

## Chapter 7

# Society's Evolving Understanding of Chemical Addiction and the Subsequent Changes in Policy and Treatment Approaches

## *The Struggle to Stay Clean*

*Oh no, this can't be good,* thought Olivia, as she impatiently waited for Carolyn to show up at the Narcotics Anonymous (NA) meeting. Olivia had a bad feeling as she hadn't heard from Carolyn for about week, and now, 15 minutes into the meeting, she was downright worried. Carolyn had missed the NA meeting last Friday that they typically attended together but had told Olivia she'd gone to meetings on Tuesday and Thursday nights last week so was giving Friday a miss as she had a head cold. She had promised Olivia she'd be back tonight.

A half hour into the meeting, Olivia couldn't sit still another second, so she left as quietly as possible and headed to Carolyn's house. She knew she wasn't responsible for keeping her young friend clean, but she also knew all too well what the pull to the dark side was like. If not for the support of a relative and a caring social worker, she would likely be in jail or dead. Paying forward the support she'd received had helped Olivia in her recovery, but she knew there were limits.

"Damn it," Olivia shouted, when her repeated knocks on the door went unanswered. She headed around back and found the back door slightly ajar. Pushing it

open, she crossed the kitchen, sidestepping the garbage strewn across the floor. Once in the living room, she saw Carolyn lying on the couch, looking pretty out of it, her bare arms and legs scratched raw. A syringe was on the floor, and a dirty spoon was on the coffee table. Olivia knew there was no point in talking to Carolyn at that moment, but she was angry, disappointed, and scared for Carolyn, so she let loose.

“Back at it, I see. I thought you were tired of being sick and tired. I thought you didn’t want to go back to prison. I thought you wanted to get your kids back. I figured that this time you’d stay away from this poison. C’mon Carolyn, think about somebody besides yourself.”

“F-you, just leave me alone,” Carolyn spewed back before nodding off. Rather than irritating Olivia, the response made her reflect on how unhelpful she was being. “I won’t leave you alone, Carolyn, because I’m your friend and I care, but I will shut up and let you sleep. We can talk later.” Olivia didn’t expect or get a response and decided that she might as well see if she could clean up enough to get rid of the horrid smell.

Olivia figured that Carolyn would be remorseful and angry at herself for using again. But feeling remorse was no guarantee that she’d get back on track with her recovery program. *Maybe being sent back to prison would be the best thing for her*, Olivia thought, *but I don’t know, and it’s not my call anyway. My job is to be her friend, not her social worker.* As she cleaned, Olivia reflected on a couple of her many conversations with Carolyn in the past six months.

After the third Friday night NA meeting that Carolyn attended, Olivia had asked her if she wanted to meet for coffee and had been surprised when Carolyn readily accepted the offer. Although quiet at the meetings, when it was just the two of them, Carolyn had opened up immediately, confiding that “all I used to want was to stay high. It was the only time I didn’t feel self-hatred, self-pity, and anger toward everyone, even my children. It was like I was stuck living in a world without sunshine or hope; a world of sadness, of gray, of losing, and especially pain. I was desperate to escape the pain I felt and actually still do feel. It didn’t seem to matter if I lived or died, so I didn’t worry about dirty needles or a contaminated batch. Thinking about that and how I didn’t care that it would hurt my kids makes me cry a lot. Part of me still wants to get high; I crave it bad, but NA is helping me stay clean.”

It was during this first coffee together that Carolyn had shared some of the childhood memories that she used drugs to avoid thinking about. “I watched my mother be physically abused by my father, who punched her regularly, and hard. He was a brute and hit me as well and would drag me by my hair. Then, after my parents divorced when I was 10, my mom got involved with another abusive scumbag. My parents were heavy drinkers and not what one would call responsible, but at least when they were together my uncle wasn’t around all the time and wasn’t sexually abusing me. That started after the divorce. I don’t know—maybe that creepy asshole was waiting until I was at least 11. When my father left, my uncle came by a lot under the pretense

of helping my mom. He gave me presents, asked me about school, and even took me on trips. He was the only adult family member who paid attention to me.” Carolyn had grown more upset telling the story and was almost in hysterics, sobbing loudly, her chest heaving. Olivia had a hard time making out the exact stream of words, but the gist of it was that “I hated myself for ‘allowing’ it to go on and not telling my mom. I hated my mom for being oblivious to it and too caught up in her worthless boyfriend to notice me. I was all alone. I had no one to turn to. When my so-called friend offered me drugs, I figured, why not? The drugs helped numb the pain and self-loathing. At first I mainly used alcohol, pot, and cocaine. I even backed off coke when I was pregnant. After my children were born is when I got into heroin.”

Carolyn went on, “It was in prison, after getting caught stealing to feed my drug habit, that I decided I didn’t want to go on living just to get high. My children, who were living with my mom, came to the prison to visit. I hated my mom for bringing them, but on the other hand, it was a wake-up call that I didn’t want to lose my kids, and I didn’t want their memories of their mom to be prison visits. I only had to spend a couple of months in prison, and despite all those good intentions, the day I got out I got high. Stupid, I know, but it was like I needed it, and I thought I deserved to not feel like crap. So much for the wake-up call.

