Stigma and the Failures of Opioid Legislation

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Abstract

Is criminalization of illicit opioid usage the best way to solve the opioid crisis? This essay explores the current approach to solving the opioid crisis and the harm that it is causing. By looking at the history behind opioid marketing and manufacturing, as well as why some people begin taking opioids, the use of judgment and legislation is moving the opioid crisis in the wrong direction. Integrating views from other sources, this paper emphasizes the stress caused by opioid laws and looks for new ways to fight the almost 30-year epidemic that currently affects the United States.

Pain has been hardwired into the human brain since the beginning of mankind. When most people think of pain, they think of physical pain, which stimulates neural responses and produces unwanted sensations. Another type of pain exists in everyday life with varying levels of intensity. Emotional pain, also called psychic or mental pain, arises from overwhelming stress. The World Health Organization [WHO] defines stress as "any type of change that causes physical, emotional, or psychological strain" (WHO, 2021). Both physical and mental pain can be chronic, but physical pain was the focus of healthcare and organizations like the American Pain Society in the early 2000s. What followed was a strong push to suppress chronic pain in patients by prescribing opioids. These drugs provide analgesic effects and feelings of euphoria, but they may also lead to addiction. Over the next ten years, addictions and opioid-related deaths skyrocketed. To combat the growing numbers, legislators created laws reducing access to opioids. Their attempts backfired, and people suffering from addiction switched to cheaper and more obtainable substances like heroin and illicitly produced fentanyl. Since then, the number of people suffering from opioid use disorder has increased and drug use has become more dangerous. The negative stigma created by lawmakers and the public about opioid use disorder has helped fuel these increases.

After more than 20 years since the beginning of the opioid crisis, it continues to worsen. The number of opioid-deaths is higher than ever, even with doctors prescribing opioids less and less. Michael Mendoza and his co-author Holly Ann Russell note this increase and provide numbers to emphasize the continuing damage of opioids. According to Mendoza and Russell, "prescription rates dropped nationally almost 13% between 2012 and 2015. Paradoxically, however, the national overdose death rate increased 38% during these years" (Mendoza & Russell 7). Nabarun Dasgupta and his co-authors give another statistic, saying that "between 2013 and 2016, deaths attributed to fentanyl analogs spiked by a shocking 540% nationally" (Dasgupta et al 183). Both statistics show that as prescription opioids have become less common, deaths have increased. Twenty years seems like a lot of time to find a solution to a problem, yet a graph used by three different sources shows that either no solution has been found, or no previous solutions have worked. The graph, used in figure 1.1 (Mendoza & Russell 4), figure 1.5 (Kelly & Wakeman 9), and *Three Waves* graph (CDC), goes through every year from 1999 to 2016 on its x-axis, and the deaths per 100,000 people in the US on the y-axis. The opioid crisisis split into three phases based on overdose death rates. The first

phase started in 1999 and was the rise in prescription opioid overdose deaths. The second phase started in 2010 and was the rise in heroin overdose deaths. The final phase began in 2013 and is labeled as the rise in synthetic opioid overdose deaths. The most current phase has the steepest slope, meaning that deaths related to opioid use are rising quicker than ever before. If any previous solutions had worked, we would see the slope decrease in steepness. All the sources above support that previous solutions have not worked and a new approach is necessary to fix the opioid crisis.

