March 2018

“I am More Than my Addiction”: Perceptions of Stigma and Access to Care in Acute Opioid Crisis

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“I am More Than my Addiction”:
Perceptions of Stigma and Access to Care in Acute Opioid Crisis

by

Heather D. Henderson

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
with a concentration in Applied Medical Anthropology
Department of Anthropology
College of Arts and Sciences
University of South Florida

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Date of Approval:
March 23rd, 2018

Keywords: Addiction, emergency care, prescription drug abuse, intravenous drug use

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DEDICATION

I would like to dedicate this master’s thesis to Dr. Roberto Loureiro of Saint Petersburg College. Without his tireless encouragement, guidance, and wisdom this would not have been possible. Obrigada por ser como uma família.

To my academic advisor, Dr. Rebecca Zarger, for her stalwart support, steadfast kindness, and invaluable humor. I am indebted for her indomitable belief in me—especially when my belief intermittently wavered.

To Dr. Jason Wilson, for his support of qualitative research in quantitative settings; for allowing me the space to attempt to interpret the phenomena of stigma and addiction according to the meaning people assigned to it; for the betterment of emergency medicine.

To my husband, who meticulously read (and re-read) every line in an effort to keep my work grounded and engaging, and to our daughter who enthusiastically sent me every scrap of opioid information she discovered.

For the anthropological professors who were always ready to listen, encourage, motivate, and lend their insights and support: Dr. Angela Stuesse, Dr. Daniel Lende, Dr. Heidi Castañeda, Dr. Linda Whiteford, Dr. Nancy Romero-Daza, Dr. Anna Dixon, Dr. Ella Schmidt, Dr. Jay Sokolovsky, Dr. Kathryn Arthur, and Dr. John Arthur.

Lastly, most importantly, to those that shared their tears, pain, and struggles with addiction. This would not have been possible without that window into your personal experiences, and I am indebted to you for your candor and support.
ACKNOWLEDGMENTS

The author would like to thank Tampa General Hospital for the support of this research; the department of Human Services at Saint Petersburg College for nomination of the Saint Vincent DePaul Substance Abuse and Recovery grant, and access and support; Lakeside Clinic for access and mentoring on the recovery process for opioid addiction; and the University of South Florida Graduate School for their continued support.
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ABSTRACT

The goal of this research is to analyze the stigmatization of opioid addiction within the framework of emergency care from an ethnographic perspective. Interviews with those who have been swept up in the current opioid epidemic indicate that stigma, or a shame or dishonor, and socioeconomic insecurity emerge often as common themes in their emergency care experiences. In many cases, socioeconomic insecurity most intensely translates into a lack of access to healthcare and emergency rooms across the country often function as primary care for uninsured populations. The central field site selected for this study was the emergency department of an urban trauma-level research hospital in an attempt to document the process of care for those in opioid crisis and the challenges healthcare providers face in facilitating this care.

The aim of this research is to discover how stigma affects care in emergency room settings during an acute opioid crisis. This is a moment when patients may be most open to the idea of detoxification and sobriety. In this study, I argue that addiction can be shifted from being viewed as a disgraceful state to a medical condition, by uncovering what experiences overdose victims have while under emergency care, how patients experience stigma related to their opioid crisis, and what challenges healthcare providers describe while facilitating care during crisis. Findings suggest that stigma permeates the interactions drug-addicted patients have with healthcare professionals and that it may have a negative impact on their decision to
seek further treatment. Application of results in the form of a community resource guide made available to patients and hospital staff indicate the potential for reducing stigma of intravenous/opioid-related addiction as healthcare providers are more able to discern gaps in care for addicted patients and facilitate greater follow-up care and access to resources.

This thesis illustrates the potential for qualitative analysis of acute care to uncover vital next steps in reducing the stigma surrounding opioid addiction. Reducing stigma in the provision of care could foster more integrative approaches to treatment, help inform new protocols for caregivers, uncover resources to aid healthcare providers, and potentially provide a more substantial level of care and access to resources for the patient in crisis—one that may facilitate recovery in lieu of relapse.
PILLS

"I destroy homes, tear families... apart - take your children, and that's just the start.
I'm more costly than diamonds, more costly than gold - the sorrow I bring is a sight to behold.
And if you need me, remember I'm easily found.
I live all around you, in schools and in town.
I live with the rich, I live with the poor, I live down the street, and maybe next door.
My power is awesome - try me you'll see.
But if you do, you may never break free.
Just try me once and I might let you go, but try me twice, and I'll own your soul.
When I possess you, you'll steal and you'll lie.
You'll do what you have to just to get high.
The crimes you'll commit, for my narcotic charms, will be worth the pleasure you'll feel in your arms.
You'll lie to your mother; you'll steal from your dad.
When you see their tears, you should feel sad.
But you'll forget your morals and how you were raised.
I'll be your conscience, I'll teach you my ways.
I take kids from parents, and parents from kids, I turn people from God, and separate from friends.
I'll take everything from you, your looks and your pride, I'll be with you always, right by your side.
You'll give up everything - your family, your home, your friends, your money, then you'll be alone.
I'll take and I'll take, till you have nothing more to give.
When I'm finished with you you'll be lucky to live.
If you try me be warned this is no game.
If given the chance, I'll drive you insane.
I'll ravish your body, I'll control your mind.
I'll own you completely; your soul will be mine.
The nightmares I'll give you while lying in bed.
The voices you'll hear from inside your head.
The sweats, the shakes, the visions you'll see.
I want you to know, these are all gifts from me.
But then it's too late, and you'll know in your heart, that you are mine, and we shall not part.
You'll regret that you tried me, they always do.
But you came to me, not I to you.
You knew this would happen.
Many times you were told, but you challenged my power, and chose to be bold.
You could have said no, and just walked away.
If you could live that day over, now what would you say?
I'll be your master; you will be my slave.
I'll even go with you, when you go to your grave.
Now that you have met me, what will you do?
Will you try me or not?
It's all up to you.
I can bring you more misery than words can tell.
Come take my hand, let me lead you to hell."