“A week after my release, my parole officer called and told me I needed to stop at NewWay for a random drug screen. I told her I wouldn’t pass it. To my surprise, instead of sending me back to prison she offered me the opportunity to enter drug court. Like I said, part of me really wanted to get clean for my kids, but a big part of me just wanted my fix, my escape. I really didn’t think I could live without it. I didn’t know how to handle the hurt and pain. I also didn’t, and don’t, want my kids with my mom. She is well meaning, but she’s a mess. And now she’s got a new boyfriend, and that freaks me out given my experience with her choice in men. I’m surprised that child welfare even considered her appropriate for kinship care.”

Those early talks, and then her convincing Carolyn to try out Sophia, the social worker Olivia herself had gone to for years, seemed like a long time ago. Sophia was employed at a facility the drug court worked with, so there was no waiting to get in to see her. Olivia believed Sophia was a godsend. She had helped Olivia reframe how she thought about herself and work on forgiving herself little by little for the death of her daughter, Lizzie. Olivia was Carolyn’s friend and would continue to support her, but she knew that she didn’t have the skill set to be her social worker, nor did she have the emotional distance.

Olivia was thinking about how much Sophia had helped her when she discovered at least a partial source of the disgusting smell: a pile of runny dog poop. She simultaneously heard Jake, a dachshund, whimpering quietly on the bed of Carolyn’s 3-year-old son, Travis. Travis was still in kinship care with Carolyn’s mom, along with his 4-year-old sister. “Come on Jake, poor little guy, let’s get you some water and food.

Who knows when you last ate, and from the smell of this place, you have definitely been doing your business inside.” Olivia continued talking to Jake as she fed him and then grabbed a bucket of soapy water and a hose to wash off some of the muck caked on him. Jake replaced his whimpering with yelping, but Olivia continued unabated.

“Jake, if only getting clean was this quick and painless, despite your protests, for Carolyn. I just hope she’ll call her parole officer and Sophia. Better that she reports she messed up again than let it show up on a random drug test. Maybe the consequence for using again won’t be prison time, since she’s had no dirty urines for over 4 months, and the drug court staff all believe she’s been working her program. They also know that relapse is not unusual. Judge Meisner warned her early on to stay away from her old crowd. I knew last week she had been in contact with some old friends who are still using, and that was a red flag for me, but I can’t control her, can I?” *Good grief*, Olivia thought, *I’m resorting to talking to a dog.*

After changing bedding, throwing a urine-soaked rug outside on the fence, and making sure Jake had left no other surprises, Olivia was exhausted, and despite the grossness of these tasks, she was hungry. She had checked on Carolyn periodically, and each time found her still sleeping fitfully on the couch. Her breathing had seemed more normal the last time Olivia looked in on her. After grabbing a spoonful of peanut butter and a bowl of stale, dry Captain Crunch, Olivia crashed in Carolyn’s room. It was the only room where she could mostly escape the lingering bad smell.

A noise awakened Olivia, and once her eyes adjusted to the dark, she saw Carolyn rummaging through her purse. As calmly she could, Olivia said, “Put it down, Carolyn. There are maybe two dollars max in there.”

“Get out of my house,” Carolyn yelled. Then she started shaking and sobbing. “You don’t know what it’s like for me. I can’t do it. I tried. Just leave me alone. You can’t save me, so stop trying. I’m sick of you.”

Olivia was well aware that part of her need to try to “save” Carolyn stemmed from watching her own daughter, Lizzie, die from a cocaine overdose that she was too high herself to prevent, or so she still told herself. That was 12 years ago and the reason that Olivia got clean. The guilt was something she was still working at letting go of. Olivia tried to push thoughts of her daughter away and be there for Carolyn, who had sat down on the bed beside her, appearing agitated and anxious. Olivia knew the agitation and anxiety were mostly the body’s reaction to coming down from the drug and craving more. She figured Carolyn had most likely been getting high a lot over the last week and maybe longer, so the need was strong.

Olivia calmly turned to Carolyn and said, “Carolyn, you’re the only one who can save yourself and get your kids back, which I know you want. I figure you’re out of drugs and money or you wouldn’t have been trying to steal from me. Given how badly beaten you were the last time you sold your body for drug money, that doesn’t seem like an option you’d want to choose.”

Another “F-you” was the only response from Carolyn before she crawled onto the bed and slept. Two hours later when she woke up, although still sounding agitated, Carolyn’s first question to Olivia was, “Do you think Judge Meisner will send me back to prison?” Then she started sobbing again, repeating over and over, “I just know I’m never going to get my kids back, but they’re better off without me anyway. I don’t know why I even bother.”

“I tried self-pity, too, but it didn’t get me anywhere, Carolyn. You were clean for over 4 months, then had a relapse, so get up, deal with the consequences, make the amends needed, and move forward.”

Carolyn didn’t respond, so Olivia continued. “If you call Sophia, she can probably pull some strings and get you into detox right away.”

“I don’t need detox. I can handle it.”

“Give it a break, Carolyn. If you get up and say that to Judge Meisner, you’ll be spending time in a cell, and your children will be visiting you behind bars, which you know is traumatic for them. You’ve been lying to me and just tried to steal money from me. Having a relapse is one thing; not admitting you need help is quite another.”

“I know, I know. I’ll call Sophia and tell her what happened. That’s our contract. I’m to let her know immediately if I’m not following my program. Oh ###, I’m just tired, and I feel so horrible. I need some H bad.”

*She’s not making a lot of sense*, thought Olivia, regarding the conflicting messages, but she attributed it to Carolyn desperately wanting to be a better mother than hers was, while at the same time physically craving opioids on top of the psychological addiction. “I’ll stay until you connect with Sophia and have a plan. I can take you to wherever you need to go.”

