "do not simply respond to external stimuli but actively make and remake their understandings of those stimuli" (Yanow and Schwartz-Shea 2009, 34; see also Pachirat 2014; Wedeen 2010). Although we did not ask questions specifically about how participants understood drug use or how to address it, we coded responses from the open-ended interviews for how individuals understood PWUD/drug use and what they thought were the most appropriate policy solutions (see appendix C), reading interviews as a relationship between parts and the whole (Soss 2015). Our analysis generated five frameworks: criminal justice, in which PWUD are the problem and a criminal justice approach is the solution; medical, in which PWUD have a disease that needs medical treatment; structural, in which PWUD face inequities that need a structural solution; selective, in which PWUD are differentiated so that some fall under the medical framework and some under criminal justice; and ambivalence, which is a mix of these frameworks (see table 1). Each framework has two components: how drug use/PWUD are understood and what ought to be done. Beyond description, these frameworks

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Table 1
Frameworks and Policy Implications

Framework	Internally consistent/ inconsistent	Description	Policy implications
Criminal justice	Consistent	PWUD are the problem, and a criminal justice approach is the solution	Support for criminal justice policies
Medical	Consistent	PWUD have a disease that needs medical treatment	Support for health policies, sometimes compatible with punitive approaches
Structural	Consistent	PWUD face inequities that need a structural solution	Support for housing, labor, transportation, poverty-reduction, and harm-reduction policies
Selective	Inconsistent	PWUD are differentiated so that some fall under the criminal justice framework and some fall under the medical framework	Support for criminal justice policies for some and health policies for others
Ambivalence	Inconsistent	This represents a mix of the other frameworks	Support for multiple types of policies

Note. Shaded rows indicate the presence of criminal justice framing and solutions.

are used analytically to identify competing issue publics represented by people with firsthand experience (Denzau and North 1994), rather than defining issue publics by external characteristics such as experience or geography (see appendix E).

Under the *criminal justice framework*, PWUD are the problem. They are described in stigmatizing terms as an "addict" who will do anything to get more drugs and as "repeaters," "shoppers," and "frequent flyers." PWUD are defined as irresponsible, rule breakers, "hard-core," and "dealers." The appropriate policy response engages the criminal justice system with arrest and prosecution. Under the *medical framework*, PWUD have a disease, a "substance-use disorder," that is the problem. They are described as self-medicating and as having a "biochemical dependency," "brain disorder," "brain-based disease," or a disability. The policy solution is individual treatment by medical personnel and public health interventions that, importantly, may also have punitive dimensions. Lastly, the *structural framework* extends further than the criminal justice or medical approaches. PWUD face broader inequities, struggle because of poverty, and are vulnerable, forgotten, and treated like "garbage." The solution includes policies that support housing, jobs, transportation, poverty reduction, and harm reduction.

Not everyone we spoke to drew on consistent frameworks, and some were inconsistent in how they described drug use/PWUD and policies to address them. Our analysis examined inconsistencies among frameworks, specifically how interviewees talked about drug use (e.g., alternating between crime and disease) and the solutions most appropriate for dealing with it (e.g., drug use is a disease, but the solution is criminal justice penalties). In addition to the three initial frameworks just described, we identified two more that are characterized by inconsistency: the *selective framework*, in which individuals treat particular populations differently from others, so that some PWUD fall under the criminal justice framework and others under the medical framework, and the *ambivalence framework*, characterized by a mix of the frameworks mentioned earlier and of support for policies characteristic of various frameworks. Although Zaller (1992) shows that it is not uncommon for people to hold several contradictory ideas at the same time because they do not have deep knowledge and are not called on to reconcile these different beliefs, our data draw from interviews with and participant observation of people who dealt with the opioid epidemic on a day-to-day basis. Following Charles Taylor (1971, 14) who explains that "the meaning of a situation for an agent may be full of confusion and contradiction; but the adequate depiction of this contradiction makes sense of it," we examine inconsistencies to reveal how people navigate old and new ideas about policy problems, showing the persistence of hidden frameworks beneath apparent surface-level agreement on the medical framework.

In total, three of the five frameworks—criminal justice, selective and ambivalence—and a fourth, a punitive version of the medical framework, where treatment is delivered in a punishing and highly stigmatized way, suggest the persistence of criminal justice and punitive approaches. In the next section, we organize our discussion by framework and select an excerpt from interview transcripts or field notes that substantively focused on an idea or event and was most illustrative of each framework and the issue public it represents.

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Findings

In the next subsections, we outline the five frameworks identified within the ecosystem of drug use and drug policy (see table 1). First, we discuss the three consistent frameworks: criminal justice, medical and structural. Of these, we find that interviewees most often use the medical framework when speaking about drug use. Some people drawing on the medical framework also express beliefs that are steeped in stereotypes about drug use and report behaviors (of themselves and others) that are consistent with the punitive delivery of services. Second, we discuss the inconsistent frameworks—selective and ambivalent—that we argue are compatible with the criminal justice approach. Although the criminal justice framework was the least common, selective and ambivalence frameworks were much more likely to be used by our interviewees, showing the persistence of the criminal justice and other punitive approaches. By focusing on interconnected issue publics, our analysis deepens and complicates what appears to be large-scale support for the medical framework as the dominant way the current opioid epidemic is perceived and addressed in the United States.