-Anonymous

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1 This poem is frequently shared on social media, and within recovery groups for opioid addiction.
CHAPTER ONE:
INTRODUCTION

During the 1990s, pharmaceutical companies had few concerns regarding the freehanded distribution of prescription opioids to doctors and hospitals such as OxyContin, Vicodin, and Percocet (Dhalla, Persaud, and Juurlink 2015). These supposedly ‘safe’ pharmaceuticals, intended for either short-term or chronic pain management, were in fact debilitating and addictive (Dhalla, Persaud, and Juurlink 2015). In the beginning of the 1990s, a small collection of doctors (receiving funding from drug firms) “began arguing that the medical profession had been systematically undertreating pain, motivated by flawed concerns about addiction” (Awdish 2016; Gounder 2013). These physicians “lobbied to have pain recognized as the fifth vital sign, and urged physicians to be more liberal in their prescribing of opioids” (Awdish 2016).

In 2001, Purdue Pharmaceuticals spent $200 million marketing OxyContin², and by 2002 sales topped the $1.5 billion mark (Awdish 2016). In 2012 OxyContin represented about 30 percent of the overall painkiller market:

Purdue backed OxyContin with an aggressive marketing campaign. Key components of this effort were pain-management and speaker-training conferences in sunshine states such as California and Florida, attended by more than 5,000 physicians, nurses and

---
² Discussed in next section
pharmacists, many of whom were recruited to serve on Purdue’s speakers’ bureau (Awdish 2016; Van Zee 2009).

By 2009, the American Journal of Public Health reported that Oxycontin prescriptions for non-cancer related pain skyrocketed from 670,000 to 6.2 million in 2002 (Van Zee 2009).

This translates to a 300% increase in opioid prescriptions written from 1991-2009 (Dhalla et al. 2009). By the time medical policymakers realized the extent of this oversight, a staggering number of the U.S. population were already addicted to prescription opioid pain killers (Wisniewski et al. 2008). Unfortunately, it was already too late to begin stringent opioid regulation, as street connections and independent pain management clinics stood ready and waiting with both prescription medication and imported heroin to fill the gaps that policy began to close (Dhalla, Persaud, and Juurlink 2015).

Currently, the effects of the opioid crisis are being felt across the entire country. Citizens and professionals from every conceivable walk of life are banding together in an attempt to find out solutions to the ever-climbing death tolls due to opioid overdose. Setting this project into motion, initial informal conversations with people in recovery exposed two clear concerns regarding the difficulties of achieving sobriety: 1) stigma, and 2) lack of social support/access to healthcare. The main aims of this thesis are to uncover what overdose victims experience during healthcare crises, document the ways stigma is experienced and internalized, understand how this creates barriers to care, and discover what challenges healthcare providers experience when facilitating care. I begin by historically situating the opioid crisis and discussing the ways researchers have attempted to understand this crisis and addiction.
Opioid Addiction: A Public Health Emergency

In the last 20 years, the prevalence of both opioid use and cases of overdose has spread like wildfire, birthing a new crisis for the United States government, labeled by many an “opioid epidemic (Public Affairs 2017).” The United States has been at the forefront in terms of prescription opioid consumption. In 2009, the United States consumed 99% of the world’s hydrocodone, 60% of the world’s hydromorphone, and 81% of the world’s oxycodone (INCB 2010). There are undeniable parallels between overdose deaths and the volume of opioids prescribed here in the United States in the last twenty years (Wisniewski et al. 2008). While other countries are feeling the effects of opioids as well, factors for the United States include a lack of agreement regarding the appropriate use and dosage of these medications, demand for the medications, and most notably the rise of for-profit clinics who free-handedly prescribe opioids to manage pain (Bell 2010).

Even considering this information, many in the public cannot fathom how opioid addiction and overdose deaths seemingly got so out of control so quickly, which is why it is important to contextualize this crisis historically to understand how and why we have a current public health emergency so severe that the President of the United States declared a national state of emergency in 2017 (Merica, 2017). Opioids have a long and problematic history here in the United States. In the late 1860s, doctors were struggling to set themselves apart as scientifically oriented professionals—distinct from traditional healers (World 2018). This was not widely achieved until the invention of hypodermic morphine to relieve pain. The ability to relieve pain immediately lent a legitimacy to medical care, separating doctors from their traditional counterparts. Unfortunately, the liberal dispensation of morphine created a
generation of people who struggled with addiction, which had scientists scrambling to invent a less addictive version of morphine—synthesizing heroin in 1874.

Heroin had twice the potency of morphine and was cheaper and more readily available. This resulted in doctors associating heroin with working-class people and immigrants—and therefore with deviant personalities. Doctor Alexander Lambert, president of the American Medical Association, went on record in 1921 to assert that “the heroin addict is of an inferior personality type compared to the morphanist; morphine is the drug of the stronger personality” (Page 2011). These historical events have informed attitudes widely shared among the public today about drug use, treatment, and “worthy” versus “unworthy” addicts that persist until this very day, remaining a rich source of anthropological examination (Lende, et al. 2007; Garcia 2010; Page 2011; Singer, et al. 2017).

Perhaps most pressing today are the concerns of addiction related to the strongest opioids currently available, including OxyContin. After the creation of heroin fanned the flames of early opioid addiction by its affordability and ease of access, chemists continued their attempts to synthesize less addictive forms of opium. After mixing opium with both Tylenol (Vicodin) and Aspirin (Percocet) Purdue Pharmaceuticals received FDA approval to manufacture and distribute a long-acting opioid, named OxyContin (Hansen, 2012). OxyContin was marketed in a very clever way by assuring medical professionals that due to its time-released nature, concerns about addiction would be almost non-existent. Data collected through both the CDC and National Institute of Health studies now shows that those prescribed opioids like OxyContin and its fast-acting form Oxycodone, are 40 times more likely to develop a heroin abuse problem

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3 OxyContin is one of the most abused opioids available currently and is often referred to as “Hillbilly Heroin.” See Appendix D for an extended definition.
Oxycodone and other opioids now kill more people than gun deaths, homicides, suicides, and car crashes combined (HHS 2016). Opioid addiction continues to cross all economic, social, and demographic boundaries, tragically impacting individuals and their families (PCSO 2017). Table 1 illustrates how far-reaching this crisis is with a selection of news articles principally from the final three months of 2017.