Olivia made a mental note that she would talk to Sophia next week, yet again, about her overwhelming need to save Carolyn and her fear that she sometimes went overboard in trying to make sure Carolyn stopped messing up. Until yesterday, she’d thought she was further along in letting go of the guilt about her daughter. This incident made her realize that she still had a way to go—she was still trying to make up for the role she believed her negligence as a mother had played in Lizzie’s death.

## BACKGROUND INFORMATION

The consequences of the ravage of substance abuse on individuals, family members, friends, communities, and society as a whole are profound and utterly tragic. Losing custody of children, broken relationships with family and friends, dropping out of school, being fired from a job, prison time, significant health problems,

destitution, and death are examples of the wide-ranging and dire consequences of substance abuse. The economic costs alone of illicit drug abuse and alcohol abuse carry a price tag of over \$400 billion per year in health care, crime-related expenses, and lost productivity (National Institute on Drug Abuse, 2015a).<sup>1</sup>

This section provides the foundational information necessary for you to gain a better understanding of the scope of the issue of substance use and abuse; the key philosophy and approach taken during the 40-plus year “war on drugs” and the outcomes of this war; the swinging pendulum on our approach to addressing illicit drug use; and the factors informing this approach. While the primary focus is on illicit drugs (and opioids, in particular), given the human, social, and economic costs of alcohol abuse, it too will be touched upon. With the information in this section in hand, you will be better prepared to discuss and evaluate policy choices relative to efforts to address substance abuse effectively.

### Scope of the Problem

The Substance Abuse and Mental Health Services Administration (SAMHSA), reporting on a 2014 trend study, states that approximately 10.2% of the U.S. population ages 12 and older had used an illicit drug within the past 30 days. This equates to 27.0 million people, which is higher than in any year from 2002 to 2013. Marijuana use, and the use of prescription painkillers for nonmedical reasons, accounts for 26.5 million of the total. While the use of some illicit drugs was down, the use of heroin was higher in 2014 than in most years from 2002 to 2013 (Hedden, Kennet, Lipari, Medley, & Tic, 2014, p. 1).

Alcohol, although not an illicit drug for the adult population, is a drug nonetheless that, when abused, can lead to harmful consequences. And it is often abused by minors. Of the 139.7 million people who indicated in the 2014 SAMHSA study that they drank alcohol in the past month, 60.9 million were binge drinkers and 16.3 million were heavy alcohol users.<sup>2</sup> Underage binge and heavy drinking showed a decline in 2014, compared to 2002 to 2013. Still, 23% of 12- to 20-year-olds reported drinking, and of those, 17.2% were either “binge” or “heavy users.” In the 18- to 25-year-old age group, the study found that 37.7% were binge drinkers and 10.8% were heavy alcohol users (Hedden et al., 2014, p.1). It is estimated that there are 88,000 deaths per year from alcohol abuse (Centers for Disease Control and Prevention, 2016a). These deaths are largely due to traffic accidents.

<sup>1</sup> Some government sources put the economic costs at over \$416 billion for alcohol and illicit drugs.

<sup>2</sup> “Binge alcohol use is defined as drinking five or more drinks on the same occasion on at least 1 day in the past 30 days, and heavy alcohol use is defined as having this number of drinks on the same occasion on 5 or more days in the past 30 days” (Hedden et al., 2014, p. 1).

There is a difference between using an illicit substance, or engaging in binge or heavy drinking, and being considered to have a substance use disorder (SUD). SUD, a clinical diagnosis found in the *Diagnostic and Statistical Manual 5*, is given to those who meet certain criteria such as significant impairment, major substance-related health issues, and not being able to carry out responsibilities (such as going to class or work). In 2014, the National Survey on Drug Use and Health found that approximately 21.5 million people age 12 or older suffered from an SUD in the past year. The breakdown of the 21.5 million is 17 million with an alcohol use disorder and 7.1 million with an illicit drug disorder, as 2.6 million had both alcohol and illicit drug disorders (Hedden et al., 2014, p. 22).

Another key grouping that provides us with evidence of the scope of the issue at hand and its complexity are those who experience both a serious mental illness (SMI)<sup>3</sup> and an SUD. In 2014, this included approximately 1% of the adult population in the United States and 1.4% of youth ages 12 to 17. If we add in adults with both SUD and any mental illness, this percentage increases to 3.3% of the total adult population (Hedden et al., 2014, p. 2). Oftentimes, individuals with mental illness use illicit drugs as a means of coping, however ineffective, with symptoms of their illness.

### Increase in Opioid Abuse

There are those who say we are experiencing an opioid epidemic, while others are not so quick to use the term *epidemic* and question if the increased attention on opiate overdoses is because of the increase in White suburban and rural women using the substance (Wood, 2014). History informs us that which subgroup in our population is using a drug greatly impacts how it is portrayed and subsequently responded to. We will return to the topic of perception and response, but for now we will cover the rising number of overdoses and deaths from drugs, especially opioids.

There were approximately half a million deaths from 2000 to 2014 attributed to drug overdoses. In 2014, the number of deaths at 43,255 was the highest ever recorded, exceeding by one and a half times the number of motor vehicle fatalities. The biggest culprit in the deaths were prescription pain relievers and heroin (accounting for 29,467 deaths), with the rate of opioid overdoses tripling in the past 4 years (National Institute on Drug Abuse, 2015b). “Every day in the United

<sup>3</sup>“Serious mental illness includes diagnoses which typically involve psychosis (losing touch with reality or experiencing delusions) or high levels of care, and which may require hospital treatment. Here we look at two of the most common severe mental illnesses: schizophrenia and bipolar disorder (or manic depression)” (Mental Health Wales, n.d.).

