Can Documentary Films Move the Levers of Discourse Around a Public Health Issue:

A Systematic Review

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Abstract

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This dissertation explores the potential of documentary films to impact the discourse around a public health issue and in particular the current opioid epidemic. In addition to reviewing the history of drug policy and drug epidemics, this dissertation analyzed an HBO documentary about the opioid epidemic as a means of contextualizing the current crisis and understanding whether documentary can change the narrative around a public health matter. A systematic review of the literature was conducted to evaluate the existing published evaluation studies relating to the potential role of documentary films to influence the levers of discourse related to the opioid epidemic and related substance use and mental health disorders and found the existing research was limited to fifty-four citations.

Documentaries can have a potential impact on public discourse most notably through raising public awareness but the impact is limited as drug use epidemics are complex and multifactorial. Further study is needed to fully understand the role that documentary films can play in shaping public discourse.
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Dedication

This dissertation is dedicated to my unwavering source of support and love, my husband Eric Ruttenberg. Throughout this journey, he has supported and believed in me, even when I no longer believed this dissertation was possible. I am so grateful for his presence. To my three incredible sons, Jacob, Noah and Ethan - they are the brightest lights in my life. Their boundless joy, laughter (with and at me!), and unwavering belief have been the driving force behind this and just about everything I do. I adore and thank them from the bottom of my heart. Lastly, to my beloved mother, Lauren Veronis. From the earliest days my mother instilled in me the belief that anything is possible. I am forever grateful for her presence in my life.
Chapter 1: A Public Health Crisis and the Narratives that Define It

The opioid overdose epidemic is one of the greatest public health challenges in United States history. While approximately 70,000 lives were lost to opioid overdoses in 2020 alone, its devastating impact was overshadowed by the global Covid-19 pandemic but remains an ongoing crisis of epic proportions. Currently, illicit Fentanyl is fueling the epidemic and is primarily responsible for the deaths of more than 100,000 people in 2021. While there have been some encouraging signs that harm reduction and increased access to treatments have helped, specific regions of the country have seen an increase in opioid-related fatalities, most notably because of Fentanyl.

A look back at the numbers is startling. A 2019 study conducted by Mark Olfson, M.D., M.P.H et. al., found that the number of unintentional opioid related deaths rose from 2.2 per 100,000 people in the year 2000 to 13.21 in 2017. Suicide by opioid more than doubled during the same period, from 0.27 to .058 per 100,000.\(^1\) In 2018 alone, 46,802 Americans died as a result of opioid overdoses, a slight decline of approximately two percent from the previous year.\(^2\)

These numbers have had an impact on life expectancy in the United States, which declined again in 2017 after beginning to decrease in 2014.\(^3\) In absolute numbers, the decline is small but it has impacted nearly all racial, ethnic, and gender groups.\(^4\) The last time there was a

\(^1\) Ibid.
drop in life expectancy was in 1915 through 1918 when World War I and a flu pandemic killed 675,000 people in the United States and then again in the 1980’s/90’s as a result of HIV/AIDS.

Nationwide, according to Kiang et al (2019), opioid -related mortality reduced Americans life expectancy by 0.36 years in 2016, a rate that was 14% higher than the life expectancy lost due to firearms, and 18% higher than deaths due to motor vehicle accidents. In two of the most severely impacted states, New Hampshire and West Virginia, more than a year of life expectancy was lost to opioid related mortality.5

The profile of opioid users has significantly evolved since the 1960’s when the majority were young white men living in urban areas, with limited access to education and employment. Their first exposure to opioids was most often heroin. However, that has since changed. A study by Mason et al. that looked at usage between 1999 and 2019 found that close to 80,000 users died by opioid overdose were 55 years of age and older. The gender gap has also narrowed, and the epidemic is no longer limited to young white men; women and men can be found in approximately equal numbers; both women and men are affected in roughly the same numbers. Their first exposure was most likely from a prescription drug and the racial composition of users is more diverse, with both white and nonwhite individuals affected. It’s worth noting that while heroin was the primary opioid of concern in the 1960’s, today, the blame can be attributed to both prescription opioids and Fentanyl.

Unlike the Covid-19 virus, with its quick pharmacological responses, a vaccine and a treatment protocol, the current opioid epidemic started at least in part by the pharmaceutical

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industry. The Centers for Disease Control and Prevention (CDC) identifies prescription opioid use as a precursor to the current opioid epidemic in the United States.\textsuperscript{6}

Initially, the epidemic disproportionately affected white Americans and often started with a prescription written by a well-intentioned physician who believed they were treating pain with a medication that had limited ability to be addictive.\textsuperscript{7} Prior to that, from 1979 through the mid 1990s, opioid substance use disorders principally revolved around heroin and affecting people of all races.\textsuperscript{8}

However, a significant shift occurred in the mid-1990s when a second phase of the crisis had emerged. This time it involved natural and semisynthetic opioids such as codeine, morphine, hydrocodone and oxycodone.

This was a prescription drug crisis and even as the third wave of the opioid crisis emerged after 2010 and spread into traditionally Black neighborhoods, which included heroin and Fentanyl, opioid use disorders among whites remained persistently high. As Monica J. Alexander et al. wrote, "Since 1979, the nature of the opioid epidemic has shifted from heroin to prescription opioids for the white population to increasing heroin/synthetic deaths for both black and white populations."\textsuperscript{9}

This is not the first time that a drug epidemic has been deemed a public health crisis. Opium was used to treat wounded soldiers in the American Revolution and during the Civil War, which resulted in reports of addiction issues. In both of these wars, there were reports of addiction problems. At the turn of the 19th century, opioid addiction was a problem for

\textsuperscript{6} Center for Disease Control and Prevention. \textit{Prescription Opioids: When the Prescription Becomes the Problem}. CDC. \url{https://www.cdc.gov/opioids/basics/prescribed.html}


\textsuperscript{9} Ibid.
approximately one in 200 Americans, the typical addict was described as an upper-class or middle-class white woman.\textsuperscript{10} There are reports that Benjamin Franklin took opium to relieve the pain from bladder stones, and it is reported that Alexander Hamilton was given an opium tincture after his duel with Aaron Burr.

The heroin epidemic of the 1960s and 1970s, began with an estimated 50,000 heroin users in 1960 and an estimated half million users by 1970.\textsuperscript{11} But increasingly in the latter half of the twentieth century, the epidemic was also cast in the public discourse as a moral issue and a criminal one. It was in response to the heroin crisis of the 1970s that President Richard Nixon first initiated the now infamous “War On Drugs” and the movement towards harsher drug policy.

The Nixon administration, while still regarding the heroin epidemic as a public health matter, criminalized the epidemic. The administration emphasized reliance on law enforcement’s involvement with the “War On Drugs,” increasing the size and presence of drug agencies while also signing into law the Controlled Substances Act.\textsuperscript{12}

The Controlled Substances Act of 1970 is notable for its creation of five schedules that restrict drugs based on their accepted medical use and the potential for “abuse and addiction.” It is seen as the basis of modern drug regulation. The act reinforced the authority of the federal government to regulate existing and new substances, consolidating the federal government’s authority to declare through policy and for public consumption which drugs were medically, socially and even politically sanctioned, and which drugs were socially unacceptable. Unintentionally, it also created a legal and public divide, distinguishing between different categories of drug problems: those involving use of prescription of “approved” drugs, and those

\textsuperscript{12} Ibid, p. 250
who suffered from disorders associated with so-called “street drugs” such as heroin, and, later, crack cocaine.

Although there was debate during the passage of the Controlled Substances Act about the definition of drug “abuse” for purposes of scheduling, it is widely acknowledged that the act expanded federal authority over the nation’s drug supply.¹³ The Nixon Administration framed its response to the heroin crisis in terms of law and order, viewing it as a personal failing and a threat to public order. The emphasis was on punishment and deterrence rather than treatment or rehabilitation. This approach resonated with the part of the public described as the predominantly white, largely middle class “Silent Majority” that the Nixon administration sought to mobilize behind that and other policy priorities.

The moralistic attitude towards drug use continued through the 1980s and 1990s, leading to the implementation of stricter drug laws and harsher penalties for drug offenses. The media frequently portrayed drug users and dealers as morally corrupt and potentially dangerous individuals who were a threat to society. While there was acceptance by large portions of the country, the approach was also criticized by some for stigmatizing people who used drugs and failing to address the root causes of drug addiction.

That same moralistic attitude continued during the crack cocaine epidemic, which often portrayed drug use often as a matter of personal choice, rather than as a public health crisis, an epidemic of addiction. In the 1980s, the Reagan administration returned to the militaristic language of “the war on drugs” that started with former President Nixon’s announcement in 1970, but cast it in more personal responsibility terms. First Lady Nancy Reagan started her infamous “Just Say No” media campaign to dissuade drug use amongst children and

adolescents. The “Just Say No” campaign was embraced and amplified by the media and early coverage of the crack epidemic sensationalized the problem. Many believed crack was instantly addictive and therefore much worse than cocaine powder and heroin. It was also blamed for various societal problems, including child abuse and prostitution. The crack epidemic was particularly devastating for women who were at times exchanging crack for sex as a way to obtain more drugs.  

Additionally, there is evidence that the punitive policies of the Nixon and Reagan administrations’ “War on Drugs” targeted poorer, inner-city neighborhoods, unduly burdening racial minorities. For instance, the Anti-Drug Abuse Act of 1986, imposed identical minimum sentences for the possession of five grams of crack cocaine and 500 grams of powder cocaine.

In 1995, the U.S Sentencing Commission recommended eliminating such a blatant disparity, primarily because it disproportionately affected Black individuals who were more often users of crack cocaine. As the Commission wrote in its 2002 report to Congress, nearly 85% of offenders subject to harsher penalties for crack cocaine offenses were Black. This contributed to the widely-held perception that the existing penalty structure for federal cocaine offenses prompted unwarranted racial disparities.

The crack epidemic of the 1980s eventually faded and in the late 1990s gave rise to another drug epidemic, an echo of one all too familiar to the citizens of the United States.
However, this was a different opioid epidemic that continues to grip this country, and this time, it represented a significant break from the drug epidemics of the past in at least two critical ways.

This epidemic did not begin with illicit street drugs as both the heroin epidemic of the Nixon era and the crack epidemic of the Reagan era had. Instead, this epidemic began with legally prescribed opioids, which were considered socially acceptable for the treatment of pain. Furthermore, it primarily impacted a different cohort of the American public. If the earlier drug epidemics had been viewed primarily as anchored to urban, largely poor and predominantly minority communities, this current epidemic was deeply rooted in the very communities that both Nixon and Reagan had viewed as their natural allies in the War Against Drugs, white, poor to middle class, and often rural. The current opioid epidemic turned the now fifty-year-old narrative of the War on Drugs, a narrative reinforced in the media and in the court of public opinion, on its head.

It began in the mid-1990s with a genuine concern that many Americans were needlessly suffering from pain, pain that didn't need to be tolerated and could be easily and safely alleviated. In the early 20th century, following a nationwide morphine epidemic, pain management often took a back seat to other health concerns among medical professionals. Efforts were made during the morphine epidemic to dissuade physicians from prescribing morphine and other narcotics, and by the end of the second decade of the 20th century, that campaign had been effective enough that it had scaled back the epidemic. As Kolodny, et al., wrote in "The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction:" by 1919, overprescribing of narcotics was primarily associated with older, less-competent physicians.”
Meanwhile, the younger practitioners tended to be better-trained, deploying a more “circumspect” and cautious attitude towards the prescription of opioids.\textsuperscript{20} However, in the decades that followed, opioid addiction epidemics resulted from transient increases in the incidence of nonmedical heroin use in urban areas. After World War II, these epidemics disproportionately affected minority populations in inner-city areas, as seen in the notable surge of heroin use and addiction towards the end of the 1960’s. The narrative promulgated by the American Pain Society (APS) coincides with the time that Purdue was marketing OxyContin, and the advocacy of this seemingly unbiased pain organization is believed to have contributed to the ongoing epidemic. In mid-2019, the society closed amidst allegations that it had colluded with pharmaceutical companies like Purdue. Indeed, Purdue was making “contributions” to the nonprofit, and according to an internal memo, was distributing APS guidelines to its sales force.\textsuperscript{21}

Between 1996, the year that APS declared pain to be the “Fifth Vital Sign” and 2002, Purdue Pharma conducted a multifaceted campaign to encourage long-term use of opioid pain relievers (OPRs) for chronic non-cancer pain. During this time, it funded more than 20,000 pain-related educational programs through direct sponsorship or financial grants, according to research conducted in 2003 by the US General Accounting Office.\textsuperscript{22}

As part of that campaign, Purdue Pharma supported the American Pain Society, the American Academy of Pain Medicine, the Federation of State Medical Boards, the Joint

Commission, as well as pain patient groups, and other organizations. As Dr. Andrew Kolodny, co-director of the Opioid Policy Research Collaborative at Brandeis University, and his colleagues declared in a 2015 paper published in the *Annual Review of Public Health*, these organizations then, “advocated for more aggressive identification and treatment of pain, especially use of OPRs.”

Purdue Pharma aggressively promoted its message by directly targeting doctors in an aggressive marketing campaign designed for its new drug, OxyContin. While drug campaigns like this are more accepted in 2023, this degree of aggressiveness was uncommon in 1996. In the first six years on the market, Purdue Pharma spent six to twelve times more on promoting OxyContin than its competitor, Janssen Pharmaceutical Products LP, spent on its brand of opioid. However, there is no scientific data to support the company’s claim that OxyContin was both “safe and effective.”

In 2001 alone, Purdue spent $200 million marketing OxyContin. While the Purdue marketing campaign has been the subject of much controversy, it was not the first time in US history that drugs were aggressively marketed to physicians. The latter half of the twentieth century and the post World War II increase in pharmaceuticals saw a surge in pharmaceutical drugs ultimately leading to competition between companies. More and more pharmaceutical

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companies looked beyond institutional advertising to communicate directly with “physicians and the general public.”

In the 1950’s, Pfizer hired a public relations firm, the William DouglasMcAdams company, led by the psychiatrist Arthur Sackler, to promote its antibiotic, Terramycin. Sackler successfully grew Pfizer, and under his guidance, many of the marketing strategies that later played out at Purdue Pharma were created. Purdue Pharma took marketing to a new level by becoming the first pharmaceutical company to directly promote high dosage opioids to physicians for the treatment of chronic pain. Previously, opioids were prescribed for post surgical care, extreme acute pain, cancer care and end of life pain. Now, opioids are being marketed for chronic moderate pain.

Purdue Pharma presented its argument, stating that the American medical system was failing its patients by undertreating pain, delivering this message directly to the doctors who were on the front lines. The Purdue campaign was not limited to physicians in the business of pain management, this time all doctors and dentists were the target.

The marketing campaign conducted by Purdue Pharma was considered extravagant according to the standards of the time. In 1996, when OxyContin was introduced to the market, there were no industry standards determining how far a pharmaceutical company could go to bring its drugs to market. It was not until 2003 that the Pharmaceutical Research and Manufacturers Association issued voluntary guidelines that encouraged drug manufacturers to refrain from distributing branded items like golf balls and tote bags to prospective prescribers. However, they did allow “speaker training” events at upscale golf courses and country clubs.

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29 Ibid.
Purdue enthusiastically embraced this option. Between 1996 and 2001, the company conducted approximately 40 speaker training events at resorts in Arizona, California, and Florida. Purdue established “speaker bureaus” where “more than 5,000 physicians, pharmacists, and nurses attended these all-expenses-paid symposia, during which they were recruited and trained.”

Having spent $200 million in the marketing of OxyContin, Purdue experienced a remarkable increase in its earnings. The drug, which had generated $48 million dollars in revenue in 1996, skyrocketed to $1 billion by 2000. Fast forward to 2017, shortly before declaring bankruptcy, it was estimated that OxyCont in had generated around $35 billion in revenue for Purdue.33

Purdue was not the sole pharmaceutical company to benefit from the changing of the narrative regarding OPRs after 1996. Moreover, pharmaceutical manufacturers were not the only beneficiaries of this new narrative. Insurers also saw cost savings since prescription medications, in the form of pills, were often less expensive than more time consuming therapies. Healthcare professionals were not the only ones to be targeted by the pharmaceutical messaging around OPRs. Opioid advertising and messaging were also increasingly targeting consumers. Direct-to-consumer marketing of prescription drugs greatly increased after 1997, when the U.S. Food and Drug Administration (FDA) loosened its interpretation of advertising regulations allowing manufacturers to legally broadcast prescription drug advertisements.34 By 2010, drug manufacturers were spending $3.3 billion each year directly targeting consumers,

32 Ibid.
though that level of spending has since tapered off. Critics have argued that consumers rarely have the kind of medical expertise required to critically evaluate the claims made in these advertisements, and further warn that “commercially-motivated messages lead to inappropriate prescribing by physicians, who face increasingly strong patient demands for medicines.” These direct-to-consumer commercial appeals, often presented with comforting images and reassuring language despite required disclaimers, have helped spread a relatively recent narrative. Consequently, the use of prescription drugs, including opioids for pain relief, has increased. By 2015, U.S. sales had reached $425 billion, resulting in a significant change in the way physicians managed and treated pain.