<table>
<thead>
<tr>
<th>ARTICLE</th>
<th>AUTHOR/DATE</th>
<th>NEWS OUTLET</th>
</tr>
</thead>
<tbody>
<tr>
<td>The key to fight opioids is money: Medical professionals and researchers say politicians’ promises for solutions must be backed by funding.</td>
<td>Justine Griffin December 3rd, 2017</td>
<td>Tampa Bay Times</td>
</tr>
<tr>
<td>The Opioid Epidemic: A Crisis Years in the Making</td>
<td>Maya Salam October 26th, 2017</td>
<td>New York Times</td>
</tr>
<tr>
<td>Trump Declares Opioid Crisis a ‘Health Emergency’ but Requests No Funds</td>
<td>Julie Hirschfeld Davis October 26th, 2017</td>
<td>New York Times</td>
</tr>
<tr>
<td>“It’s the deadliest drug crisis in American History: how opioids kill 90 Americans every day.</td>
<td>Yousur Al-Hlou, Josh Katz, and Drew Jordan October 26th, 2017</td>
<td>The Philadelphia Inquirer</td>
</tr>
<tr>
<td>Babies Fall Victim to the Opioid Crisis</td>
<td>Fran Smith September 2017</td>
<td>National Geographic Magazine</td>
</tr>
<tr>
<td>The Family that Built an Empire of Pain: The Sackler dynasty’s ruthless marketing of painkillers has generated billions of dollars-- and millions of addicts.</td>
<td>Patrick Radden Keefe October 30th, 2017</td>
<td>The New Yorker</td>
</tr>
<tr>
<td>Veteran’s Day 2017: Suicide, Opioid Crisis Killing Veterans</td>
<td>Sy Mukherjee November 10th, 2017</td>
<td>Fortune</td>
</tr>
<tr>
<td>Minnesota struggles to rein in prescription opioids</td>
<td>Christopher Magan October 7th, 2017</td>
<td>Twin Cities Pioneer Press</td>
</tr>
<tr>
<td>Colorado Opioid Crisis: Combating the Prescription Opioid and Heroin Epidemic</td>
<td>John Frank November 5th, 2017</td>
<td>The Denver Post</td>
</tr>
<tr>
<td>Opioid Pain Pills, Drug Addiction, and Overdose: America’s Addiction to Pain Pills</td>
<td>John Rosengren June 2017</td>
<td>AARP Special Report Bulletin</td>
</tr>
<tr>
<td>Governor declares opioid epidemic in South Carolina a ‘silent hurricane,’ declares state of emergency</td>
<td>Tim Waller December 18th, 2017</td>
<td>WYFF News Channel 4</td>
</tr>
<tr>
<td>Overdose deaths continue to soar in Ohio</td>
<td>Alan Johnson, Catherine Candisky May 28th, 2017</td>
<td>The Columbus Dispatch</td>
</tr>
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</table>
Florida’s Role in the Opioid Crisis

As demonstrated in Table 1, the opioid crisis has been felt all throughout the United States. Data from 2010-2015 showed that more than 90 Americans died from opioid overdoses every day (Rudd et al. 2016). According to the National Institute of Health (NIH), “opioid misuse and addiction is an ongoing and rapidly evolving public health crisis” (Volkow et al. 2017). I chose to conduct my research project in Florida, which has been dubbed by popular media as the Colombia of prescription drugs (Web 2009). In Florida alone, opioid-related autopsies jumped 125 percent between 2014 and 2015 (Public Affairs 2017). According to the medical examiner for Pinellas County, there will be an estimated 300% increase in opioid related deaths in 2017 versus 2016 (Newman, et al. 2017). The first step to understanding why the opioid epidemic has been felt so keenly in Florida starts with first understanding prescription drug practices.

One of the key reasons Florida remains the epicenter of prescription opioid abuse lies in the fact that unlike many other states, Florida had no prescription drug monitoring plan.
[database to track pill movement] until 2010, and participation was not made mandatory. The Florida Prescription Drug Monitoring Program, known as E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), was formed by the Florida Legislature “in an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the state” (Health 2017). This oversight in prescribing practice monitoring, especially in a state with one of the highest retirement-aged populations, opened the doors for the freehanded dispensation of opioids, with OxyContin the most popular choice (OxyContin is a time released narcotic, while Oxycodone is its rapid release form). As mentioned above, when OxyContin was initially marketed, it was touted by pharmaceutical representatives as a superior opioid, with claims that addiction would be a non-issue due to the drugs time released nature (Garcia 2010).

It is now glaringly apparent how erroneous this claim really was. In the Peabody Award winning documentary OxyContin Express, filmmakers travelled to Florida to understand how Florida became the main source of an illicit prescription drug pipeline that stretches up the entire eastern United States and beyond (Van Zeller, 2009). In speaking with one documentary participant about the appeal of OxyContin, they state, “OxyContin is the same as heroin. But it’s made by pharmaceutical companies, so you know what you’re getting. Why try to track down a drug dealer when you can just get an MRI and go to a pain management clinic?” (Van Zeller, 2009). An FBI agent in 2016 surveyed people he arrested over the course of the year what drugs they had tried, and which they thought were the most addicting. “One hundred percent of the time, people immediately said Oxycodone was most addicting” (Newman, et al. 2017). Doctors in Florida prescribe OxyContin at five times the national average (Van Zeller, 2009), and
the top 50 dispensing physicians of OxyContin are all in Florida, with 33 of them residing in Broward County alone (Van Zeller 2009).

Unfortunately, the effects of liberal OxyContin dispensation (and other controlled prescriptions) are radiating from Florida up the entire Eastern coast of the United States and beyond (PCSO 2017). As the economy continues to struggle in the rural south, many have turned to selling pain pills to make ends meet, adding fuel for to the fire of this crisis (Van Zeller 2009). One bottle of OxyContin that may cost five hundred dollars in cash to fill in Florida without insurance has a street value of over five thousand dollars in other states where access is more closely monitored (Personal Communication, Field Notes, 2017). People come from Ohio, Kentucky, Tennessee, and all along the Appalachian mountain range to be seen at Florida pain management clinics—gaining access to ~240 OxyContin pills per prescription (Van Zeller 2017). This cross-state trafficking of opioids has resulted in a heavily increased law enforcement presence, compounding an already highly penalized disease. As law enforcement presence increases, access to pharmaceutical opioids becomes scarce. This results in people turning to other options to stave off withdrawal.