Consistent Frameworks

The three frameworks in this section demonstrate consistency in the perceptions people hold about PWUD/drug use and the appropriate response. Although opinions vary *across* them—for example, whether the opioid epidemic is a criminal justice problem requiring a response like imprisonment or a medical one that should be treated through medical interventions—respondents *within* each category were often consistent in the application of those beliefs.

Criminal Justice Framework

Local Official 1: They do not go. They sign off. Either we Narcan them, fire department will Narcan them, or the
Local Official 2: Police agency.
Local Official 1: Or the police agency; not all police agencies are doing it, but those that we interface with do. Either way they are getting Narcanned. And once they are alert, oriented, and know that they are not in trouble with the law, and the police are just pshh, "You are okay? We're done for this, no possession, there's no… they sign off and out they go.
Author: So, uhm, Narcan, why, why do you both dislike it?
Local Official 1: Enabling. Plain and simple. That's the term I use is we've become enablers. Of course, it is a miracle drug, of course on a humanitarian side.
Local Official 2: Saved thousands of lives.
Local Official 1: Saved so many lives.
Local Official 2: But it really only saved that life for a day, for two days, because we have repeaters.
Local Official 1: Repeaters, and and…
Local Official 2: All the time.
Local Official 1: Yeah.
Local Official 2: They're frequent; we call them frequent flyers…
Local Official 2: So, I don't know how you feel about the disease concept, but again I'm not a disease guy, [laughter] you are an addict.
Local Official 1: And yeah, it is a disease, looking at it from the medical, 'cause it affects the dopamine levels in our body and it's the one thing that makes this different from other drugs [Author: yep]. However, after the first or second time [Local Official 2: you are an addict!], you are done.

The two elected local officials in this interview excerpt consistently expressed themselves in criminal justice terms, showed resistance to the classification of opioid drug use as a disorder, and lamented the changes in policy that allow this behavior to be treated in a way that they consider reinforces rather than curbs opioid use. Overall, they considered the medical approach as unable to curb drug use and slow down the epidemic. The interviewees considered Narcan as enabling drug use, because it removes or decreases consequences, including the worry about dying (PWUD feel safer than they would in its absence) and the possibility of being arrested or confined against one's will by public health officials, as they can be under the criminal justice model.

Although this framework occurs only in two categories of expertise (criminal justice and government) and geographically only in rural and suburban areas, it was expressed by interviewees that hold power over the implementation of drug policy. The local officials' views about Narcan that we highlight were not uncommon, and some veered into particularly extreme positions. For example, when members of a panel at a 2018 town hall we attended were asked about limits on how many times a person can be revived with Narcan, a panelist in recovery responded that he would not be alive if these restrictions had been in place. The openness with which views about not administering naloxone are voiced, and the acceptance of those opinions when these views meant letting people die (see also Lauber et al. 2018), seemed remarkable to us. Throughout our research, we saw how often and how casually individuals—from government officials to community members to academics—spoke of PWUD in dehumanizing language as having lives not worth saving with Narcan. This openness is captured in an interview with a mother whose child died from drug-related causes: "I went to the gas station and there was… the chief, a fireman was there… so he said, 'How are you?' I said, 'Oh, I'm alright.' And I said, 'Oh, we just… interviewed somebody that, um, revived somebody from Narcan,' and he's like, 'Oh, that Narcan, I say Oh let them die' … and he really upset me, you know" (#20).

Because they wield broad powers, it matters how local officials—either elected ones who often face little scrutiny or electoral competition or street-level bureaucrats who

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have a lot of discretion—frame the opioid epidemic. They influence the way in which policies are implemented, which results too often in reinforcing stigmas, misapplying or only superficially implementing policies, or in the downright refusal to enforce laws that are contrary to their ideologies (Farris and Holman 2024; Green et al. 2013). Indeed, interviewees reported being reluctant to implement Narcan policies, disagreeing with the policy of channeling PWUD to treatment instead of jail, and opposing the classification of drug use as a disease instead of criminal behavior. These actions varied from not supporting policy, not faithfully implementing it, to opposing broad policy change.

This issue public thus supports policies that criminalize drug use, favoring incarceration or involuntary confinement over treatment. They view current reforms as driven by outside interests such as pharmaceutical companies or Medicaid expansion. They reject the medical framework and associated policies, which they see as failures unable to impact the dynamics of the drug trade's supply and demand. Yet, while expressing support for a criminal justice framework, this support was at times contradictory—for example, acknowledging the lifesaving effectiveness of Narcan and then quickly segueing to an emphasis on drug users' personal failures and repeat behaviors—highlighting the tension between the criminal justice and medical frameworks.

We consider this issue public to be the most resistant to adopting the medical or structural frameworks and to enacting the associated policies willfully and faithfully. Their resistance to adopting alternate frameworks may contribute to the continuation and reinforcement of punitive tendencies in drug policy.