Between 1999 and 2009, Purdue Pharma experienced a fourfold increase in opioid sales, an indication that its campaigns were working. The company’s push and financial investment to promote a message that opioids should be used for conditions beyond cancer care, post-surgical pain, and end of life pain was paying off. However, this new narrative of success was hiding a far more alarming statistic. As opioid sales increased so too did overdose deaths. From 1999 to 2014, opioid sales continued to steadily rise, paralleled by a corresponding increase in opioid related overdose deaths. For instance, the opioid overdose death rate in 2008 was nearly four times the rate in 1999, while sales of opioids in 2010 were four times those in 1999.

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Figure 1:

The pharmaceutical industry, supported by the American Pain Society and other organizations, maintained that prescription opioid pain relievers were “safe and effective” and had a low risk of addiction, portraying them as “good” medications. As a result, it stood to reason that the problem was not with the drugs themselves but rather with the people who became addicted to them, the people who were labeled as “abusers”.

That was the message that the pharmaceutical industry emphasized and promoted, and it found willing amplifiers among much of the mainstream media. Although there were news outlets that periodically pointed a finger of blame at the industry for its role in the unfolding opioid crisis as early as 2002, by and large, studies have shown that most news stories on the
crisis adhered to the familiar narrative, attributing the problem in some way to “bad kids abusing good drugs.”

At the time, there was limited awareness beyond academic, medical, and treatment communities about the pivotal role prescription opioids were playing in the overdose epidemic that was sweeping through the United States. Consistent with the prevailing narrative of abuse, a study analyzing news media reports on the opioid epidemic published between 1998 and 2012 found that prescription opioid addiction was more often framed as a criminal justice issue rather than a public health matter.

A separate analysis of 6,399 news stories, conducted by the several of the same authors and published in the July 2019 issue of Preventive Medicine, found that not only did nearly half (49%) of the news stories and broadcasts analyzed over a ten-year period use "terms shown to be stigmatizing," but the use of such terms actually increased as the opioid epidemic mushroomed. "The proportion of news stories mentioning stigmatizing terms over the 10-year study period increased from 37% in July 2008–June 2009 to 45% in July 2017–June 2018," the authors found.

Further complicating matters, the current opioid epidemic initially began predominantly with prescription opioids like OxyContin. However, it quickly evolved into a more multifaceted crisis involving various opioids and illicit drugs, each carrying its own narratives within American culture. Heroin, in particular, played a significant role in the expanded scope of the crisis.

39 Kolodny, A. Personal communication.
Due to the escalating costs of prescription opioids, and the introduction of obstacles such as restricted access to prescriptions, many individuals who were already addicted sought an alternative and found it in a cheaper and more readily accessible opioid. Namely, they found it in prescription opioid’s chemical cousin, heroin. The shift in drug choice occurred as a result of the changing landscape and challenges with obtaining prescription opioids.

Heroin, an opiate, produces comparable feelings of euphoria as prescription opioids.\textsuperscript{42} Prescription opioid use, as well as non-medical use (using prescription opioids that were not prescribed or for recreational purposes), pose a risk factor for transitioning to heroin use, according to the National Institute on Drug Abuse. In fact, a 2012 study of injection opioid users found that 86% had used OPRs non-medically before turning to heroin.\textsuperscript{43}

According to a National Survey on Drug Use and Health conducted in 2013, 4 out of 5 current heroin users reported that their opioid use began with OPRs.\textsuperscript{44} The data strongly suggests that the increase in use of OPRs and the widespread availability of OPR prescriptions have led to a significant increase in heroin use and the subsequent rise in heroin-related deaths.\textsuperscript{45}

The convergence of the new narrative promoting opioids as safe and effective, combined with the narrative that individuals who use them are “bad people abusing good drugs,” created a perfect storm that led to the stigmatization of people with substance use disorders, particularly those struggling with opioid addiction..

\textsuperscript{45} Ibid, pp. 560-561
Stigma is dangerous for many reasons, but when it comes to addiction, stigma can limit political and social support for public health initiatives designed to address the opioid epidemic. It can also reinforce barriers to treatment allowing addictions to become further entrenched and increased difficulty in providing effective care. Stigma can cause a person to feel shame, creating an environment that makes it less likely for someone to seek treatment. It can limit the options for those who seek treatment by undermining the political will to address the opioid crisis as a public health issue worthy of a comprehensive and robust public response. Even the language, choice of words, “abuse” and “abuser” can perpetuate stigma and contribute to negative perceptions surrounding addiction.46

A study conducted in 2009 revealed that even highly trained mental health professionals and the general public exhibited different judgments when exposed to loaded words like “abuse” and “abuser”. The study concludes that the commonly used term “substance abuser” may perpetuate stigmatizing attitudes.47 Stigma plays a significant role in discouraging healthcare providers from prescribing office-based medication assisted treatment (MAT) to people with opioid use disorders, despite evidence showing that MAT can help a person recover from addiction.

That stigmatization, previously used in an unsuccessful attempt to stem previous drug epidemics, now is an obstacle to effectively treating individuals affected by the current opioid epidemic. Multiple studies have shown that physicians throughout the United States have been reluctant to prescribe office-based MAT to people with opioid use disorders.48 Consequently,

stigma can be attributed to an increased number of deaths in this country, and the prevailing narrative may further contribute to this problem.

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Against this backdrop, in 2016, I was commissioned by HBO to produce and direct a documentary about the opioid epidemic. Our assignment was to tell a compelling and engaging story while delving into the alarming rise of overdoses. Initially, there was no specific public health directive, but it soon became evident that the story needed to help shift the narrative around the epidemic from one of “abuse” to one of “addiction.” By using the term “addiction,” we aimed to convey that those affected by this epidemic are suffering from a disease not a desire to get high.

To gain a deeper understanding of the complex issues, we sought the expertise of Dr. Andrew Kolodny, MD to help us understand the intricacies of the problem. It was his suggestion to feature people whose addiction originated from prescription opioids. Our intention was to inform viewers that the opioid pills prescribed by their doctors were highly addictive, and despite patients’ best intentions and compliance, the use of prescription opioids could lead to addiction and overdose. This was not solely a story about drug seeking behavior, but rather a narrative about the pervasive and stubborn nature of addiction.

This issue served as the inspiration for this dissertation: the current opioid epidemic, its devastating effects on our nation, and the prevailing narrative surrounding it. The dissertation aims to shed light on the need for narrative transformation that accurately reflects the nature of the epidemic.

We believed then, and posit here, that documentary filmmaking holds a unique position in shaping and influencing public narratives, for better or worse. Can documentary films have a potential impact on the discourse around drug epidemics, specifically the current opioid addiction epidemic? If so, how do documentary films influence the levers of discourse concerning the epidemic? Lastly, is it possible to modify the narrative surrounding a critical public health issue such as the opioid epidemic?

These questions will be explored in the next chapter.
Chapter 2: The History of Drug Policy and Drug Epidemics

The history of drug policy and drug epidemics in the United States can be viewed through two distinct lenses. First, as an absolute, – a public health crisis and the impact the epidemic has had on the lives of drug users, their families and society at large. Second, as competing narratives that ultimately each framed the opioid public health crisis through a particular, and frequently inaccurate, counterproductive, popular-cultural lens. These two perspectives have often impeded both a full and complete assessment of the adverse individual and societal effects of each of these discrete epidemics while also limiting and hindering an adequate public response. These competing and often contradictory imperatives have, over time, had controversial and disturbing consequences, particularly when those narratives reflected prevailing racial views and prejudices.49

At the end of the 19th century and into the early 20th century, the use of opium was seen as both a crisis of addiction and a significant social problem that required an official response. Much of the initial reaction echoed the prevailing narrative of the time, a narrative reinforced in the pages of America’s newspapers, that opium addiction was primarily a problem associated with Chinese immigrant laborers who, in the wake of a devastating economic downturn, were already being vilified in the press and by politicians as an imported threat to American workers.50

During the same period, from 1900 to 1915, America was facing another emerging drug epidemic, specifically involving cocaine. David Musto points out that the crisis was predominantly viewed through a racial filter. Powdered cocaine use, which would later become associated with affluent white Americans in the 1960’s, 1970s and early 1980’s, was originally

depicted as primarily associated with impoverished Black Americans at the turn of the last century.\(^{51}\)

Drawing upon the crude racial stereotypes that permeated the media and public entertainment in the early days of Jim Crow, a narrative emerged that depicted African Americans in general, and Black men specifically, as savage, bestial and highly dangerous. Newspapers throughout the country ran alarming accounts of cocaine-crazed Black men wreaking havoc. Perhaps the most glaring example was in an article published on February 8, 1914, in the pages of The New York Times, written by a white physician named Edward Huntington Williams, and published with the headline “Negro Cocaine ‘Fiends’ Are a New Southern Menace.” Dr. Williams made unfounded claims, without any evidence, suggesting African Americans who used cocaine became better marksmen and had “temporary immunity to shock,” making them impervious to police bullets. His racially charged language insinuated that police officers in some parts of the American South lived in fear of “the increased vitality of cocaine-crazed negroes (cq)” and that in response, southern police chiefs had equipped their men with more powerful firearms for “the express purpose of combating the fiend when he runs amok.”\(^{52}\)

Despite the lack of evidence, similar claims were made in the press throughout the United States, both in the north and in the south, and they resonated among a population that had then only recently turned D.W. Griffiths’s unashamedly racist Birth of a Nation – originally released under the title The Klansman – into a blockbuster. The media had cast the drug crisis firmly within the context of the nation’s dominant racial narrative. As Musto noted with regard to the

cocaine epidemic, that narrative became an article of faith, and that article of faith was that cocaine needed to be stamped out, principally because it was feared that cocaine would turn Black men violent against whites and threaten white society.53

Even the more progressive voices of that time succumbed to the racially charged prevailing narrative of the era. These reformers approached the issue of addiction with two distinct perspectives based on race.54 Whites, referred to as “Anglo Saxons,” in Hertzberg’s original sources, were deemed morally superior, and their struggles with substance abuse, primarily related to over-the-counter medications and tonics, were considered accidental or the result of drug makers and marketers. The response was to regulate those industries, leading to the culmination of the Food and Drug Act of 1906, which required truthful labeling of medications and imposed penalties on drug manufacturers who violated the law.

In contrast, urban drug users, predominantly Black, were seen through a different lens. As David Hertzberg described, “Progressive reformers already thought little of their innate intellectual and moral capacities, and their purchase of drugs in the seamy and racially mixed worlds of urban vice rather than through the medical system only reaffirmed this prejudice.” He concludes that these Progressive reformers believed that those struggling with addiction were “pleasure seekers with undeveloped moral compasses” and that their dependency “could be controlled only through prohibition and strict and punitive policing of the criminals who contravened it.”55

The social stigma fueled anti-drug sentiment, coupled with regulatory requirements stemming from the Hague Convention of 1912, culminated in the Harrison Narcotic Act of 1914.

55 Ibid.
The Act was the first major national attempt to control drug use and addiction, by regulating and taxing the production, importation, and distribution of coca and opiate products. Although not as punitive as anti-drug laws adopted in the coming decades, there is little doubt that the Harrison Narcotics Act set the tone for the laws to come. However, it was racism that drove acceptance of tighter drug regulations and softened public attitudes toward drug restriction and regulation. Case in point is that cocaine was removed from Coca-Cola 13 years before the enactment of the Harrison Narcotics Act due to that “negro cocaine fiends” were raping white women.56

The United States’ approach became increasingly punitive and severe from the 1930s and into the 1950s, when the country began imposing its most serious penalties for drug possession and distribution. The Boggs Act became the first legislation to establish minimum sentences for drug convictions. The act included the possibility of the death penalty for selling heroin to minors, and was later followed by the Narcotics Control Act of 1956, which increased minimum sentences. The zeal to pass legislation was fueled by increases in drug arrests post World War II. However, it is important to note that public sentiment was softened in part by a racialized public narrative. This narrative propagated the ideathat “white” children in America’s emerging suburbs were being targeted by “Mexican” pushers peddling “Chinese” heroin.57

As those suburban children, the Baby Boomers, whose safety had inspired the U.S. Congress in 1956 to levy the death penalty against certain heroin dealers, came of age, however, a new narrative began to take hold. This narrative downplayed, in many cases, the risks of addiction and, to a great degree, viewed the recreational use of many categories of drugs,

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regulated and illicit, not through a racial lens but by age, pitting the more conservative, older
generation against a rebellious, younger one.

Despite the draconian laws and anti-drug sentiment portrayed in traditional media, drug
tolerance and use increased in the 1960s. Young people, growing up in an affluent society, had
the financial means just as they were reaching the age range, between 15 to 25, when experimentation with drugs usually begins.58 This cohort had its own media and cultural
mechanisms to promote the more permissive attitude toward drugs. For example, alternative
newspapers, claiming the title “underground,” as well as popular music and films celebrated the
nascent “drug culture” of the 1960s and 1970s. Marijuana and other drugs were used at celebrations of youth culture like Woodstock in 1969. Musto suggests that the stress of drafts for the Vietnam war may also have also contributed to the increased drug use.59 This new wave of
drug tolerance marked the beginning of the second era in the history of drugs and pharmaceuticals in the United States, which historian David Herzberg has called the Civil Rights/Reform Era.

The emerging drug culture had a darker side. In the early 1970’s, heroin use in the United States soared in spite of the fact that it was not as openly embraced by the youth culture as marijuana and hallucinogens. In April 1971, Congressman Robert Steele (R-CT) investigated reports of rampant heroin abuse among U.S. servicemen in Vietnam. He found an estimated addiction rate of 10% to 15%. The United States began a tumultuous period with an estimated 50,000 users in 1960 and an estimated half million by 1970.60 It was this spiraling problem and its link to crime that made heroin use a priority for the Nixon administration and its drug policy

59 Ibid.
agenda. Seeing a potentially lucrative market in the nation’s depressed urban centers, organized crime began to aggressively push heroin, primarily targeting minority communities. The domestic fascination with heroin was reflected in popular culture with films like *The Man With the Golden Arm* (1955) and in plays like Jack Gelber’s 1959 play *The Connection*, which both vilified and romanticized heroin use. Nothing highlights the complexity of the era more than the United States’ embrace of a form of narcotic maintenance, methadone, for tens of thousands heroin addicts. At the same time, the relatively liberal state of New York passed the most stringent criminal statute, the Rockefeller Drug Laws, which imposed mandatory life sentences for those found guilty of selling or trading even small quantities of drugs.

No matter the cause, the increase in drug use and the epidemic surprised government officials. They had believed that the punitive mandatory sentences and the negative drug imagery in some quarters of the press would effectively curb the spread of illicit drug use.

However, penalties failed to curb the advance of heroin use and dependency and they did not, initially, effectively combat the emerging counter-cultural narrative. Instead, a cultural divide began to widen between two discrete groups of American people, broadly defined as older, largely white conservatives, and a more diverse assortment of Americans who saw themselves as less conservative and more receptive to recreational drug use.

In 1970, seeking to rally his conservative base and tackle the growing heroin problem, President Nixon reaffirmed the punitive narrative that had shaped official drug policy in the United States since the early 1900s. This marked the beginning of his infamous War on Drugs.

In keeping with the paradigm established in 1914 to 1956, the Nixon administration prioritized law enforcement’s role in the War on Drugs and expanded the size and presence of

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drug agencies. The enactment of the Controlled Substances Act was one way to ensure that it happened.\textsuperscript{62} However, this new law embraced an emerging narrative that went beyond the traditional vilification of immigrants and minorities, and included a new dangerous subgroup, the long-haired hippy freak sons and daughters of the “Greatest Generation,” and it targeted marijuana, that generation’s generally accepted drug of choice, with the same harsh designation as heroin.

As discussed in Chapter 1, the Controlled Substances Act of 1970 categorized federally regulated substances into one of five schedules based on the substance’s medical use, potential for abuse, and addiction level.\textsuperscript{63} Marijuana and heroin were both classified as Schedule I drugs, which meant they were considered the most dangerous, with the greatest potential for abuse and no accepted medical purpose. President Nixon's ardent push to ban marijuana laid bare his political machinations as he knew this Schedule I classification would be a blow to his adversaries, the anti-war left. This dynamic illustrates how marijuana did not solely become a Schedule I drug because of its psychoactive potential; its categorization was a political means to an end used by the Nixon administration once again fueled by racism.\textsuperscript{64} For the next several years, the two competing narratives remained in contention, and there is little evidence that the rhetoric of the War on Drugs was winning the argument on the streets, urban or otherwise.

In 1978, almost a decade after the adoption of the CSA, marijuana acceptance and use had become widespread among a broad swath of American teens, with only 35% of high school seniors believing at the time that marijuana was harmful and 37% admitted using it in the prior


\textsuperscript{63} United States Drug Enforcement Administration. \textit{The Controlled Substances Act}. DEA. \url{https://www.dea.gov/drug-information/csa}

month. The emerging and more tolerant counter-narrative about drugs was no longer contained only within the cohort of “rebellious” adolescents and young adults. As early as the 1950s and gaining traction in the 1960s, a rising number of physicians, lawyers, and others joined sociologist Alfred R. Lindesmith who advocated treating people addicted to drugs as patients with a medical problem and not as criminals. In the early 1970s, because so many returning Vietnam veterans were returning home addicted to drugs, the Nixon White House formed the Special Action Office of Drug Abuse Prevention (SAODAP) in 1972, followed by the National Institute of Drug Abuse (NIDA) and the National Institute of Alcoholism and Alcohol Abuse (NIAAA). These agencies made millions of dollars available for drug treatment.