**Chasing the Dragon: The Progression of Opioid Addiction**

The process of opioid addiction and withdrawal can be extremely difficult to comprehend. Often, it can be unclear to those not struggling with addiction, why someone “doesn’t just stop using.” A phrase that gets passed around rather frequently regarding opioid and heroin addiction is *chasing the dragon*, to explain why it can be impossible to put opioids down and walk away. Below is a personal definition from someone in recovery:
“This term [chasing the dragon] is a bit more complicated than merely "smoking opium". It starts when you have your first high, the world is peaceful, everything is perfect, you're numb, but in the best way possible. But, soon, it starts wearing off. Fast. Your mind races, you're pulled out of your dream world. You crave the drug more and more, wanting to feel the same way as you did on your first high. You go to the dealer and buy the same amount you had the first time, and smoke. Still feels good, but not as good as the first time. You go and buy more. Closer, but not quite there. You're stuck, you don't know what to do. You want to go back to that little dream world and stay forever, but your body is already developing a tolerance. You panic. You use all your money to buy more and more and more, but still, not the same as that first time. You realize that you have no more money, so you start selling your things, pawning whatever could get you that next bag. Still, nothing compared to what you had on that first, magical time. So, you're broke and own nothing. But you don't care, all you care about is getting back to the first high. You start stealing, doing "favors", whatever gets you the money for the attempt. Your life becomes a living hell, all in search of a repeat of the first high. That's chasing the dragon” (Addicted Definition 2017).

Addiction (in the most uncomplicated sense) centers around the concepts of tolerance and withdrawal. Tolerance is defined as “the capacity of the body to endure or become less responsive to a substance (such as a drug) with repeated use or exposure” (NIDA 2007). Prolonged exposure to opioids can make a person feel more pain due to tolerance and has recently been recognized as an ineffective first line treatment for acute pain (Lopez and Allyn 2018). At a recent summit on opioid addiction that included professionals from law
enforcement, the coroner’s office, and non-profits who manage care for those suffering addiction, an anonymous participant commented on how opioid addiction accelerates:

“Tolerance always increases. Almost as if the pills were designed to make you addicted. The constant search for pills... just waiting by the phone” (Newman, et al. 2017).

Another critical factor of opioid addiction is withdrawal. When a user quits opioids cold turkey, “the body quickly starts to experience the opposite effects of the original drug, resulting in a tortuous withdrawal process that can persist for days or weeks” (Lurie 2017). Hyperalgesic states, or the detoxification process, can be accompanied by abdominal cramps, uncontrollable diarrhea, sensation of burning and cramping in arms and legs, severe headaches, physical agitation, and feelings of anger and depression (Garcia, 2010). Where opioids reduce pain, withdrawal makes the body hypersensitive to it, “so, if opioids induce euphoria, withdrawal feels like the world is going to end” (Lurie 2017). Facing these difficulties can prove impossible, and the actions of getting high (or overdose/suicide) become preferable to sobriety as a way to escape this endless cycle. These examples highlight the critical role of applying medical anthropology to inform research on such a social disease. While all people who go through opioid addiction experience withdrawal symptoms if they abstain from using, they all unfortunately go through the journey of detoxification alone. It is a very isolating experience, and isolation leads to relapse. The detoxification process can “be a kind of purgatory, where addicts are seen as sinners, who must expiate their sins before being able to go to heaven (Garcia, 2010:51). If they do not appropriately absolve themselves of their addiction, they are sent back to purgatory (detox or jail) over and over again, until they either "get it" or die (Garcia, 2010).
Criminality and Addiction

The intense national scrutiny of opioid addiction because of skyrocketing overdose rates has set off a chain reaction at state level from law enforcement to contain the issue, in order to “make streets safe again” (PCSO 2017). An unforeseen barrier to this approach is the vacuum that is created when more law enforcement means fewer prescription pills available (PCSO 2017). People are forced to rely on street options to cope, which exacerbates overdose rates due to the uncertainty surrounding what a person is actually buying. Prescription opioids have an air of safety due to regulated production, but heroin is much more affordable on the illicit market than prescription pills; currently, a person can purchase four full syringes of heroin for one Oxycodone 80mg pill (Personal Communication, Field Notes, 2017). Also responsible for the steep rise in overdose rates are synthetic opioids, such as fentanyl.

Fentanyl is a synthetic opioid that was created for end of life pain. It is extremely potent, and much easier to create in a laboratory setting rather than relying on poppy-producing countries [it is mainly being mass produced in China due to lax laboratory regulations and shipped to the United States via Canada and Mexico] (Lopez and Allyn 2018). Currently, fentanyl is either being sold as “heroin” due to its inexpensiveness and accessibility or being used as a cutting agent for heroin so that street dealers can yield a higher profit by stretching the quantity of heroin they sell. Fentanyl can be between 100-300 times more potent than opium—so when a drug user takes their normal dose of heroin it results in overdose [as evidenced in figure 1 on pg. 19] (Newman et al. 2017; Summit 2017).

It is becoming more apparent to healthcare providers, politicians, and law enforcement officers that a purely punitive response is not working (Garriott 2013). Many medical and
scientific sources are beginning to advocate shifting from retaliatory responses to a public health model of addiction treatment. In the 2016 report *Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health*, chapter 7 is dedicated to shifting addiction treatment from a punitive response to a public health approach⁴, stating “It is time to change how we as a society address alcohol and drug misuse and substance use disorders (HHS 2016).” Prisons are overflowing with people arrested due to opioid related charges, though they [prisons] are poorly equipped to deal with addiction care (Garriott 2013). By locking someone up, you are shutting them off from treatment, community, mental health care, and facilitating a sense of despair and isolation (Lopez and Allyn 2018). Furthermore, if drugs are used as an escape, confinement will exacerbate use upon release, making recovery even more elusive. Instead, moving to a harm reduction and public health solution to addiction mitigates the risks of drugs and facilitates sobriety. In the next section, I explore how criminality has exacerbated addiction in an emergency setting.