Medical Framework

Physician: There´s no really collective statewide process of how to manage substance-use disorder in the prison system. There´s some that don't do it at all. So, you have somebody that has a history of opiate-use disorder that gets arrested that now is going through severe withdrawals. So, they'll treat their hypertension, they´ll treat their diabetes, they´ll treat their HIV, and then they´ll let them suffer through what is also a chronic disease with a substance use disorder.

…I had a patient years ago that asked me—his mother had died of an overdose—and he asked me if that meant that he was predisposed to becoming addicted to substances. And the reality is, yes, it is definitely a genetic component to it. So, I didn´t beat around the bush with him. I said you want to stay as far away from any addictive substances as possible, because you likely have a genetic predisposition to becoming addicted. So, at all costs even if it's something as simple as pain medication after a tooth procedure, which folks have gotten addicted from even that short term course of opiates (#82).

In this excerpt, a physician who works providing substance-use disorder services offers a starkly different take on opioid use. Unlike in the criminal justice excerpt, substance-use disorder is not a term that he dismissed; he has a very clear understanding of drug use as a disease requiring medical treatment. When describing the denial of medical care for opioid-use disorder, the interviewee asserted that addiction is a medical condition deserving equal treatment, and the behavior that landed a user in prison is irrelevant. Instead, PWUD were not receiving the treatment needed as they would for other chronic diseases, and the physician believes that they should.

The medical framework was prevalent across expertise and geography, although it was most common among health services providers and in suburban areas. This issue public frequently compares substance-use disorder to other chronic diseases such as diabetes, cancer, high blood pressure, and HIV. One local official called it a "brain-based disease" (#71), and another described addiction as a "horrible, horrible disease" (#7). Viewing substance use as a disease changes who is responsible for creating the problem and what the appropriate response should be: "In order to manage the disease of addiction in the correct way," explained one health provider, "you need three things: you need a primary care doctor who understands and is willing to treat, you need an addiction medicine specialist who does the evaluation and comes up and helps develop the plan, and you need concurrent therapy to figure out what happened and why is this person needing to use" (#154).

People who embraced the medical framework used it frequently to defend medication-assisted treatment. Treating opioid addiction with methadone or buprenorphine was not trading "one drug for another" (#71). Instead, it was similar to treating diabetes with insulin. "Well, you wouldn't stop insulin for a diabetic," explained one health services provider. "We're agreeing this is a disease; why would we stop Suboxone or Vivitrol [medications to treat substance-use disorder] or whatever?" (#42).

This issue public generally opposes a criminal justice response to drug use and to drug-related offenses: "They should be in treatment… providing treatment for the substance abuse, providing treatment for mental illness, as opposed to locking them up, at least initially" (#206). Additionally, they step away from a stance of otherness, embracing that this is a disease that can happen to anyone, and some are emphatic that associated behaviors that are so stigmatized and difficult to deal with—for example, lying, stealing, or acts of aggression—should be seen as *symptoms*: "*The behaviors are symptoms of the disorder, not the disorder itself*" (emphasis added, #72).

Within this issue public, however, we also identified a punitive variant of the medical framework: although it considers drug use a disease and treatment the correct policy response, this framework remains steeped in

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suspicion and stigma toward the population, perceptions that seep into punitive practices in treatment. A frontline worker, the gatekeeper for detoxification services in an emergency department, occupies a conflicted position—she wants to help and feels sympathy for her patients, yet she works in a system where she has to deny care unless or until PWUD meet strict medical criteria. She finds it confusing as to where to draw the line between illness and personal choice: "Whose fault is it if the patient dies? Is it the doctor who didn't make the call to admit? Or the patient who took that decision?" But she also described situations that opened her eyes regarding whether it is her fault or not when patients who were admitted for treatment signed out against medical advice: that was "another eye opener for me, like, it's not me, it's them, this is them, this is what they want" (#9).

Additionally, medical protocols might translate into practices that are onerous for patients and subject them to physical and mental distress and to humiliation. For example, PWUD looking for help in emergency departments are often not admitted because they do not meet the medical emergency threshold, which includes being in withdrawal distress. This interviewee tells patients in that situation, "Listen, come back in here when you are literally vomiting, crapping your pants, your body is achy, hang out in the waiting room if you can, if you can. You're not supposed to, but, don't use, you cannot go out and use, if you really, you just have to be sick and just come back when you can" (#9).

Furthermore, patients are treated with suspicion. To make sure people are not "faking," she asks them, "Can I see your hands?" She continues,

> It's very easy to do this. I'll ask them to like lock their elbow, cause it's hard where they can still do this.… I'll hold their hand, and you can feel their hand shaking, if they are really shaking; if they are faking it, you can feel that they're faking it. Another trick is to have them stick out their tongue. If you're tremulous your tongue's going to be going up and down. So that's like a trick (#9).

Burdens are also evident in other treatments for PWUD, such as methadone, where clients have difficulty accessing and receiving their treatment not based on medical reasons but on distrust toward the population (e.g., excessive toxicology tests). Additionally, burdens are also imposed on providers treating PWUD, directly affecting service provision (Zuber, Strach, and Pérez-Chiqués 2024).