States, 44 people die as a result of prescription opioid overdose” (Centers for Disease Control and Prevention, 2016b, p. 1). In regard to the upward trend in heroin use and overdose, the key factors for this are its increased availability coupled with relatively low prices and high purity (Rudd, Aleshire, Zibbell, & Gladden, 2016, p. 1). Moreover, it is generally believed that efforts to make it harder to obtain prescription opioid drugs increased their price and drove many addicts to heroin.

The newest player in the opioid abuse arena is fentanyl, a powerful synthetic painkiller that looks like heroin but is up to 50 times more potent. It is cheap, extremely strong, and fast-acting, leaving little time for naloxone<sup>4</sup> to be administered in the case of an overdose. Fentanyl is most present in the Northeast, Mid-Atlantic, and Appalachia though it has started to infiltrate the Midwest. While there are no nationwide statistics, as state laboratories do not track fentanyl-related deaths, the drug killed 336 people in Massachusetts from 2014 to 2015, an increase of 53% from the year before (Seelye, 2016, para. 17). As users seek out a cheaper, more intense high, it is possible that fentanyl will be the next epidemic.

The numbers regarding the prevalence and economic costs of substance abuse, even without the full picture of the tremendous pain and suffering experienced by millions, beg for an effective societal response to address the negative consequences of drug abuse. A historical look at our nation’s drug policies provides valuable lessons that have impacted thinking and policy action by the Obama administration.

### Drug Policy and Race

Historian Richard Miller claims that U.S. drug policies have always been associated with race. In 1907, the smoking of opium was criminalized in California. Chinese were known for their opium dens, and they were also viewed with animosity by many. Miller believes that outlawing opium was used as a way to lock up the Chinese since they weren’t breaking any other laws. States, Miller says, started criminalizing cocaine when it began to be associated with Blacks using it at the turn of the 20th century. And marijuana was outlawed in the 1930s after Mexican Americans started using it for recreational purposes (Fuchs, 2013). While one might argue about the racial underpinnings of early drug laws, if we look at the drug policy during the war on drugs there is clear evidence of racial disparity.

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<sup>4</sup>Naloxone (Narcan) is administered to reverse the effects of a heroin overdose and prevent death. It is sometimes administered in hospitals to patients after surgery to counter the effects of the narcotics administered during surgery (National Institute of Health, 2016).

Studies show that Blacks and Whites use drugs at the same rate, and Whites are more likely to sell drugs than Blacks. Yet Blacks are far more likely to be arrested for selling or possessing drugs than Whites (Ingraham, 2014). Moreover, when convicted, the sentences received by Blacks are longer than those of Whites. According to the U.S. Sentencing Commission, the sentences for Blacks in the federal system are 10% longer for the same offense than if the offender is White. Findings from the Sentencing Project indicate that Blacks are 21% more likely than Whites to receive mandatory-minimums and 20% more likely to get prison time (Kerby, 2012). It is no wonder that many question whether it is just coincidence that the shift away from harsh and punitive policy for drug users comes at the same time that those affected by heroin addiction are largely White, not people of color (Haberman, 2015).

## War on Drugs

In 1971, the Nixon administration launched the war on drugs and set the wheels in motion for a long fight. Referring to it as “a serious national threat,” Nixon successfully crafted a narrative that shifted public perception of drug users to “dangerous criminals” who were “attacking the moral fiber of the nation, people who deserved only incarceration and punishment” (Dufton, 2012, para. 3). The irony is that during the Nixon administration, before the war was in full swing, more money was spent on prevention and rehabilitation than on enforcement in any administration since.

In the 1980s, under President Reagan, the war on drugs escalated. By the mid-80s, mandatory-minimum sentences for drug offenders, supported on both sides of the aisle, resulted in thousands of nonviolent offenders being sent to prison. First Lady Nancy Reagan had started her “Just Say No” campaign, and President Reagan was effectively convincing Americans that drug use was “public enemy number one.” (There was indeed a rise in crack cocaine use.) In 1985, a poll indicated that between 2% and 6% of those in the United States saw drug use as our number one problem, but by September 1989, 64% believed it was the number one problem we faced. It is important to note that not even a year later, fewer than 10% polled indicated drugs were our number one problem. The power of this narrative told and repeated over and over again by the media cannot be overlooked in understanding how people are influenced and public policy is made (Drug Policy Alliance, 2016).

The “tough on crime” rhetoric pervaded policy discussions, and although evidence of its ineffectiveness was well known, the war on drugs continued unabated under President George H. W. Bush, President Clinton, and President George W. Bush. Finally, a shift in the rhetoric of how best to deal with drug abuse began during President Obama’s first term.

## The Changing Tide

President Obama called for adopting a public health/harm reduction approach<sup>5</sup> to drug abuse and argued that criminal justice reforms to reduce incarceration rates were needed. He also called for “boosting community-based prevention, expanding treatment, strengthening law enforcement and working collaboratively with our global partners” (Obama Drug Control, 2010, p. 1). There are many advocates for reform who support the approach President Obama proposed, but they want to see more evidence that the budget matches the improved rhetoric. They point out that, still today, less than half of drug control funds are being used for prevention. In its early assessment of the Obama administration’s approach, the General Accounting Office (GAO) was not overly positive about the progress made, noting that prevention services were fragmented across 13 agencies (Sledge, 2013).