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⁴ “Drug use and misuse creates public health challenges in the United States, leading to overdose deaths, HIV and hepatitis C infections, and other chronic health conditions. Public health approaches offer effective, evidence-based responses, but some of the most effective interventions are not currently allowed in the United States owing to outdated drug laws, attitudes, and stigma” (APHA 2013).
Figure 1. Number of Drug-Related Overdose Deaths by Drug Presence, PA 2016
Law Enforcement in the Emergency Setting

Opioid overdose deaths are now the leading cause of injury death in the United States. Figure 1 was taken from a National Drug Early Warning System (NDEWS) communication, highlighting how opioids have engulfed overdose death statistics, giving a snapshot of overdose deaths in Pennsylvania, which reflects many other cities and towns throughout the United States. In acute crisis, or in the absence of health insurance, the emergency department (ED) is a person’s safety net when accessing healthcare. This disease of addiction comes packaged with heavy stigmatization, which results in opioid users struggling for access to treatment and fearing reprisals when seeking treatment in an emergency setting. Stigma and fear of reprisals surrounding opioid addiction also result in care delays for patients with opioid use disease. Though stigma can be a slippery concept to contend with scientifically, recent public health work states:

... we define stigma as the co-occurrence of its components—labeling, stereotyping, separation, status loss, and discrimination—and further indicate that for stigmatization to occur, power must be exercised. The stigma concept we construct has implications for understanding several core issues in stigma research, ranging from the definition of the concept to the reasons stigma sometimes represents a very persistent predicament in the lives of persons affected by it. Finally, because there are so many stigmatized circumstances and because stigmatizing processes can affect multiple domains of people's lives, stigmatization probably has a dramatic bearing on the distribution of life chances in such areas as earnings, housing, criminal involvement, health, and life itself (Link and Phelan 2001, 363).
With addiction, stigma transforms addiction from a relapsing brain disease into a moral failing—laying the blame squarely on the person suffering addiction. Addicts are stuck between the 12-step program\(^5\), or the "ever-expanding punitive approach to addiction, which emphasizes the addict’s capacity to reason, and therefore control their drug-using behavior" (Garcia, 2010).

Law enforcement utilization of the ED as a drop off point for those in opioid crisis, combined with limited access to healthcare insurance among the opioid user population, results in the current situation that places the ED front and center in this public health emergency. Combined with this are systemic issues that can result in the absence of adequate healthcare insurance, leaving the emergency room as the only way to access treatment. This means that emergency rooms facilitate the first point of entry for treating patients suffering from addiction, and the care they experience could mean the difference between sustainable sobriety and an endless cycle of relapse. Anthropologists such as Nancy Scheper-Hughes (Scheper-Hughes 2008), Paul Farmer (Farmer 2002; 2008), Merrill Singer (Singer 2004; 2017), Angela Garcia (Garcia 2010), Helena Hansen (Hansen et al. 2010) have extensively studied the effects of lack of access to adequate treatment on overall health outcomes, and how government systems of power (such as the legal system) can exacerbate already-present inequalities to further widen the gap between sickness and health.

The punitive approach to opioid addiction in the United States has created a frontline role for law enforcement agencies (Garriott 2013), but limited funding creates a scenario in

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\(^5\) Popularized in 1939 (Wilson 1939), the core tenets of 12-step programs force sole responsibility for addiction on the addict, requiring that they “find a way out of the downward spiral of addiction” with the help of a higher power. While effective for some, this model can undermine the fact that addiction is a legitimate disease, which often cannot be conquered by willpower alone.
which law enforcement often rely heavily on the emergency department. However, limited resources also mean that there are few longer-term detoxification options. When an addicted person attempts to seek treatment of their own volition, they are frequently met with exorbitant costs and long waiting lists due to a lack of funding or governmental support regarding the detox process. Unless a person is arrested and convicted with a felony drug offense, it can be nearly impossible to obtain a bed in a detoxification treatment center (Anton 2010). In an article published by the Tampa Bay Times in 2010, Ann Weeks (featured in the article) arrived at Operation PAR (Parents Active in Recovery) in Pasco County, Florida to seek treatment for her stepdaughter Karen, who was nauseous and shuddering on the ground after ingesting Oxycodone and Xanax. Karen’s journey with prescription opioids began at 13 when she was diagnosed with chronic pain for scoliosis. Ann had already attempted to seek treatment at three different hospitals but was turned away because Karen was not suicidal.

Though the worker at PAR was sympathetic, she informed Ann that because Karen did not have a drug conviction, there was not a bed available for her; there was nothing they could do. Unsure where to turn, Ann states that she attempted to treat Karen at home: “We tried to detox her ourselves, but we don’t know anything about it and we knew she could die at any time (Anton 2010).” After struggling for months to detox without any professional support, Karen seemed to be doing better. She gained 15 pounds and started a diary. Ann was hopeful, until one day in June, Karen went to the apartment of a man she had met at Publix earlier in the day. First responders found Karen the next morning, dead in a bathtub from an Oxycodone overdose (Anton 2010). In June of 2010, Karen was one of 267 people who died of an opioid overdose in Pasco County due to lack of treatment options (Anton 2010).
Public perception of drug use and its inherent illegality serve to shape ideas of addiction, and how addicted persons end up internalizing these societal notions. Because opioid use is so heavily penalized, forms of government become forces for the creation of new forms of subjectivity (Foucault 1977, Garcia 2010), such as regarding addicts as filthy, junkies, worthless, or a scourge on society. These stigmatized terms, subconsciously perpetuated among health and police “are absorbed by the addict, exacerbating a sense of personal failure, and contributes to the sense of hopelessness that fuels the [opioid] epidemic” (Foucault 1990, Garcia, 2010: pg. 9).