Although interviewees in this category hold consistent beliefs that drug use is a disease, the medical framework can also be applied punitively, reflect societal stigmas, and result in burdens that are accepted and routine, which could lead to people not getting help. Our results are consistent with other research findings that treatment-based alternatives to punishment can be as punishing or more than regular criminal interventions (Stitt 2025). This issue public supports policy change that treats drug use as a disease, but it may not preclude punitive policies for PWUD that are not applied to other types of medical conditions, limiting the potential of the medical framework to address drug use.

Structural Framework

This is a true case, a participant came to us on a Sunday and said, "I am ready for detox." We said, "Alright go to [the hospital], which is in the city… And the entry point is the ER. Go into the ER, say what you're interested in and ride it out until Monday morning." The person did that. When they finally came to them on Monday morning after basically being for 12 hours, dopesick, waiting for them to open… he was basically told there are no open beds, and [they] sent him home, come back tomorrow. You think the person came back? No! Of course, no.… He lives on the streets. He just literally—and that's the kind of thing that happens every day. They try, they try so, my participants are freaking heroes, they try so hard. And it is a system that has created these very high threshold requirements, needs, that then sends them back into that chaotic drug use. So, in my ideal world, harm reduction… is literally being able to access detox facility 24/7. It is literally having wound care specialist, bilingual case managers, and social workers in multidisciplinary teams going into the streets. There's a certain kind of privilege that is embedded in the system right now. Where you need to go to the hospital, you need to go to the harm reduction organization. But if I don't have the money, how am I gonna afford that subway ride, right? And not, not just afford it, but I'm smelly. I haven't taken a shower in two days. What kind of stigma and shaming am I going to receive as I move across the city and leave my encampment in order to see whether I can get a bed into detox? Maybe by the time I go and come back, my encampment is gone. Police came through and threw it out. Sanitation came through. Maybe I was robbed; my one sleeping bag is gone. So, I think I really envision harm reduction 24/7 that is participant focused. That means I am going to them. I am making it easy for that person to access resources. I'm doing it in a way where I am humanizing, where I am mobilizing the resources and the people to come to them. Instead of expecting them to come to me. I'm also doing it late at night. I'm doing it on a holiday, right. You know, I think that's, that's the utopia. That's the utopia (#217).

This urban interviewee working in harm reduction vividly shows how, from their perspective, the medical framework falls short of meeting the needs of the most vulnerable PWUD. In their account, the medical framework focuses on diagnosing and treating opioid use but fails to address the broader realities of those it aims to serve and can even increase barriers to treatment by making people who want help to access it through unfriendly medical systems. They emphasize the importance of humanizing PWUD and responding to their everyday needs. According to the interviewee, the system is structured around the privilege of being stably housed or having reliable transportation, for

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example. People using the structural framework talk about systemic issues—racism, white supremacy, gentrification, and inequities, more broadly—as the context for opioid use while being aware how difficult it is to address such issues. Even relatively modest changes in service delivery are described as "utopian," constrained by the inflexibilities of medical treatment and existing funding streams.

The structural framework—which occurs across expertise and geography, although most often in our urban interviews—draws attention to the ways in which opioid use affects both people and communities. Like the medical framework, most who adhere to the structural framework accept the understanding of addiction as requiring medical treatment. But their understanding goes beyond the individual to focus on how drug use is rooted in larger, systemic problems. People who embrace structural frames believe that treating substance use is more than treating the individual. It means addressing structural inequities that lead to opioid use, including poverty, trauma, racism, and mental health.

Under the structural framework, poverty is seen as a major driver of drug use and an obstacle for those with substance-use disorder. People who use opioids "really, really struggle… because of poverty," explained a health services provider (#197) in one of the most disadvantaged counties in the state. Poor communities are targeted with dangerous illicit drugs like fentanyl, "because you get away with a lot more than you would someplace else" (#197). In these communities, there are a lot of drugs, little access to care, and problems with mental health and homelessness. People who use opioids may start because they have trauma from "abandonment and neglect, being exposed to community-level violence, being a person of color, and being treated poorly by schools and by hospitals and doctors"; drugs make them feel "better about themselves," explained another provider (#207).

Systemic racism was identified as another contributing factor to the current opioid epidemic and is reflected in the structural framework's policy stances. In addition to the awareness of the racial demographics of the opioid epidemic, people holding the structural framework talked about how issues of race, racism, and white supremacy helped shift policies from a punitive to a public health response. One local official of color asked, "Why was this rehabilitative approach taken? Because the people who are using those drugs don't look like me. And so, we want to help people that don't look like me…. We want to be rehabilitative. We don't want to criminalize." Now that the face of the opioid epidemic is white, this official told us that PWUD are considered "bad on their luck" or on painkillers. "So, it's the pharmaceutical company's fault. It's not their fault why they got hooked on painkillers" (#220).

In this understanding, the role of race is rooted in a long-standing system of punitive drug control that disproportionately targets communities of color. Yet class also structures how people are treated within the system. Privileged people, for example, who are "not under the constant surveillance of the government" get to exist as "both drug users and good parents." According to one policy expert,

> The government doesn't attach that drug war narrative to privilege.… The government's response to opiate use in middle-class and white communities has been… a gentler response than it was to the crack crisis.… I've been in communication with poor white folks upstate, and the response to them has been violent in the way that the War on Drugs responded to the crack crisis.… The government's response to structural hierarchy, if you are a white class privilege person, yes, the narrative around opioid use and how we support—it's a public health issue is very different than if you are a non-class-privileged white person (#215).