Although slower than many would like, there have been changes in how the government is addressing drug abuse that go beyond rhetoric, even if they don’t go far enough. In 2010, the Fair Sentencing Act was signed into law by President Obama. This act reduced the disparity in the penalties between crack cocaine and powder cocaine from a 100:1 weight ratio to an 18:1 ratio. It also struck down the mandatory-minimum of 5 years of imprisonment for possession of crack cocaine. In 2014, the U.S. Sentencing Commission reduced penalties for many nonviolent drug crimes, and in 2015, approximately 6,000 inmates who had been charged with nonviolent low-level drug deals in the 1980s and 1990s were given early release from federal prisons (Schmidt, 2015). In 2015, a bipartisan group of senators joined forces and proposed the Sentencing Reform and Corrections Act that would, if it becomes law, be a step forward in bringing about an array of changes such as reducing the number of low-level drug offenders sentenced to prison, replacing life in prison sentences for third-time offenders under “three strikes” laws, giving judges discretion in sentencing and increasing funding for re-entry programs (Smith, 2015).

Michael Botticelli, who became director of the Office of National Drug Control Policy in 2015, stated that “the drug epidemic in America is at its worst ever, because the war on drugs was all wrong” (Top Drug Official, 2015, para. 1). After more than 40 years of ineffective policies that (1) cost over a trillion dollars, (2) resulted in hundreds of thousands of people (disproportionately African

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<sup>5</sup> Harm reduction is aligned with a public health approach. It entails strategies that seek to reduce the negative outcomes associated with drug use and ineffective drug policies. It recognizes that drug use and abuse should be treated as a health issue, not a criminal issue (this approach is not aimed at those who traffic drugs, which is still seen as a criminal act). This approach does not minimize the tragic consequences and great harm that results in drug abuse but focuses on reducing the harm through education, services, and various forms of treatment.

Americans) being locked up, (3) destroyed lives, (4) negatively impacted entire communities, and (5) harmed police-community relations, the pendulum is swinging toward an approach that changes how drug abuse is defined. Botticelli, by defining drug addiction as a public health issue rather than a criminal issue, reinforced the change in language President Obama began in 2008 that put in motion legislative changes. Changing the definition of the problem will result in changing the policy prescriptions.

What Botticelli is calling for is consistent with the public health approach to drug addiction. He states that “we can’t arrest and incarcerate addiction out of people. Not only do I think it’s really inhumane, but it’s ineffective and it cost us billions upon billions of dollars to keep doing this” (Top Drug Official, 2015, para. 3). Mr. Botticelli summarizes the White House policy changes as follows:

Using a public health framework as its foundation, our strategy also acknowledges the vital role that federal, state and local law enforcement play in reducing the availability of drugs—another risk factor for drug use. It underscores the vital importance of primary prevention in stopping drug use before it ever begins by funding prevention efforts across the country. It sets forth an agenda aimed at stripping away the systemic challenges that have accumulated like plaque over the decades: over-criminalization, lack of integration with mainstream medical care, insurance coverage and the legal barriers that make it difficult for people once involved with the criminal justice system to rebuild their lives. (Botticelli, 2015, para. 9)

Past leaders, with the help of the media, shaped public perception of drug abusers as criminals destroying our country. Botticelli aims to reshape public perception, believing it is vital that “we fundamentally change the way we think about people with addiction” (Botticelli, 2015, para. 10). He states:

Addiction is a brain disease. This is not a moral failing. This is not about bad people who are choosing to continue to use drugs because they lack willpower. You know, we don’t expect people with cancer just to stop having cancer. (Top Drug Official, 2015, p.1)

Maia Szalavitz, author of *Unbroken Brain: A Revolutionary New Way of Understanding Addiction*, calls for a further paradigm shift in how we view addiction. She relies on neuroscience findings to support her position that addiction is a learning disorder. Yes, she says, it is a brain problem, but it is not necessarily a progressive one. What is needed is for the addicted person to redirect their compulsive drive to use a substance into healthier channels. Referring to her personal experience with drug addiction, she states that “heroin provided a sense of comfort, safety and love

that I couldn't get from other people. . . . Once I'd experienced the relief heroin gave me, I felt as though I couldn't survive without it" (Szalavitz, 2016, para. 10). She likens addiction to healing a broken heart and believes those who rely on drugs for emotional needs can find other ways of getting those needs met.<sup>6</sup>

### What Science Tells Us About Addiction

Neuroscience, the study of brain mechanisms, has greatly expanded our understanding of addiction. Recent research findings based on advances in brain imaging, genetic studies, and molecular biology provide evidence to make better informed policy decisions (Nutt & McLellan, 2014, p. 6). Simply put, research, using the tools of neuroscience, informs us that while the decision to take a drug is initially voluntary, over time brain changes occur that impair an addicted person's self-control and hamper his or her ability to resist intense impulses to take drugs. Therefore, addiction is defined as "a chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her" (SAMHSA, 2011, para. 1). This evidence-based definition of addiction is information that should be used in the message to foster a change in the public perception, which is exactly what Mr. Botticelli is adamant needs to happen. More important, recent findings from research must inform public policy. Writing about the advances in neuroscience, Nutt & McLellan conclude:

[The advances] mean that the addiction potential of existing and new "designer" drugs can now be assessed—offering the potential for the design of more effective prevention and early interventions; and more sensible and sensitive public policies to reduce the risks and harms of drug abuse. (2014, p.10)

We still need more research to better understand the interactive effects of, for example, drug use and one's emotional experiences or drug use and the interactive effect on the developing brain (Weiss, 2015).

If everyone who used drugs became addicted, it might be easier to change public perception and influence policy, but that is not the case, and leads too many to think addiction is simply about will power. (That is not to say that there is no ability to change the choices one is making.) One's risk of addiction is influenced by various factors, including genetics, environment, and development. Evidence suggests that genetics account for about half of a person's vulnerability to addiction. Genetic

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<sup>6</sup> A *New York Times* article (<http://www.nytimes.com/2016/06/26/opinion/sunday/can-you-get-over-an-addiction.html>) provides an overview of Szalavitz's perspective on addiction and recovery.

factors combine with environmental factors (e.g., stress, peer pressure, family, parenting, abuse) and developmental factors that increase the likelihood of addiction for some (SAMHSA, 2015).

There is ample evidence to argue for more effective prevention and intervention programs involving not just individuals but families, schools, and communities. Since the media conveys the message, media sources discussing drug use and abuse need to be informed. In regard to intervention, there are evidence-based practices that fall under two broad categories: pharmacotherapies and behavioral therapies. Pharmacotherapies include medication and are more effective when combined with behavioral therapy or some form of counseling. (As with any treatment, it is more effective when it is holistic. All the needs of the person, for example, medical, psychological, employment, and housing, must be addressed, not just the drug abuse.) Some of the primary behavioral approaches include motivational interviews, motivational enhancement therapy, cognitive behavioral therapy, safety seeking and prize-based contingency management, and 12-step facilitation therapy (Centers for Disease Control and Prevention, 2012; Society of Clinical Psychology, 2016).

The good news is that there are many effective prevention and intervention programs (noted in previous paragraph) being implemented, and, as noted, the Obama administration took steps to treat addiction as a public health issue rather than a criminal issue. Still, we have a long way to go in terms of having a public that understands the dynamics of addiction, how important prevention is, and ensuring that those in need of treatment receive the services needed.<sup>7</sup>

## CAROLYN'S JOURNEY

Carolyn waited nervously for her turn to stand in front of Judge Meisner. The drug court participants had gone before her all had good reports and were applauded. Carolyn knew that would not be the case for her. When her name was called, she approached the bench thinking over what she and Sophia had discussed. Carolyn had actually missed her last drug court appointment as she was in detox. She knew Sophia, and really the whole drug court team, were on her side. But she also knew they would all hold her accountable.

“Hello, Carolyn, how’s it going?” asked the judge. She was aware that the judge knew all about her relapse and what had transpired since. She had watched a few times as drug court participants had been handcuffed and hauled off to jail for lying about their drug use, for not following their program, or for exhibiting an indignant attitude.

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<sup>7</sup> There is no one-size-fits-all approach to intervention, and there are many people who at one time met the *Diagnostic and Statistical Manual* criteria for substance abuse but are no longer using and never received treatment.

A what-the-hell-do-you-know attitude was one Carolyn herself exhibited before her first prison stay. Through her sessions with Sophia she knew it was, for her at least, just a defense mechanism, a cover for not wanting to deal with her own issues.

“I think I’m back on track, Judge Meisner. I messed up pretty bad. I was doing so good for over 4 months, then instead of using the coping strategies Sophia and I have talked about, I let myself give in to old and familiar habits. I told myself this time it would be different, that I would just use drugs once in a while. I wasn’t being honest with myself. The only reason I wanted to hang out with my old crowd was so that they could supply me with drugs, and I gave in to the craving for a good high. I admit I’m scared; I really don’t want to mess up again. The difference now is I know even if I stay away for a while, it’s easy to relapse. I’m an addict and can’t just use stuff a little. That desire to use is there, and I know I need to stay away from the people I used to get high with. I started working my program again, which now includes going to Begin ANEW every morning for Suboxone.<sup>8</sup> I have to meet with a counselor there as well as attend my other meetings.

“Carolyn,” responded Judge Meisner, after each of the members of the treatment team weighed in mentioning the revised treatment plans and some of the positive steps Carolyn was taking. “You have a lot of support here, but the hard work it up to you. Is there anything else you need?”

“No, judge,” Carolyn quickly said.

“Okay, well, we’ll see you in 2 weeks, and I expect a good report.”

That was it. No jail. Carolyn breathed a sigh of relief as she left the courtroom. She was extremely relieved but, at the same time, disappointed that the usual clapping that always lifted her spirits didn’t happen. The judge had not asked for a round of applause for her. She knew she had let not only herself down but the whole drug court team who had invested in her. Four months ago she didn’t care what others on the treatment team thought, but today, although she was not quite sure why, it mattered a lot to her.

### Five Weeks Later

“Carolyn, I’ll be right with you,” shouted Sophia from her office when she heard the outer door to the waiting area slam shut. Carolyn had not missed a session since she had gone through detox again and started on Suboxone. During the past session, Sophia’s intuition told her that Carolyn was struggling, although verbally Carolyn indicated that all was good, and she had not missed any of her

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<sup>8</sup> Suboxone is one of the prescription medications, as are methadone and naltrexone, currently used as part of medically-assisted treatment approaches for opioid addiction. Suboxone contains buprenorphine and naloxone. Medically-assisted treatment includes counseling and other supports along with the medication to suppress withdrawal symptoms and reduce the cravings (National Institute of Drug Abuse, 2016).

appointments or work. Before calling her in, Sophia wanted to take a couple minutes to make extra sure she was centered for the session with Carolyn and able to be keenly alert to nonverbal as well as verbal messages.