Medicalizing Opioid Addiction

Stigma reduction is a clear first step in situating addiction within the realm of legitimate disease. Published in the Journal of Academic Medicine in 1995, public health approach advocate Kurt Schmoke states:

...Most medical colleges, teaching hospitals, and other health education and treatment institutions are already expanding their horizons to include attention to the public health needs of their communities. But one pressing public health problem--substance abuse--that should be treated as a disease and handled by doctors and nurses is at present entrusted primarily to law enforcement... a health-regulatory strategy, or “medicalization” must be employed to pull addicts into the public health system.

One of the key reasons this aim still has not been fully realized more than twenty years later is due to the intense stigma of drug addiction. The next section charts the history of stigma, and how it stands in the way of medicalizing addiction.
Stigma, Social Identity, and Health

Ancient Greece created the term stigma to refer to images cut or burnt into someone’s skin in an attempt to mark them to the rest of society as a criminal or morally bankrupt. These broadcasted the person to everyone that could see as “a slave, a criminal, or a traitor—a blemished person, ritually polluted, and to be avoided, especially in public places” (Goffman 1963). As time went on, different societies and religions retained this practice, extending the definition to include occurrences such as birthmarks and mental illness as a way to exclude members from society.

Today the term stigma has morphed from bodily symbolism to a concept of shame, a fall from grace. To understand stigma, it is first important to understand the structural preconditions of stigma, and how society establishes meaning by categorization. When a person possesses a stigma (such as addiction), a variety of assumptions about the person’s character leads to a variety of discrimination which “effectively, if often unthinkingly, reduces life chances” (Galtung 1969). Often in an instant, an elaborate construction of theories morphs into being, justifying the stigmatized reaction based on the inherent inferiority and danger the addict represents. This line of thinking can also rationalize animosity based on further differences, such as those of social class (Goffman 1963; Galtung 1969). Explicit stigma terms such as addict, junkie, or druggie in our daily discourse instantly conjures the imagery of what a person like this would look like. This leads to assigning a wide range of additional depravities to the person for what we reason must go along with words like junkie—such as criminal, dangerous, liar... often by the assertion of “I just know”.
This becomes a bit of a chicken versus egg argument: does the person truly possess these traits, or do they embrace them based on the internalized judgment of their peers:

*Stigma conceals a double perspective: does the stigmatized individual assume his differentness is known about already or is evident on the spot, or does he assume it is neither known about by those present nor immediately perceivable by them? In the first case one deals with the plight of the discredited, in the second with that of the discreditable. This is an important difference, even though a particular stigmatized individual is likely to have experience with both situations (Galtung 1969).*

While slave owners used brands to mark the bodies of slaves, something such as track marks can serve as a modern branding, identifying the opioid user as a slave to their addiction. This marking serves to immediately categorize an individual/patient as different— as having a significantly inferior social standing, resulting in profound misery and social disgrace. (Singer, Ostrach and Lerman 2017: viii)

Singer et al. "conceive... health as a product of the enduring interaction of diverse biological and social factors" (Singer, Ostrach and Lerman 2017: vii) Stigma therefore, as a social factor, has particular effects on the biological and structural dimensions of health and as such drives many deleterious health interactions (Singer, Ostrach and Lerman 2017). As a health and social science concept, stigma has a fifty-year history that first gained attention with Erving Goffman's seminal work (Goffman 1963). Its roles in disease processes, human social suffering, life chances, and social control have been addressed in a broad, multidisciplinary literature (Goffman 1963; Hopper 1981; Kleinman and Hall-Clifford 2009; Jenkins and Carpenter-Song;
Social scientists Link and Phelan (2006) assessed stigma as involving a set of five components:

1) identification and labelling of socially charged human differences; 2) stereotypic association of certain differences as undesirable or even threatening; 3) some form of social separation of the stigmatized from others in society through discrimination or other mechanisms; 4) harmful loss of social status among those in a stigmatized social grouping; and 5) the exercise of power and social control with corresponding loss of rights, access, and privacy.

Health is socially contextualized and produced, and, in turn, has dramatic impacts on society. Lewis et al. 2006 discuss stigma consciousness, or the expectation of prejudice and discrimination, and subsequent internalization and acceptance of said prejudice and discrimination. This can have far reaching health consequences, such as high stress, intrusive thoughts, negative mood, depression, anxiety, suicidal thoughts, and even a manifestation of physical symptoms. Stress is a key biological mechanism in stigmatization, linking stigma to the production of disease (Rusch et al. 2013).

Anthropology is uniquely situated to “shed light on the human beliefs and activities that shape patterns of disease within and across populations” (Carroll 2014: 41). As discussed in this thesis, there is a rich fabric of anthropological discussion in an attempt to uncover how stigma affects addiction and recovery, from Michael Agar’s *Ripping and Running: A Formal Ethnography of Urban Heroin Addicts* (1973), to Angela Garcia’s *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande* (2010), to Daniulaityte et al.’s *I’m not afraid of those ones just cause they’ve been prescribed: Perceptions of Risk Among Illicit Drug Users of*
Pharmaceutical Opioids (2012), and most recently, Singer et al.’s Foundations of Biosocial Health: Stigma and Illness Interactions (2017).

By no means is this list exhaustive. Stigma has been a focus of research regarding addiction, and health in general, for decades. I hope to contribute to the discussion by focusing on whether stigma creates barriers to care and how it may limit access to recovery resources when an addicted person is suffering acute crisis in the emergency room. Throughout the research, numerous discussions with people in recovery and treatment providers in the Hillsborough/Pinellas County Florida area revealed concerns regarding how stigma prolongs the recovery process and also point to emergency rooms as a launching point for addiction treatment. To pursue this research, I was able to work for close to a year in the emergency department of a high trauma urban research hospital in the Tampa Bay, Florida area, conducting participant observation on the care process for patients in acute opioid crisis.

Questions that informed the project included: How do drug overdose victims experience a healthcare crisis related to opioids?; How do opioid addicted patients experience and internalize stigma/stigmatized reactions regarding their addiction?; and What challenges or constraints do healthcare providers experience while attempting to facilitate care? The aim is to assess how healthcare providers (either subconsciously or overtly) contribute to stigmatized narratives regarding addiction, and how can this be reduced/eliminated in order to provide greater access to care and resources in an opioid crisis event, along with a meaningful way to provide follow-up care for the patient.