States and insurers have tried to solve the opioid crisis through harsh laws that have both criminalized opioids and restricted access to them, but these laws have had more negative effects than positives (Kelly & Wakeman 11). While good things have come out of legislation, such as restricting prescriptions to only those who need it, that only helps people who are not already suffering from opioid use disorder. For those who physically and mentally depend on opioids, these legislations have consequences. By reducing access to prescription opioids, legislators caused a notable shift in drug usage towards more dangerous drugs like heroin and fentanyl (Kelly & Wakeman 11, Mendoza & Russell 8). Since these two drugs gained popularity after the introduction of harsh laws, it is evident that the intended outcome of these laws has not materialized. As a result, more people are becoming addicted to deadlier drugs. With the increased criminalization of opioids, an ongoing law enforcement crackdown has led to more unsafe practices by illicit opioid users. In an ethnography by Philippe Bourgois and Jeffrey Schonberg, the two authors followed a group of homeless people who used heroin even though several laws were made against the drug. These laws resulted in an increase in police sweeps, and "sent the [homeless group] into survival crisis mode and noticeably exacerbated their risky injection practices" (Bourgois & Schonberg 112). Throughout the ethnography, members of the homeless community were attempting to admit themselves to the hospital because of complications from their unsafe injections. Deaths due to unsafe injection practices have increased since laws were put into place, showing yet another grave repercussion from legislators' attempts to fight the crisis. Their actions have contributed to thousands of deaths, and a new approach must be taken to stop more deaths from happening.

Aggressive marketing in the early stages of the crisis caused was a factor in addictions for many people, but those people still get judged for something that they could not control. To empathize with those suffering from opioid use disorder, it is important to understand the impact that marketing might have had on starting their disorder. In the 1990s organizations like the American Pain Society introduced pain as the fifth vital sign alongside blood pressure, body temperature, pulse, and respiratory rate. This pushed hospitals to try to look for better ways to address pain (Damiescu et al 343). Around this time, a paragraph came out in the *New England Journal of Medicine* indicating that opioids were not addictive under certain circumstances (Porter & Jick 123). This paragraph became misunderstood throughout the medical community. Purdue Pharma took this information without researching more and it "became a landmark justification to aggressively market OxyContin" (Jones et al 4280). Marketing strategies included "[devising] lucrative incentives to prescribers to promote and prescribe opioids," and directly advertising opioids to patients (Mendoza & Russell 7). Jones and Mendoza both agree that pharmaceutical companies pushed false information to patients and the patients believed that information. Patients in hospitals with chronic pain trusted their doctors to give them accurate information about their treatment. Due to the factors explained above, doctors were left miseducated about the dangers of opioids, and they began to overprescribe them. Incognizant of the addictive qualities that opioids carry, patients followed the prescription, and many became addicted. While not everyone currently suffering from opioid use disorder started with prescription opioids, there are many people who did.

Still, there are critics who believe that opioid use disorder is a "willful choice" (Olsen & Sharfstein 1393). Any negative judgment only adds stress that might cause someone to continue using opioids.

Socioeconomic disparity has also contributed to opioid usage, but critics disregard this factor and continue to be censorious towards people suffering from opioid use disorder. Dasgupta and his co-authors focus their journal article on the social and economic factors surrounding the crisis. He finds a correlation between low-income areas and opioid use. According to Dasgupta, "the most lucrative employment in poorer communities is dominated by manufacturing and service jobs with elevated physical hazards, including military service" (Dasgupta et al 183). With a higher chance of getting hurt, these areas receive more opioid prescriptions, increasing the number of possible opioid addictions.

Changes to insurance and the price of care rooted in neoliberalism has turned healthcare delivery into a "commodity to be purchased rather than a natural born right" (Ratna 1). One important change in insurance was when the federal government took steps to reduce the benefits of the Affordable Care Act, causing an increase in the number of people uninsured in the US (Ratna 2). The result of this benefit decrease was a difference in access to care between those in a higher economic class and those in lower economic classes. Through their fieldwork, Bourgois and Schonberg witnessed exactly what Ratna talked about. The colleagues tried bringing one of the men to the hospital, but "institutionalized hostility of emergency room services for the indigent" resulted in them turning down the man (Bourgois & Schonberg 98). Other members of this community experienced similar incidents, which increased their risk of deaths related to opioids (98). Socioeconomic disparity allows some people to have greater access to treatments for opioid use disorder than others. With less access to treatment because of the inability to cover the cost, some people in lower-income areas are at a disadvantage. It is unfair to judge others for something caused by economic factors out of their control. With the difficulty already brought by low socioeconomic status, openly criticizing their opioid use disorder only brings them more pain.

Stressors during any part of a person's life can cause mental pain. Travis Rieder specifically focuses on drug use emerging during childhood, saying that "people self-medicate physical or psychic pain, anxiety, or depression; they experiment when they are young, or the stakes don't seem as clear" (Rieder 31). While critics of opioid use understand that those with opioid use disorder are not usually in physical pain while taking opioids, they also do not put enough emphasis on the mental pain that causes opioid use. In addition, they ignore additional stress that their criticisms may cause. An example of this is the use of language by the public when talking about opioid users. According to Olsen and Sharfstein, words used to describe opioid users include "dirty" if they are still suffering from opioid use disorder and "clean" if they have recovered. Opioid users are called "junkies" as well (Olsen & Sharfstein 1394). While "clean" may not sound like it holds a negative connotation, all three are deprecatory names given to those suffering. There is an argument that opioid users also sometimes use these terms, but they are rooted from the names given to them by the general public and still hold negative connotations that may damage their self-worth. For users who don't use these terms, the language used by critics of opioid use disorder adds stress by making the user feel judged for a disease out of their control. While Rieder and Olsen take different approaches to the topic in their statements, both agree that there is an interrelationship between stress, mental pain, and opioid use disorder. To advance efforts in solving the opioid crisis, more focus needs to be directed toward the effects of stress on opioid usage, and better language needs to be used when talking about people suffering from opioid use disorder.

It is evident that previous solutions to solve this crisis haven't worked. In recent years, there have been new approaches that focus on healing rather than punishment. Important solutions

include personal narratives and medications for opioid use disorder. Personal narratives offer a resource for those suffering from opioid use disorder and their families, showing them that recovery is possible. The CDC offers non-judgmental stories from opioid users. While not all the stories have happy endings, they at least raise awareness and provide useful information on how they have dealt with opioid use disorder. Some narratives end with recovery, like one featuring a recovering opioid user named Mike. After fighting hard to overcome the disorder, "Mike overcame his addiction and is now thriving in recovery" (CDC). Mike, along with others, uses personal narratives to assist people in achieving recovery. They omit any judgment and give opioid users hope. Kelly and Wakeman agree with the use of personal narratives. The two co-authors believe that increasing access to these stories can "reduce the prejudice, stigma, and discrimination that has retarded and undermined an adequate, rapid, response to the current crisis" (Kelly & Wakeman 16). Patient or personal narratives could benefit lawmakers too, who most likely use statistics as reasoning for creating laws against the opioid crisis. According to Damiescu and her co-authors, "the patient narrative adds multiple perspectives that case reports may not contain" (Damiescu et al 350). Instead of focusing on the numbers, legislators can see why people are taking them, because these narratives contain important information about social and economic background as it relates to drug usage. This will hopefully create more empathy towards those suffering from opioid use disorder and point new solutions in the right direction.

Another promising solution to the opioid crisis is medication for opioid use disorder, also called MOUD. Unfortunately, users who resort to this treatment are often disparaged, as some of the treatments still act on the brain in a similar way to other opioids. According to Mendoza and Russell, this treatment is "the use of pharmacotherapy, usually in combination with counseling or behavioral therapies, for the treatment of substance use disorders" (Mendoza & Russell 10). The drugs used include opioid agonists like buprenorphine and methadone as well as the opioid antagonist naltrexone. Opioid agonists stimulate opioid receptors and reduce withdrawal and opioid cravings. Antagonists block opioid receptors completely, preventing any opioid from reaching these receptors (Rieder 27-28). Both categories contribute to MOUD, and they have helped people struggling with opioid use disorder. There are currently limitations to this form of treatment though. Administration of methadone must happen at specific sites multiple times per week (Mendoza & Russell 11). Distance is a problem for those without access to vehicles, such as the people in Bourgois' and Schonberg's ethnography. The biggest barrier is the negative stigma surrounding this treatment. Since methadone targets the same receptors as opioids, "people taking these highly effective medications [remain] misunderstood and, ironically, re-stigmatized as being 'still using'" (Kelly & Wakeman 16). Rieder touches on this as well, saying that people believe that it "simply replaces one drug with another" (Rieder 28). Kelly, Mendoza, and Rieder all praise the effectiveness of MOUD in treating opioid use disorder but point out that the negative stigma surrounding this treatment keeps most people from getting the help that they need. Medication treatment is currently one of the best solutions for solving the opioid crisis, so people should promote MOUD rather than humiliating people for using it.

While it is true that opioid agonists like methadone stimulate opioid receptors, it is wrong to label this treatment as "still using." Critics of MOUD point out the similarity in function between methadone and other opioids. To get a better idea of why people resort to MOUD, it is important to understand the differences between opioid agonists like methadone and more potent opioids like heroin. With any addictive drug, there is a risk of withdrawal. Symptoms of opioid withdrawal range from nausea and vomiting to increased vitals and increased anxiety. These symptoms are often dreadful and difficult to endure. Methadone prevents withdrawal by activating opioid receptors and

reducing a craving of more drugs. A review by Richard Mattick and his colleagues highlighted the differences between methadone and heroin. According to the authors, methadone use does not create any euphoric effects and works almost four times as long as heroin (Mattick et al 3). Its long-lasting effects reduce the urge to turn to heroin, and this may also reduce cases of HIV or other infections that result from dirty needles. By getting rid of the urge to constantly use opioids, patients following this treatment can go to work and spend more time with their families. Another issue that critics may have with MOUD is cost since this treatment requires professional supervision and administration. They might believe that taxpayers will have to pay a large amount of money to support people struggling with opioid use. This is a reasonable concern to have, but research has shown that this amount is significantly less than the cost of incarcerating someone for substance use. Legislations criminalizing drug use have cost more money for taxpayers than MOUD treatment. Jones provides evidence for this, saying that "for every dollar spent on addiction treatment, there is a $12 return on investment through reduced healthcare and criminal justice costs" (Jones et al 4283). This extra money can either be saved or reallocated to building more treatment centers. Paying taxes for criminalizing opioid usage and paying taxes for running addiction treatment centers both affect people suffering from opioid use disorder, but evidence shows that MOUD is more successful at reducing illicit drug use. Medication for opioid use disorder is an efficient and cost-effective solution to the opioid crisis and should be the primary approach in battling this epidemic.

The claim by critics that opioid users do not deserve money or help for treatment rests upon the assumption that opioid addiction is a willful choice. A lot of people who oppose the treatments mentioned above think that people are fully responsible for their actions and should solve their problems by themselves. They may also think that judgment and punishment are necessary to prove that those struggling with opioid use disorder made the wrong choices. These claims ignore social and economic hardships that might have sparked opioid use. They also ignore the factors that started the opioid crisis, which led to thousands of overdose deaths and even more new addictions. One factor that can lead to opioid use, especially in lower income areas, is genetic polymorphisms. Dasgupta gives an example of this, saying that "individuals living in low socioeconomic neighborhoods were more likely to develop chronic pain after car crashes, a process mediated by stress response genes" (Dasgupta et al 183). This chronic pain can lead to opioid use, and these people are more likely to continue using opioids because these genes are part of their biological makeup. Once again, their addictions were created from factors that they could not control. Understanding these unavoidable precursors to opioid use is paramount to creating effective solutions to a crisis that has lasted three decades.

While opioids were originally made to treat physical pain, more and more people suffering from opioid use disorder in recent years have attributed their use to mental pain. Social and economic factors responsible for mental pain aren't viewed with much importance by legislators when looking for solutions. Critics of opioid addiction resort to judgment, often using reproachful names to describe those suffering from opioid use disorder. Their judgment has created a negative stigma that has prevented users from getting help and added to their stress. Evidence supports the use of MOUD to successfully treat someone with opioid use disorder. A better understanding of the factors that influence opioid use is important to slow down overdose deaths caused by these drugs. More funding should go towards research-backed treatment rather than criminalization. Ending the crisis begins with empathy.

References

Bourgois, Philippe and Jeffrey Schonberg. *Righteous Dopefiend.* University of California Press, Berkeley, 2009.

CDC. "Understanding the Epidemic.", Mar 19, 2020, https://www.cdc.gov/drugoverdose/epidemic/index.html. Accessed April 26, 2021.

Damiescu, Roxana, et al. "Health(Care) in the Crisis: Reflections in Science and Society on Opioid Addiction." *International Journal of Environmental Research and Public Health*, vol. 18, no. 1, 2021, pp. 341. OneSearch, doi:10.3390/ijerph18010341. Accessed April 26, 2021.

Dasgupta, Nabarun, Leo Beletsky, and Daniel Ciccarone. "Opioid Crisis: No Easy Fix to its Social and Economic Determinants." *American Journal of Public Health (1971)*, vol. 108, no. 2, 2018, pp. 182-186. OneSearch, doi:10.2105/AJPH.2017.304187. Accessed April 26, 2021.

Jones, Greg H., et al. "The Opioid Epidemic in the United States—Overview, Origins, and Potential Solutions." *Cancer*, vol. 124, no. 22, 2018, pp. 4279-4286. OneSearch, doi:10.1002/cncr.31713. Accessed April 26, 2021.

Kelly, John F., and Sarah E. Wakeman. "Killing More than Pain: Etiology and Remedy for an Opioid Crisis." Springer International Publishing, Cham, 2019. OneSearch, doi:10.1007/978-3-030-16257-3_1. Accessed April 26, 2021.

Mattick, R. P., et al. "Methadone Maintenance Therapy Versus no Opioid Replacement Therapy for Opioid Dependence." *Cochrane Database of Systematic Reviews*, no. 4, 2002, pp. CD002209. OneSearch, doi:10.1002/14651858.CD002209.pub2. Accessed April 26, 2021.

Mendoza, Michael D., and Holly A. Russell. "Epidemiology and Public Health Implications of the Opioid Crisis." Springer International Publishing, Cham, 2020. OneSearch, doi:10.1007/978-3-030-36287-4_1. Accessed April 26, 2021.

Olsen, Yngvild and Joshua M. Sharfstein. "Confronting the Stigma of Opioid use Disorder—and its Treatment." *JAMA : The Journal of the American Medical Association*, vol. 311, no. 14, 2014, pp. 1393-1394. OneSearch, doi:10.1001/jama.2014.2147. Accessed April 26, 2021.

Porter, Jane and Hershel Jick "Addiction Rare in Patients Treated with Narcotics." *N Engl J Med*, vol. 302, no. 2, 1980, pp. 123, One search, doi:10.1056/NEJM198001103020221. Accessed April 26, 2021.

Ratna, H. "Medical Neoliberalism and the Decline in U.S. Healthcare Quality." Journal of Hospital Management and Health Policy, vol. 4, no. 0, 2020, doi: 10.21037/jhmhp.2020.01.01. Accessed April 26, 2021.

Rieder, Travis N. "Solving the Opioid Crisis Isn't Just a Public Health Challenge—It's a Bioethics Challenge." *The Hastings Center Report*, vol. 50, no. 4, 2020, pp. 24-32. OneSearch, doi:10.1002/hast.1169. Accessed April 26, 2021.

World Health Organization. "Stress." 12 Oct. 2021. www.who.int/news-room/questions-and-answers/item/stress. Accessed Nov. 2, 2022.