In terms of policy preferences, the structural issue public supports the broadest policy changes, which address underlying structural inequalities, because treatment only manages symptoms of something much broader. They advocate for policies that expand access to housing, food, employment, and education. Under this framework, medication-assisted treatment—the gold standard under the medical model—is considered insufficient on its own: "It's unrealistic of us to think that someone who is unstably housed, food insecurity, unemployed, very low education level, in a social system that has no supports, is going to do well because you're providing them with buprenorphine, or methadone, or some counseling when they come into the office. It's not going to work" (#197).

Others emphasized the need for comprehensive drug policy reform. One interviewee said, "We need to start looking at systems and solutions that are in the systems," including wholescale drug policy reform. "We really do need to end the War on Drugs. We really do need a safer drug supply. And we really do need to look at the criminalization of drug use, and its disproportionate impact on Black, brown, and low-income communities" (#217).

The structural issue public highlights the limits of existing treatment systems in addressing the broader needs of PWUD. Interviewees described engaging in practices such as wound dressing, syringe pick-up, outreach services to people in extremely vulnerable situations, and policy advocacy. This issue public advocates for broad, systemic change, but operates in political environments where such changes are currently not viable. The framework offers a shift from individualizing addiction to understanding it as deeply embedded in systems of inequality. Yet their efforts unfold in a context shaped by competing frameworks, where criminal justice approaches continue to be prevalent.

Inconsistent Frameworks

Not everyone we interviewed had such "well-crystallized" beliefs (Converse 2006), as in the frameworks just described. Some people were, in fact, inconsistent in those beliefs. Although some held sympathetic views, applying

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the medical framework to people they were close to but not to everyone (selective), others applied multiple frames (ambivalence), including the criminal justice framework, even when their direct experience was not in the criminal justice field. We turn next to the selective issue public.

Selective Framework

So, at first, because of the stigma, you know, we must have been bad parents. Trying to live through the guilt of trying to understand what happened to our son and try to help him, at the same time be shunned by, you know, the entire universe. It's only the last year or two where people are realizing because lily-white young beautiful children are now dying every week, you know. And so. And people of means, and people of good families, in other words, it's not a low-life, illegitimate child, broken-home type of situation, that I'm not alone.… So… up until this point we've kind of, you know, lived in a bubble.… [My son was] in a second-rate facility and that's all of the facilities that are state-run.… He was surrounded by people that are going to just continue to do drugs. Most of the people came from the city, most of the folks were, you know, just biding their time to not do prison time. And so, it wasn't a very good climate, and they didn't do anything for him, he just rotted. I mean, he paid attention, he didn't break.… But he got through that period of time even though it was disgraceful, degrading; in other words, you are treated like a second-class citizen in some of these things. So he now, they're done with him, so what do they do with him, is they dump him in the middle of [City], a block away from the shittiest, most drug-infested place on Earth, to a halfway house that he… for 23 hours a day he is on his own, and for five days a week, one hour a day, he has outpatient.… I need to get my kid out of that halfway house. Because…he's in there with three other individuals. They've stolen his money, stolen his food. You know, it's like inmates are running the asylum. These are four addicted, crazy people. Probably not good for each other… the place has bedbugs. He was fine, and then now, a month later… he's not, you know, it's just such an awful place and who is he going to tell? (#31).

In this excerpt, the rural parent was struggling to understand her son's drug use outside the traditional criminal justice framework. She continually differentiated her son —whom she knows and loves—and family from other drug users and families that face this problem. She noted that the population that is now affected included people from good families, and contrasted families like hers with stereotypical perceptions of drug users as coming from "broken-homes." Furthermore, she applied the medical framework to her son but not necessarily to others, whom she talked about in highly stereotypical ways as using treatment as a means to escape punishment (jail) or just acting strategically overall to keep on using drugs. The mention of this strategic behavior evokes the manipulative behavior often associated with PWUD. This individual recognizes that she has lived in a bubble where she did not have to interact with people using drugs or with the state in the way she is now being forced to. This rural parent was visibly in pain, feeling like a bad mom and that everyone was thinking she was a terrible person. Because drug use is so stigmatizing, she was trying to carve out a space for her son while holding these very negative views about drug users.

The selective framework is used across expertise and geography, although most commonly in the criminal justice and PWUD/family of PWUD categories. The tendency to view a loved one as different from "other addicts" or differentiating those deserving of help based on proximity is widespread among the selective issue public. One local government health official described "an amazing program" where "God forbid," she would send her child, "but then you have to deal with who else is there." She said that is why parents send their kids out of state for treatment. "Who else is there." She continued: "It's such a funny statement when you hear people say that. I mean, why do you think they're there? But that's stigma. You're there for the same reason" (#70).