The first chapter of the thesis introduces the opioid epidemic the United States. Chapter two strives to situate this epidemic theoretically, and how emergency care plays such a critical
role in addiction today. Chapter three covers research methods, the field site, an expanded explanation of research questions and design, and ethical considerations. Chapter four includes the results from this study, along with additional complications of addiction, such as the role emergency departments play in the criminalization of opioid addiction. In the discussion and conclusion, chapter five, I discuss why anthropology is uniquely situated to address the complications stigma brings to addiction and recovery, along with the applied goals of this project and thoughts on my positionality as a researcher.
CHAPTER TWO:

LITERATURE REVIEW

More often than not when I am introduced to someone who participated in my research, I was met with “medical anthropologist? Huh. Well, what do you do?” In a technical sense, a medical anthropologist...

Examine(s) how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds (SMA 2018).

Put more plainly—while diseases present with biological symptomatology, the origins of disease are social and cultural in nature. One of the most critical factors affecting the disease of addiction is the stigma people experience when seeking treatment (White and Kelly 2010). Next to cost and disbelief, stigma was the third most prevalent reason individuals chose not to receive treatment, even in the face of life threatening consequences such as overdose.
It is vital to bridge the gap between the socioeconomic and systemic factors of addiction, and the chemical and biological markers of disease. Medical anthropology is uniquely situated to bridge this gap by blending both qualitative and quantitative research and treatment strategies.

**Applied Medical Anthropology: An Emic Approach to Addiction Study**

Since the formation of medical anthropology as a formal sub-discipline of anthropology, the study of drug use and its effects have had a pivotal role in health-related policies and practices. Early ethnographic works such as Castaneda’s *The Teachings of Don Juan* (1968), Dobkin de Rios’ *The Healing Vine* (1971) and Michael Agar’s *Ripping and Running* (1973) provided evidence in support of ethnography as an important new tool in the effort to understand, prevent, and treat health and social problems related to the misuse of drugs (Page 2011: 358). The National Institute for Drug Abuse (NIDA) was formed in the 1970’s, and anthropologists have been present since its inception. The primary focus of NIDA was assisting in the fight against the “war on drugs” begun by Richard Nixon in 1974, and ethnographic
studies carried out by anthropologists proved to be very rich sources of information about worlds unknown to NIDA bureaucrats. Unwittingly, however, these ethnographic studies also served to highlight how damaging the war on drugs has been, “from the formulation of its objectives to the nature of its impact on society” (Page 2011: 358).

In their article, “‘Not human, dead already:’ Perceptions and experiences of drug-related stigma among opioid-using young adults in the U.S.,” anthropologists Alana Gunn and Honoria Guarino (2016) conducted 26 semi-structured interviews with participants aged 18-29 living in New York City who reported opioid use in the past month and/or were currently in treatment for opioid use to examine the static and widespread nature of stigmatization regarding the disease of addiction (Gunn and Guarino 2016). It was discovered that all members in the participant group emphasized that stigma regarding opioid use was “pervasive and acute” in contrast to perceptions regarding heavy alcohol use which was deemed acceptable due to its legal nature.

Taking this into account, this constant struggle between health and criminality with competing institutional claims turn the addict’s life into an either/or—patient or prisoner (Garcia, 2010). Drawing on Foucault (1982), Garcia explains that forms of government become forces for the creation of new forms of subjectivity. Labeling people suffering from addiction as filthy, junkies, worthless, scourge on society-- become internalized into mainstream consciousness and normalized. These stigmatized terms from health and police are also “absorbed by the addict, exacerbating a sense of personal failure, and contributes to the sense of hopelessness that fuels the heroin epidemic (Garcia, 2010:9).”
This stigmatization has greatly deterred users to seek drug treatment and harm reduction services and “contributed to family members’ failure to recognize early signs of opioid addiction due to the user’s reluctance to seek treatment” (Gunn and Guarino 2016). This eventuality means that the opioid addiction is often not discovered, and treatment not started (if at all) until the addiction is extremely severe (Gunn and Guarino 2016). This study investigates the ways barriers to care hinge on issues of stigma and (il)legality, in other words, what is either legally and societally acceptable or unacceptable to penalize. Applied anthropology is well suited to potentially reduce stigma and create greater access to care and recovery by bridging the gap between patients and healthcare providers through socially contextualizing the disease of addiction. This is discussed in more detail in the conclusion chapter of the thesis.

**Structural Violence and the Social Implications of Disease**

“If you understand the history, you are likely to understand heroin addiction as a contemporary consequence” (Garcia, 2010:10). It is important not only to understand the pressing factors affecting people dealing with opioid addiction, but also to contextualize this problem historically to uncover long standing factors that have created a gateway for such vulnerability. In addition to new disease theories of addiction that state opioid dependence is a chronic, relapsing brain disease (Garcia 2010; Robinson & Berridge 1993; Jaffe 1978), there are also far-reaching systemic issues that exacerbate addiction, making rapid sustainable detoxification treatment in the emergency department (ED) impossible. The theoretical paradigm of structural violence helps to frame these issues.
One of the earliest occurrences of the term ‘structural violence’ (Galtung, 1969) made a distinction between violence where there is and where there is not a specific actor who inflicts that violence upon its victims. Violence that occurs with no single, identifiable actor is therefore defined as indirect or structural violence (Galtung 1969: 170). Galtung further clarifies that:

*In both cases, individuals may be killed or mutilated, hit or hurt in both senses of the word, and manipulated by means of stick or carrot strategies. But whereas in the first case, [direct or personal violence] these consequences can be traced back to concrete persons as actors, in the second case this is no longer meaningful. The violence is built into the structure and shows up as unequal power and consequently unequal life chances (Galtung 1969: 170-171).*

Structural violence illuminates ways in which larger social systems become apparent when dealing with something as pervasive as our current opioid crisis in the United States. This paradigm uncovers a number of social, political, and behavioral factors that cause or shape health inequalities. Medical anthropology’s employment of the term structural violence has strong ties to classical Marxist ideas about the social origins of disease, and harmful governmental policies that perpetuate inequality. Many structural inequities are so long-standing that they seem a natural part of the social order. But as anthropologist Nancy Scheper-Hughes reminds us (1996:889), “invisible” does not mean “secreted away and hidden from view, but quite the reverse…. [T]he things that are hardest to perceive are often those which are right before our eyes and therefore simply taken for granted.” (Rylko-Bauer and Farmer 2017).
Medical anthropologist Paul Farmer’s work centers on structural violence, which he defines as:

“the social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to the people affected by inequality, not the ones responsible for perpetuating it (Farmer et al. 2006).