Sophia knows that she overidentifies with Carolyn, probably because Carolyn strongly reminds her so much of an earlier “messed-up” version of herself. That seems like a lifetime ago, and Sophia is thankful she has grown so much and can truly be there for others. She is also keenly aware of how important it is for her to continue working on taking care of herself and not “overinvesting” in her clients as she did early in her career. Though it was long ago, she clearly remembers a time when she allowed a few clients, who claimed to have “no other supports,” to call her at home at night. It was on her work phone, but still it quickly got out of hand with a couple of them. She recalls many talks with her supervisor regarding her role and responsibilities versus those of the people she was working with. Her supervisor was fond of saying, “As much as we may want to, we can’t make the change for them.”

In theory, Sophia fully believes in the concept of self-determination, but, in practice, she sometimes still finds herself wanting to “fix” clients and believing she knows what is best for them. The bottom line is that she really just wants them to make the choices she thinks will bring them contentment, and at times sees it as her fault when clients don’t make progress toward their goals. It is a constant struggle. On the one hand, she knows that only Carolyn can make the changes necessary to get her children back, but on the other hand, she wants so badly for that to happen that she fears it interferes with her ability to effectively carry out her role. A year ago, Sophia considered quitting her job because she started again to allow poor choices made by clients to gnaw at her. She went back to meet with her former social worker about this struggle and has made great progress.

Sophia steps out into the waiting area to greet Carolyn and immediately sees that something is not right. Carolyn looks upset, unkempt, and she has a bruise on her cheek. Just yesterday, Sophia spoke to Carolyn’s counselor at the Suboxone clinic and was told Carolyn was compliant with the medication part of the treatment and appeared to be doing well. Clearly, she’s not doing well today. *Crap*, Sophia thinks, *not again*.

“Carolyn, please come in,” Sophia said calmly but with concern in her voice. Before Carolyn is all the way into Sophia’s office, the tears are flowing as she meekly says, “I started seeing Jeremy again a couple weeks ago. He told me he wanted to stop using and even attended a couple NA meetings with me, but it was only a ploy to get me back. Last night we got into a fight when he accused me of just substituting one drug for another. I told him he didn’t know what he was talking about and called him a loser and all sorts of vile names. As the fight escalated, I pushed him, and he shoved me back. I lost my balance, fell, and hit my face on the table. I don’t know what to do. I know Jeremy may be bad for me in some

ways, and that I'm supposed to stay away from him since he's using, but, despite the fight, I still want to be with him, and he is the father of my daughter.

While I'm making confessions, I better tell you that it didn't help that before the fight we each had a few beers. Well, I had a few, Jeremy had quite a few. That's part of what made me mad about his comment. I know that drinking is against my treatment plan. I don't even know why I had those beers as they didn't really give me a buzz. I just fell back into old habits, but I didn't use anything else, I swear."

Carolyn looks at Sophia for a response. Sophia doesn't want to put Carolyn on the defensive so knows she needs to be careful. "Carolyn, I'm glad you kept your appointment and want to talk about what's going on. You bring up some important issues we definitely need to discuss, but how about if we do our standard 'things I did well this past week' first and then get back to the issues at hand?" Sophia is a little hesitant to switch gears, but it accomplishes what she hoped it would. Carolyn isn't too upset to rattle off a number of positive things she has done during the week, including working an extra shift and using the money to buy her kids gifts. She sits up taller as she speaks, and her voice grows stronger and more confident.

Sophia returns to the serious issues of Carolyn's appearance and confession. "Carolyn, despite continued struggles and difficult situations, you are making progress in many areas of your life. Let's keep that in mind as we come up with a plan for dealing with the challenges you just shared. You told me in one of our early sessions that Jeremy had broken your jaw one time and cracked your ribs another. A minute ago, when you lifted your arm I saw what looked like a large bruise, so even if the table caused it, you've told me more than once that Jeremy is bad news. While I'm concerned that you violated your commitment to distance yourself from your old crowd, especially those who are still using, I am most concerned for your safety."

The first words out of Carolyn's mouth are "You won't tell the treatment team, will you? I told you about Jeremy in confidence. You said that I could talk to you openly." She ignores Sophia's comment about being concerned about her safety. Despite her plea, Carolyn is well aware that, while as a drug court participant she can expect many things to be kept confidential, the breaking of the treatment plan contract is something Sophia must share with the court.

Rather than address the question Carolyn asked, Sophia again brings up the issue of Jeremy's violent outbursts and Carolyn's safety. Carolyn quickly says, "It's only really bad if he drinks. He doesn't want to hurt me; he just underestimates his strength. Still, I promise to honor my contract and stay away from Jeremy. Just don't say that I even mentioned seeing him to you. I'll do what I have to do. I'll even take Olivia up on her offer to stay with me for a while. If I didn't trust that I could tell you about Jeremy and the beer, you would have never known, but I want to be honest with you. But I can't have another strike against me, or I'll never get my kids back." Carolyn moves from being upset to being scared and almost

combative, which is not what Sophia expected. She also knows that Olivia will do anything for Carolyn and, like herself, wants Carolyn to stay clean.

“What about the drinking, Carolyn? That violates your contract as well. You know it’s dangerous to drink while on Suboxone,” is the only thing Sophia can think of at the moment, so that’s what she says. Sophia knows that she should have taken a minute to think before responding and that allowing her emotions to get in the way is a mistake. She is feeling frustrated because she already informed Carolyn that using any substance is something she must report.

Rather than responding angrily, Carolyn resorts to her hunched posture and says in a meek voice, “I know. I honestly only had a few drinks last night, and they didn’t make me feel any different. In fact, they made me feel nauseous and gave me a horrible headache. I don’t plan on drinking again, and if I make it another day or two without another drug screen, unless you say something, no one on the team will know I had a few drinks. It’s not like I used again. Jeremy was over and kept on me to drink with him. I know I’m messing up in small ways, but like we said, I’m making progress, too. I’m really trying, but it’s just so hard. You said you were on my side. Please, you’ve gotta give me one more chance. My kids aren’t safe with my mom, and they need a mom who’s not in prison. You and Olivia and almost everyone else can have a drink. That’s not illegal. Please, Sophia, you know I can do it. You believe in me, right?”

## QUESTIONS FOR DISCUSSION

1. Based on the background information provided, discuss the outcomes of the “war on drugs.” Also, what are your thoughts about the relationship some claim there has always been between what is determined to be an illicit drug and race?
2. Drawing on information in the background section, respond to the following claim: “I used to be an addict, and I got clean on my own. Staying clean is a matter of will power, and those who keep using illicit drugs deserve to do jail time.”
3. The current director of the Office of National Drug Control Policy is a recovering alcoholic. How might this be an advantage or a disadvantage to him in his position?
4. If you were to work with someone who had an addiction to a substance, what are some of the lessons set forth in the case that you would want to keep in mind?
5. If you were designing policy to increase the likelihood of recovery from addiction, what would you make sure to include in the policy?

6. The case only spoke briefly to the issue of the relationship between mental illness and substance abuse. Discuss why it is important that interventions take both into consideration. Which do you think should be primary, if either?
7. Along with a great deal of information on chemical dependency, this case presents challenges faced by social workers regarding setting appropriate boundaries, confidentiality, and self-determination. Does it appear that Sophia has appropriate boundaries with Carolyn? Explain your answer.
8. What options does Sophia have for responding to Carolyn? What is the best option, given what you know of the case? Put yourself in Sophia's shoes, and craft a response for her to Carolyn's last comments.
9. What challenges with boundaries can you see yourself having in the field?
10. In micropractice, what strategies might you use to make sure that the challenges clients are faced with don't eat away at you? Think about the population you want to work with at this time. Can you see yourself going home after your shift and not continuing to think about the hardships you heard about? What types of issues would you find most troubling? Least troubling?
11. Besides being a caring individual, what draws Olivia to Carolyn? Does it appear that Olivia is doing what a support person should, or is she possibly doing too much for her? Provide a rationale for your answer.
12. Besides boundaries, are there other ethical issues involved in the case, specifically for Sophia?
13. Optional: Read the article at <http://www.nytimes.com/2016/06/26/opinion/sunday/can-you-get-over-an-addiction.html>. Discuss whether Szalavitz's perspective is consistent with the public health approach to substance abuse.

### CASE ANALYSIS WRITING ASSIGNMENT

1. Read the assigned case study thoroughly prior to class in order to be fully prepared to join in the discussion.
2. Providing education to 7th and 8th graders is part of your job responsibilities as a social worker for a substance abuse treatment center. Drawing on content from this case study, "The Struggle to Stay Clean," write an essay that lays out what you think would be of key importance to include when you meet with this age group.
3. The essay should be approximately two pages, typed, and double spaced. Your essay should reflect the standards and expectations of college-level

writing: spelling, grammar, and appropriate use of paragraphs all matter. If you quote directly from the case study, use quotation marks, and at the end of the quote, indicate the page number the quote appeared on. For example, “Blacks are far more likely to be arrested for selling or possessing drugs than Whites” (Ingraham, 2014, p. 1, as cited in Lewis, 2016, p. 11).

4. Your case analysis is due \_\_\_\_\_ and worth a maximum of \_\_\_\_\_ points.

## INTERNET SOURCES

Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)); Resources (<http://search.cdc.gov/search?query=drug+abuse&utf8=%E2%9C%93&affiliate=cdc-main>)

Drug Policy Alliance ([www.drugpolicy.org](http://www.drugpolicy.org))

Hazelden Addition Treatment Center (<http://www.hazelden.org>)

The National Council on Alcoholism and Drug Dependence (NCADD) ([www.ncadd.org](http://www.ncadd.org))

National Institute of Health: National Institute of Alcohol Abuse and Alcoholism (NIAAA) (<http://www.niaaa.nih.gov>)

National Institute of Health: National Institute of Drug Abuse (NIDA) ([www.drugabuse.gov](http://www.drugabuse.gov))

Substance Abuse and Mental Health Services Administration (SAMHSA) ([www.samhsa.gov](http://www.samhsa.gov))

TED Talks: Why do our brains get addicted by Nora Volkow (<http://www.tedmed.com/talks/show?id=309096>)

TED Talks: Top 8 TED Talks to Inspire Recovery (<http://www.reneweveryday.com/top-8-ted-talks-to-inspire-the-recovery-journey>)

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