At least partially as a reaction to the growing acceptance of drug use, particularly marijuana, and to the more tolerant attitude in some academic circles, a counter movement began to form, echoing the hard-line and punitive approach taken by the Nixon administration. This counter movement reflected many of the same abstinence-only themes of earlier anti-drug movements. Beginning with parent activists who were alarmed about the personal and societal effects of drugs on their families, the Parents’ Movement echoed the narrative of older movements that had proclaimed all drug use, including alcohol consumption, was dangerous to children and families. In the politically polarized and heated environment of the 1970s, these parents’ organizations soon became a political force to be reckoned with. They formed prominent and influential organizations like the National Federation of Parents for Drug Free Youth, a group that was successful in provoking NIDA (National Institute on Drug Abuse) to amend and, if necessary, retract official publications that were not viewed as sufficiently

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anti-drug. Their dire warnings of a nation under threat from the drug scourge, enabled at least in part in their view by a liberal society that had become too tolerant, dovetailed with the broader narrative of groups like the Rev. Jerry Falwell’s Moral Majority, which argued that the nation was in a moral downward spiral that could only be reversed by a revival of traditional values.

The evolving narrative became a centerpiece of Ronald Reagan’s 1980 campaign. While it was not the sole factor influencing the election outcome, as other factors like the Middle East oil crisis, the Iranian hostage situation, and the domestic impacts of “stagflation” on Americans at home all played a role, there is little doubt that the Parents’ Movement in particular, aligned with the Moral Majority, helped to elect President Reagan. Even before he became president and during his tenure as the governor of California, Reagan approached the drug epidemic from the perspective of a “social war.” He perceived it as part of an existential struggle, between an upright but yet vulnerable “us” and somewhat less traditionally American: “them.”

As president, Regan remained firmly committed to that narrative, taking a hard line against drugs and expanding the War on Drugs approach. In practice, the Reagan Administration “emphasized enforcement [and] the reduction of availability, rather than treatment and education about the danger of drugs.” To that end, the Reagan Administration reduced federal funding for drug treatment and limited the federal government’s influence over how treatment dollars were spent by creating a block grant system that gave programmatic responsibility to states.

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68 Ibid.
69 Ibid, 267.
2.1 The Crack Epidemic and Punitive Policy

The Parents’ Movement, also known as the “Just Say No” campaign, was likely based on genuine concerns and fears about the impact of drug use in some parts of the country. However, as well-intentioned as these initiatives might have been, the narrative promoted by these initiatives and the policies inspired by that narrative, particularly punitive criminal sanctions, helped support an even older narrative, the “us against them” theme that has influenced drug policy in the United States for more than 100 years. Historically, the “them” in this case, disproportionately referred to minorities. The punitive drug policies inspired by these movements unjustly burdened minority groups in society. The stark disparity caused by these policies would become evident during the height of the crack epidemic.

By the mid-1970s, cocaine had gained popularity among wealthy and famous, primarily white users. By 1977, that view had become deeply ingrained in the dominant cultural drug narrative. Filmmaker Woody Allen even parodied its recreational use without explanation of the drug in his film Annie Hall. However, the 1980s brought a technological advancement that made cocaine more accessible to a wider population. The powder form was transformed into a cheap, smokable crystal known as crack. Smoking crack allowed for a stronger, more intense “high.”

Some habitual and casual users of intravenous drugs, predominantly portrayed in the public narrative as mostly minorities and the poor, switched to crack as a means to avoid diseases like hepatitis and the then-new and fatal HIV virus during the expansion of the epidemic. However, crack is an extremely addictive drug, even deadlier than cocaine. Its absorption through the lungs as opposed to the linings of the nasal passageways created a rapid and powerful high that

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72 Ibid, 267.
could bring on full-blown addiction within as little as two to three weeks. In some cases, even first time users could become instantly addicted.73

In its earliest stages, the crack epidemic was primarily seen as an urban and minority problem. Similar to the narrative surrounding the cocaine epidemic in the early 20th century, the media often portrayed the problem with images and stories of crack-addicted minorities, street crime and irrational violence. Smoking crack was conflated with violence and crime, including murder.74 While perhaps less explicit than Dr. Williams’ portrayal of cocaine-using Black men in the *The New York Times* in 1914, the prevailing narrative touched many of the same themes. Phrases like “crack whore,” “crackhead,” and the use of the phrase “on crack” to describe something out of control, quickly became part of American vernacular.

As the early adopters had begun using the new crystallized and smokable form of cocaine, others, including many middle-class and white individuals, soon followed suit. The crack epidemic began with existing cocaine users who switched to crack. As other drug users made the change, the epidemic expanded to include new users, typically around the age of 18. This aspect of the epidemic aligned with the prevailing narrative of the time, which suggested that an epidemic originating in a poor, predominantly minority community was now posing a threat to middle-class, presumably white, Americans. The crack epidemic continued to spread until 1989 when it began to decline. However, before the decline began, a harsh drug policy was implemented, which would significantly impact the lives of millions of people for years to come.75

The Anti-Drug Abuse Act of 1986, enacted during President Reagan’s second term, became the dominant narrative in the administration’s approach to the War on Drugs. It aligned with another narrative that gained traction during the Reagan years and its aftermath, suggesting that America had become soft on crime. The proposed solution according to this narrative was a return to harsh criminal penalties, including the death penalty, which had been overturned by the Supreme Court a decade earlier but was restored in several states. The primary objective of the 1986 Anti-Drug Abuse Act was not to address the issues surrounding addiction, but rather to establish mandatory minimum sentences for charges related to controlled substances, specifically cocaine products.

Crack, which had by then become its own chapter in the evolving anti-drug narrative by that time, was demonized in congressional hearings and portrayed as more dangerous and harmful to society than powder cocaine. For example, the penalty for possession of five grams of crack was equivalent to the sentence for possession of 500 grams of powder cocaine. This sentence was according to Musto, “five to forty years for an uncomplicated violation; the sentence cannot be suspended, nor can the convict be paroled on probation,”. This meant the ratio of sentencing for crack possession to cocaine possession was 1 to 100.

Two years later, in an election year, George H.W. Bush, who has served as Reagan’s vice president, launched a controversial and racially charged campaign ad known as the “Willie Horton Ad,” it was in this context that the Anti-Drug Abuse Act of 1988 was enacted. This legislation included the Kingpin Law, which reinstated the death penalty, first applied to drug offenses in 1956, for major traffickers engaged in a “continuing criminal enterprise.” Additionally, the law imposed the death penalty on individuals convicted of a drug felony if their crime resulted in the intentional death of another person.76

76 Ibid, 275.
One consequence of these laws was a dramatic rise in the incarceration rate in the United States. The number of incarcerated people in the United States rose nearly 100% per 100,000 residents from 1990 to 1995. Furthermore, there was a staggering 500% increase in incarcerated drug offenders between 1983 and 1993. Congress abolished parole in the federal prison system, resulting in a decline in the number of parolees contributing to overcrowding in the prison system.

As the War on Drugs progressed, its focus shifted its focus to the possession and sale of crack cocaine particularly by Black people. In 1995, in its report, “Cocaine and Federal Sentencing Policy,” the US Sentencing Commission, recommended eliminating such a blatant disparity between crack and cocaine sentencing, because of the unfair burdens it placed on minorities. By this time, the crack epidemic had mostly subsided, but the long lasting impact of these policies would continue to be felt well into the 21st century.

2.2 The New Epidemic and New Hope?

The anti-drug narrative and the tough stance on those who were affected by the epidemic persisted throughout George H. W. Bush’s one-term presidency and continued into the administration of centrist Democrat Bill Clinton. Many of the same themes of the prevailing narrative continued to dominate as exemplified by the enactment of the Violent Crime and Law Enforcement Act of 1994.

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77 Ibid, 90.
Enforcement Act of 1994 commonly known as the 1994 Crime Bill. While the crime bill had a complex legacy, it ultimately was seen as “a major driver of mass incarceration.”

However, despite the decades-long hardline and punitive approach that defined federal drug policy, it had to prevent the emergence of the next drug epidemic. The next chapter in America’s drug history did not come from the streets but instead from American industry. This epidemic was not America’s new epidemic, the opioid epidemic was not urban minorities, this time the epidemic impacted white Americans, young and old, rural and small town areas. That twist in the narrative caught the various regulatory powers off guard.

As discussed in Chapter 1, the ongoing epidemic began shortly before the turn of the century with the introduction of Purdue Pharma’s allegedly “safe and non-addictive” prescription painkiller, OxyContin. Approved in 1995 and heavily marketed, Oxycontin became a significant impact on prescription drugs, much as crack cocaine had been in the 1980s. Prior to OxyContin’s entry into the market, Purdue Pharma was not a strong competitor compared to other drug companies such as MSD, Eli Lilly, and Parke-Davis, which had been developing numerous new drugs for more than three decades. However, this changed when the company bought MS Contin from a British company.

Unfortunately for Purdue, the patent for MS Contin was set to expire by the late 1980s, prompting the company to begin working to seek an alternative that would allow them to extend the patent. Through their experiments, they developed the drug OxyContin by combining their patented time-release Contin covering with oxycodone.

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83 Ibid.
Although Purdue Pharma had never conducted any clinical trials to support its claim, the company argued that OxyContin differed from other opioid pain relievers due to its patented time-release mechanism called Contin. Purdue argued that this feature would reduce the drug’s potential for addiction compared with other painkillers.\(^8^4\) Despite the lack of clinical evidence supporting the non-addictive claim, the FDA approved the drug without requiring these studies. The reasons for the approval are myriad, but notably, there was an inherently cozy relationship between the American Medical Association (AMA), the pharmaceutical industry, and Purdue (it is worth noting that after overseeing the approval of the drug, FDA examiner Dr. Curtis Wright left the agency for a job at Purdue Pharma).\(^8^5\)

The Sackler brothers, in particular, took advantage of this cozy relationship through an unprecedented multimillion dollar advertising and marketing campaign. The AMA knew that opioids were highly addictive and until the mid 1990s, it was the official position of the AMA. However, the narrative began to shift as the industry reshaped a century-old narrative that had emerged in the course of the opioid epidemic in the first quarter of the 20\(^{th}\) century, a narrative that discouraged doctors from prescribing opioid painkillers.

Purdue Pharma initiated an aggressive, widespread, multifaceted, multi-million dollar campaign to promote long-term use of OxyContin and other opioid pain relievers (OPRs) for chronic non-cancer pain.\(^8^6\) According to Dr. Andrew Kolodny et. al., “as part of the campaign, Purdue provided financial support to the American Pain Society, the American Academy of Pain Medicine, the Federation of State Medical Boards, the Joint Commission, and pain patient groups.”\(^8^7\) Then, these groups advocated for more aggressive identification and treatment of pain,

\(^{8^4}\) Ibid.
\(^{8^5}\) Ibid, 126.
\(^{8^7}\) Ibid.
including encouraging physicians to prescribe OPRs, Kolodny wrote. In addition, he wrote, the campaign minimized the risks of OPRs by using physician-spokespeople. Casting aside decades of precedent, the Purdue-backed physician-spokespersons published papers and gave lectures that claimed the medical community was confusing addiction with “physical dependence” which they said was different.  

88 They claimed addiction was rare and “clinically unimportant,” citing studies with deep methodological flaws, overlooking studies that contradicted their position.  

89 At the same time, and again without clinical trials to document the claim that OPRs were safer or more effective than other more traditional pain management regimens, the campaign and its spokesmen extolled the benefits of long-term OPR use.

One measure of the effectiveness of that narrative-changing campaign is the fact that consumption of oxycodone (the main ingredient in OxyContin and other brands like it) increased by nearly 500% from 1999 to 2011.  

90 However, the increase had profound and far-reaching implications.

As opioid sales escalated, so did opioid-related overdoses, opioid-related overdose deaths, and opioid addiction treatment admissions. The CDC reported that from 1999 to 2020, more than 263,000 people died in the United States from overdoses involving prescription opioids. In 21 years, from 1999 to 2020, overdose deaths involving prescription opioids increased by five times. Furthermore, in 2020, 74.8% of all overdose deaths involved opioids.  

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88 Ibid.
89 Ibid.
90 Ibid.
The annual number of overdose deaths involving both prescription and illicit opioids has nearly quadrupled since 2000, and this trend parallels marked growth in the quantity of opioid pain relievers being prescribed. Eventually, Purdue Pharma pleaded guilty in federal court to criminal charges for deceiving regulators, doctors and patients about the drug’s risk of addiction and its potential for abuse. As part of the settlement, they agreed to pay $600 million in fines, the largest amount ever paid by a drug company. However, the fine had little impact, and the messaging persisted, leading to continued growth in prescribing practices.

Additionally, the opioid manufacturers, through the nonprofit pain organizations they created, disseminated messages that predominantly framed overdose deaths as primarily the result of “bad kids abusing good drugs,” relying heavily on the word “abuse” while disregarding the current scientific understanding of the brain chemistry involved in addiction. To date, media reports often wrongly use the word “abuse,” a pejorative term that contributes to the stigma

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associated with opioid addiction. Heroin use has increased as patients who had become addicted to OPRs were no longer able to access the pills. These patients turned to the illegal opioid, heroin, to quiet the extreme and painful withdrawal symptoms that come with addiction. Researchers argue that the increase in prescription opioid use has driven the rise in heroin use because of the similar chemical composition between the OPRS and heroin. For example, in a study of individuals with opioid use disorder who had switched to heroin, 94% reported transitioning from prescription opioids to heroin because prescription opioids were more expensive and harder to obtain.93

The rising cost of prescription opioids and the implementation of more conservative prescribing practices that restrict access have driven many individuals who initially developed their addiction through prescription pills to heroin. This shift in drug usage patterns has contributed to a significant increase in heroin use and heroin related fatalities, along with an increase in associated diseases like HIV and Heroin related many individuals who began their addictions with prescription opioids have resorted to using heroin. This shift in drug use patterns has contributed to a rise in heroin use and heroin-related deaths, and as a result, an increase in associated diseases like HIV and hepatitis, primarily as a result of intravenous drug use.94 In the United States, 8% of all new HIV infections in 2010 occurred among people who inject drugs. 22% of adults and adolescents living with HIV infection in the United States were also intravenous drug users, and 16% of persons with acute HBV infection.95

94 Ibid.
According to the Federal Substance Abuse and Mental Health Services Administration National Survey on Drug Use and Health conducted in 2013, four out of five current heroin users reported that their opioid use began with OPRs. In light of those trends, there was mounting anxiety in multiple sectors about the risks associated with the comparative availability of prescription OPRs. Additionally, a new narrative, countering the claims made by Purdue and its agents, has taken root and begun to influence public policy-making.

Just six years after the OxyContin was approved, in 2001, regulations started to be strengthened. Stronger warnings about potential for misuse and abuse were added to OxyContin’s label. In 2003, the FDA issued a warning letter to Purdue Pharma for their misleading advertisements used in the drug’s marketing campaign.

Four years later, in 2007, as the full extent of the OPR crisis was becoming apparent, Purdue Pharma pleaded guilty to criminal charges in federal court for its misleading advertisements and false information about OxyContin. In January of 2017, the city of Everett, Washington, filed a lawsuit against Purdue Pharma seeking to recover the increased costs incurred by the city. Legal action against Purdue continued to escalate, with 27 states and Puerto Rico filing lawsuits against the company by September 2018.

Simultaneously, policymakers were grappling with the severity of the opioid crisis. As early as 2010, lawmakers and the administration had already begun to distance themselves from the harsh, punitive approaches that had characterized drug policy during the Nixon, Reagan, Bush and Clinton eras. In that year, Congress and the administration recognized the burden drug

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policy placed on minority groups and enacted the Fair Sentencing Act, which reduced the 
crack-to-cocaine sentencing ratio from 100:1 to 18:1.

In the following year, the Global Commission on Drug Policy, consisting of influential 
world leaders commissioned with challenging the conventional approach to drug policy and the 
criminalization of drug related matters declared that the so-called “War on Drugs” had failed, 
causing devastating consequences for both individuals and societies.\(^{100}\)

Against this backdrop, the 21st Century Cures Act of 2016 was adopted, emphasizing a 
medical approach instead of a punitive judicial response to the OPR crisis. The act allocated $1 
billion in grant funding to states to fight the opioid epidemic. At the beginning of 2018, in 
response to a narrative that cast those addicted to OPRs as victims rather than the villains, $4.6 
billion was dedicated to fighting the epidemic.

### 2.3 Health Communication

In the opioid/overdose crisis, as in any public health crisis, and now as we see with the 
SARS-CoV2 pandemic, effective health communication is essential to define the threat, educate 
leaders and the public, and to establish a frame through which responses, both personal and 
public, can be developed, assessed, and implemented.\(^{101}\) Broadly defined, health communication 
is “the study and use of communication strategies to inform and influence individual and 
community decisions that enhance health” as well as those communication strategies that help

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mold both attitudes and practices. In practice, health communication campaigns and other programs utilize a variety of methods. These include media advocacy, framing the public debate by influencing the stories the media focuses on and by shaping the debate on those topics. Recently, the vast amount of media, including new social networks, has provided more mediums through which the public can consume information. Increased media literacy, educating the population on how to interpret the stories they see in the media and to evaluate the information they contain is more apparent than ever. In contrast to the initial form of health communication in the 18th century conducted by the Reverend Cotton Mather in 1721, there are now an abundance of outlets through which this type of information can be disseminated. Three hundred years later, Reverend Mather used pamphlets to educate about a smallpox outbreak in Boston. Today, we can read, listen, and watch at any moment in the day.

In 2004, the National Cancer Institute defined education entertainment as efforts to “embed health-promoting messages and storylines into entertainment and news programs or to eliminate messages that counter health messages.” It can also include seeking entertainment industry support for a health issue. Public health communications face the challenge of evolving narratives, as we witnessed during the Sars-Cov2 pandemic. Nothing stays the same, requiring different strategies at different times.

Generally, it is accepted that health communication campaigns and programs can increase knowledge and awareness of a health issue, problem, or solution, as well as influence perceptions, beliefs, attitudes, behavior intentions, and social norms. However, the extent to

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103 Ibid.
which health communication can influence behavior or change behavior is unclear and subject to debate.

Health communication professors Ruth Cross, Sam Davis, and Ivy O’Neil have noted that an issue with many health communication programs is that they operate on the assumption that “an increase in knowledge directly translates into change of healthy lifestyle behavior,” which is not always the case. Human behavior is complex. If changing behavior was easy, then there would be very few smokers.

The Knowledge, Attitude, and Behavior (KAB) model proposes that behavior changes gradually, and that people accumulate knowledge at different rates. As a result, the perception of a behavior evolves through interactions. Telling someone through advertisements, television, public service announcements and any other communication that something is unhealthy does not translate directly into action. Previous research has shown that education independently by itself is a negative agent for influencing changes in behavior. It can take considerable time and even then successful behavior change is not always the end product.

In many cases, these campaigns focus on a more grass-roots approach, targeting individuals with the idea that changes in knowledge, attitudes and beliefs among a cohort of individuals will eventually lead to changes in behavior which in turn can lead to broader changes in a community, society, or culture in stress.

There is significant debate over the efficacy of traditional health communication initiatives and interventions, like campaigns, that primarily focus on individuals and their

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behaviors and attitudes. Several scholars have addressed this in research that argues that an overemphasis on the individual ignores aspects of the wider social environment, including the impact of public policy and the influence of an individual’s community, which enforce norms of behavior that can have an equally determinative, if not greater, impact on health.  

As Meghan Bridget Moran, et al. noted in their 2016 paper “An Argument of Ecological Research and Intervention in Health Communication,” much of the focus of health communication scholars is on the individual, including their personality traits, core beliefs, and attitudes. However, this perspective represents only a small part of the broader picture. Effective health communication must also focus on the microsystem in which individuals function, including their immediate environment such as peers and families. Furthermore, it must take into account the entire social ecosystem, encompassing neighborhoods, communities, and the way local and regional values, popular culture and mass media form and guide their attitudes and behavior. Finally, there is the macrosystem, which involves the values and mores that transcend individual and regional differences. Health communication theories are often criticized for failing to incorporate the real-world dynamics and pressures in which people actually operate.

There is general consensus among health communication researchers that a single health communication campaign or a campaign focused on a single medium such as public service announcements, is typically unlikely to generate widespread change at levels sufficient to impact public policy or significantly alter a community’s culture.  


designed to influence people by changing the environment in which they live and work remain rare. However, researchers, like Moran, argue for the need to develop and implement a more ecological approach. They advocate for programs and interventions that target multiple levels of influence. Additionally, they call for the development of a more comprehensive health communication theory that includes and utilizes an ecological framework.  

That rigorous theoretical framework is widely seen as lacking in health communication initiatives. Many health communication programs in the U.S. do not utilize theory to inform the design, implementation, and evaluation of their initiatives, which could limit progress in their field. This is beginning to change. Recently, theoretical frameworks have been used more frequently but the increase has been limited, according to a recent assessment. The "600-entry Encyclopedia of Health Communication," embodies a new approach to the health communication field that includes international perspectives. This set of diverse opinions and findings contribute to a more holistic sense of health communications globally. This type of shift in this field can serve as a foundation for the emergence of other theories as more viewpoints and data are necessary for further development in this space.

Additionally, the evaluation of the effectiveness of health communication initiatives and strategies is often an after-thought, if they are done at all, rather than planned and built into the design of health communication programs. Furthermore, when evaluations are done, they are frequently not published in journals. This issue hinders broader assessments of outcomes, as

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111 Ibid.

they are not subjected to peer reviews or rigorous design.\footnote{Hannawa, A. F., Kreps, G. L., Paek, H.-J., et al. (2014). Emerging Issues and Future Directions of the Field of Health Communication. \textit{Health Communication}, 29(10), 955-961. https://doi.org/10.1080/10410236.2013.814959} Importantly, there is sometimes the troubling question of whether the funding sources for such evaluation and assessments may influence the results. As a result, research in the field of health communication may be driven by the interest of funders rather than the actual needs and challenges faced within the field. It is important to prioritize research that is grounded in scientific principles in order to ensure its effectiveness in addressing public health issues.\footnote{Ibid.}

### 2.4 Health Communication Theories


All of these theories propose that cognitive processes play a role in decision-making and behavior.\footnote{Ibid.} Gehlert and Ward (2019) have characterized the theories as rational choice-based
theories, as they are based on the idea that human behavior stems from rational and logical thought processes.\textsuperscript{118}

The Health Belief Model theorizes that health behaviors are predicted by six constructs: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy, and cues to action.\textsuperscript{119} In other words, people make decisions about which health behaviors to engage in based on how much they perceive risk, the severity of the risk, the perceived benefits and barriers, their confidence in their ability to perform the behavior (self-efficacy), and external factors that motivate them to act. However, one critique of this model is its vagueness in explaining how these constructs operate to influence health behavior.\textsuperscript{120} It does not clarify whether the constructs mediate or moderate their relationship with health behaviors.\textsuperscript{121}

The Theory of Planned Behavior, which builds on the Theory of Reasoned Action, posits that an individual’s intention to engage in a behavior, influenced by their attitudes and subjective norms, as well as their perceived behavioral control (the degree of control they believe they have over a behavior), determines their actual behavior.\textsuperscript{122} A significant criticism of the TPB is its failure to consider how environmental and economic factors can influence an individual’s intentions. Attitudes and subjective norms primarily focus on the internal thoughts and opinions of individuals, neglecting the influence of external factors.

\textsuperscript{121} Ibid.
A fourth theory, the diffusion of innovation theory often emerges in health communication discussions and it is markedly different from the previous three theories. Diffusion of innovation is a macro level theory that describes the acquisition and dissemination of innovative behaviors among members of the social system; defining the process as predominantly a collective social process rather than primarily a matter of individual decision making.  

The diffusion of innovation is typically described as the process through which innovations, new practices, ideas, technology, etc., are disseminated through certain communication channels and adopted in a social system. Diffusion of innovation can be graphically represented as a relationship between time and proportion or number of adopters. This relationship typically forms an s-shaped curve with early adopters at the bottom of the curve and late adopters at the top. Adoption of innovations or behaviors can be influenced by a number of factors at any point throughout the dissemination and adoption process. As a result the classic adoption curve may not always represent what actually happens in society - missing critical dynamism.  

As a theory, diffusion of innovation is potentially useful for health communication because strategies can be designed and implemented to increase the rate of adoption or to target those that would be late adopters. Increased diabetes awareness illustrates this phenomenon. During the 2010s, public health officials used mass-media as well as the expertise of established experts in the medical field to highlight the dangers of diabetes to Americans. Though these strategies are more readily accepted by certain segments of the population, reaching the late  

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125 Ibid.
majority poses more of a challenge. Nevertheless, if public health officials offer diverse strategies, such as unique media spots and accessible educational forums, individuals that may not be as accepting of new information or ideas can become more amenable to public health initiatives.

Diffusion of innovation provides insights regarding Covid-19 vaccine hesitancy here in the United States. The rapid development of a vaccine to prevent a novel coronavirus resulted in a significant group of resistant individuals, referred to by the theory as “laggards.” According to this theory, once the early adopters embrace the innovation, the subsequent groups, the early and late majorities, are more likely to follow suit and accept the innovation more rapidly. Consequently, a large portion of the population, 84% is expected to adopt the innovation. As of July 2022, the CDC found that 78% of the total population in the United States had received at least one dose of a COVID-19 vaccine, which is consistent with the predictions made by the diffusion of innovation model.126

Figure 3:

2.5 Media and Tobacco: How They Relate to Drug Epidemics

There was another substance use epidemic that significantly impacted the country over the course of the last century, causing illness and millions of deaths. The lessons learned, the strategies adopted, the health communication campaigns that were waged to manage and control that epidemic offers valuable, practical information on how best to combat the current opioid epidemic. The epidemic threat was tobacco use. Tobacco, which originated in this hemisphere, had been widely used in the United States and beyond since colonial times. However, in the final decades of the 20th century, the consequences of the highly addictive but nonetheless socially acceptable drug became clear. Despite mounting data and internal research confirming the dangers that tobacco was a dangerous and deadly substance, tobacco companies aggressively marketed their product, often using sophisticated techniques targeting specific, and vulnerable populations. Specific brands were aimed at specific groups including African Americans, LGBTQ individuals, and even adolescents.127

The tobacco industry strategically created brand identity by establishing narratives tailored to specific segments of the market. Their marketing campaigns relied on demographic targeting, using carefully selected imagery and associations to establish connections between tobacco use and social status, appealing to the desire for social acceptance within their target populations. Tobacco marketing campaigns were first and foremost a visual exercise, designed to imprint an image in the viewer’s mind, and the images they chose were selected with care. To

counter the well-established health risks, they presented images that linked tobacco use with athleticism and good health. In ads targeted toward women and some minority groups, they linked smoking to glamor and fashion, often aligning their ads with emerging concepts that were redefining social roles. For instance, Virginia Slims’ widely aired “You’ve Come a Long Way, Baby” explicitly linking the product to the emerging women’s movement. Marlboro, a cigarette brand that was originally introduced to the market as a woman’s cigarette, was repackaged and rebranded to appeal to a male audience. The promotional campaign created an American icon, the Marlboro Man, a rugged and adventurous man reminiscent of John Wayne. The campaign tapped into nostalgia and resonated with the fears common among some American men during the culturally charged 1960s and 1970s. Though the ads were deceptive and misleading, there is evidence that marketing continued despite the industry’s knowledge of the health consequences of tobacco consumption.

By 1965, approximately half of all adults in the United States smoked cigarettes. However, a backlash was brewing. It started with a report from the US Surgeon General in 1965, which explicitly established a connection between smoking and tobacco-related diseases, highlighting the high number of deaths attributed to smoking. This pivotal moment marked the beginning of a shift, as more and more advocates emerged, working against the acceptance and prevalence of tobacco use.

Eventually, the anti-tobacco advocates were successful. By 2006, the percentage of adults who smoked cigarettes had decreased to only 21%. A decade later in 2016, CDC data showed that the smoking rate dropped to about one in six adults. The prevalence of youth smoking has

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128 Ibid.
129 Ibid.
also decreased dramatically; according to a study by the National Institutes of Health. The study found that high school student smoking decreased from 39% to 22%.¹³¹ As of 2022, the rate had fallen to less than 15%.

This dramatic shift is the result of several, interconnected factors, but clearly a series of campaigns designed to counter the manufacturers’ sophisticated and calculated narrative about the glamor and romance of smoking contributed to a decline in the social acceptability of smoking. That in turn empowered significant public policy changes like new regulations for tobacco companies, taxation on tobacco products, the reduction of smoking areas, and restrictions on tobacco advertisements and promotions. While not the sole reason for the massive decline in smoking, mass media campaign efforts played a role in changing the attitudes and creating the possibility for action by altering the prevailing social narrative surrounding smoking and tobacco use.

The trend of using mass media to alter the trajectory of the tobacco use narrative is usually traced back to 1967 when the Federal Communications Commission (FCC) applied the Fairness Doctrine, which required broadcasters to offer free airtime for one anti-tobacco message for every three cigarette commercials aired.¹³² The FCC, are mandated to ensure that the broadcast airways are used in the public's interest. In 1967, John P. Banzhaf, the so-called “Ralph Nader of the tobacco industry” was responsible for the FCC’s role in cigarette advertising. Banzhaf filed a formal complaint to the FCC in Washington against WCBS. Although the FCC rejected his demand for equal time, they found the fairness doctrine applied to smoking advertisements. The FCC decided that it was not in the public interest for radio and television to

advertise cigarettes without providing some warning about the health hazards involved with smoking.

If narrative-shaping media had been an effective tool for tobacco companies looking to boost sales, it was an equally powerful weapon for those looking to counteract the high rates of use and the high death rates attributed to tobacco consumption. There is evidence from both controlled experiments and population studies that mass media campaigns designed to dissuade tobacco use can, “change youth attitudes about tobacco use, curb smoking initiation, and encourage adult cessation.”

Certainly, some of the anti-tobacco campaigns were more effective than others. Television ads, including some produced by the tobacco companies themselves in response to public, political, and legal pressure, that focused on normative issues like disproving the “coolness” of cigarettes did not perform well in subsequent analyses. Philip Morris’s “Think. Don’t Smoke” advertisements serve as a good example. On the other hand, ads that used images and brief stories depicting the serious, sometimes tragic, consequences of tobacco use performed much better in those analyses. Evidence suggests that campaigns designed to arouse strong negative emotional responses perform better, viewers are more inclined to remember them and be persuaded by their content than they will remember or internalize the message of campaigns that fail to arouse strong emotions.

If the media can change such a pervasive public health problem, there is hope that media can also be effectively utilized to bring an end to the current opioid drug epidemic. Two media campaigns meriting consideration as successful prototypes to combat the opioid epidemic are the Florida Tobacco Pilot Program and the American Legacy Foundation’s “truth” campaign. These

\[133\] Ibid.
\[134\] Ibid.
campaigns targeted adolescents ages 12 to 17 and were unique for their anti-industry approach. They capitalized on the building blocks of an existing social narrative, allowing viewers to identify with the message by presenting a clear antagonist, the big tobacco industry, and portraying anti-tobacco activism as both romantic and heroic, thereby appealing to the targeted demographic. The Florida campaign focused on the tobacco industry’s manipulative duplicity and created television advertisements that portrayed industry executives as indifferent in response to information about the negative health effects of smoking. Modeled after Florida’s campaign, the American Legacy Foundation’s campaign, launched in 2000, marketed it as a youth brand that delivered direct and straightforward facts and messages about the tobacco industry. It used a variety of themes in its advertisements, all aimed at shedding the tobacco industry’s misleading practices.

The shared anti-industry narrative is widely credited with steering both campaigns toward success. A longitudinal study of the Florida campaign found that a significant number of viewers both remembered and agreed with the key campaign message and that was associated with a decrease in smoking initiation. The evidence suggests that the campaign effectively changed attitudes and beliefs, reducing the number of young people who started smoking. Similarly, the Legacy campaign also changed attitudes. For example, one study found that “awareness of specific campaign advertisements was significantly associated with greater anti-big-tobacco attitudes and with beliefs that were targeted by the campaign.” A cross-sectional study of the same campaign credited the effort with a 22% decline in smoking prevalence among eighth, tenth, and twelfth graders. Given their success in promoting a persuasive, anti-industry

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135 Ibid.
136 Ibid.
137 Ibid.
138 Ibid.
139 Ibid.
narrative and persuading potential adolescent smokers to align with their core message, these campaigns could serve as valuable models for media campaigns addressing the opioid epidemic.

On many levels, prescription opioid companies utilized similar strategies to those used by tobacco companies. Their misleading advertisements and dissemination of misinformation influenced the perceptions of both consumers and healthcare professionals, making them clearly complicit in the current opioid epidemic. Consequently, considering this similarity, if the media were to adopt an anti-industry approach against opioid companies, it is possible that such a campaign could achieve similar successes with its target audience. However, without research, it remains unclear whether campaigns targeting Big Pharma will resonate as strongly or prove as effective as those that targeted big tobacco were.

There is a key difference between the tobacco epidemic and the current opioid epidemic that could pose a challenge to crafting a successful narrative-changing campaign to combat the opioid epidemic: the stigma. Prior to the concerted efforts of anti-tobacco activists to alter the narrative, there was, largely no stigma associated with smoking. On the contrary, it was not only socially acceptable, but consumers had been carefully conditioned to view smoking as elegant, sophisticated, glamorous and adventurous. The task of the anti-smoking campaign was to reverse that perception; it aimed to create and promote a narrative in which smoking was none of those things, but instead a pernicious, destructive addiction peddled by nefarious big tobacco executives. The campaign was effective and one of the reasons for its success was the gradual establishment of a social stigma associated with smoking.  

One of the main challenges in replicating the successes of anti-smoking campaigns to address the opioid epidemic lies in the fact that opioid use and opioid use disorders already

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carried stigma, a legacy that had been further exacerbated by the policies and propaganda propagated by the War on Drugs.

In American society, a powerful stigma persists regarding opioids, which reinforces a narrative that views opioid addiction, or addiction at large, as a personal failing. This perceived failure to simply “just say no” reflects the influence of the Protestant work ethic, with its focus on diligence, deferred gratification and the primacy of work. Instead of recognizing addiction as a mental illness, stigma isolates and marginalizes those who struggle with addiction.141

This culture still perpetuates stigma towards mental illness, and despite efforts by psychologists, governments, and advocacy groups, stigma against mental illness in general and drug addiction specifically has continued to grow significantly.142 Stigma presents a formidable obstacle that those working to combat the opioid epidemic must confront. It is evident that unless stigma is addressed, the tactics used by anti-tobacco advocates might not be as effective against the opioid epidemic.

2.6 Drug Epidemics in Documentaries

Documentary films and other media have been used to shape opinions and attitudes about social issues including drug use. At times, documentaries have used traditionally journalistic methods to present a narrative that promotes a particular viewpoint on social justice and to inform the public about the challenges people face. However, the distinction between documentary filmmaking and journalism can be blurred, and the boundaries separating the two can often be unclear.

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Some films, like the recent critically acclaimed documentary film *Collective*, which follows the investigation of a Romanian healthcare scandal, lean heavily on the journalistic principles of “truth, fairness and objectivity.” Conversely, other films express opinion and veer more clearly into advocacy, hoping to “inspire and persuade.”\(^{143}\)

Documentary filmmaking is not a one size fits all proposition. Documentary films can easily turn into a type of propaganda and ideological advocacy, as was the case with a number of USIA propaganda films produced explicitly by the US government to advance its agenda overseas and, to a lesser degree, domestically.\(^{144}\) In most cases, the social or political agendas of documentaries are made explicitly clear, and those that are not based in journalism do not pretend to be so. However, clearly defined motives do not necessarily translate into social impact, nor do they guarantee that the target audience will receive or internalize the messages conveyed by these films. Moreover, it is also not assured that such films will shift public opinion or sway public policy or private practices. The efficacy of advocacy documentary filmmaking in comparison to journalistic documentary filmmaking is also up for debate. Creating a film that establishes and advances an effective narrative requires both artistry and scientific understanding, particularly in the realm of health communications. Currently, there is no consensus on whether documentary journalism or advocacy is an effective component of a health communication campaign. The question of how much documentaries can measurably change attitudes and opinions has remained largely unanswered, despite attempts dating back to 1968 to uncover the answer.\(^{145}\)

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That being said, there is reason to believe that in recent years, documentaries have drawn on and perhaps reinforced certain aspects of existing narratives portraying specific groups and issues in an unfavorable and counterproductive light. Documentaries focusing on drug use are no exception. Across the board, in the documentaries studied, white people suffering with addiction, even those with significant criminal involvement, were depicted as victims of the disease and worthy candidates for medical treatment. However, people of color, addicted to drugs were significantly underrepresented in medicalized narratives. When they were portrayed, they were often discussed in the context of criminality, described as threats to society deserving incarceration and state control.  

Given that media, including documentaries, likely exert some influence over public opinion, it is likely that these stereotypical, negative depictions of people of color in documentaries have influenced at least some portion of the public opinion with regard to minorities and the various drug epidemics. Consequently, these documentaries may well have established and reinforced misconceptions about drug use and addiction. A 2014 study of 64 drug documentary films produced between 1991 and 2008, found widespread racial inequality in both the representation of drug users and explanations of their addictions. This echoes the racially biased characterization of drug crises that goes back to Dr. Williams’ racially inflammatory examination of cocaine use in The New York Times more than a century ago.  

During the heroin epidemic of the 1960s and 1970s, documentaries specifically focusing on the epidemic were rare. Consequently, it is difficult to analyze a sufficient number of samples to draw a definitive conclusion about how they may have shaped public opinion. However, there is evidence of bias and misinformation in several drug documentaries produced at that time.

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146 Ibid.  
A series of four documentaries titled *The Distant Drummer*, released in the early 1970’s, aimed to serve as a warning against the growing drug problem in American Society. It was intended to be a warning against the proliferation of drugs in American society.\(^\text{148}\) One film in the series, *Flowers of Darkness*, explained the history of how heroin was produced and discussed dangers associated with heroin sale and addiction. Produced by the reputable George Washington University Department of Medical and Public Affairs, the film featured the acclaimed actor Paul Newman as the narrator, whose own son had died of a drug overdose. The film was not intended, nor is there any evidence that it was received, as a tabloid spectacle, although press coverage about the series is scarce. It is reasonable to assume that those who watched the film, and the larger series, accepted the imprimatur of the university and one of America’s most beloved celebrities and accepted the information it presented as factual. The short film can be found on YouTube, and while much of the information about the drug itself is accurate, it contains several stigmatizing descriptions including references to the “teeming slums” and “tenement prisons” where drug abuse is rampant. The film also portrays addiction as “willful indulgence” necessitating punishment.\(^\text{149}\) Some of these misconceptions can likely be attributed to the time of production in the early 1970’s, but the departure from fact-based reporting has the potential to perpetuate real stigma. When the crack epidemic of the 1980s and 1990s began in earnest, the errors and misconceptions that had been promulgated by the well-meaning heroin series produced by George Washington University a decade earlier were repeated and magnified with great intensity.


\(^{\text{149}}\) Head, M. (1972). *Flowers of Darkness*. [Film series]. Airlie Productions, George Washington University, Department of Medical and Public Affairs.
According to the 2014 study on drug documentaries referred to earlier, minority drug users caught up in the early stages of the crack epidemic were primarily cast as players in a criminal narrative. In 1986, CBS News, then a dominant source of news in America, presented 48 Hours on Crack Street, a television documentary that would become the first episode of the world-famous 48 Hours. With an audience of fifteen million viewers, it became the most watched documentary in television history, and its impact was amplified when several large newspapers, including The New York Times and The Washington Post, discussed the documentary following its premiere. In 1988, 48 Hours on Crack Street received the esteemed Alfred I. duPont Columbia University Award, and its prestige and public acclaim were sufficient to warrant a thematically identical sequel Return to Crack Street in 1989.

Despite the attention and acclaim, concerns regarding the documentary’s ethics surfaced shortly after its premiere, primarily due to its racially and socio-economically distorted depictions of drug users. Specifically, the film employed facial blurring techniques to grant anonymity to individuals who appeared to be “Wall Street types,” as one journalist described them, while the faces of those who seem to have a lower socioeconomic status are not blurred in the film. This selective treatment of anonymity reinforced prevailing, negative attitudes toward those suffering with addiction. It also highlighted the arguably harsh drug penalties of the time, which exposed drug users from lower socioeconomic status while protecting the identities of upper-class individuals, largely white, who were also drug users.

2.7 Documentary Films and Public Health

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In recent decades, there has been a proliferation of documentary films focused on public health issues, attracting attention from both the media and the general public and garnering large audiences. Examples include Vice President Al Gore’s Oscar winning *An Inconvenient Truth* (2006), which warned in stark terms about the risks of global warming, and Morgan Spurlock’s *Super Size Me* (2004), which contributed to McDonald’s decision to remove the super-size option from its menus. Additionally, Josh Fox’s provocative Academy Award-nominated documentary *Gasland* (2010) effectively framed the contentious debate about natural gas and hydraulic fracturing in the United States. *The Interrupters* (2011) focused on violence as a public health issue in Chicago communities, *How to Survive a Plague* (2012) examined the AIDS epidemic and the impact AIDS activists had on the course of that epidemic, and the highly acclaimed short documentary *Heroin(e)* (2017) focused on the public health crisis of drug overdoses. These documentaries represent only a small fraction of public health films. Documentary film is widely used and accepted, produced by a diverse range of entities ranging from the entertainment industry to the World Health Organization, resulting in a wide range of productions that can be equally varied.

Generally, when organizations produce public health documentaries, there are ethical considerations. These include obtaining informed consent and protecting the privacy of subjects featured in the film, determining the level of subject influence and ownership during collaborations, determining whether the project meets the needs of stakeholders (including funders and the members of the audience); and upholding the filmmaker’s obligation to share

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accurate information.\textsuperscript{156} As referenced earlier, considering public health’s connection to community-engaged research and community-based participatory research, and given the risk of establishing or reinforcing counterproductive narratives and stereotypes, the ethics surrounding subjects is particularly important for public health documentaries. However, in the realm of public health documentary filmmaking, as in all documentary filmmaking, there is no formalized set of guidelines that all documentary filmmakers adhere to. Nevertheless, research indicates that many documentary filmmakers grapple with similar ethical issues and make comparable ethical considerations, and the discourse on documentary ethics continues.

One of the most significant ethical issues relates to filming individuals who are often in the throes of a crisis or in the midst of a tragedy, such as addiction, disease, or environmental challenges, among others. Unlike research studies, there is no Institutional Review Board (IRB) to protect those subjects, and in the zeal of “getting a story,” an unfortunate reality is that the “subject”, and what is in that person’s best interests, can at times be overshadowed by the intensity that comes with capturing the scene. At times “subjects” can be objectified, and there is no oversight board to approve or disapprove. Currently, there is no single organization solely dedicated to protecting the rights of human subjects.

In my own experience as a young reporter, I vividly recall the abject fear I felt after my promise to shield the identity of a young person in recovery from heroin addiction, failed. Our small camera team set up the lighting so the young man would be obscured by the silhouette, but when broadcast, the silhouette was less than fully protective, and the loose outlines of his face could be seen. Some people who knew him well could identify him. As a result, the young man

disappeared for two full days after his parents learned through neighborhood gossip that their son was in recovery. It should never have happened, but it did. While the problem of revealed identities has not been quantified or analyzed, my suspicion is that “blown covers” occur all too often adding stigma, shame, and other downstream, unintended consequences. It was an awful experience, and I know my shame and fear did not compare to this young man’s devastating experience. “Getting the story” is often a perilous proposition made even more so without the oversight of a governing body responsible for safeguarding the well-being of the subjects involved.

Willemien Sanders, a scholar focused on ethics and documentary filmmaking, has called for more empirical research to understand the experiences and perspectives of documentary filmmakers. Anecdotally, implementing such standards would be a positive step. Too often, documentary filmmakers find themselves navigating similar terrain as social science researchers, but without the same level of oversight and protection for the subjects involved. Studying medical anthropology at Mailman School of Public Health, I spent time reading various ethnographies focused on public health. This exposure prompted me to critically reflect on the ethics of reporting in areas where I believe the addition of oversight would be beneficial.

2.8 Impact Evaluation of Public Health Documentary Films

It is often the hope of every documentary filmmaker to inspire change and forge a path of progress. We hope we can connect with viewers, appealing to both their hearts and minds. However, this raises the question of whether we truly succeed in our endeavors. To be sure, as a discipline and as a proportion of films made, documentary films are a growing phenomenon, but

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debate continues about the extent of their impact.\textsuperscript{158} To even begin to assess the impact of documentary films, we must first define the term. Impact can refer to a variety of changes that happen to individuals, groups, organizations, systems, and social or physical conditions. In short, “how the world is different” as a result of media efforts.\textsuperscript{159} Although there is general agreement among researchers and practitioners in various fields that documentary films can create change in the world and have an impact on people’s knowledge, beliefs, attitudes, and/or behaviors, there is no consensus on how to evaluate documentary films’ impact.\textsuperscript{160}

In 2015, American University Professor Patricia Aufderhide proposed the inclusion of a variety of professions and academic disciplines should be included in the discussion to first define impact, and then determine what principles and theories should be applied to measure it.\textsuperscript{161} American University Professor Caty Borum Chattoo argues that an ideal impact assessment would require the use of a variety of research methods selected specifically in response to the stated objective of a documentary film or media project; in other words, one set of methods for a project whose stated goal was to change individuals’ knowledge or behaviors, and a different set if the filmmaker’s objective was to promote public policy initiatives, or prod organizational change.\textsuperscript{162}

In her report, Chattoo identified four main types of media research by type of impact: digital and media coverage metrics, audience impact, content and cultural impact, and

\textsuperscript{160} Ibid
institutional impact. At present, documentary film impact is commonly evaluated with three types of methods. First, case studies examine the impact of one specific documentary. Second, systematic frameworks that typically measure impact on five to seven dimensions, including influences on the individual, community, and society; and finally, simple computational methods. The ConText software developed by Diesner et al. is a notable computational method for documentary film impact evaluation that utilizes language processing and network analysis. Of the three methods used for evaluation, case studies seem to be used most frequently. Case studies can evaluate a variety of impact types, but typically focus on metrics like audience reaction, and/or measurements of the digital and media coverage the film generated. In practice, case studies usually include counts of screenings, film website traffic (measured through individual hits on a website), audience surveys, focus groups, in-depth interviews and studies of psychological effects on viewers.

While most case studies principally or exclusively focus on individual responses, there have been some studies that evaluate the impact of a single documentary on individual-level changes. Although there are some rare case studies that have studied the influence of a single documentary on public policy, they are not common. While case studies are more frequent and valuable for assessing the impact of a single documentary film, their specificity often makes it difficult to generalize the findings and replicate the factors that made them successful.

163 Ibid.
167 Ibid.
168 Ibid.
That is not to say that there is not ample literature assessing the extent to which specific documentaries have increased awareness among individuals and communities or whether they in fact did spark personal or political change, or whether they succeeded in the attempt to be “storytelling for change,” as Catto described.\(^{169}\)

Among the case studies examining individual public health documentaries, Hans and Kimberley’s conducted a study on the film, of the *Business of Being Born*, which aimed to raise awareness and increase support for midwifery. Additionally, Burmiester et al.’s randomized control trial involved a documentary that aimed to reduce the stigma surrounding obesity.\(^{170}\) Another case study by Grimmett et. al. examined the impact of the documentary *My Masculinity Helps* on knowledge, beliefs, and social norms related to African American men and boys’ perspectives on masculinity.\(^{171}\)

Other examples include the 2916 study by Brandt et al., which tested if a collaboratively made documentary affected awareness of food access in a food desert community with high obesity rates. Additionally, the study by Bieniek-Tabasco et. al. exploited the effects of a climate change documentary on the audience’s efficacy beliefs, outcome expectations, emotional responses, and motivations and intentions to address climate change.\(^{172}\)

These studies contribute to the understanding of how documentaries can influence public awareness and attitudes towards important issues such as food access and climate change.


Furthermore and as noted earlier, it is difficult to assess the actual impact of these documentaries in the broader health communication context of change around public health issues. Conducting a systematic review of public health documentary films could address this limitation and establish connections with health communication theories as a framework for measuring their impact. Additionally, a review can help provide a framework about how documentaries communicate health information and whether these strategies are likely to affect viewers' perceptions and behaviors. The goal would be to provide tools for filmmakers about how these strategies can be used as an effective way to communicate health information, improve overall health messaging and increase impact.
Chapter 3: HBO Documentary Films and the Opioid Epidemic,

Warning: This Drug May Kill You

By 2015, the opioid epidemic in the United States had reached critical mass, as discussed in Chapters One and Two. This epidemic was fueled significantly by the influx of prescription drugs and the efforts of the pharmaceutical industry to promote them.

The crisis had become a significant part of the national dialogue, but the debate was being held on the pharmaceutical industry’s terms. The accelerating addiction rates among patients who had been prescribed opioids had begun to erode confidence among researchers and some caregivers in the industry’s campaign to promote opioids as safe and non-addictive, and so the industry, abetted by much of the media, largely shifted focus, framing the crisis as a weakness on the part of those who became addicted. The prevailing narrative suggested that, if there was a problem at all, it was a problem of “bad kids abusing good drugs”, drugs that the pharmaceutical companies claimed were urgently needed to relieve people’s legitimate pain. The narrative continued to portray drug-abusing kids getting in the way of the good people of this country and their desperate need to relieve their legitimate pain. This was the prevailing narrative in 2015 when HBO became interested in making a documentary about drug overdoses.

Filmmaker Ellen Goosenberg and I had just completed a documentary about alcohol use disorder for HBO Documentary President Sheila Nevins. Risky Drinking, looked at alcohol use disorder as an entity that exists on a continuum in an effort to dispel the outdated notion that alcohol use disorder is binary -the belief that one is either an alcoholic or they are not. Working in tandem with the National Institute on Alcohol Abuse and Alcoholism (NIAAA), we told different stories from different points on the drinking continuum, trying to narratively demonstrate that people could be at different places vis-a-vis their drinking at different points in their lives. Often, with
time, people would advance along the continuum, but the NIAAA maintained that alcohol use disorder did not boil down to an either/or classification. Alcoholism use was far more nuanced and a narrative shortcoming had failed the American people. After the film’s premier and the NIAAA sponsored online outreach campaign drew to a close, Sheila turned her attention to opioids.

At a meeting to discuss next projects, Sheila handed me several newspaper clippings that she had collected over the last few months. That’s the way she worked and it served her well. In her illustrious and well-decorated career, having earned 26 Oscars, 45 Emmys and 23 Peabody's, Sheila is believed to have more awards than any other documentary filmmaker. Sheila is also credited with moving the industry away from the more traditional didactic forms of documentary storytelling, instead creating films that feel more like “real movies.” These narratives engage the viewer like any good scripted film. Sheila eschewed “voice of God” type narration, a surfeit of “talking heads” and distracting, onerous graphics. She believed that was the formula of old form documentaries, and she had little appetite for them for HBO’s air. Sheila wholeheartedly believed in the strength of real people to tell their own stories and the power of verité filmmaking to tell those tales in an emotionally resonant and compelling way that would more effectively reach and connect with the viewer. She rejected the use of celebrities to deliver messages and always preferred to hear the stories of “real people” struggling at the edges of society - people who were most often not heard from. There was no one like her, and as such she presided over HBO’s documentary division as its president for more than 40 years before leaving at age 80 to run MTV’s documentary division where she continues to work.

On that particular day, Sheila gave me her clippings and talked about “these kids, who had it all” and were seemingly “dropping dead”. She wanted to know what was going on and
how we could help parents understand what was happening. Did they know their kids were taking drugs? What were they taking? And how were they getting the drugs? Most importantly, how could unsuspecting parents know what to look for? It appeared to be children of privilege, was that true? I left the meeting armed with clippings and a shared desire to understand what was happening. Given that my three boys were mid to late teens at that time, I found myself in a unique position as both a filmmaker and a mother. I was tasked as a filmmaker to explore the subject, but as a mother, I wanted to know what new drug was furtively knocking at their door.

At this early stage, neither Sheila nor I, nor anyone else associated with the project had a clear vision of where the story would lead. We had no idea that it would end up examining the devastating impacts of the rising use of prescription opioids. We could not yet predict that it would ultimately become a story that focused on a cohort of the population distinctly different culturally, economically and racially from those usually depicted in drug-related documentaries, or that it would at least in part focus on the actions of the drug manufacturers, the marketers, and the doctors who were writing prescriptions at a rate that less than a generation ago would have been unthinkable.

HBO producer, Sascha Weiss, and I started working the phones, and met with a handful of young people. We had conversations with street corner drug dealers who told us about how they were encountering a different kind of customer often looking for a different kind of drug like Xanax, or repackaged as “Xanibars.” Others told us about young people who had drifted from those substances to heroin. We spoke to drug counselors who told us about a new phenomenon, “pill parties,” though the nature of the pills still remained a bit of a mystery to us. None of these leads felt like the right story, they all felt like retreads, stories that had been out there. The drug dealers told us house calls were now de rigeur and that kind of service was time
intensive and made it much harder for them to turn a profit. Cell phone texting made the business very competitive and the exclusive relationships that drug dealers once had with their clients were now largely history. Drug dealers reported having to work hard by constant texting clients to see who would buy. Users were value shopping, comparing prices from multiple dealers all selling similar products. Carrie Wilkens, co-founder of the Center for Motivation and Change, a drug treatment center, confirmed that drug dealers' direct outreach to their clients had become an enormous hurdle in the treatment process. A patient could walk out of treatment certain of their sobriety and within minutes the drug dealers were calling, relentlessly texting, making a fragile hold on sobriety that much more tenuous. Dr. Wilkens and the other therapists would insist that clients surrender their phones and get a new phone number, but even then she said, the dealers were usually a few steps ahead and it was very hard for patients to stay away. The mix she described sounded very challenging.

Sascha and I were captivated. The changing nature of drug dealing was fascinating, and that parents didn’t know that the dealers were no longer selling their goods in back alleys but instead were being carried around in their children's mobile devices, felt important. The dealer had, in essence, become a part of the home, omnipresent, only a text away, and always ready to make a drop. It was that easy, and according to the experts we spoke with, it had changed the complexion of drug recovery in profound ways.

While drug dealing was part of the problem, and felt important, it was not our story. Next we spoke with Gail Cole, mother of Brendan Cole. Gail and her husband Brian raised Brendan and his two brothers in a relatively affluent neighborhood in northern New Jersey. Brendan’s story was somewhat consistent with some of the clippings Sheila had given me, a privileged kid who did well in school, went to a four year college and eventually died. However, when Gail told
us that Brendan had been prescribed Oxycontin for a sports injury and that she suspected he became addicted, we felt we may be onto something.

During the early 2000s, when Purdue Pharma was aggressively promoting the use of prescription opioids to treat all types of pain, Brendan became addicted to Oxycontin. The doctor renewed the prescription a few times before stopping, but by then the 20 year old was addicted and turned to heroin as an available alternative. He faced immense challenges, going in and out of rehab facilities as he struggled to overcome addiction.

After graduating from college, Brendan returned home. His parents said they believed he was doing well and maintaining his sobriety. One afternoon Brendan told his parents he was picking up sneakers at the local mall so he could exercise and get in shape. Gail told us they didn’t suspect any problem. Gail says she didn't worry, after all he was at the mall texting his parents pictures of different sneakers but when he came home, a half hour later, Gail said it was like being “punched in the stomach.” The minute he walked in the door, it was clear that six months of hard-earned sobriety was for naught. The dealer had discovered Brendan’s new phone number and lured him back, she showed us the texts. Gail and Brian were devastated.

Deadly overdoses can happen immediately following rehab when tolerance levels are low or nonexistent. In these instances, people may consume the same amount of opioids they used before, which overwhelms their body. Brendan overdosed a few hours later. He was revived with Naloxone (Narcan), a life saving antidote that binds with the opioid molecule. More specifically, naloxone has a high affinity for μ-opioid receptors, where it acts as an inverse agonist, causing the rapid removal of any other drugs bound to these receptors.\(^\text{173}\) People who have witnessed a Naloxone revival often describe what they see as nothing short of miraculous; one minute the person is turning blue, seemingly moments from death, and then minutes later, they walk away

\(^{173}\) Drug Bank, Online. Naloxone. [https://go.drugbank.com/drugs/DB01183](https://go.drugbank.com/drugs/DB01183)
like nothing had ever happened. For Brendan, Naloxone was that miracle, -it saved his life.

However, as Gail points out, she was never informed at the hospital that Naloxone immediately induces sudden withdrawal symptoms, leaving patients sick and often desperate for more opioids, anything to alleviate the violent withdrawal symptoms. Anything.

When Gail and Brian returned from the hospital with Brendan, they scoured his bedroom, looking for a stash of heroin. They found nothing, but it turns out they missed a hidden supply, Brendan’s childhood teddy bear. Home from the hospital after being resuscitated with Naloxone, Brendan was in agony, in desperate need of an opioid fix to quiet the relentless withdrawal symptoms. He found that solace in the heroin he had stashed in his teddy bear. Gail and Brian didn't know how profoundly he was suffering in the room down the hall.

They acknowledged how angry and frustrated they were, after all, Brendan had been sober for six months, overdosed, revived and then overdosed again all in a 24-hour period. Brendan didn't survive the second overdose. The paramedics returned to their home, and tried to revive him, but this time their efforts failed. It was a 24-hour period that will haunt Gail and the family for the rest of their lives. What could they have done differently? How could they have prevented the second overdose? Where did they go wrong? Gail says there isn’t a day that passes when she doesn’t play those questions over and over in her head. She says there isn’t a day where she doesn’t think of her eldest, beloved son.

It was Brendan’s story that pointed us in a different direction. We reached out to a physician named Andrew Kolodny. At the time Dr. Kolodny was the Chief Medical Officer at Phoenix House. By training, he was a psychiatrist who specialized in opioid addiction but what was more relevant for us and where our story started to take shape was his work as co-founder of an organization called Physicians for Responsible Opioid Prescribing (PROP). It was Dr.
Kolodny who made us focus on the prescription element of the ongoing and evolving opioid story.

Sascha and I knew we had found the story we would pursue for our HBO film. However, allowing people to feel comfortable enough to share their stories on film is another matter entirely. More complicated is telling that story as it is unfolding, the verité school of filmmaking. It is easy enough to find someone in recovery, who has already lived the story. That kind of storytelling is typically less compelling as it has already been resolved and the narrative becomes in the past tense, largely told in interview. Finding people willing to trust and open themselves up to share their raw reality is understandably difficult. Their stories are often grim and their behaviors often illegal. They are buried deep in shame and stigma. Why would anyone agree to share those stores? Typically the answer to that question are people who are paid to share their stories. HBO, and for that matter any reputable network or platform, won't pay money to individuals in exchange for their stories. A stipend for travel, or for lost work time is allowed, but that’s it.

Our challenge on this film was to achieve what Cattoo described as “storytelling for change”, to challenge preconceptions and to do so in a way that humanized the issue and made it accessible, all while still appealing to HBO’s viewers in a way that might spark what Dutta-Bergman and Dearing and Cox would describe as “diffusion of innovation.” It also had to be compelling television, and if not it would never see the light of television air.

We had experience from my past HBO documentary Risky Drinking. As noted in Chapter 2, only the most basic studies have been conducted to gauge the effectiveness of documentary films on public attitudes regarding public health issues. However, we had anecdotal indications about how the film was received at least within a portion of the at-risk community.
The NIAA reported that in the days following the initial airing of *Risky Drinking*, it fielded a measurable uptick in inquiries from viewers. That increase continued for some period of time. They also felt good because their outreach programs were given exposure on HBO, and it was, in some senses, an affirmation of their work, but the information was largely anecdotal.

We set out to do the same with the still unnamed opioid film. We began with a three month phase of development to determine whether our story was simply a curiosity, an outlier, a statistical blip, or an indication of a larger, more critical problem. The next step was to determine how best to tell the story, how to use the same theories and techniques that we had applied to *Risky Drinking*, in order to make the film both informative and motivating, and to guarantee that it would be compelling.

### 3.1 Development

Well before we began our research, Dr. Kolodny, then the Chief Medical Officer for Phoenix House and one of the founders of the advocacy group Physicians for Responsible Opioid Prescribing (PROP), had begun a campaign to highlight the dangers of the prescription opioid epidemic. Dr. Kolodny had drawn links between the unfolding crisis and the efforts of the pharmaceutical industry, Purdue Pharma in particular, to expand the market and to downplay the addictive nature of the newly formulated drugs. Though he lacked the kind of well-financed platform that the industry had been using to advance its own narrative, Dr. Kolodny’s efforts were being noticed. There had been some media coverage of his warnings about the role prescription opioids were playing in the then emerging epidemic. In October 2015, he was quoted in a story in *The New York Times*, detailing how, for the first time in his presidency,
President Barack Obama had traveled to West Virginia to call attention to what was by then an already significant rise in the cases of prescription opioid use disorder and related drug overdoses and deaths. At that point, more than 120,000 Americans had already died of opioid drug overdoses, and Dr. Kolodny expressed frustration with what he viewed as a lack of action from the president, and the failure to establish a new narrative to catalyze a response. “This is the first time in his presidency that he’s speaking to a live audience about the problem,” Kolodny remarked.174

This epidemic had a significant impact on a broader segment of the population, extending beyond those who were traditionally marginalized. Our research provided compelling evidence suggesting a link between the abuse of illegal narcotics, such as heroin, and a continuum that often began with prescription drugs. This correlation became even more clear when we learned about called GRASP (Grief Recovery After a Substance Passing), which had a growing network of chapters nationwide. They held an annual rally in Washington, D.C. to bring attention to the crisis. Dr. Kolodny had addressed the rally and drove home the messaging around the role of prescription opioids in the opioid addiction epidemic.

When we first spoke with Dr. Kolodny in 2015, he started by challenging the accepted narrative that was taking shape in the media with the encouragement of the industry’s robust marketing and public relations campaign. This narrative asserted that thrill-seeking young people were obtaining prescription opioids because they were cheap and ubiquitous, and then turning to heroin because it was more convenient. That was the “bad kids abusing good drugs” narrative. However, Dr Kolodny pointed out, the narrative was not supported by the data. This was the worst drug epidemic in decades, 52,000 Americans had died of drug overdoses in 2015 alone,

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33,000, the result of opioids. Dr. Kolodny was able to illustrate that this epidemic had coincided with the industry’s efforts to not only aggressively market opioid pain relievers in a way that had not been done since the early twentieth century, but also to urge, and in some cases reward, the physicians who prescribed them. The research he shared also demonstrated that far from being a problem of disaffected thrill-seeking youths, the expanding epidemic was effecting a far broader swath of the American people, including older Americans, ages 40 to 80, who in the vast majority of cases had been prescribed opioid painkillers for long-term, chronic pain in the years after the OPR boom. Despite the assurances of the industry that the drugs were safe and non-addictive, these individuals had become addicted.

As documented earlier in this dissertation, the industry, with Purdue Pharma leading the charge, had mounted an aggressive, years-long campaign to reverse a narrative that had been in place since 1919, a narrative which had discouraged physicians from prescribing opioids in any but the most extreme cases of pain, even to the point of shaming those who physicians who chose to do so. This campaign had replaced the long-held narrative with a new one, claiming that pain was in and of itself an intolerable condition that could be successfully treated with opioids without fear that patients would become addicted. The industry, principally Purdue Pharma, promoted the OPRs using a sophisticated “multi-faceted” marketing strategy, heavily steeped in narrative techniques, which, in Dr. Kolodny’s words, “changed the way the medical community thought about opioids and changed the culture of opioid prescribing in the United States in a way that would lead to a public health crisis.”

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Dr. Kolodny argued that the industry had mounted what we have come to recognize as a very effective public health communications strategy using an array of techniques, but rather than advancing public health, it was instead advancing an opioid use epidemic. When we met with Dr. Kolodny, it was estimated that between 10 and 12 million Americans had become regular, chronic users of opioids. Moreover, he explained, many of these users were taking them with diminishing returns. He explained that the longer a patient remained on opioids, the greater “tolerance” that patient developed rendering it less effective, requiring higher doses to treat the pain. Indeed, the result is that for some patients the pain is perceived as worse, a process called opioid induced hyperalgesia and that in turn could lead to the need for stronger opioids or more of them, leading to more addictive behavior.177

As we tested each of Dr. Kolodny’s assertions, seeking out research and documentation to support or disprove his case, it became increasingly clear that he had correctly identified and framed the unfolding crisis, and his insights were indispensable to us not just in establishing the scope of the story that we were about to tell, but in helping us frame it in an accurate and compelling way. We were grateful for his insights and we quickly asked him to serve as the medical advisor to the film, which he accepted.

Next, we needed to identify people who were experiencing addiction, who were directly impacted by this unfolding crisis. We needed to find people whose story reflected the larger issues and who would be willing to share their stories in front of a camera. Dr. Kolodny provided a critical frame; each of the stories, he said, should begin with a doctor’s prescription.

Through our own on-the-ground research, and in our discussions with Dr. Kolodny, we had come to understand that the first steps on the road to opioid abuse were often taken in good

faith. As indicated, most had their initial opioid exposure from a physician, often after surgery, though on occasion for something as relatively minor as a toothache or a sore throat, which had, in a significant number of cases, led to addiction.\textsuperscript{178} Even when a doctor would no longer prescribe the opioids, often unaware that their patient had become addicted, the person would find other means to obtain the drug, in some cases doctor shopping, in other cases faking an injury or pain, and in extreme cases actually injuring themselves simply to obtain a prescription. In other circumstances, they would steal opioids from the medicine chests of relatives or friends who had also been prescribed OPRs. In one case, a teenage opioid addict in Maine admitted to stealing Oxycontin that had been prescribed for her dying grandmother and replacing them with Tic Tacs. When all else failed, trying to stave off often debilitating withdrawal symptoms, they would turn to the prescription drugs’ illicit, chemical cousin, heroin.

3.2 The Framing

Once we had determined that there was a compelling story to be told, our challenge was to translate our own findings, our process of discovery, into a compelling narrative that would accurately tell the story of the crisis, while at the same time able to evoke an emotionally resonant response.

We were mindful of the conclusions cited in Chapter 2, that media depictions of public health challenges, smoking as an example, were more memorable and more likely to influence the viewer’s understanding and attitude toward an issue when they were framed in a “negative”

way.\textsuperscript{179} These negative portrayals could also add to the risks of stigmatizing the victims of the opioid epidemic. As noted earlier, there is a lingering narrative both in the media and in popular culture that stigmatizing opioid addicts as personally flawed could make their individual situations unwittingly, that much worse.\textsuperscript{180} What’s more, our reporting had demonstrated clearly that this latest drug epidemic had deep roots as a physician-driven crisis, and was impacting a different social cohort than the poor, urban and largely minority communities that previous narratives had depicted as the principal victims of drug abuse. We were mindful not to amplify the very narratives that we felt needed to be unraveled.

As we moved from development and into production, our first task was the search for stories of people who had actually experienced opioid addiction. Sheila’s idea was to produce a documentary that told about five different and unique stories, each told from a different space of the epidemic; young and old, rich and poor, and offered geographic diversity. The core premise was that this present crisis was not some distant threat, or one that emanated from what many Americans would view as some shadowy and distant “urban” landscape, as many previous drug documentaries had previously depicted. We did not want to portray the victims of this crisis as some stereotypical “other,” but rather to place the crisis where it was actually unfolding. We sought to establish that in the opening montage of the film which included a series of shots of people, most of them apparently middle class, and white, slipping into drug induced nods or otherwise succumbing to the effects of opioid abuse. These scenes were often shot in broad daylight, as opposed to the dark corners of past documentaries.


The partnership with NIAA for *Risky Drinking* was successful, even if just anecdotally so. There was no testing to evaluate the impact of the outreach program. For our purposes, NIAA was working in tandem with us and offering resources for viewers of the film while showcasing their work.

The film’s opening is intentionally stark and alarming. We hide nothing from the viewer making a conscious decision not to shy away from the harsh reality of drug overdose, using startling imagery to convey the profound stakes of the epidemic. We questioned whether to include these disturbing images but ultimately believed that the portrayal should be unfiltered. It is crucial for viewers to fully comprehend and, at least through visual representation, witness the profound consequences of overdose.

Interspersed with these images, we included clips of a Purdue Pharma spokesperson circa 1997, touting the virtues of opioid drugs while minimizing concerns about addiction. The goal was to educate the viewer about the state of the epidemic before the opening title. Once we had established a visual and thematic template with the montage, our next task was to anchor the case we were building through a series of deeply personal one-on-one stories with the people who would each in their own way advance the narrative. In contrast to other documentaries, notably *The Distant Drummer* series and *48 Hours on Crack Street*, we chose not to focus not on the potential criminal or legal aspects of the epidemic. Instead, we focused on the victims of the epidemic, and with the Dr. Kolodny directive that every story must begin with a prescription opioid.

Of the four principle stories that would later become *Warning: This Drug May Kill You*, only one featured the person struggling with addiction, Stephanie, speaking for themselves. In

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the remaining vignettes, the narrative was presented from the perspective of the loved ones, -the other victims of the epidemic.

Even in Stephanie’s case, as an engaging lower middle class white woman from Illinois, her struggle with addiction served as a lens through which the audience could witness the tragedy of yet another victim of the opioid epidemic, Stephanie’s sister Ashley.

Stephanie had first been prescribed Oxycontin, followed by Vicodin and other opioid drugs, to deal with painful menstrual cramps. Stephanie later shared those pills with her sister, who asked for them to help her sleep. Ultimately, both found it increasingly difficult to have the prescription renewed and were promised by a friend that a little bit of “white powder would relieve withdrawal symptoms.” The white powder was heroin, and as an opioid it successfully relieved withdrawal. Stephanie, a young woman in her 20’s. Her mother, also an important person in this story, is open and accessible as she struggles with the grief over the death of one daughter and the fear of that same disease killing her now only child. Finally, we also see the contours of the epidemic through another victim of the epidemic, Stephanie’s young daughter. In a particularly poignant moment of the film, Stephanie’s mother carefully reminds her granddaughter of the procedures she would need to follow if she ever had to administer Narcan to save her mother’s life.

We expanded that theme with the story of Wynne, an upper-middle-class woman. We believed that Wynne’s story would resonate with HBO’s audience, especially with women. In so many ways Wynne’s story mirrored the larger crisis at hand. In 1996, at the height of the Purdue publicity blitz, she had been prescribed opioids to treat postpartum pain after giving birth to her first child. She quickly became addicted, despite seeing numerous treatments in expensive rehabilitation centers, and tragically succumbed to an overdose. In her case, the opioids that
ultimately killed her were given to her by an attending physician at a local San Francisco emergency room in San Francisco.

Wynne’s story serves as a vivid illustration of the ongoing involvement of the medical community in fueling the epidemic and the grave consequences for those affected by it. Wynne had already died by the time we began researching her story, and therefore we chose to tell her story from the perspective of those she had left behind, allowing their voices to recount her narrative. She left an estranged husband, who had ended the marriage when he could no longer cope with the destructiveness of her disease. Additionally, it is told through the stories of Wynn’s three teenaged children, who together discovered their mother’s dead body in her bed the morning after her deadly overdose. It becomes apparent that the victims extend well beyond those directly consuming the drugs; the epidemic is also catastrophic to the people who love them the most. Through these stories, and the others that convey the grief of two sets of parents from an affluent New Jersey neighborhood, the audience can see that a public health crisis like this epidemic is indeed public, with ramifications that go far beyond the struggles of the addicts. By depicting a crisis with consequences that ripple out in concentric circles from the addict to their loved ones, to the community at large, and even across generations, we sought to redefine the existing arms-length narratives of previous drug documentaries. We tried to make the project true to the mission of “storytelling for change.” But we aimed to do so in a respectful way that treated the people using drugs as any other victim of an illness, -people who should have our sympathy and understanding, people who should not be vilified nor stigmatized.

3.3 Response
As noted in Chapter 2, we had limited capability to evaluate whether we were successful. There were no studies done after the film’s release to determine whether viewers retained or internalized the themes of the film. There was no data about our viewers. Were they struggling with opioids? Did they have a loved one who was struggling? Were they just watching because they were interested? We can, however, gauge the reaction from other members of the media through published reviews and commentaries, which may reinforce the theme of the film in the memories and attitudes of the viewers.

It is also worth noting that HBO subscriptions, while they vary depending on point of purchase (whether as part of a cable bundle or as a direct purchase), are expensive. Currently, the purchase of the streaming service, HBO Max costs $14.99 per month. While it is difficult to make generalizations about the socioeconomic status of HBO viewers, it is likely that the viewership is skewed towards people with higher levels of education and income. As a premium cable service it does require a monthly subscription fee. That said, the film was reviewed and the feedback was useful.

The media, The Wall Street Journal, The Atlantic, and Self magazine in particular, all commented and reviewed the film. On April 30, 2017, an interview with The Wall Street Journal allowed us to tailor the message to a particular demographic, that of affluent influencers. Additionally, the film served as a springboard to allow others who were not featured in the film to share their personal stories of addiction, stories that reflected the film’s overarching theme that the current opioid epidemic was not a crisis in some shadowy urban netherworld, but a crisis on Main Street that afflicted people with whom a mainstream audience could easily identify. As Erin Kahr, then a 21-year-old recovering heroin addict who began her addiction at the age of 13

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by stealing Vicodin from friends, wrote in a May 14, 2017 essay in Self, “Warning: This Drug May Kill You rightfully shows that no amount of privilege can insulate anyone against the turmoil and death that accompany opioid addiction.”183

A sample of reviews also suggests that we achieved another key goal of the film, to present the crisis in a way that revealed the trauma of opioid addiction in sometimes graphic and emotionally charged narratives without stigmatizing or “other-izing” the addicts themselves. That theme was amplified in mass media outlets, as well. Sophie Gilbert wrote in The Atlantic on May 1, 2017:

What This Drug May Kill You does is put a human face on a full-blown disaster, which in turn helps to de-stigmatize addiction. There have been numerous accounts published recently that interrogate the many victims of opioid addiction: the addicts themselves, their children, and their parents who find themselves taking care of grandchildren when they’d planned to enjoy retirement.184

As we concluded our preliminary reporting and developed the story arc of Warning: This Drug May Kill You, our objective became clear: we hoped to portray the unfolding opioid crisis in America as a widespread epidemic that threatened a broad swath of the population. We chose to present this narrative through the stories of real people with whom viewers could easily identify. Our intention was to challenge the existing narratives, including the belief that addiction was principally a law and order issue afflicting a generally minority population, and the narrative propagated by the pharmaceutical industry's powerful media campaign.

Furthermore, drawing upon the theories of Public Health Communication outlined in the previous chapter, we hoped to amplify the themes of the film by encouraging the media to

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explore the crisis, viewing it through the same lens that we had used to frame our narrative.

HBO’s *Warning: This Drug May Kill You* serves as a case study of one documentary that was not evaluated by researchers, but which was helpful in understanding the state of documentary film evaluation in the field of public health. The impact and outcomes of this specific film factored into the approach of the systematic review, which will be the focus of the next chapter.
Chapter 4: Systematic Review: Methods, Analysis, Results

This chapter presents the systematic review of the literature relating to the ability of documentary films to influence the levers of discourse around substance use. “Influences on the levers of discourse” are defined as changes in knowledge, behavior, attitudes, beliefs or stigma related to substance use and mental health. Studies that measure one or multiple types of changes are included in this review. Initially, there were 41,382 results after searching all the databases using the search terms shown in See Table 1. Database searches were performed in June 2020 through September 2020 and covered articles published over the past three decades (1988 – 2020). The databases that were searched include Campbell Library, Cochrane, Google Scholar, the Impact Field Guide and Toolkit Library, Open Grey, ProQuest APA PsychInfo, ProQuest Dissertations and Theses, PubMed, Web of Science, and WorldCat. Search terms were applied to databases as shown in Table 2.

After evaluating the studies for relevancy to the potential role of documentary films as levers of discourse around substance use, limiting to English language citations, and eliminating repeat citations, 54 citations were included for review. Two reviewers read and evaluated these 54 citations, and 26 citations were included in the final systematic review (articles presented in Figure 1). The 26 citations were analyzed for study design type, length of assessment, documentary film, main subject of film (drugs, alcohol, drugs and alcohol, opioids, tobacco, or stigma related to substance use and mental health), target population, research location, study methods, collection methods, and primary and secondary outcomes.
This chapter includes an overall description of the articles that evaluated documentaries and a look at how documentaries assess changes in knowledge, behavior, attitudes, beliefs, perceptions, stigma (related to substance use and mental health) and intentions.

These articles were studies on documentary films or documentary videos related to stigma, drug and alcohol use, mental health, tobacco use, or opioid use. Notably, there were far more documentary studies identified that focused on stigma related to mental illness that often included substance use disorders (N = 15) (Penn et al., 2003; Kerby et al., 2008; Larøi & Linden, 2009; Quinn et al., 2011; K. Anderson & Austin, 2012; Perciful, 2012; Page, 2013; Seroalo et al., 2014; Cerully et al., 2016; Regina Vila-Badia et al., 2016; Thonon et al., 2016; Burmeister et al., 2017; Hankir et al., 2017; Linton et al., 2017; Hodgkins, 2018). There were five articles specifically related to drug use (T. L. Anderson et al., 2015; Diesner et al., 2014, 2016; Barghouti et al., 2017; Dey, 2017), three related to tobacco use (Sutton & Hallett, 1988; So et al., 2011; Brown et al., 2016), one was related to alcohol use (Jaffe, 2012), one related to drug and alcohol use (McWilliams, 2014), and one was related to opioid use disorders (Brannock et al., 2020). Of the 26 studies, two focused on analyzing multiple documentaries (Seroalo et al., 2014; T. L. Anderson et al., 2015). Anderson et al. (2015) performed a content analysis on 64 documentaries focused on drug use produced between 1991 and 2008. Seroalo et al. (2014) performed a systematic review of interventions to reduce stigma attached to mental illness, and their documentary film was one method included in the interventions that the authors discussed. The documentaries that were evaluated, excluding ones that were evaluated in the two studies that analyzed multiple documentaries, are as follows:

It is important to note that not all of these documentaries were created by production companies for primarily entertainment or media purposes. Of these documentaries, four were documentary films/videos produced for the purposes of being part of a larger study/project or in collaboration with the study/project (McWilliams, 2014; Brown et al., 2016; Regina Vila-Badia et al., 2016; Hodgkins, 2018). Additionally, two documentaries were part of dissertation projects (McWilliams, 2014; Hodgkins, 2018).

There was also variation in terms of the dates and geographic setting of studies analyzed. Only four of the 26 studies were published before 2010 (Sutton & Hallett, 1988; Larøi & Linden, 2009; Penn et al., 2003; Kerby et al., 2008), which indicates that much of the work analyzing the impact of documentary films has been conducted in the last decade. Of those four studies, three were focused on stigma related to mental health more broadly rather than specifically focused on substance use. Additionally, the studies mainly occurred in the United States (N = 11). One study included participants from Canada and US (K. Anderson & Austin, 2012), one was conducted in...
France (Thonon et al., 2016), one in South Korea (So et al., 2011), one in Spain (Regina Vila-Badia et al., 2016), and one in Switzerland. The remaining studies were neither location based, nor participant based, but more program or documentary based. Furthermore, the studies that included participants were generally small with a sample size that ranged from 11 to 558 participants (So et al., 2011). The smallest study included just eleven participants.

There was variation in the design of studies that were included. Six of the studies were randomized controlled trials and four were qualitative studies. Other studies were quasi-experimental with pre-test post-test design. Only one of the studies was a cross-sectional design (So et al., 2011). Most of the studies measured individual level changes in knowledge, beliefs, attitudes, or perceptions. Only two studies directly measured if the documentary resulted in behavior change (Sutton & Hallett, 1988; Brown et al., 2016). Sutton and Hallett (1988) used four studies and tracked whether participants stopped smoking or attempted to stop smoking, and those that reported that they had stopped smoking were given carbon monoxide breath tests to verify the self-reported behavior change. The researchers found that those that had watched the documentary Dying for a Fag? had the highest cessation rates compared to those that watched control videos, and those that watched the documentary accompanied with a five-minute motivational video to increase confidence had higher rates of cessation and cessation attempts compared to those that only watched the documentary. Conversely, Brown et al. (2016) found that there was no significant difference in quit attempts between the groups that watched their documentary 4Weeks2Freedom compared to the control or the other treatment group that watched an informational film.

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Other studies employing pre-post designs found that documentary films were associated with individual level knowledge, attitudes, beliefs, perceptions, and behavioral intentions. The studies used a variety of instruments and measures. Notably, these studies employed different measures and there was some overlap in use of measures across studies. Specifically, six studies used the Social Distance Scale (SDS) (Penn et al., 2003; Kerby et al., 2008; Larøi & Linden, 2009; Perciful, 2012; Page, 2013; Thonon et al., 2016), four studies used the Community Attitudes to the Mentally Ill scale (CAMI) (Page, 2013; Regina Vila-Badia et al., 2016; Hankir et al., 2017; Linton et al., 2017), two studies used the Mental Health Knowledge Scale (MAKS) (Hankir et al., 2017; Linton et al., 2017), and two studies used the Reported and Intended Behavior Scale (RIBS) (Hankir et al., 2017; Linton et al., 2017). Since the studies generally use different instruments and measures without much overlap and there is a small number of studies overall, quantitative analysis traditionally used in systematic reviews would not be appropriate. With these limitations in mind, I briefly describe the findings below.

4.1 Attitudes and Beliefs

For the purposes of this review, attitudes will refer to affective judgment of an idea or object, while beliefs are convictions or assumptions that are held to be true.\(^\text{186}\) Since stigma includes negative attitudes and beliefs, which often constitute stereotypes, one component of stigma, changes in stigma are also discussed in this section.\(^\text{187}\) There were generally favorable

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results for documentary films being associated with changing attitudes and beliefs related to substance use and mental health more generally, and among these limited studies, these associations seem to be sustained over time.\(^{188}\) Barghouti et al. (2017) found that after watching a documentary, *SMASHED: Toxic Tales of Teens and Alcohol* about driving while under the influence of alcohol, there was a significant decrease in adolescents’ negative drinking behaviors after watching the documentary. High school seniors who watched the documentary had stronger attitudes that drinking and driving was dangerous compared to the control (high school senior who had not watched the documentary) at post-test and 30 day post-test.\(^{189}\) Brannock et al. (2020) found a significant decrease in participants’ bias determined by the Drug and Drug Problem Perceptions Questionnaire. After engaging in the educational program ROBIN (Reducing Opioid Bias is Necessary), which included a viewing of the HBO documentary *WARNING: This Drug May Kill You*, participants had a significant reduction in their bias against those with opioid use disorder, but the effect cannot be attributed solely to the documentary since it was embedded within the larger ROBIN educational program that included background materials, short videos, and writings from individuals and community members affected by opioid use disorders. Another study examined stigma that is indirectly related to substance use and/or mental illness. After viewing a film about homelessness (which recognizes that there is

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Jaffe, J. M. (2012). “SMASHED”: A quantitative study on adolescents’ attitude about drinking and driving after viewing a documentary film [Ph.D., Capella University]. https://search.proquest.com/docview/1013836700/abstract/478AB60427E84843PQ/1


Jaffe, J. M. (2012). “SMASHED”: A quantitative study on adolescents’ attitude about drinking and driving after viewing a documentary film [Ph.D., Capella University]. https://search.proquest.com/docview/1013836700/abstract/478AB60427E84843PQ/1
ahigh prevalence of mental illness and substance use among the homeless population), participants reported more positive attitudes towards persons experiencing homelessness.\textsuperscript{190}

Two studies that utilized Community Attitudes towards Mental Illness, which is a scale used to measure social stigma, observed no change in participants' attitudes after watching a documentary film about a doctor’s experience with mental illness, but this result may be attributed to the small sample size.\textsuperscript{191} Regina et al. (2016) conducted a randomized trial evaluation study at the school level to evaluate an intervention program that included viewing a documentary on mental health and a discussion afterward, and they found that there was a significant difference between the control schools and the treatment schools on selected CAMI subscales. Specifically, they found differences on the scale that measures authoritarianism, the view that those who are mentally ill are inferior people, and social restrictiveness, which assesses perceived dangerousness of those that are mentally ill. The findings of this study showed that the intervention, which included the screening of a documentary film and contact with healthcare staff in order to reduce the social stigma environment was effective at reducing social stigma. Cerully et al. (2016) also showed decreases in perceived stigma after viewing a documentary on mental illness. This study surveyed individuals at screening events and generally found that participants were more willing to live, work, and socialize with people with mental health challenges, felt better able to provide support, less likely to believe danger, more likely believe in potential for recovery, less likely to conceal mental health problems. However, the effect was


stronger among individuals who had never personally experienced a mental illness or who never had family members with a mental illness.\textsuperscript{192}

It is important to note that most of the studies that assessed attitudes and beliefs related to stigma focused primarily on mental illness stigma similarly to the studies mentioned before that utilized the CAMI scale. Kerby et al (2008) showed two anti-stigma documentary films to medical students to determine the feasibility of a study about stigma and mental illness and psychiatry. Students were shown “A Human Experience” and “A Day in the Mind Of.” The study found that these documentary films significantly improved general attitudes toward mental illness among medical students in the UK, but this result seemed to attenuate over time after eight weeks, although there was specifically a trend towards reducing perceived dangerousness. Austin and Anderson (2012) focused on healthcare providers’ stigma towards people with mental health disorders, specifically genetic counselors from North America. Those that took part in the study had attended a conference and watched a documentary about mental illness. Immediately after viewing the documentary, 34.5\% reported feeling more comfortable asking their patients about mental illness. At the three-month follow-up, 48.7\% reported feeling more comfortable.\textsuperscript{193} This demonstrates a change in attitudes, but stigma measures, specifically stereotype endorsement and desire for social distance, decreased right after viewing the documentary. However, they returned to initial levels at three months.

Three studies focused on stigma towards people with schizophrenia. Laroi and Linden (2009) found that after watching a documentary on schizophrenia, participants had less negative and derogatory stereotypical attitudes about schizophrenia and desired less social distance with


schizophrenia patients. They also determined that this effect was not related to social desirability, age, sex, or years of education, suggesting that the documentary alone was effective at reducing stigma. In contrast, Penn (2003) in a study examining whether viewing a documentary about people with schizophrenia could reduce psychiatric stigma found that the documentary, *I'm Still Here* could change some beliefs but not attitudes. Viewing the documentary resulted in attributions that ascribed less blame and responsibility to persons with schizophrenia for their disorder and that viewed the disorder as more changeable relative to participants that did not watch the documentary, but there was no difference in general attitudes. Thonon et al. (2016) also compared those who watched a documentary film to a control group. Only participants in the film group revealed a significant decrease of negative stereotypes (specifically dangerousness and unpredictability), desired social distance, and showed a significant increase in the perception of sociability in persons with schizophrenia.\(^{194}\)

Three studies evaluated the impact of different media, including documentaries, on stigma. Perciful (2012) studied schizophrenia stigma and randomized participants into four groups, one that viewed a fear-based inaccurate film (the film *Donnie Darko*), a likable-inaccurate film (the film *Me, Myself, and Irene*), an educational accurate film (the documentary film *The Brush, The Pen, and The Recovery*), and a control film that follows a deaf photographer as she questions the meaning of life. Notably, the study found that those that viewed the documentary film had lower stigmatizing attitudes compared to likeable-inaccurate, which could indicate that documentary films are more effective at reducing stigma than inaccurate films that portray characters with schizophrenia as likable.\(^{195}\) Page (2013) evaluated


\(^{195}\) Perciful, M. S. (2012). The Impact of Film on the Construction and Deconstruction of Mental Illness Stigmatization in Young Adults [Wright State University]. https://corescholar.libraries.wright.edu/etd_all/1128
how mental illness stigma among police officers who worked in suburban Chicago was affected
by viewing a stigmatizing film about mental health, *Shutter Island*, or a non-stigmatizing
documentary *I’m Still Here: The Truth About Schizophrenia*. Their MANOVA found no
multivariate effect of film exposure on measures of mental illness stigma, but ANOVA found a
significant effect of film exposure on officers’ reported levels of dangerousness, social distance,
and social restrictiveness – those in the stigmatizing film group perceived individuals with
mental illness as significantly more dangerousness than those in the documentary film group. 106
Additionally, those in the stigmatizing group reported significantly higher ratings of social
distance compared to the documentary film group. There was also a control group that did not
significantly differ from the other two groups on the different measures, which may indicate that
the effect of the films was not solely attributed to the different films. In fact, the MANOVA in
this study found a significant interaction between education level and film exposure on
dangerousness, social restrictiveness, and a small effect on social distance, which suggests
education may serve as a mediating factor in the relationship between film exposure and mental
illness stigma. 107 Dey (2017) studied stigma towards seeking treatment for substance use disorder
and compared two documentary style television shows, *Celebrity Rehab with Dr. Drew* and
*Intervention*. The impact of the different documentaries depended on whether they already had
positive or negative views of substance abuse treatment and not on the media itself. Those with
lower stigma about seeking treatment prior to the experiment had more stigma towards
professional psychological help afterwards. However, those that had higher stigma towards

Chicago School of Professional Psychology].
https://search.proquest.com/docview/1496775541/abstract/13E7902E276C4158PQ/1
107 Ibid.
seeking professional help prior had decreased stigma after watching either show. This could suggest that documentaries may be effective for specific audiences.

4.2 Intentions

Documentary films were found to be associated with altering behavioral intentions, but there were mixed results and the small number of studies that evaluated behavioral intentions makes it difficult to reach a solid conclusion about documentary film’s impact on this measure. After watching a documentary on teenage drinking and driving, seniors in high school showed less intention to drink and drive at immediate posttest and 30-day posttests compared to the control group that did not watch the documentary.198 Those who watched a documentary film about smoking had stronger intentions to stop smoking.199 In addition, those that watched a documentary film on homelessness had more positive behavioral intentions towards those experiencing homelessness.200 Cerully et al. (2016) found that after participating in a screening event, people were less likely to conceal mental health problems. However, Hankir et al. (2017) and Linton et al. (2017) did not find any effect of the documentary on behavioral intentions, but this may be due to small sample size as previously mentioned. However, Penn (2003) also found no significant effect of a documentary on schizophrenia on behavioral intentions towards those

198 Jaffe, J. M. (2012). “SMASHED”: A quantitative study on adolescents’ attitude about drinking and driving after viewing a documentary film [Ph.D., Capella University]. https://search.proquest.com/docview/1013836700/abstract/478AB60427E84843PQ/1
with schizophrenia, which potentially indicates that documentary films’ impact on behavioral intentions is weaker compared to beliefs and attitudes.

4.3 Knowledge

Most of the studies reviewed did not assess changes in knowledge. Only four studies specifically tracked changes in knowledge (Perciful, 2012; Hankir et al., 2017; Linton et al., 2017; Brannock et al., 2020). After completing the ROBIN program, which included watching the film Warning: This Drug May Kill You as stated earlier, participants qualitatively reflected statements showing “a better understanding of the epidemic, awareness of its effect in their community, awareness of addiction as a brain disease and mental illness that is chronic and lifelong, [and] awareness of treatments.” This suggested that there may be an increase in knowledge even if it cannot be directly attributed to the program. In addition, the Linton et al. (2017) and Hankir et al. (2017 studies) both found a statistically significant difference in mental health related knowledge after viewing the documentary The Wounded Healer: Perciful (2012), which compared the impact of a documentary film to films that portrayed people with schizophrenia as likable or unlikable, found that there was no significant difference in knowledge about schizophrenia between the groups.

4.4 Conclusions

Overall, there are a limited number of citations that can be used to evaluate documentaries and their ability to influence the levers of discourse and their possible ability to

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change public health outcomes. The relative lack of studies comes as no surprise given that documentaries are for the most part not created with behavior change and scientific rigor in mind. Post viewing analysis and evaluation are typically not part of the original conceit. Impact is typically considered around the time of completion of the film.

This systematic review bears that out through the 26 studies that were identified and evaluated. Of the 26 studies, the documentaries were disparate as some of them were didactic in nature, others were long-form, and others were short. Some were narrated and some were experiential, while others were created strictly for the classroom. Many of the studies were limited by small sample sizes. Too often there were no control groups, and standardized measures were often non-existent and uneven at best. When randomized controlled trials were conducted, it was usually in the case when the documentary was part of a larger intervention program making it challenging to draw any direct conclusions about the ability of documentary film to influence the levers of discourse around public health issues. Most of the studies did not assess knowledge and further study would be worthwhile.

There appears to be an increase in studies focused on de-stigmatizing mental health and, in some cases, substance abuse. Notably, there were more studies addressing stigma than studies that focused on increasing knowledge, intentions, and more generally on changing behavior. This is not surprising given that documentaries can bridge divides and introduce viewers to people living with mental health illness in a non-threatening way. While there is evidence to suggest that documentary can be useful in reducing stigma around mental health conditions, far less is known about increasing knowledge and changing behavior.
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Chapter 5: Conclusions

The opioid overdose epidemic in the United States is a major public health crisis, with devastating consequences for individuals, families, and communities. According to the Centers for Disease Control and Prevention (CDC), in 2020, there were 93,331 drug overdose deaths in the United States. Of those deaths, approximately 69,710 (74.8%) involved opioids. The mortality rate has increased since the widespread use of Fentanyl, a synthetic opioid that is approximately 50 to 100 times stronger than heroin and prescription opioids.\(^2\) Fentanyl overdose deaths are largely attributed to illicitly manufactured Fentanyl, which is often added to drug supplies to increase volume and amplify the high.

The factors that have contributed to the current dire situation are complex and warrant in-depth study. In short, the causes are multifaceted and encompass various aspects including the excessive-prescription of opioid pain medications, the widespread availability and use of illicit opioids most notably heroin and Fentanyl, the highly addictive nature of opioids themselves and the limited and the limited availability of addiction treatment services. All of these causes have been exacerbated by the stigma surrounding addiction, which has made it difficult for individuals to seek treatment and for effective public health measures to be put in place.

This dissertation examines the role of narrative discourse in addressing the opioid overdose epidemic. Narrative discourse matters. It matters that there is a clear and fact based communication about the numbers of people being impacted, it matters that people understand that the pain medications they're being prescribed are addictive, and that the illicit drugs they are taking are not only dangerous but may be contaminated with a synthetic opioid, Fentanyl which can be fatal.

Narrative discourse plays a significant role in combating stigma. Through clear communication we can help reduce the stigma surrounding addiction and dispel mistruths and misconceptions. Narrative discourse is inextricably tied to public perception and making the public more aware of the fact based realities of an epidemic that has claimed way too many lives. By presenting a fact-based narrative, we can help fight misinformation that often shrouds this emotionally charged, stigma-laden issue. The power of narrative can shape public perception and increase awareness of an epidemic which has claimed way too many lives.

This dissertation explores the potential for documentaries to play a role in shifting public perceptions and attitudes about the opioid epidemic. Documentaries are but one small part of a large and shifting media landscape. It is difficult to ascertain what percentage of documentaries occupy the ever changing media landscape, but documentaries have certainly gained increasing popularity in recent years. According to a report by the International Documentary Association, the number of feature documentaries released in the United States has nearly tripled since 2008, with 942 documentaries released in 2018 alone. In part, the increase can be attributed to the rise of streaming services, increased accessibility to filmmaking equipment, decreased costs of camera equipment, and a growing interest in nonfiction storytelling. Whatever the reason for their increased popularity, documentaries are an effective form of storytelling, offering a platform for raising awareness and sparking conversations about important issues, including public health crises like the opioid epidemic. Documentaries can capture viewer interest and catalyze that interest into an ability to engage the viewer in change-making, either for themselves or for others.

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Documentaries are promising as public health tools because when done properly, they have the ability to humanize an issue. By featuring real people and their stories, documentaries can evoke emotional connections with audiences, which can be an important first step in changing behavior. This is consistent with the concept of emotional appeals in health communication, which suggests that people are more likely to take action when they feel emotionally engaged with a message.\textsuperscript{204}

Furthermore, documentaries can reshape the discourse surrounding public health topics by providing access to information that may have been previously inaccessible. This is important in the context of the opioid epidemic, where there is still a surfeit of misunderstanding and stigma. By presenting accurate and informative content about addiction, the opioid crisis, and potential solutions, documentaries can help shift public perceptions and attitudes.

The history of drug epidemics shows that “history repeats itself”. These epidemics share common patterns often characterized by mistruths, driven by stigma effectively marginalizing the people who have fallen into the grips of addiction. Drug epidemics are often fueled by a combination of societal factors, including economic distress, social unrest, and changes in cultural norms. All too often, the response to drug epidemics have often focused on law enforcement and criminalization, rather than addressing the underlying social and health issues that contribute to drug use.

The current opioid epidemic is distinct from previous drug epidemics not only because of the specific substances involved, the demographics of those affected, and the ways in which it has been addressed by policymakers and public health professionals. However, there are promising approaches to address this epidemic including Medication-Assisted Treatment (MAT),

harm reduction strategies like needle exchange and legal interventions targeting the pharmaceutical industry and the illegal distributors. As the current opioid epidemic is ongoing, it is difficult to say how these more multidisciplinary approaches will ultimately impact the outcome which remains uncertain,

Documentaries, particularly those focusing on public health issues, can intersect with health communication theories. While many documentaries created for broad audiences may not have been produced with health communication theories in mind, the question of whether a successful public health documentary is, at some level, using any of the health communication models, has been explored.

Documentary films about public health issues have, can intersect with the principles of health communication theories. While many documentaries may not have been designed with communication theory in its design, films that inherently utilize elements of these models may contribute to successful storytelling. Documentaries have the power to raise awareness, engage in discussions and catalyze action within communities like the Health Belief Model that suggests that people are more likely to take action if they perceive themselves to be at risk and believe that the action will reduce the risk. Similarly, they can also serve as communication channels for disseminating knowledge and ideas, as proposed by diffusion theory.

However, when it comes to complex issues like drug epidemics, communication theories have their limitations. While these theories provide valuable frameworks for understanding the communication of public health information, they should not be solely relied upon. A comprehensive approach that combines health communication theories with policy changes, community engagement and multifaceted collaborations is necessary to effectively address the multifaceted factors involved in illicit drug epidemics.
In summary, health communication theories provide valuable insights into the communication of public health information through documentaries. However, it is essential to recognize their limitations and employ a holistic approach to address the multidimensional challenges presented by drug epidemics.

How does a documentary get produced and find its way to movie theaters and the homes and computers of the audience? It's a complex question that doesn’t have a straightforward answer. If we remove the content created by organizations that have vested interests, we are left with a quixotic system that lacks any set rules or clear guidelines. In the case of the HBO documentary Warning: This Drug May Kill You, it began with a newspaper clipping and commissioned in 2015. It was not commissioned as a public health documentary, nor was it meant as a didactic film. It aimed to reshape the prevailing narrative about the epidemic based on the insights shared by Dr. Andrew Kolodny. Dr Kolodmny explained the story behind the headlines and highlighted the role of the pharmaceutical industry as it pertained to the opioid epidemic.

Although there were no studies of note to measure the impact of the film, there is some evidence to suggest that it was effective in changing the narrative about prescription opioid use and addiction. The film raised public awareness, created a sense of urgency, and drew attention of the need for action. It is hoped that the documentary also contributed to reducing the stigma associated with addiction and increased awareness about the need for treatment and support for those struggling with substance use disorders. A systematic review of documentary films on public health issues was conducted and revealed a limited number of films (N=54) few conclusions could be drawn.
In short, yes, documentary films have the potential to move the levers of discourse, largely through raising awareness, promoting understanding, and shaping attitudes and beliefs among viewers. Documentaries have the ability to engage viewers emotionally and intellectually, and to provide a new perspective. Documentary films can help frame public health issues in a way that encourages public discussion and debate, potentially catalyzing action among policymakers.

My first documentary film, HBO’s *The Education of Dee Dee Ricks* (2011), played a small role in advocating for legislative change for women without health insurance who were seeking breast care. However, the path to legislative impact was not direct and offers limited insight about how documentary can drive legislative change. Nevertheless, the power to present real human in the context of public health issues creates an environment conducive to discussion and exchange, potentially informing audiences and fostering greater empathy and understanding.

While documentaries may not be a silver bullet for solving public health problems, specifically the opioid epidemic, they can play an important role in a broader public health strategy. This strategy should include other components including changes in provider practices, legal action against pharmaceutical companies, and improving access to treatment and prevention programs.

How does this impact the way I think about my own storytelling? It does, but not in the way I expected. Impact has always been a central consideration in my approach to journalism and storytelling. I believe documentaries should have meaningful impact, and that impact can manifest in various ways. Each documentary has its own unique filmic DNA and these unique characteristics make drawing any real conclusions particularly difficult. Moreover, there are many types of storytelling that are also able to put a human face to a public health issue.
including books, news articles, TV news reports, Tik Tok videos, Instagram posts, and so many more an increased and diverse range of platforms and formats available for sharing narratives.

I remember many years ago when I was still a relatively young reporter in local TV news, and a celebrated musician visiting New York City left his prized violin in a taxi cab. Clearly devastated, he described the loss as no less violent than losing his arms. He did all he could to be reunited with his violin but to no avail. He was devastated, but our viewers came to his aid.

It is important to keep in mind that this happened pre-social media, a time when instantaneous communication was much more challenging. Nonetheless, the response was overwhelming. Hundreds of people called the station, offering cash, violins, places to stay, and even an offer or two of marriage. Witnessing this outpouring awakened a sense of the possible.

This experience was a lesson about impact and the power to shape public discourse. It showed me that stories have the ability to move people and inspire action. While I attempted to analyze the situation through a more scientific lens, it became evident that impact is not always something that can be quantified or predicted. It was a reminder about the potential for storytelling to touch hearts, mobilize communities and create positive change.

It happened in *Warning*, only because Dr. Andrew Kolodny guided it in that direction by establishing a public health perspective from before the first frame was shot. His input allowed us to partner with NIDA, create a robust impact plan, and provide a repository of information to support those who may be dealing with addiction or have a loved one who is. This collaboration shows the deep connection between documentary filmmaking, academic research, scientific inquiry, and public health initiative. It also emphasizes the need for more frequent, qualitative, and quantitative testing of documentary filmmaking’s socio-political impact.
If we consider documentary films as an essential component of the narrative-building toolkit, both in terms of public policy and social discourse, then they should also be subject to more thorough evaluation. With increased, quantitative knowledge of the influences and consequences of specific documentary topics, techniques, and structures, we will be able to cultivate filmmaking more effectively as an implement for social and political change.

Although we do not have detailed information about the outcomes of "Warning: This Drug May Kill You" we took proactive steps and implemented an impact program that provided resources for those in need. It wasn't perfect, but it was a real effort, and it felt rewarding.

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I firmly believe in the potential of documentaries to shape the discourse around a public health issue, in particular the opioid epidemic. I could not spend such a significant amount of time making these films if I thought differently. However, it’s important to recognize that documentaries are only one component of a much larger, far more comprehensive public health strategy. While documentaries play a small role, I believe it is a potentially important role. It is essential to use documentaries in conjunction with other strategies to create a more holistic and comprehensive approach.

In conclusion, documentaries have considerable potential to have an impact on the discourse around public health issues, including the opioid epidemic, is significant. By educating and engaging audiences, documentaries can help to change attitudes, behaviors, and policies that contribute to the epidemic. However, the effectiveness of documentaries in this regard requires further research and evaluation to fully understand their role in shaping public health discourse.
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