The increased proximity of the opioid crisis has brought more empathy and acceptance of the medical framework because of the nearness (e.g., my friends' kids are dying) and a lessening of its stigma. As an interviewee explained, it was different years ago: "Back then it was like, when we went to the memorial service, nobody even mentioned drug use or heroin or anything, but now, people are writing in the obituaries of their loved ones, that the person died after a 'long struggle with addiction.'… I think the world has grown more understanding, even though the stigma is very much with us" (#32). Another expressed that when the crisis hits home, when it affects people they know and care about, people are much more likely to be empathetic (#87).

Many interviewees—especially those in the criminal justice field—make distinctions between "drug dealers" and "drug users." While the rural mother just quoted sets her son apart from a broader understanding of drug use as something deviant, these interviewees were carving out a space for law enforcement in a policy response they view as overly medicalized. They do this by defining drug dealers as the people to target. The appropriate response to "drug dealers" and people who commit violent crimes to purchase drugs is prosecution, not treatment. For example, one district attorney who was receptive to the idea of medication-assisted treatment talked about the importance of holding "people accountable for their actions" (#33). When the people he prosecutes for drug-related crimes such as robbery or assault ask to "get into treatment," his reaction is "that's good and fine on the one hand, but what sort of treatment do we give to people who knock [down] 80-year-old men and beat them up for their wallet? Do we have a treatment facility for that? We don't. That's antisocial, violent behavior that requires someone to be

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locked up." For this district attorney, requesting treatment is simply a way to avoid prison: "Everything is now treatment."

Racial distinctions are another major classification used among this issue public to determine those who are deserving of treatment. One state legislator explained how the policy response is contingent on racial demographics: "It wasn't until I became a legislator that I started to kind of really get hit in the head, with, like, how bad some of this stuff is, and how much it had racial biases baked in and how discriminatory it could be." He described a Republican colleague who was "appalled" when they changed the state's punitive drug laws. "What I came to understand from him is that he was ideologically convinced of the idea that there are differences between us and them. And *them* are people who are… criminals, drug users, they're scum of the earth, like they deserve to be incarcerated forever" (#219).

Racial stereotypes attached to particular types of drugs are also used to distinguish between people who deserve treatment and those who deserve punishment. The legislator explained that for people who use opioids, an increasing number of whom are white, "we need treatment, not jails for these folks." But when K2, a type of synthetic marijuana, ravages communities of color, he said, "We have to criminalize that." He continued,

> We got to be honest here. That we're just switching up the criminalization of it.… It's as if though we've forgotten that we already decided over here, we saw that facts tell us that criminalization is not going to solve our drug problem. But apparently, it's just for this population. But over here, oh, we have to criminalize…; we got to get to the scourge. And it's just the criminalization of a population. … I just can't get over the hypocrisy of saying, well, we need to make sure we treat these folks. But these folks, we keep them at a distance (#219).

Interviewees expressed different policy preferences depending on categorizations of users, which reflected the prevailing and enduring biases and narratives of the criminal justice approach to certain populations; in contrast, their policy preferences were consistent with the medical approach for their loved ones, for populations similar to them demographically, or for populations who started opioid abuse "accidentally" by being overprescribed medication, for example. Other interviewees were keenly aware of the selective empathy that accompanies the changing policies. When it spread to the suburbs, one urban health services provider noted that drug use "became a disease" (#102).

In contrast to people favoring either the criminal justice framework or the medical framework, who prefer a unitary response to the opioid crisis, people in the selective issue public make distinctions among populations. The rural parent who used the language of drug use as a medical issue still drew from traditional stereotypes to describe other PWUD surrounding her son. But distinctions can be made along other lines as well. People who apply the medical approach selectively often distinguish between drug users and drug dealers, and their opinions tend to be filtered through underlying stereotypes about gender, race, and class.

This framework could lead to policies that would continue to treat specific populations primarily through a criminal justice approach, rather than enabling them to benefit from the potential advantages of policies grounded in a medical framework. Overall, negative attitudes about drug use and the PWUD are still available. In turn, these perceptions can be drawn on to support tough-on-crime policies for certain populations.

Ambivalence Framework

Louis suffers from PTSD. He says you're either born into addiction or you had a traumatic experience. Someone offered him drugs during an episode.… Louis says we need a different classification. Something other than "disease" because not everyone's born with it. I think what he might have been saying was that some people choose it. … His mom, Rose, explains that addicts deserve to live, too, but… they need stricter laws. Second time someone gets resuscitated, they should be court ordered. A third or fourth time, it's not helping them. People only change when they want to change. … When he [Louis] graduated from drug court, Rose said she thought about inviting the state trooper who arrested him.… Rose says there was a famous line in drug court: "Must have been a bad test." One woman who was six or seven months pregnant said that. "Must have been a bad test." Rose wanted to punch her in the face [because of Rose's own experience growing up].… Rose says they should bring detox back to the local hospital. Stop giving people medication. You're just giving them another addiction. Cold turkey.… Rose says a lot of people will shoot heroin. One of two things can happen. (1) It kills them; or (2) They say, "Eh, I want to keep doing it. This was good. You don't want to help me, I'll keep doing it. …We gather our things and head for the door. As we're about to leave, Cecilia [a family friend] mentions the idea of harm reduction. When someone asks for $5 you give them $10 and tell them to buy a sandwich. That didn't sound right to Rose who said she'd never give an addict $10. (field notes, July 2019)

The family members in this interview excerpt illustrate an ambivalence that we frequently found among interviewees. They hold views that are similar to the criminal justice framework, emphasizing the need to limit assistance in the form of Narcan and to impose stricter laws. They think that addiction is sometimes a disease and sometimes a choice, but in contrast to the selective issue public, they did not make distinctions based on proximity or group identity, nor did they make exceptions for use in their own families. In this interview, the mother described how she threatened to call the police on her son. She believes that a criminal justice response was appropriate, even to the point of considering inviting the state trooper who initially arrested him to his drug court graduation celebration.

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Although ambivalence is expected and common among the general public, it is less expected among issue publics, who are considered more experienced and invested in a particular issue. Yet the ambivalence category appeared in each expertise and geography category: however, it was most common for government officials, PWUD and their families, and rural populations. Some interviewees were highly skeptical of medical treatment (medications), considering that the right way is to go cold turkey and receive the support of Narcotics Anonymous. They consider that using medication for addiction—methadone, buprenorphine, etc.—is similar to substituting one drug for another. In terms of harm reduction, some expressed support for measures such as legalizing marijuana and skepticism for other approaches, such as giving PWUD money or legalizing all drugs.

Throughout the course of our interviews, it was not uncommon for people who referred to addiction as a disease that "takes over their entire brain" (#20) to also hold traditional stereotypes about drug use as irresponsible, reckless, and the product of bad choices. One interviewee who understood "they are talking about drug addiction being a disease," and who recognized that "a certain number of people enter drugs because there is a certain emotion pain," also expressed that "the larger share of people who enter into drugs here, especially young people, do it through a series of bad choices" (#14). Finally, a behavioral healthcare screener described drug use as "a choice," even though she worked for a provider that offered medication-assisted treatment (#27).

The ambivalence issue publics held similarly inconsistent policy preferences. They did not exhibit one central tendency nor a coherent take on opioid use but rather drew on a variety of frameworks and practices to explain and address opioid use, including ones that can be considered extreme, such as limiting the number of times Narcan should be administered to the same individual. They may advocate both for treatment and for punishing mechanisms.

Like those in the selective issue public, ambivalent interviewees were inconsistent in how they described both appropriate societal responses and their own actions. They might, for example, state that their son's addiction is a disease but see jail as the appropriate response.

This issue public frequently held conflicting beliefs and moved between competing frameworks, often without seeming to recognize the inconsistencies. When addiction was framed as a medical condition by interviewees, treatment and compassion were seen as the proper responses. Yet the same individuals also invoked criminalizing language or punitive solutions, suggesting jail, expressing frustration with repeated overdoses, or characterizing drug use as the result of bad choices or boredom. These contradictions were not merely rhetorical, they extended into policy preferences and everyday practice, with interviewees supporting both harm reduction and punishment, often in a matter of seconds. These tensions remained unresolved, revealing the deep embeddedness of ambivalence.

This issue public often oscillates between various frameworks, without the targeted exceptions seen in the selective framework. Rather than presenting a consistent or clearly articulated view of opioid use, their responses revealed a mix of conflicting perceptions, which is unexpected given their professional or personal experience. Although this issue public, in the aggregate, reinforces support for the criminal justice approach, their ambivalence suggests they may be persuadable toward policies in either direction.

Discussion and Conclusion

In this article we categorize individuals into issue publics according to the frameworks they hold. Similar to research finding broad support among the population for the medical framework, when looking at people with direct experience, we, too, find that individuals more often talk about the opioid epidemic in the language of the medical framework than the criminal justice one. Yet looking more closely at what they say shows that support for the medical framework may be weaker and support for the criminal justice framework——and punitive approaches more broadly—may be stronger than may first appear. Individuals with direct experience did not always apply the medical framework universally. Some did so selectively to people proximate to them and applied the criminal justice framework to others, while others were ambivalent, drawing on multiple frameworks (including criminal justice) even when their direct experience is outside the criminal justice field. Moreover, the medical framework itself is compatible with many punitive elements. We suggest that the cross-cutting cleavages based on frameworks—not professions or personal experience—may offer other scholars leverage in their own analyses of issue publics and public perceptions.

Our research has implications for drug policy in particular and for theories of public perception and policy change more broadly. First, beyond support for the policies currently in place, our findings suggest what is politically possible in drug policy making. People with direct experience—who are more knowledgeable, more likely to take action, and more likely to have the ear of policy makers—do not share a common framework for addressing the opioid epidemic. What is more, support for frameworks compatible with the criminal justice approach extends far beyond the criminal justice field. Even those people with personal experience, who are closest to PWUD and who represent the ceiling for what is politically possible, show support for criminal justice compatible frameworks. Because support for the medical framework is shallow and may include punitive elements, reverting to the criminal justice approach remains a distinct possibility. Indeed, at the same time that policy makers are promoting policies for

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a medical approach to treating opioid-use disorder, they are criminalizing *other* types of drug use. In the future, policy makers may continue to treat drug use by particular PWUD more favorably than other types of drug use by other types of drug users, as seen in the disparate treatment of cocaine and crack cocaine under federal sentencing guidelines. It is also possible that government policy makers will bring the criminal justice approach to drug use consistently back to the forefront.

Beyond drug policy, our findings have implications for research on public perceptions and policy change as well. Our research shows that public perceptions are difficult to change, especially for value-laden issues. Even when people use language associated with one issue framework, they may still harbor long-standing perceptions compatible with another. Our findings go beyond Zaller's important work (1992), demonstrating that many people answering survey questions do not have consistent, well-thought-out beliefs on issues. We show how people who *are* invested in a policy issue may employ language of one framework and still hold another, including individuals in professional positions who deal with this issue day in and day out. Two-thirds of people who work in criminal justice, for example, adopted selective or ambivalence frameworks, far more than held the criminal justice one. The vast majority of people working in health services used a medical framework, which is not surprising, but nearly one-fifth were ambivalent, which is more unexpected. Even with their personal connection, half of PWUD or their families employed selective or ambivalence frames.

How can arguably well-informed individuals hold seemingly contradictory frameworks at the same time? Our research shows how inconsistencies do not necessarily imply ignorance or irrationality. Instead, individuals' language can "reflect, exemplify, or demonstrate important political phenomena" (Wedeen 2010, 261) and might be constitutive of value-laden, heavily contested policy arenas, like drug policy. Negative perceptions about PWUD are both broad and deep, reinforced by government policy, health and social service systems, personal experiences, and shared cultural practices. Even when language shifts, the underlying beliefs may remain. The inconsistencies that we study are portals into frameworks that people hold onto and the work that they do making sense (see also Eliasoph 1997) of changing public narratives.

Although scholars demonstrate that policy change may be short-lived due to incomplete transformations in features of interest groups and institutional organization (e.g., Patashnik 2008; Patashnik and Zelizer 2013), we show that the durability of ideas can also limit it. Building on Baumgartner and Jones (1993), who argue that American politics is characterized by a partial equilibrium disrupted when the ideas undergirding policy change, we show how difficult this may be. Perceptions remain sticky, especially for negatively constructed and powerless populations such as PWUD (see also Soss and Schram 2007).

Against this backdrop, a rising tide does not lift all boats. People make exceptions for *some* individuals while reinforcing negative social constructions for others (see also Little 1999). In addition, the incentives to dismantle punitive policies are limited because policy makers share the same negative constructions or fear being penalized for providing positive services to this population (Schneider and Ingram 1993; Strach, Pérez-Chiqués, and Zuber 2024).

Our research suggests that dramatic policy change is difficult and may not be long lasting because preexisting ideas, which were never dismantled, reemerge. Omar Wasow (2020), for example, shows a whipsaw in public opinion as concern for civil rights was replaced by concern for social control (law and order) in the 1960s and 1970s. This phenomenon might be explained by the "top of the head" answers that people give on surveys (Zaller 1992). But these results may also be the result of holding frameworks inconsistently and of the entrenchment of specific constructions, as was the case for individuals we interviewed working in the criminal justice system who held selective or ambivalent frameworks, illustrating how new and old ideas can coexist. Schneider and Ingram (1993; Ingram and Schneider 2006) describe this dual perspective as degenerative, because it exacerbates divisions between supposedly equal citizens. It can further erode support for broad-based and lasting change by carving off positive benefits for those people who are most sympathetic and limiting support for more comprehensive policy change (e.g., Bertram 2015; Hacker 2002).

There are limitations to our study that offer opportunities for future research. Notably, our interviews are restricted by who would agree to speak to us. With a sample skewed toward health services personnel, we would expect to see greater emphasis on the medical framework (which we do) and on its consistent application (which we do not). Even those individuals whom we would expect to be likely to embrace the medical framework often did so only incompletely. Future research can probe further beliefs about drug policy, looking at the complex relationship between criminal justice and medical frameworks. It can also examine the role that institutions have in mediating political understanding; how people navigate institutional settings that support specific conceptions of a problem, such as the criminal justice or medical system. It also has the opportunity to examine the connection between race and perceptions. Existing research shows there are differences in beliefs about the most appropriate solutions based on race (e.g., de Benedictis-Kessner and Hankinson 2024). We did not, however, ask our interviewees to identify their race, and only some chose to self-identify during our discussions.

Finally, we employ qualitative methods (interviews, participant observation) in a theory-building exercise.

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We cannot assess how widespread our findings are among the general public. Mixed-methods research (Thorson and Farris 2024) may be able to tease out how widely held the frameworks we have identified in this article are, and it can tell with greater precision how many people with what kinds of characteristics fall into the different issue publics. Beyond the frameworks relevant to drug policy, however, researchers can identify frameworks that undergird issue publics and draw out the implications for policy and policy change in other areas too.

Public perception matters for policy outcomes, both what individuals support and what is politically possible. Although research shows great support for the medical framework during the current opioid epidemic, analyzing in-depth interviews, we find that people often held frameworks compatible with the criminal justice approach or punitive policies more broadly. Our research has implications for drug policy and for research on public perceptions and policy change.

Supplementary material

To view supplementary material for this article, please visit http://doi.org/10.1017/S1537592725104349.

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