The concept of structural violence then “informs the study of the social machinery of oppression” (Farmer 2004: 307). Perhaps one of the most critical observations that Farmer makes is that structural violence is fluid; structural violence is both structured and structuring. It constructs the agency of its victims. It tightens a physical noose around their necks, and this garroting determines the way in which resources—food, medicine, even affection—are allocated and experienced (Farmer 2004: 315). Most importantly, structural violence is extremely dynamic, in that it changes with society and causes secondary and tertiary changes in return, shaping and ultimately constraining the lives of individuals (Carroll 2014).

Anthropologist Kelly R. Knight and colleagues (Knight et al. 2015) conducted research on risk factors for stimulant use among homeless women, studying 260 women currently addicted to drugs and living in unstable conditions. The results uncovered that due to structural insecurity and violence, the most common cause of death among homeless and unstably housed women is acute intoxication of unprescribed opioid analgesics (Knight 2015 as cited in Riley, et al. 2015: 175). Riley goes on to state that “addressing homelessness and sexual violence is critical to reducing drug use among impoverished women” (Riley, et al. 2015: 179). Similarly, social scientist Abigail Fagan and colleagues analyzed structural (economic
disadvantage, immigrant concentration, residential stability) and social (collective efficacy, social network interactions, drug use, and legal cynicism) factors related to the likeliness of substance abuse among 79 Chicago neighborhoods in 2015 (Fagan et al. 2015). Predictably, Fagan uncovers that contextual influences and hardships need to be adequately addressed in order to reduce the likeliness of substance abuse and delinquency (Fagan, Wright, and Pinchevsky, 2015: 183).

In the thesis, I argue that the lens of structural violence is useful to understanding the opioid crisis because opioid users often have limited access to sustainable addiction treatment due to stigma, coupled with unstable living conditions due to the social structures that have created these hardships. This is compounded by the political isolation that perpetuates these living conditions (which is not created by a single actor, but rather by organizational and governmental policies). By framing my research within this theoretical lens, I suggest it is then possible to better understand how the stigmatized response to longstanding socioeconomic inequalities further compound and exacerbate the stigma and crisis of addiction.

**Syndemics**

The fundamental understanding that addiction encompasses much more than biological triggers for craving and withdrawal has to be a part of any discussion on opioids. The socioeconomic inequalities discussed in the previous section not only leave those suffering from addiction vulnerable to compounding problems such as homelessness or lack of access to healthcare, but the chronic social stress of addiction and its subsequent problems such as poverty and constant insecurity results in compounded threats to a person's health that
surpasses the struggle with addiction itself. This chronic stress effects blood pressure, blood glucose, immune system functioning, and also opens the door for coping mechanisms and risky behavior (unprotected sex, smoking, increasing drug use) (Lick et al. 2013). Stigma discrimination habitually forces people to live in unsafe conditions and prevents them from having equal access to resources like health care, compounding the issue of disease. "The end result is often a potential clustering of diseases in a stigmatized population" that cannot be addressed just by treating the originating disease alone (Singer 2009). This pathology is referred to as syndemics.

The term syndemic is derived from the Greek word synergos, meaning two or more agents working together to create a greater effect than each working alone, and demos or "people," commonly used in the public health concept of epidemic (Singer 2009, Singer and Clair 2003). According to the Centers for Disease Control, syndemic refers to two or more epidemics interacting synergistically and contributing as a result of their interaction to excess burden of disease on a population (CDC 2001). The Syndemics Prevention Network of the Centers for Disease Control states:

*Syndemics occur when health-related problems cluster by person, place, or time. The problems—along with the reason for their clustering—define a syndemic and differentiate one from another (though they may have nested or overlapping relationships). To prevent a syndemic, one must not only prevent or control each disease but also the forces that tie those diseases together (CDC, 2001)*

In an addicted population, this has far reaching implications. It could manifest in addiction and hepatitis C, addiction and HIV/AIDS, addiction and mental illness, or a variety of additional
combinations. These co-morbidities exponentially increase the likelihood that a person will visit the emergency room, particularly in a population with extremely limited access to health insurance (Marcus 2017). Syndemic theory highlights the challenges emergency departments across the country currently face, as it can be impossible to effectively treat the co-morbidities of addiction without first achieving remission from opioid addiction.

**Emergency Care**

The concept of syndemics discussed in the previous section supports current data reflecting increases in emergency visits due to the compounding issues that accompany addiction (TGH 2016). Many patients suffering from opioid addiction can also have polysubstance abuse issues, mental health issues, unstable living conditions, food insecurity, and no/inadequate access to healthcare insurance. Because no one is usually turned away from hospital emergency departments due to an inability to pay, this marks them as one of the only reliable points of contact for treatment for this population. In this section, I explore how a patient is categorized once they arrive at the hospital. All healing systems distinguish sickness events on the basis of detectable features or fundamental diagnostic traits (Singer and Clair 2003). In emergency care, this is referred to as triage.

Triage from an emergency department perspective is the “process of sorting injured people into groups based on their need for, or likely benefit from, immediate medical treatment” (Singer and Clair 2003). I created Figure 3 below to illustrate how difficult it could be to assess which is the most pressing issue to address in a patient suffering from addiction to opioids. This model visually highlights how difficult it can become to know which problem to
address first after the patient is medically stable, along with how stigma weaves its way through the entirety of addiction and recovery.

Figure 3: Dynamics of Opioid Addiction

The quick assessment of patients is not only based on the ailment the patient presents with, but also upon visual assessment. Unfortunately, the phrase “don't judge a book by its cover,” is not often applied in emergency room settings. First appearances consistently result in the categorization of a person's physical appearance into their social identity, and further into their social status (Goffman, 1963; Galtung 1969; Farmer 2002; Scheper-Hughes 2008; