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The Opioid Epidemic: How Our Society is Contributing to the Stigma

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Abstract

The ongoing opioid crisis in the United States is continuing to worsen as prevention strategies for opioid abuse and addiction are ineffective or improperly regulated. Behaviors of the providers, the public, and the patients must all be addressed to create effective prevention strategies because the attitude toward opioid addiction is a significant factor in the treatment of the disease. Many people view substance abuse as a choice and while this may be an accurate assumption in the beginning, citizens across America are not comprehending the full impact these substances have on a person's body over time, specifically their brain. In recent years, medical scientists and researchers have termed addiction as a disease but there are still significant barriers for those seeking treatment for it, especially for those in rural communities. The opioid epidemic is exacerbated by a lack of compassion as well as the stigma surrounding addiction, which has clouded the judgment of our health care providers to the point that they have become desensitized while treating a patient struggling with substance abuse. There are several factors contributing to this stigma such as the understanding of addiction as a disease instead of as a willful choice, negative language surrounding substance use, confusing the symptoms of mental and/or physical health issues with symptoms of substance abuse disorders, and limited access to rehabilitation and treatment, which all affect the user's willingness to seek health care.

Keywords: opioid epidemic, addiction, disease, stigma, treatment, compassion, health care providers, mental health

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Opioid abuse is considered a long-term issue and has become increasingly worse within the last thirty years. The leading cause of premature death in the United States is opioid-related overdose and in 2017, the White House Opioid Commission urged that the opioid crisis "be declared a national emergency as the widespread effects of the crisis span geographic regions, socioeconomic class, and race" (Collins, Bluthenthal, Boyd, & McNeil, 2018). The CDC has described it as one of the nation's top five public health challenges, and the implications to our medical infrastructure and health care system will be devastating if the opioid crisis is not addressed and resolved within the next ten years (Stoicea, Costa, Periel, Uribe, Weaver, & Bergese, 2019).

A public health emergency is defined by the U.S. Department of Health and Services (HHS) as "a disease or disorder that presents a public health emergency (PHE); or that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists" (HHS, 2019). Other examples of public health emergencies throughout the years have been events such as COVID-19, hurricanes such as Harvey and Katrina, H1N1 flu outbreak, severe storms such as floods and tornadoes, Zika virus outbreak, wildfires, and earthquakes (HHS, 2021). It is astonishing to see the opioid crisis in the same category as these other crises, but it makes sense with the research conducted regarding the effects of the opioid epidemic on our nation.

The factors relating to the opioid epidemic are all exacerbated by the treatment substance users receive. Some health care providers are unaware of their own biases and may not realize the full impact their attitudes have on the patients they are treating, but the stigma does not stop there. Our society contributes to the stigma by believing addiction is a willful choice instead of a

disease. Yes, a substance user's addiction may begin as a choice, but eventually their brains and their bodies come to rely on this substance and without it their bodies are unable to function normally. To reduce the stigma, we must encourage compassion and understanding by health care providers as well as the public and demonstrate that substance abuse stems from more than just a choice.

The history of the opioid epidemic is complex, and the stigma began as early as the eighteenth century when those who were considered abusers were thought to be "deluded or malingering" (Jones, Viswanath, Peck, Kaye, Gill, & Simopoulos, 2018). Jones, et. al., (2018) may have described their article as a brief history of the opioid epidemic, but it was very detailed. In their article, these authors discussed the early beginnings of the epidemic and how opioids were utilized before the 1800s as well as into the twentieth century. The study provided specific events throughout history that shaped the way the epidemic has evolved to its present point. Before the 1800s, pain was believed to be a consequence of aging and without any regulations, opioids were prescribed for a vast array of ailments "ranging from diarrhea to toothache" (Jones, et. al., 2018).

Legislation was passed in 1914 known as the Harrison Narcotic Control Act that ultimately discouraged the use of opioids and caused health care institutions to avoid them completely (Jones, et. al., 2018). The avoidance of opioids continued until the 1970s to 1980s when the attitude towards opioid analgesics shifted. It was believed by a few authors who published articles in medical journals that pain was being under-treated. In 1995, the American Pain Society launched a campaign to address pain as the fifth vital sign, and in 1999 the Veterans Health Administration supported this by utilizing pain as a vital sign (Jones, et. al., 2018). Agencies such as the Joint Commission (TJC), the Federation of State Medical Boards, and the

Drug Enforcement Agency (DEA) eased regulations, scrutiny, and restrictions regarding the prescribing of opioids "thereby assuaging physician reluctance to prescribe more liberal amounts of opioid analgesics" (Jones, et. al., 2018).

After this new attitude towards pain management was adopted, opioids were prescribed more carelessly and was unfortunately encouraged by pharmaceutical companies to increase their profits. "It must be noted that pharmaceutical companies contributed significantly to the rise of the opioid epidemic" (Jones, et. al., 2018) and

> the culture change, driven by intent to ensure access to pain relief, had opened the floodgates to the current opioid climate. In just the past 15 years, there has been a proportionate quadrupling of prescription opioid sales and mortality in both men and women based on National Vital Statistics System mortality statistics from the Centers for Disease Control and Prevention (Jones, et. al., 2018).

Hospitals were also feeling pressure to comply with new standards set by the TJC regarding pain management because they were afraid of losing funding if they failed to receive good satisfaction ratings among patients (Jones, et. al., 2018). Consequently, opioid medications such as OxyContin were regularly prescribed. "From 1997 to 2002, OxyContin prescriptions increased from 670,000 to 6.2 million" (Jones, et. al., 2018), and the consumption of opioids more than tripled between the years 2000 to 2012 (Jones, et. al., 2018).

However, the government, health care systems, and communities across the nation began to realize the detrimental effects of this overzealous approach to pain management. Patients and physicians alike were previously led to believe that opioids were not addictive, but as we know now these substances are highly addictive and have led to the public health crisis we are dealing with today. Programs to help avert this crisis were initiated as early as 2002, but real policy

changes and attitudes towards treating this epidemic did not begin until 2016. It seems too little too late because of how massive the opioid epidemic is now, but if real strategies and programs are continuing to be created to address the issue then there may be a real chance to treat those suffering and curb the negative effects into positive outcomes.

Demographics of this epidemic include ethnicity, culture, gender, and religion and evidence states that while all ethnic groups are affected, non-Hispanic whites ages 45 to 54 suffered the highest rates of drug overdoses in 2016 (Stoicea, et al., 2019). There is also a higher number of patients with mental health issues, such as bipolar and schizophrenia, abusing opioids compared with the general clinical population. Hospital systems are faced with significant financial and resource burdens due to opioid-related overdoses and from 2001 to 2012, approximately $700 million dollars was accrued because of over 660,000 hospitalizations as a result of opioid overdoses (Stoicea, et al., 2019). Prescription medications and substances abused include OxyContin, Valium, Xanax, Vicodin, methamphetamines, heroin, cocaine, etc. The list continues, but these are a few of the substances most likely to be abused.

While abusing prescription pills is not a disease, addiction is a disease and the U.S. has the highest addiction rate in the world (Stoicea, et al., 2019). Over-prescription by health care providers is one of the leading factors of addiction (Stoicea, et al. 2019). The CDC lists addiction as one of the top five public health challenges in the United States and reported 63,632 opioid overdose deaths in 2017, with an increment of 45.2% for synthetic opioid-involved overdose from 2016 to 2017 (Stoicea, et al., 2019). This evidence indicates the severity of the issue and proves why opioids are still a viable threat to our nation’s overall health.

Increased efforts have been made to reduce the problem and opioid prescriptions have decreased 13.1% from 2012-2015 as a result of new policy implementations as well as physician

awareness (Stoicea, et al., 2019). Prescriptions have also been reduced because of a system known as prescription drug monitoring programs (PDMP). This program relates to the concept of "doctor shopping", where people will visit multiple providers to obtain a surplus of opioid medication, so the implementation of PDMPs are one of the policies contributing to the success of this reduction in prescriptions. "Although laws mandating provider review of these data do not guarantee that all prescribers will comply, dramatic increases in providers' use of them have been demonstrated following implementation of these laws" (Dowell, et. al., 2016). In July of 2012, Kentucky mandated the use of PDMPs and "the number of provider requests for patients' prescription history reports increased from 811,000 in 2011 to nearly 4.6 million in 2013" (Dowell, et. al., 2016).

Not only do opioids affect our nation's overall health, but it also affects our economy. The article states that "the estimated total cost placed on the US healthcare infrastructure involving opioids is $72.5 billion annually" (Stoicea, et al., 2019). Insurance companies would rather provide more coverage for opioid prescriptions to at-risk individuals than to cover other pain-relieving methods that are considered too time-consuming. Several studies have shown that interdisciplinary treatment programs are more cost-efficient and many organizations such as the American Medical Association and the American College of Physicians support the use of these programs (as well as non-opioid pharmacologic therapy) as a preferable alternative to opioid prescriptions. However, "a correlation between cost management, profitability, and the coverage provided to Americans by health care providers do not respect the personal health of consumers" (Stoicea, et al., 2019), and the "financially incentivized coverage decisions made by health care providers twenty years ago play a role in the opioid crisis" (Stoicea, et al., 2019) we see today.

Even though the appropriate use of opioids is necessary for pain management, there is no denying the overwhelming evidence that the misuse and abuse of these drugs has caused us to lose control over the opioid crisis (Stoicea, et al., 2019). The unfortunate reality is that no one single factor can be blamed for this epidemic. It has been suggested that "a 3-point approach accentuating the prevention, treatment, and rehabilitation of both those currently affected and at-risk in the future may be the comprehensive solution" to the crisis we are facing (Stoicea, et al., 2019). Because of the negative impact on our overall health care system and population health, this issue should be both the responsibility of the individual as well as the government.

The importance of understanding addiction as a disease is monumental to changing the stigma associated with addiction. For us to understand addiction as a disease, we must first understand what these two terms mean. The American Society of Addiction Medicine (ASAM) defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences" (ASAM, 2019). According to the Merriam-Webster dictionary, disease can be defined as "an illness that affects a person, animal, or plant: a condition that prevents the body or mind from working normally" (Merriam-Webster, 2019).

By seeing the definitions of these terms, we can see how the terms are related. "Although addiction is influenced by environmental, genetic, and behavioral attributes, after initial exposure to a substance, addiction is driven by neurochemical changes in the brain that occur as a result of substance exposure" (Bartlett, et. al., 2013). Because these substances affect neurochemical changes in the brain, addiction can be considered a disease due to the definition of disease being "a condition that prevents the body or mind from working normally" (Merriam-Webster, 2019).

Over time, substance users must increase the dosage of substances they're consuming to achieve that original feeling they had in the beginning or to even function like normal, which is what causes the changes in the brain resulting in addiction. This is known as tolerance and this tolerance is what makes drug addiction so hard to overcome.

It is common knowledge that certain substances such as alcohol, nicotine, and opioids are harmful to our bodies. The severity of harm inflicted on our bodies depends on what we are ingesting and how much. There are acute as well as long-term health problems associated with using these substances.

> Addiction results in organ function changes similar to other chronic diseases. Addiction affects the circuitry of the brain in many ways, including those circuits involving reward, memory, learning, motivation, motor activity, and the ability to inhibit behavior. Addictions also affect several neurotransmitter pathways (e.g., dopamine, serotonin), and the changes can result in inability to stop the drug use, even when life is affected negatively (Bartlett, et. al., 2013).

A popular belief by many people is that substance abuse is a choice, and the user can stop at any time. However, those who believe this must not be aware of the science behind addiction. There is no cure for addiction just like there is no cure for other chronic conditions such as asthma, heart disease, cancer, diabetes, etc. With any chronic disease, the treatments are all the same and the treatment for addiction is the same as it is for other chronic diseases: medication, therapy, symptom management, and lifestyle changes.

Drug addiction has the biggest effect on our brains due to disrupting the way our brain sends and receives messages, but it also has negative effects on every organ in the human body. By abusing substances, an individual is more likely to engage in risky behavior or do things they

would not normally do. This can cause them to commit crimes or have an accident. Physical symptoms related to drug abuse are cancer, infectious diseases, harm to a fetus, acne or skin lesions, collapsed veins, baldness, some women can develop facial hair, jaw and teeth issues (bad breath, cavities, gum disease), mood swings and erratic behavior, accidental overdose, and death (Better Health Channel, n.d.). Some more effects on the brain include but are not limited to, higher risk of mental illness, depression, psychosis, and brain damage. Opioid withdrawal can be especially difficult and include symptoms such as anxiety, insomnia, abdominal issues such as nausea and diarrhea, excessive sweating, flu-like symptoms, muscle cramps, body aches, and many others (Sharp, 2021).

There are several treatment options for those suffering with addiction, but as stated previously, addiction is a chronic disease that will never be cured. It is a lifelong process and a commitment one must make to being healthy and having a better quality of life. There must be a comprehensive approach to the treatment of addiction because not every substance user is the same. There are several reasons why a person decides to consume a chemical substance whether it be experimentation or because of a medical issue, and addiction is different for everyone. Treatment options include detoxification, cognitive behavioral therapy, rational emotive behavior therapy, contingency management, twelve step programs, medication, inpatient and outpatient rehabilitation, and substance abuse/mental health counseling.

Contrary to the popular rhyme ‘Sticks and Stones’, words do hurt, and they greatly affect the way a substance user is viewed and treated. Collins, et. al. (2018) collaborated to bring valuable insight into the language and stigmatization surrounding the opioid crisis in their respective countries. Their article focuses on the extent that language affects the way people

understand and react to public health issues, specifically substance use (Collins, et al., 2018). The articles they studied to contribute to their research spanned twenty years, from 1998 to 2018.

During their research, Collins, et. al. (2018) discovered that Canada has a serious problem with addiction due to the significant number of opioid-related deaths in their country. Because of this, Canada has started implementing strategies to try to bring more awareness to the public regarding the opioid epidemic and provide more resources for those struggling with substance use. One of the programs being implemented is in the Province of British Columbia. They have "supported the rapid implementation of low-threshold supervised injection facilities, termed Overdose Prevention Sites" (Collins, et al., 2018), as well as provide safe places for people "to inject – and, in some cases, smoke – drugs under peer or support worker supervision, and be administered naloxone in the event of overdose" (Collins, et al., 2018). These facilities were previously called, "supervised injection facilities," until it was determined that these words were depicting a negative image of those who use drugs. It suggested that the public's resources were being utilized for substance users to "get high" and escape any consequences for their actions. Changing the term of the facility to "Overdose Prevention Sites" helps refocus the public's attention to the fact that the opioid crisis is a public health emergency and should be treated as such (Collins, et al., 2018).

"Words matter" (Collins, et al., 2018). These are the first words of the article's introduction and remain the prominent idea throughout. The authors discuss how much the language we use can affect the way a person perceives and treats someone who is struggling with addiction. They question that if we can change the medical terms for other diseases/diagnoses such as diabetes and AIDS because they target a specific group, then why can't we do the same for those involving substance use? The leading cause of premature death in the United States is

opioid-related overdose and the authors claim that if we change the language regarding addiction, we will have a better chance of "garnering wider support for the rapid roll-out of life-saving interventions" (Collins, et al., 2018).

Altering the language surrounding the opioid crisis has had such a positive influence in Canada. The public has a more accepting view of people using substances and Canada now has "updated drug education curriculums and outreach in schools, wide-reaching efforts by parent groups to highlight the damaging effects of stigmatizing language and changing support for overdose prevention interventions" (Collins, et al., 2018). The authors state that it is imperative that the United States imitates Canada's example in order to achieve the best results possible in handling the opioid crisis occurring here. Utilizing stigmatizing language "to discuss substance use and people who use drugs (e.g. 'substance abuse,' 'addicts') is morally-centered, largely impacting provider attitudes and can create barriers to accessing care" (Collins, et al., 2018). Continuing to utilize this language is causing more division among citizens who do not participate in substance use against those who do, and furthermore subjecting those who do to unprecedented discrimination.

Doctors are included among these citizens and those with substance use issues will be less likely to seek health care services when confronted with the callous behavior of providers due to the stigmatizing language surrounding addiction.

> More recently, messaging around the opioid overdose crisis and response strategies has emphasized individual responsibility (e.g. drug use as a 'choice'), suggesting people who use drugs knowingly consume too much (e.g. overdose vs. poisoning). However, the use of such language conceals the underlying factors perpetuating the overdose crisis (e.g.

> contaminated drug supply, social isolation, inadequate distribution of naloxone, lack of social supports) (Collins, et al., 2018).

A comprehensive approach of the issue should include emphasis on "the need to address the North American overdose epidemic through decriminalized tactics that encourage engagement in health services" (Collins, et al., 2019). Kentucky has implemented what is known as The Needle Exchange Program in over seventy locations across the state providing education to substance users as well as supplies to ensure the individual is using these substances in a safe manner with proper equipment. The article would describe this health intervention as an "evidence-based harm reduction strategy" (Collins, et al., 2018).

As referenced previously, the White House Opioid Commission in 2017 stated that the opioid crisis must "be declared a national emergency as the widespread effects of the crisis span geographic regions, socioeconomic class, and race" (Collins, et al., 2018). While there are multiple factors associated with the opioid abuse crisis, the argument of this article is that language is a significant barrier to the solution. We can conclude from the gathered evidence and agree that an effective health intervention for the opioid crisis would be to alter

> the way we speak about this public health emergency…Utilizing destigmatizing language (i.e. 'overdose prevention') in conjunction with drug policy reforms can help us realize our moral imperative to provide rapid public health interventions in the throes of a national crisis, and is thus an important first step in saving lives (Collins, et al., 2018).

The text provides evidence-based research throughout to support the authors' argument. Terms such as "addict" or "substance abuse" are considered stigmatizing language, but many people still use these terms simply out of habit. This is because these are the terms that were utilized

when describing this disease or a person's behavior. Health care providers must alter their own language to provide these individuals with better care.

Research has demonstrated that there is sufficient evidence that reinforces the assertion that substance users are treated differently, and that stigmatizing language is one of the reasons why health care providers have a negative view of this population. It also explains why these individuals are more reluctant to ask for help when they need it due to the harsh judgment they receive. Our own society is contributing to the stigma surrounding addiction because of the negative language associated with it. "Addiction is often an emotional and uncomfortable topic for health care providers. Even popular media sometimes portray addicted individuals negatively. Persons who struggle with addiction often are depicted as criminals or prostitutes, weak, lazy, and morally corrupt" (Bartlett, et. al., 2013).

Johns Hopkins Bloomberg School of Public Health conducted a national survey consisting of 709 participants regarding their opinions towards mental illness and drug addiction with questions that focused on stigma, discrimination, treatment, and public policy (Barry, McGinty, Pescosolido, & Goldman, 2014). This study was published in *Psychiatric Services* and found that the public had more negative opinions towards drug addiction than mental illness, and the public were against policies that support substance users in their recovery (Barry, et. al., 2014). While mental illness is still stigmatized at times, it has come a long way in recent years being accepted by the public as a true health condition. However, the public still fail to recognize addiction as a chronic health condition despite the science behind it.

The substance user is viewed as a weak or bad person and the survey demonstrated that the public regard drug addiction in a more negative manner than mental illness.

> Only 22 percent of respondents said they would be willing to work closely on a job with a person with drug addiction compared to 62 percent who said they would be willing to work with someone with mental illness. Sixty-four percent said that employers should be able to deny employment to people with a drug addiction compared to 25 percent with a mental illness. Forty-three percent were opposed to giving individuals addicted to drugs equivalent health insurance benefits to the public at-large, while only 21 percent were opposed to giving the same benefits to those with mental illness (Barry, et. al., 2014).

There is so much shame associated with drug addiction that it makes it extremely difficult for a user to come forward. This study reveals and supports the theory that our own society contributes to the stigma and is therefore worsening the public health crisis we are currently facing. One of the authors of the study suggests that just educating the public about why addiction is a treatable health condition will go a long way in reducing the shame associated with addiction and will result in more support for policy changes that will benefit those struggling with mental illness or drug addiction (Barry, et. al., 2014).

Health care providers are obviously part of our general public and users are aware that they can face discrimination anywhere, including a doctor's office or a hospital. Bartlett, et. al. (2013) discusses how nurses are the main face of health care and interact with patients the most, but found studies where nurses admitted to having a negative bias of drug addicted patients. These nurses believed the patients were able to stop their addiction at any time, shrugged off medical symptoms as being related to their drug use, and had negative attitudes towards patients they deemed were exhibiting drug-seeking behavior (Bartlett, et. al., 2013). "Negative attitudes by caregivers toward persons with addiction may affect a caregiver's willingness to assess patients for substance problems, affect caring relationships with persons suffering from addictive

diseases, and exacerbate avoidance of health care by those with substance problems" (Bartlett, et. al., 2013).

This type of negativity is exactly why substance users are hesitant or even unwilling to seek care for any medical problems.

> When a person with addiction perceives a care provider is negatively judgmental, he or she may react in angry and hostile ways that are helpful to neither of them…Individuals with addiction may react with less hostility if they do not believe they have to defend themselves. According to Monks and colleagues (2013), lack of knowledge by nurses about addiction and their negative attitudes toward addicted persons perpetuates poor care given by nurses to persons with addiction (Bartlett, et. al., 2013).

Some users postpone treatment for long periods of time, and this can worsen other medical conditions. "Addicted persons also often are reluctant to seek health care, so they present to a health care facility with more advanced illness" (Bartlett, et. al., 2013). Because of their shame and lack of self-esteem, patient outcomes are not as good as that of other patients who are not addicted to substances. Most of the time, they are denied medications due to the knowledge that they abuse substances, and they leave before their treatment is complete. The shame is too great already and it is intensified by the negative bias of health care providers.

In the article published by Saloner, McGinty, Beletsky, Bluthenthal, Beyrer, Botticelli, & Sherman (2018), the leading cause of injury death in the United States is opioid overdose and 64,000 people died from drug overdose in 2016. In their article, they mention how the language surrounding opioid addiction hinders rehabilitation and shows no evidence that this approach works. As an example, the 'War on Drugs' slogan has done nothing to decrease access to illegally purchasing drugs on the street (Saloner, et. al., 2018).

> The national dialogue around opioids has been dominated by several approaches that on their own are inadequate or harmful…Likewise, defining drug use as an individual's moral failing that can be remedied through willpower alone is inconsistent with biological triggers that create susceptibility to addiction. The moral failing approach also fails to recognize the role of trauma and adverse childhood experiences in addiction (Saloner, et. al., 2018).

Most substance users report that their addiction started in their teen/adolescent years. Because our brains are not fully developed at that age, we are more susceptible to the negative changes in our brains that reinforce addiction, and the longer a person abuses substances the harder it is to overcome the addiction.

There is a term known as self-medicating and it is unclear if the general public is aware of this phenomenon. Many individuals who struggle with drug addiction began using these substances to escape their own reality or to manage the symptoms of another disease such as a mental illness. They are using the substance to mask or alleviate other issues they are dealing with, and these substances provide a temporary escape. What truly needs to be understood is that addiction stems from more than just a choice, and the dialogue surrounding addiction should always include all factors relating and leading to addiction.

It is very difficult to stem the spread of the opioid crisis when the effects of opioid abuse are so hard to treat. An article written by Carlyle, Rockliff, Edwards, Ene, Marsh, Hartley, and Morgan (2019) discusses the factors relating to opioid use disorder (OUD) and explains that compassion focused therapy (CFT) is an effective treatment technique to treat OUD because it addresses common feelings associated with the disorder. Before this study, the effectiveness of CFT had never been evaluated. The authors of this research studied the effectiveness of CFT

involving therapeutic interventions such as compassion-oriented psychoeducation and self-compassionate exercises for three 2-hour sessions over a 3-week time period to gather data (Carlyle, et. al., 2019). This study was brief but provided a reasonable amount of data for the effectiveness of this treatment intervention for OUD.

"Adverse experiences in early life can interfere with the adaptive development of emotion regulation which is typically acquired in childhood and adolescence" (Carlyle, et. al., 2019). Those living with substance abuse disorders have reported psychological traumas in their childhood at a disproportionately higher rate than other individuals such as "inconsistent parental responsiveness, lack of affection, neglect, bullying and abuse, all of which are vulnerability factors to later developing a substance use disorder" (Carlyle, et. al., 2019). As discussed previously, substance users report experimenting with substances in their teen/adolescent years and addiction stems from more than just a choice. A substance user is more susceptible to abuse substances because they are trying to self-medicate, which can numb their unpleasant and negative emotions. These individuals abuse substances because they do not have the ability to self-regulate their emotions due to the psychological trauma and lack of nurturing during their childhood (Carlyle, et. al., 2019). Carlyle, et. al. (2019) states that if these traumatic experiences are not dealt with, they will persist into adulthood and this can include "high levels of self-criticism, guilt and shame, all of which are frequently reported among those living with addictions" (Carlyle, et. al., 2019).

To treat substance users, you must treat them holistically and demonstrate true compassion for their situation and how they ended up in it. Most importantly, substance users must acquire the ability to have compassion for themselves. Because these individuals have such a low opinion of themselves, they are full of shame and guilt which is why they feel the urge to

experiment with drugs to produce positive feelings. Having self-compassion for themselves "is positively associated with improved emotion regulation abilities and mediates the relationship between childhood trauma and later emotional dysregulation" (Carlyle, et. al., 2019). Carlyle, et. al. (2019) mention that substance users who abuse alcohol and have high rates of self-compassion have better mental health than those who have low rates of self-compassion, as well as longer periods of sobriety and have less feelings of negative emotions such as depression, anxiety, self-criticism, and stress.

"Treatments aimed at fostering self-compassion have already proven highly successful in the treatment of mental health problems, particularly in people who express high levels of shame and guilt and have histories of trauma" (Carlyle, et. al., 2019). Like those struggling to manage their mental health issues, those who struggle with substance abuse have higher levels of shame and guilt also, and many substance users report a history of physical and psychological trauma. Because this treatment has helped mental health patients, it makes sense that a therapy focused on improving self-compassion would work well for substance users also. "Importantly, self-compassion was recently shown as inversely related to risk of developing a substance use disorder, potentially indicating its protective involvement in reducing problematic drug use and demonstrating its therapeutic value" (Carlyle, et. al., 2019). However, those who have OUD can be hesitant to participate in therapies involving self-compassion because the lack of nurturing in their childhood could mean that compassion is something that is foreign to them and may resist such treatments (Carlyle, et. al., 2019).

Those who abuse substances often avoid situations that have the potential to cause negative emotions because of their decreased inability to self-soothe. Therapies such as CFT will assist OUD patients in cultivating self-soothing techniques by encouraging them to face any

difficult or unwanted emotions (Carlyle, et. al., 2019). When these individuals can show themselves compassion, it will lessen their desire to abuse substances because they are abusing the substances to cope with their problems and experience the positive emotions that a high from the drugs provides them (Carlyle, et. al., 2019). The relevance in CFT for patients with OUD is that "users feel large amounts of shame both currently around their drug use and historically due to trauma" (Carlyle, et. al., 2019) and "most frequently report taking opioids to manage difficult emotions" (Carlyle, et. al., 2019). The focus of CFT is to help substance users comprehend the nature of the human brain and understand how it has become "susceptible to rumination, negativity bias, and self-critical self-monitoring" (Carlyle, et. al., 2019), and teaching them how to "shift attention from shaming the self for these difficulties to how to work with them compassionately" (Carlyle, et. al., 2019).

Emotional regulation is something that is arduous for substance users, and emotional regulation can be measured by heart rate variability (Carlyle, et. al., 2019). "Physiologically, recent research has demonstrated that CFT leads to improvements in heart rate variability. Heart rate variability is a measure of emotional regulation, and therefore, enhancing emotional regulation is key to recovery…" (Carlyle, et. al., 2019). The results demonstrated that the patients of the study responded well to the overall technique, even though some did report an increase in their desire to use opioids after the 3-week time period (Carlyle, et. al., 2019). This was most likely due to confronting emotions they did not want to face and increasing their awareness of the issues they had been suppressing.

"Thematic analyses of interview data suggested positive effects from individuals in 3 areas: reducing self-criticism, facing negative emotions and a better understanding of themselves" (Carlyle, et. al., 2019). A fourth theme emerged, and it was the participants feeling

the need for more sessions because they felt as if the study was too brief. One participant stated, "'Personally I think they could have done with a bit more, because just basically you're scratching the surface ain't you and then it's the end'" (Carlyle, et. al., 2019). Overall, the CFT study demonstrated several positive impacts on the participants. One of the participants stated it reduced their self-criticism because the treatment "'enables you to not be so harsh on yourself'" (Carlyle, et. al., 2019). Another claimed that the study did better their understanding of themselves and the brain because "'I used to get annoyed with people that would look for sympathy all the time. Now I can understand why they're doing it, because they're looking for that part of the brain that needs like filling up basically'" (Carlyle, et. al., 2019). Other participants claimed it helped them overcome their fear of dealing with difficult emotions because it positively impacted their "ability to sit with discomfort and not to over-engage or feel the need to shut down or use to numb their emotions" instead of trying to "'run away'" or "'take short-cuts'" (Carlyle, et. al., 2019).

There were 81% of participants who were present for every session, adhered to all treatment guidelines, and reported that they wanted more CFT sessions after the study was over. CFT could be a viable treatment option for those with OUD, but Carlyle, et. al. (2019) state that this intervention would benefit from a more in-depth and longer randomized study. "Overall, these results indicate this new treatment to be feasible, and careful consideration should be given as to whether this should be systematically investigated in a higher powered, randomised control trial" (Carlyle, et. al., 2019). Individuals suffering from OUD receive less than adequate treatment due to physician bias and the evidence in this study supports the assertion that a more compassionate approach is needed for those suffering with addiction.

Contrary to popular belief, it is not only because of physicians and pharmaceutical companies that our opioid crisis has continued to worsen. Our opioid crisis is more complex than that and to begin eliminating the problem, we must confront all factors relating to it. Dasgupta, Beletsky, and Ciccarone (2018) state that we are ignoring the root causes of addiction when we seek to blame only the tangible causes; there are more intangible causes than there are tangible ones. Dasgupta, et. al. (2018) demand that we open our minds and focus more on the suffering and personal conflicts of the users to help them to determine why they view opioids as a refuge from their personal lives.

While Dasgupta, et. al., (2018) are not denying the major impact the prescribing volume has had on the evolution of our current opioid crisis, they are asserting "that the crisis is fundamentally fueled by economic and social upheaval, its etiology closely linked to the role of opioids as a refuge from physical and psychological trauma, concentrated disadvantage, isolation, and hopelessness" (Dasgupta, et. al., 2018). The authors feel as if physicians are trying to provide simplistic solutions to complex physical and mental health problems, and state that even cutting back on prescribing opioids is an illusory resolution to this crisis (Dasgupta, et. al., 2018). Ignoring the root causes of this public health emergency will impede any of the best-intended interventions, and we should adopt a health framework that includes structural and social determinants due to their significant effectiveness in reacting to public health crises (Dasgupta, et. al., 2018).

"Eroding economic opportunity, evolving approaches to pain treatment, and limited drug treatment have fueled spikes in problematic substance use, of which opioid overdose is the most visible manifestation" (Dasgupta, et. al., 2018). It was discussed previously in this research paper how in the 1980s health facilities were under attack for their undertreatment of chronic pain

management and this resulted in an increase of opioid prescriptions. The potential for addiction was significantly minimized, and physicians seemed shameless in meting out opioids such as OxyContin for any type of pain reported without considering whether the patient had a true medical need for it (Dasgupta, et. al., 2018). Factors such as these are generally believed to be the root cause of the consistent rise in the abuse of opioids over the last thirty years, and the number of overdoses and addictions rose simultaneously with it (Dasgupta, et. al., 2018).

Drugs that mimic the pharmaceutical effects of fentanyl, such as heroin and prescription analgesics like OxyContin, are in high demand for those with substance abuse issues. “Between 2013 and 2016, deaths attributed to fentanyl analogs spiked by a shocking 540% nationally, with pronounced regional increases. The rapid acceleration of the crisis has led to its designation as a national public health emergency” (Dasgupta, et. al., 2018). Recent policies have become stricter regarding the prescribing of opioids, but even with the decline in prescriptions, the number of overdose deaths have not decreased so far (Dasgupta, et. al., 2018). Between 2012 and 2015, outpatient opioid prescriptions declined to 13% nationally but overdose death rates continued to surge to 38% during this time, which demonstrates that “overdose deaths attributable to prescription opioids have not decreased proportionally to dispensing” (Dasgupta, et. al., 2018).

One issue that we have been seeing in the media lately involves incarcerating individuals for drug offenses. According to the Prison Policy Initiative, one in five people who are incarcerated in the U.S. are being locked in prison for a drug offense (Lee, 2021). Dasgupta, et. al. (2018) state that we cannot improve the overall well-being of our communities if we continue to condone incarceration for certain drug charges. Although some people believe that incarcerating these individuals will help them get off drugs and become sober, this is a wrong assumption. “Perversely, incarceration of people with opioid dependence leads to interrupted

opioid tolerance and a drastic elevation in overdose risk" (Dasgupta, et. al., 2018). This contradicts harm-reduction approaches to help treat the substance user's addiction, which is what many medical experts recommend in order to curb the effects of this epidemic. Having a record also makes it difficult when these individuals were living in a community that was lacking opportunity anyway, which could be a factor in their drug use. "Having a public record because of a drug conviction limits one's ability to obtain meaningful employment, reinforcing the penury that drove problematic drug use in the first place" (Dasgupta, et. al., 2018).

According to research from the University of Pennsylvania, there has been over a trillion dollars spent in the "war on drugs" since it began in 1971 and this campaign is believed to have done more harm than good, and it doesn't seem like it's going to pay off anytime soon (Lee, 2021). While overprescribing may have contributed to the epidemic we are facing today, it is not the sole cause, and it is not the most significant cause. "Adverse childhood experiences have been strongly linked to subsequent substance use; likewise, childhood trauma, is associated with increased opioid use years later" (Dasgupta, et. al., 2018). Researchers agree that other root causes include lack of economic and career opportunities, deficient working conditions, lack of trust and cooperation in disadvantaged communities, and the overall feeling of hopelessness and despair that substance users face (Dasgupta, et. al., 2018).

Another cause contributing to the public health crisis is the lack of education, resources, and compassion provided to substance users by health care providers in various health care systems. Some places do not have the resources to treat a community that has been ravaged by substance abuse and it is difficult for some providers to deliver the essential clinical attention this population requires (Dasgupta, et. al., 2018). Because these providers struggle to manage the care of these patients, several safeguards have been put into place to try to prevent misuse of any

opioids prescribed to the patient. “Patient contracts, urine drug tests, and prescription monitoring can generate mutual distrust in the provider–patient relationship when applied inconsistently, giving rise to uneven care delivery and inducing perceptions of intentional mistreatment” (Dasgupta, et. al., 2018). After dealing with this type of treatment, this can deter substance users from seeking help in the future.

This drug epidemic has made it difficult for health care providers and their patients to have a quality professional-patient relationship.

> ‘Suffering’ may be a better focus for physicians than ‘pain.’ Others have argued for ‘compassion.’ Health care providers have a role in reducing suffering historically and ethically. We have lost the commonsense imperative to engage those who use opioids in comprehensive care, especially during periods when access to opioids may be fluctuating. These tenets also may justify limited regimes to treat acute pain for veritable patient need (Dasgupta, et. al., 2018).

Patients can be denied the enhanced level of care needed if a health care provider feels that they are exhibiting drug-seeking behaviors. Providers have become desensitized to their patient’s concerns and lack the compassionate care this type of individual needs.

Providers must also keep in mind while treating these patients that we must combine compassionate clinical care along with coordinated efforts to address and better a patient’s physical and social environments (Dasgupta, et. al., 2018). While health care providers do not normally integrate such elements into their plan of care, it is critical for a substance user to have this type of holistic care because it involves public health, and this opioid crisis is a public health emergency. The type of community these individuals reside in, the job outlook and economic opportunities, a sense of solidarity with members of their communities, any disadvantages the

individuals face such as racism, and their overall quality of life and how they would rate their life satisfaction are all crucial aspects of the patient's life that need to be considered when providing care (Dasgupta, et. al., 2018). "As with previous drug crises and the HIV epidemic, root causes are social and structural and are intertwined with genetic, behavioral, and individual factors. It is our duty to lend credence to these root causes and to advocate social change" (Dasgupta, et. al., 2018).

As the title of the article by Dasgupta, et. al. (2018) states, there is no easy fix to our opioid crisis, and we must be vigilant in the treatment of patients who struggle with addiction. Health care providers and patients alike must explore the causes close to home that lead to addiction and discover the avenue of treatment that works best for the user. If health care providers can set their bias aside, they will determine the factors relating to the user's addiction as well as the treatment options that will aid in their recovery. This can only be accomplished if providers choose to see the person instead of the disease.

Speaking of social determinants and factors, it is also important to consider the theories of market justice and social justice relating to our opioid crisis as well. The social justice theory emphasizes the importance of equal treatment of all individuals. However, Moskalewicz and Klingemann (2015) believe that those who abuse drugs have been considered inferior to those who do not and therefore do not receive equal treatment. Moskalewicz and Klingemann (2018) believe that drug use is a social justice issue because substance abusers are not given the same treatment as those who do not abuse substances. There is evidence in the text that suggests substance users experience discrimination in the workforce as well as when they opt to receive health care services. The text also states that substance users are not viewed as human beings but instead as untrustworthy, mentally ill individuals who will commit any crime just to satiate their

habit. Moskalewicz and Klingemann (2015) assert that the behavior of substance users is being utilized as an excuse to explain the social inequality they face, and that the opioid crisis is a social justice issue because it affects those with lower socio-economic status and racial minorities. Therefore, this text reinforces the contention that substance users are not treated with the same compassion or equality as their peers.

Social justice is defined as emphasizing "the well-being of the community over that of the individual…" (Shi & Singh, 2019). The market justice theory is defined as placing "the responsibility for fair distribution of health care on market forces in a free economy" (Shi & Singh, 2019). When viewing opioid use through the market justice theory, the substance user must be willing to quit abusing drugs and pay for any necessary treatment that assists them in quitting such as drug rehabilitation facilities. The market justice theory emphasizes that everyone is responsible for their own health, therefore those making the choice of using drugs are doing so knowing the dangers and the risks. It also emphasizes that if people are obtaining these drugs legally or illegally, they are doing so with their own money that they have earned, and it is ultimately their choice what to do with it. Abusing opioids is an individual choice, which fits with the market justice theory.

The implication of the market justice theory is that not everyone has access to the resources to make informed decisions regarding their health care or their choices. Therefore, it is difficult to know whether an individual is fully aware of the choice they made and if they had the resources to make an informed decision. The market justice theory states that all individuals are responsible for the costs of their health care. This means that if you have a drug-related illness or disease, you are solely responsible for the medical care required to treat it. Research has shown that drug usage is higher in low-income communities and in areas with less educational efforts to

advise against it. This would be a conflict with the market justice theory because the market is not allocating resources equitably among all socioeconomic backgrounds.

When viewing opioid use through the social justice theory, you are agreeing with the belief that it is the responsibility of society rather than the individual when a person chooses to abuse drugs. The responsibility for this choice is shared because "society has an obligation to the collective good. An unhealthy individual is a burden on society…Society is obligated to eliminate (cure) the problem by providing health care to the individual, because this benefits society as a whole" (Shi & Singh, 2019). So instead of the substance user being responsible for the costs of their own treatment, the social justice theory believes that the government should be responsible.

The social justice theory also emphasizes the importance of equal treatment of all individuals. However, those who abuse drugs have been considered inferior to those who do not and therefore do not receive equal treatment (Moskalewicz & Klingemann, 2015). Moskalewicz and Klingemann (2015) believe that drug use is a social justice issue because substance users are treated unequally compared to those who do not abuse substances. As stated in the text, Moskalewicz and Klingemann (2015) assert that

> people suffering from addictions still experience discrimination in the labour market as much as in their access to appropriate health services…addicted individuals are perceived not only as mentally incapable but also as sinful criminals…they are persistently marginalized, socially excluded, and deprived of the prospects of being treated equally to their fellow citizens.

The behavior of substance users is being utilized to "justify social injustice" and that social justice is being affected due to this injustice affecting only a particular segment of the

population, such as “underprivileged classes and ethnic minorities” (Moskalewicz & Klingemann, 2015).

The implication of the social justice theory is that many people still view drug use as an individual choice. It is hard to say that the government should pay for a treatment that is completely preventable, or to say that society should be responsible for an individual’s decision to abuse opioids. The market theory conflicts with that because it would beg the question of why society should be held accountable for the individual actions of one. As far as social justice, it should not inherently be the responsibility of all when one decides to do something that negatively affects their personal health and therefore the overall health of our nation and economy; that decision is ultimately the responsibility of the individual. However, if this one individual accepts responsibility, seeks help, and is committed to their health and the health of their community, that is when the matter of social justice should prevail. Substance users should be responsible for certain aspects of their treatment, but they should be treated with the same care and compassion as anyone else who is battling a disease. By providing the appropriate resources, the social justice theory will be prominent by treating the disease of one to enhance the well-being of the community.

There are many primary care providers (PCP) who have expressed discomfort with prescribing opioid medications and prefer to treat patients without a history of addiction. They find the management of chronic pain is challenging and fear the risks of opioid misuse and opioid-related overdose, and the resulting ramifications of prescribing this medication to a patient who already has an addiction issue or becomes addicted. Dowell, et. al. (2016) discusses recommendations to ease the anxiety a PCP may feel when treating a patient with chronic pain or when they must consider prescribing opioids for effective pain management. Dowell, et. al.

(2016) offers specific recommendations a provider can utilize when treating a patient who may need opioids for chronic pain. It helps start the communication of benefits and risks of opioids, and how providers can better treat their patients. Those with addiction struggle to seek health care services because they are ashamed and do not want to be treated with contempt from the person who is supposed to help them. These recommendations may help a provider initiate the conversation and make their patient feel more comfortable.

According to Dowell, et. al. (2016), it is estimated that 11.2% of adults in the United States experience chronic pain. As we know, opioids are unfortunately a common but sometimes necessary treatment for pain, but there are serious risks associated with their consumption. "From 1999 to 2014, more than 165,000 persons died of overdose related to opioid pain medication in the United States. In 2013 alone, an estimated 1.9 million persons abused or were dependent on prescription opioid pain medication" (Dowell, et. al., 2016). When making the decision to prescribe opioids to a patient, the provider must consider several factors and determine if the benefits outweigh the risks for this patient. This isn't always easy to do, but the CDC guidelines includes key questions to assist the provider in determining what treatment is best for each patient. These questions can also help in initiating a conversation with a patient regarding whether opioid therapy is the best route for their chronic pain management.

While there have been positive effects from these guidelines, there have also been several negative ones. Dowell, et. al. (2019) discusses how some physicians have not implemented the CDC's guidelines correctly. Some physicians did not even attempt to taper their patient's dosing of their opioid medication and abruptly stopped prescribing the medication or completely dismissed them out of their care (Dowell, et. al., 2019). This type of abrupt discontinuation can have harmful effects on the patient's body systems and patients can suffer the effects of

withdrawal. The guideline states that physicians should not increase opioid dosage over a certain amount and does not specifically address the discontinuation of the opioid, but this guideline is being utilized as an excuse for the abrupt discontinuation.

Each patient is different, and policies should allow physicians to keep each patient's circumstances in mind when tapering dosage or discontinuing to prescribe the opioid medication completely. Dowell, et. al. (2019) demonstrates the hesitancy providers feel when prescribing opioids and how some will stop prescribing completely even if it results in harmful effects. These authors provide statements that health care providers have utilized the CDC's guidelines unjustly to excuse their behavior towards those they perceive with addiction (Dowell, et. al., 2019).

> For example, the guideline states that 'Clinicians should…avoid *increasing* dosage to ≥90 MME [morphine milligram equivalents]/day or carefully justify a decision to titrate dosage to ≥90 MME/day.' This statement does not address or suggest discontinuation of opioids already prescribed at higher dosages, yet it has been used to justify abruptly stopping opioid prescriptions or coverage. This recommendation also does not apply to dosing for medication-assisted treatment for opioid use disorder (Dowell, et. al., 2019).

The guidelines are being misconstrued purposely because it clearly does not state to stop prescribing even to those who have been diagnosed with OUD. These guidelines are meant to be exactly what they are termed: guidelines. These guidelines are not strict laws or policies, and the CDC is trusting health care providers to use the appropriate judgment and use these guidelines to formulate treatment plans that are in the best interests of their patients.

One of the main strategies for reducing the opioid crisis in our country is to control the prescribing of opioid medications, which is why we have prescription drug monitoring programs

to ensure there is no excessive prescribing of these addictive substances. Dowell, Zhang, Noonan, & Hockenberry (2016) investigates the effectiveness of these programs as well as pain clinic laws and other policies implemented regarding opioid prescriptions. Dowell, et. al. (2016) initially hypothesized that the policies related to opioid prescriptions caused an increase in heroin-related overdose deaths, but it was related to other factors instead. Their study provided evidence that mandatory provider review policies as well as pain clinic laws were instrumental in reducing the number of opioid prescriptions and opioid-related overdose deaths (Dowell, et. al., 2016). These evidence-based strategies aim to reduce the opioid crisis and discusses the value of the utilization of pain clinics for those addicted to opioids.

People suffering with substance abuse issues visit pain clinics frequently and the "combined implementation of mandated provider review of state-run prescription drug monitoring program data and pain clinic laws reduced opioid amounts prescribed by 8 percent and prescription opioid overdose death rates by 12 percent" (Dowell, et. al., 2016). During their study, Dowell, et. al. (2016) discovered that even utilizing only one of the two strategies demonstrated a significant decline in prescribing rates compared to states who did not use either. For states implementing both policies, there was a 10.6% decrease and for those who chose to only implement pain clinic laws there was a 26.9% decrease compared to the 5.5% decrease in states that opted to implement neither strategy (Dowell, et. al., 2016).

The ongoing opioid crisis in the United States is continuing to worsen as prevention strategies for opioid abuse and addiction are ineffective or not properly regulated. Because of these new policies, we can affirm that there has been a decline in opioid prescriptions since 2012 but even with this decline the epidemic has not improved (Haegerich, Jones, Cote, Robinson, & Ross, 2019). In 2017, there were still 191 million opioids dispensed to patients and it is estimated

that at least 11 million people misused their opioid prescriptions (Haegerich, et. al., 2019). As of 2015, the total cost for the opioid epidemic overall was well over $500 billion and approximately 2.1 million people were believed to have OUD (Haegerich, 2019). The behaviors of providers, the public, and the patient all need to be addressed to create effective prevention strategies because their attitudes towards opioid addiction is a significant factor in the treatment of the disease. Identifying effective strategies to eliminate this problem will benefit the overall treatment a substance user receives and consequently improve our overall health care system.

According to the research conducted by Haegerich, et. al. (2019), some of the most effective strategies are "PDMPs, insurer strategies, pain clinic legislation, clinical guidelines, and naloxone distribution." Public safety as well as public health collaborations are promising strategies as well but need to be studied further to determine effectiveness (Haegerich, et. al., 2019). The former governor of New Jersey, Chris Christie, made the remark that "addiction is a disease, and no life is disposable. It can happen to anyone" (Lee, 2021). The former governor is right. It can happen to anyone, which is why it is so vital to our nation's overall health and economy to pinpoint the strategies that work the best so we can begin to minimize the damage this epidemic is wreaking.

Health care providers sometimes allow their own bias to cause misjudgments and interfere in a patient's care. The opioid crisis has been declared by the White House as a national public health emergency and addressing provider bias as well as understanding racial discrepancies of this issue in our health care system will help control this epidemic (Collins, et. al., 2018). Ethnic minorities and nonwhite races have less access to health care and do not receive as many prescription medications for opioids as Caucasians do. Santoro & Santoro (2018) provide staggering statistics that 79% of Caucasians died of opioid-related overdose

compared to 10% of non-Caucasian minorities. The epidemic has grown significantly over the last thirty years due to racial as well as cultural biases. The bias against those suffering with addiction affects both public opinions and medical practices. Providers are more hesitant to prescribe to non-white minorities in fear of the potential for abuse. Physicians play a major role in the effects of this epidemic due to biases that influence their judgment when providing health care services. This bias impedes a patient's overall care and quality of life.

Opioid-related overdose is one of the leading causes of premature death in the United States with approximately forty people dying from it each day (Losby, Hyatt, Kanter, Baldwin, & Matsuoka, 2017). Health care systems are scrambling to find a balance between appropriate pain management for their patients and diminishing the risk for opioid abuse (Losby, et. al., 2017). Losby, et. al. (2017) conducted a study that spanned from 2010 to 2015 and it focused on the results of the policies Kaiser Permanente Southern California has implemented in response to maintaining this balance, and some of these policies included "prescribing and dispensing policies, monitoring and follow-up processes, and clinical coordination through electronic health record integration" (Losby, et. al., 2017). According to Losby, et. al., the study they have conducted "adds promising results that a comprehensive system-level strategy has the ability to positively affect opioid prescribing. The basic components of the intervention are generalizable and applicable to other health care settings" (2017).

Studies such as the ones implemented by Losby, et. al. (2017) demonstrates that physicians can effectively treat a patient's chronic pain while also reducing the risks for opioid misuse if utilizing the appropriate strategies. This will improve a patient's overall quality of care as well as benefit our health care system. The results showed dramatic improvement in Kaiser Permanente Southern California medical facility and these positive outcomes can be attributed to

the facility's "comprehensive initiative to transform the way that chronic pain is viewed and treated" (Losby, et. al., 2017). The CARA Act of 2016 also involves a comprehensive approach to treating those suffering with substance abuse issues, which only validifies the assertion that we must treat the person and not just the disease if we want to improve patient outcomes.

Rothstein (2017) is the previous editor of the *American Journal of Public Health* and he has the credentials and qualifications to be able to provide valuable insight into this opioid epidemic. In his article, he discusses what is contributing to the problem and his concerns regarding how it is being handled. Rothstein (2017) argues for the utilization of opioids for patients with chronic pain and for physicians to have more compassion treating pain management. The focus of his article is just as the title suggests; he is advocating for more compassion when treating pain management. He makes a very strong case for the continued utilization of opioids while also recognizing the need for efficient regulations to control the problem. Rothstein (2017) also provides solutions for physicians so that they can continue providing their patients with adequate pain management as well as assist in the prevention of opioid abuse. The author acknowledges that more compassion is needed for patients who are dependent on opioids and not every patient should be viewed as a "deceitful drug seeker" (Rothstein, 2017), which is someone who's faking illness and/or symptoms just for an opioid prescription. He provides solutions to the opioid crisis and addresses the anxiety prescribers and patients feel concerning opioid prescriptions.

Rothstein (2017) provides statistics of how much the opioid crisis has affected our nation, such as how much opioid sales and opioid-related deaths have "increased nearly fourfold" (Rothstein, 2017) between 1999 and 2014 as well as how many U.S. citizens have died due to opioid-related overdoses between 1999 and 2015 (183,000) (Rothstein, 2017). He also discusses

new policies surrounding opioid control and while he agrees that some policies should remain in place, he argues against the support for the new "no opioid" policies. In our nation's haste to reduce and eliminate the opioid problem, Rothstein fears that physicians have been neglecting the patients who "desperately need effective pain management" (Rothstein, 2017).

"In 2012, health care providers in the United States wrote 259 million prescriptions for opioid pain medication, one for every adult in the country" (Rothstein, 2017). Because of the overwhelming amount of opioid medication that was being prescribed, a prescription drug monitoring program (PDMP) was enacted along with several other federal and state laws and regulations to limit physicians' prescriptions as well as limit patients' opioid dependence (Rothstein, 2017). In addition to these laws and regulations, some physicians required their patients to sign private contracts consenting to "random pill counts and drug testing to ensure that they are actually taking the medicine and not diverting it" (Rothstein, 2017).

Many physicians fear repercussions for prescribing opioids and therefore even withhold opioid prescriptions from their patients diagnosed with chronic pain conditions. However, this exacerbated our nation's opioid crisis because when these patients were unable to refill their pain medication, they searched elsewhere for pain relief.

> With no alternatives for pain control, long waiting lists for substance abuse treatment programs, and the physical and mental pressure of unremitting pain, many patients turned to illicit drugs, especially heroin. The result has been greater addiction, more deaths from overdoses, and an increase in cases of HIV/AIDS and hepatitis from contaminated syringes (Rothstein, 2017).

The author argues that without an effective analgesic, these patients are unable to live full and healthy lives while combatting a debilitating pain condition.

It is difficult for a person suffering with addiction to quit any substance "cold turkey." Physicians know that smoking is bad for you, yet they still advise their patients, even pregnant mothers, to slowly wean themselves off the addictive substance in order to avoid withdrawal symptoms and stressing their bodies. However, some of these physicians simply stopped prescribing these opioids to their patients due to fear of disciplinary action and the new "no opioid" policies. Rothstein (2017) describes the arguments made in support of "no opioids" and then introduces a rebuttal to these arguments explaining why they are insufficient. The first argument in support of essentially states that there are no benefits and there are serious risks to long-term opioid treatment, which is an argument that Rothstein does not refute. He acquiesces that there are no long-term benefits, but that opioids are needed when a patient with chronic pain experiences a flare-up in symptoms. The second argument in support of "no opioids" states that physicians do not want to treat persons with addiction because they have insufficient training and experience in handling their care. Rothstein (2017) declares that "patients with substance use problems that most likely began by receiving lawful prescriptions for opioids to control pain should not be cast aside by their physicians."

Rothstein (2017) makes a very strong case for the continued utilization of opioids while also recognizing the need for efficient regulations to control the problem. Neither patient nor physician should be burdened by these regulations, but the potential of abuse as well as illegal activities should be considered when creating these policies (Rothstein, 2017). Physicians refraining from prescribing pain medication due to fear of negative impacts to their medical license and/or practice should reconsider because "such conduct lacks compassion for suffering

patients, fails to meet a reasonable standard of care, and contravenes foundational principles of medical ethics" (Rothstein, 2017). In his article, Rothstein (2017) provides solutions for these physicians so that they can continue providing their patients with adequate pain management as well as assist in the prevention of opioid abuse. Rothstein (2017) concludes his article with a powerful statement: "Desperately ailing patients who legitimately need medical relief from serious pain should not be the latest unintended victims of societal opioid abuse."

Volkow, Jones, Einstein, & Wargo (2019) analyze what led to our current status in this opioid crisis and how it will continue to evolve as well as provide interventions required to help reduce the severity of the crisis, such as involving psychiatrists to address the psychological causes of opioid abuse (depression, anxiety, etc.), and improving access to medications and treatments for opioid use disorder (OUD). While there is still a risk for relapse, Volkow, et. al. (2019) state that with more involved help from all fields of health care as well as increased access to medications and treatments for OUD may be the resolution to eradicating our opioid crisis. This demonstrates that there are more reasons people become addicted to opioids other than chronic pain management. Some utilize drugs as a refuge or have other underlying mental health issues, and they are using opioids to self-medicate. The approaches Volkow, et. al. (2019) mentions have the potential to improve the opioid crisis, thus improving our overall health care system and providing those with addiction problems the treatment to aid in their sobriety.

Despite efforts to curb the effects of this opioid crisis, the fact is that there are still thousands of opioid-related deaths every year and they are continuing to increase. It is vital that we continue conducting research with the focus of discovering the reasons why this epidemic has only worsened instead of improved, and what effects this has on our health care system. Many Americans have witnessed the contempt substance users face in various health care facilities and

current research has demonstrated that it does have an impact on their quality of care as well as their willingness to seek care. After searching countless articles and reading several studies, there is a noticeable element they all have in common. One of the biggest contributors to our current opioid crisis is our own society.

Kahn (2011) states that if we can pinpoint and utilize effective strategies, we can increase patient outcomes and reduce costs associated with addiction treatments for insurance companies as well as the patients. Her article addresses strategies to mitigate the risks of opioid abuse and addiction when prescribing opioid medications. These strategies include approaches such as encouraging the safe use of opioid medications including provider and patient education, and continued utilization of drug monitoring programs. By implementing these approaches, Kahn (2011) concludes that opioid misuse and abuse will be minimized, there will be less utilization of health care services relating to opioid abuse, patient outcomes will be enhanced, and overall costs will decrease.

Kahn's article was published in 2011 and the opioid crisis has continued to worsen. However, there was a major health care policy bill signed into law in 2016 known as the Comprehensive Addiction and Recovery Act (CARA) that focused on prevention strategies and evidence-based treatments to help those in need. Some of the strategies Kahn mentioned in her article were included in the provisions of this law along with several others. The opioid crisis has continued to gain more attention, but attention alone will not curb the effects of it. The White House Opioid Commission declared the opioid epidemic as a public health emergency because it not only affects opioid users and their families, but it affects our entire nation.

CARA is the "first major federal addiction legislation in 40 years and the most comprehensive effort undertaken to address the opioid epidemic, encompassing all six pillars

necessary for such a coordinated response – prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal" (CADCA, 2016). This policy receives $181 million of funding every year to serve our communities with the assistance they need to stand a chance in the battle against this epidemic (CADCA, 2016). CARA includes resources such as prevention education, life-saving medications to reverse overdoses, counseling and treatment options for individuals while incarcerated to promote a sober lifestyle once released, increasing access and providing safer alternatives for medication disposals, providing evidence-based research supporting techniques aimed at treatment options and intervention programs, increasing health care access to at-risk individuals, and improving and reinforcing prescription drug monitoring programs (PDMP) (CADCA, 2016).

As stated before, the policy design is focused on harm reduction with treatment and intervention programs to combat our nation's opioid crisis. Some of the interventions include the Law Enforcement Assisted Diversion (low-level drug violations are handled by evidence-based treatment and other services instead of incarceration), expanding distribution of medications needed to assist in treating those with opioid dependence (buprenorphine, methadone, etc.), and expanding the utilization of the life-saving medication naloxone to first responders as well as family members to reverse an overdose (Newman & Smith, 2016). However, the CARA act does not include a provision for federal funding, so funding must be allocated through the appropriate channels. Senator Whitehouse collaborated with several stakeholders in Rhode Island to strengthen the bill, as well as over 100 organizations such as National Council on Behavioral Health and Community Anti-Drug Coalitions of America. By the time Whitehouse was finished developing the legislation for the bill, he had the support of at least 250 organizations

("Whitehouse Applauds Signing of Comprehensive Addiction and Recovery Act into Law", 2016).

Building public support of this policy involved several members of Congress, federal health agencies such as the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), state and local health agencies, the organizations previously mentioned, and even President Obama. Earlier in the year, before Congress passed the law to the president for his signature, President Obama "proposed one billion dollars in new funding from Congress to help treat the opioid problem" ("Congress passes opioids bill to address addiction and support recovery", 2016). Legislative decision making and building of policy support was also a collaboration between the president, Senator Whitehouse as well as his group of co-authors for the bill, the organizations that assisted in crafting the bill offering valuable insight and expertise regarding a comprehensive approach to treating the crisis, and federal as well as state and local agencies advocating for assistance in managing the opioid crisis.

Legislative decision making and policy implementation was the work of Congress and President Obama. Senator Whitehouse introduced the bill in February of 2015 but it was not sent to the Judiciary Committee until February 2016. From here, it was sent to the Senate and was passed in March 2016, and then passed in the House in May 2016. Conference committee actions were performed on July 6th, 2016, to resolve any differences between the House and Senate regarding any controversial legislation. House and Senate both agreed to the changes made that were listed in the conference report, and Congress officially passed the bill on July 13th, 2016. It was then presented to President Obama on July 14th, 2016 and was signed into law on July 22nd, 2016.

Once President Obama signed CARA into law, it was passed on to the Department of Health and Human Services (HHS) and the Drug Enforcement Administration (DEA) for implementation. The Secretary of HHS had the opportunity to revise any requirements set forth by the policy and collaborated with appropriate officials in determining what did and did not need to be revised. The DEA was required to revise parts of their regulations "to reflect the new statutory language" (Implementation of the Provision of the Comprehensive Addiction and Recovery Act of 2016 Relating to the Dispensing of Narcotic Drugs for Opioid Use Disorder, 2018). The "window of opportunity" for this bill was due to the increase in deaths relating to opioid overdose in Senator Whitehouse's state of Rhode Island. The yearly number of overdose deaths in Rhode Island was more than all the other manners of death combined (homicide, suicide, accidents, etc.) and the CDC approximated the national average in 2015 at 16.3 per 100,000. The opioid crisis was worsening and was considered a leading cause of death in the United States. It was on track to becoming a public health emergency and was finally declared one in 2017 after this bill was passed. Everyone in Congress was committed to having a solution to the opioid crisis and so was President Obama.

One positive implication of the bill is that it is addressing our nation's problem and has expanded the use of life-saving medications to reverse an overdose, which will have the potential to save many lives. This policy helps to treat the person rather than just the disease. It encourages rehabilitation and treatment rather than incarceration for low-level drug violations. Other positive implications are expansion of prevention and education resources to communities and strengthening PDMPs. As Whitehouse stated, "Together we have changed the course of drug policy in this country and helped to recognize the humanity behind addiction" ("Whitehouse Applauds Signing of Comprehensive Addiction and Recovery Act into Law", 2016). However, a

major negative implication of this health policy is that it has no funding. How will people have better access to the resources provided by the CARA bill without appropriate funding for facilities to provide these services? Some treatment programs have waiting lists anywhere between a month to six months. It will be difficult for those who suffer with addiction to access the services they need if they are turned away due to lack of funding.

The public seems to forget that even though those suffering with addiction are costing our society almost $600 billion due to loss of productivity and medical treatment annually, these individuals and their families are paying the ultimate price. When a person struggling with addiction seeks health care services, they are confronted with cold indifference and contempt. Bartlett, et. al. (2013) addresses this as a barrier to care because this type of behavior can cause the individual to cease seeking help and ultimately miss out on treatment opportunities to become sober. Bartlett, et. al. (2013) provides harm reduction strategies as well as evidence-based practices regarding the treatment of addiction that have resulted in positive outcomes. Due to the stigma surrounding addiction, substance users receive harsh judgments while seeking treatment from health care providers and Bartlett, et. al. (2013) validify this assertion by explaining why this population is perceived in such a negative manner, as well as how this can dissuade a user from seeking treatment. Bartlett and her colleagues also focus on the personal effects of addiction on the person and their families. The best care for a substance user is to provide nonjudgmental treatment to achieve the best outcomes.

The opioid epidemic spans across the nation, but there are certain parts of the country where the epidemic has hit the hardest. “Geographically, the greatest burden of overdoses is in Appalachia, the Southwest, and New England” (Saloner, et. al., 2018). Those who have grown up in the Appalachian Mountains have been provided with a unique perspective of the opioid

crisis and have personally witnessed the devastation it has on not only the communities but the families as well. There is a small town in southeastern Kentucky with a population of less than five thousand people that has been hit especially hard by this public health crisis. In a study by Dexur in 2017, Perry County, which is in the city of Hazard, KY, has the highest opioid abuse hospitalization rate in the nation with a six percent opioid abuse rate (Maser, 2017).

Out of the millions of people living in Kentucky, there are thousands surrounded by those who do not always make the best choices concerning substance abuse. Many children are raised by their grandparents because their biological parents struggle with addiction, and other adults in the household are likely to have substance abuse issues as well. As a child living in Appalachia or anywhere there is a significant substance abuse issue, it is difficult to comprehend the impact this kind of environment will have on an individua. It will either completely deter them from experimenting with any type of addictive substances or it will pique their curiosity and they will feel the need to see what it's like. However, substance abuse and addiction aren't so black and white. There are a lot of gray areas, and many families struggle to find the balance between enabling and nurturing their loved ones. At what point does the nurturing end and the enabling begin when a loved one is struggling with addiction? Many family members grapple with this question immensely because it is difficult for a loved one to determine the right amount of tough love.

Many people who abuse substances report reasons such as economic hardship, lack of social interaction and isolation, and a general feeling of hopelessness as being the cause of their drug use (Dasgupta, et. al., 2018). There is a lack of job opportunities and not enough support from their communities to seek treatment for their addiction. This is especially true for the folks living in Hazard, KY because what was once considered a coal town is now considered a ghost

town. As we have seen in the news and media, thousands of people have lost their jobs due to the pursuit of clean energy. “The collapse of the coal industry forced many of the town’s residents into joblessness and also exacerbated the burgeoning opioid crisis in the region. In the last nine years, eastern Kentucky has lost over 11,000 coal mining jobs” (Kavilanz, 2017).

Due to the loss of so many jobs, the community also lost a significant source of income. When people are unemployed, there is less spending being put back into the economy so when several of the mining plants shut down, there were other businesses in the area that had to close as well (Kavilanz, 2017). The individuals who became unemployed began experiencing hardships and soon developed a sense of despair, which exacerbated the ever-increasing opioid problem in the community (Kavilanz, 2017).

> Poverty and substance use problems operate synergistically, at the extreme reinforced by psychiatric disorders and unstable housing…When sustained over years, on-the-job injuries can give rise to chronically painful conditions, potentially resulting in a downward spiral of disability and poverty. Although opioid analgesics may allow those with otherwise debilitating injuries to maintain employment, individuals in manual labor occupations appear to be at increased risk for nonmedical use (Dasgupta, et. al., 2018).

As with any other place in the country, addiction does not discriminate. However, it seems as if in Hazard, KY, addiction can occur in the whole family from grandparents down to their grandchildren (Kavilanz, 2017). To effectively convey the significant opioid crisis in Hazard, KY, 13% of the 251 babies born at the Hazard Medical Center “were exposed to opiates while in the womb” (Kavilanz, 2017).

OxyContin is one of the most abused and especially popular opioid medications in Hazard, KY, and is even referred to as “hillbilly cocaine” (Kavilanz, 2017). Opioid prescriptions such as OxyContin are readily prescribed to unemployed miners because of their unique working conditions. “‘Miners contort their bodies, spending long periods of time in small, cavernous holes. It puts them in significant pain’” (Kavilanz, 2017). Hazard’s chief of police, Minor Allen, claims a whole generation of Kentuckians were lost to the addictive effects of this drug (Kavilanz, 2017). According to the Economic Development Alliance, if the city were able to create more jobs that would be the first major step towards fixing the opioid problem in this small town (Kavilanz, 2017).

“In Kentucky, the drug overdose rate is higher than the national average” (Grayson, 2021). According to Adam Maggard, who is the Program Director for Mountain Comprehensive Care Centers (MCCC) for Southern Kentucky, the overdose rate is higher in Kentucky because of the isolation and the poverty experienced by the Appalachian region (Grayson, 2021).

> One powerful line of structural analysis focuses on ‘diseases of despair,’ referring to the interconnected trends in fatal drug overdose, alcohol-related disease, and suicide…In an analysis focused on the Midwest, Appalachia, and New England (where the heroin, fentanyl, and both comingled epidemics are most pronounced), combined mortality rates for diseases of despair increased as county economic distress worsened (Dasgupta, 2018).

The concept of ‘diseases of despair’ is very interesting because it demonstrates the correlation between environmental, economic, and social factors and how these factors can lead to things such as substance abuse, drug overdose, and suicide. Hazard, KY is full of socioeconomic disadvantages, and it is transparent why the ‘diseases of despair’ are more pronounced in this area.

During an interview with Janet, who is the Coordinator of the Perry County Health Department, she had a lot to contribute regarding the treatment of substance users and the handling of the opioid problem in Hazard, KY. Janet states that for there to be true growth and improvement within the community, the treatment aspect of addiction in health care needs to be changed. To assist with this change, the Perry County Health Department recently implemented a program specifically for substance users in the area called the Needle Exchange Program, which has also been implemented in approximately seventy other locations in Kentucky. She believes that every substance user should be treated with respect and care, and she admires the compassion her staff has for these patients. Janet states, "Many people give up on addicts and I believe that sets them up for failure. They are treated as pariahs, so they never move out of that setting. Even when they have recovered, they are still seen in that light because of their past. They are still treated as an addict and not as a productive member of society."

I also interviewed a clerk by the name of Kristin who works for the Perry County Health Department as well, and she says it is devastating to hear and be a witness to the harsh judgment and treatment a substance user receives while seeking health care. She claims that several of the substance users that come to the health department for treatment do so because other clinics refuse to treat them, and the substance users report feeling belittled and judged at other places. "They basically get rehab places shoved down their throat and judgy comments such as 'Well, if you stopped using you wouldn't have these problems.' It's honestly horrible how they are treated. One patient said other health care providers have not treated her with an ounce of compassion and looked at her like she was dirt on the bottom of their shoes. When I offered to let her speak with the nurse about the rash she was experiencing, she began crying hysterically

because she was afraid of being treated badly." Kristin also stated that this woman eventually ended up leaving and did not receive any medical treatment.

No individual should feel this way towards seeking medical care. All patients should be treated with compassion, dignity, and respect. A doctor's oath of 'Do No Harm' should not only include the oath to do no physical harm to another human being but should also include psychological harm as well. Another barrier to care that substance users face in rural communities such as Hazard, KY is lack of access and insurance coverage to properly treat OUD.

> Access to evidence-based treatment for opioid use disorder, such as methadone and buprenorphine, must be rapidly improved. The hardest hit states, such as West Virginia and Kentucky, prohibit Medicaid coverage of methadone maintenance, and insurance preauthorization prevents low threshold access among privately insured patients (Dasgupta, et. al., 2018).

An additional barrier is the debilitating stigma surrounding addiction. While national policy has advocated and emphasized the importance of "medically assisted treatment, the social stigma of these treatments is widespread, carrying unrealistic expectations for quick fixes and a pervasive belief in 'detox,' as exemplified by television shows popularizing coercive interventions" (Dasgupta, et. al., 2018).

There have been several policies and programs created to address the opioid problem in Appalachia. "The Appalachian Regional Commission recommended economic development strategies in addition to increased access to treatment services, prevention, and overdose medications. Yet, proposed federal health care reforms threaten to further exacerbate existing

service gaps" (Dasgupta, et. al., 2018). There is also a grant that has been awarded to seven organizations throughout Kentucky, including MCCC, to help reduce the overdose rate in the region known as the Rural Communities Opioid Response Program (RCORP) (Grayson, 2021). Maggard states, "We want to talk about what may have caused these individuals to end up in active addiction. Their past history, maybe their home life as children, you know something contributed to that" (Grayson, 2021).

Maggard also states that there are three essential components that RCORP focuses on: reducing stigma, instituting "drop-in" recovery centers, and creating rapid response teams to combat addiction (Grayson, 2021). The stigma associated with addiction is when "a lot of people see somebody on the street and see someone that is struggling and think negatively of them" (Grayson, 2021). By instituting "drop-in" recovery centers, substance users will be provided with an environment where they can feel safe, "get a free hot meal, they can get a shower, they can wash clothes. We can help them with job interviews. We can help them put in applications" (Grayson, 2021). The purpose of the rapid response team is to identify what are known as "hotspots" in a community where there is an increase in substance abuse and drug overdose so that care can be provided quickly if there is an emergency (Grayson, 2021).

For our nation to properly address and reduce opioid use and overdose, we must treat those suffering with this disease as human beings. Their quality of care should not be diminished based on the misjudgments and bias of others. Health care providers, as well as the public, should have more compassion for these individuals and try to understand what led them to their situation rather than condemn them. Our health care system must utilize a comprehensive approach to treating substance abuse disorders if we want to have any hope of reducing the crisis. The benefits will be great to our health care system and our economy, but most

importantly the benefits will be life-altering for those with the disorder and their families. U.S. Surgeon General Dr. Vivek Murthy said it best: “We must help everyone see that addiction is not a character flaw – it is a chronic illness that we must approach with the same skill and compassion with which we approach heart disease, diabetes, and cancer.”

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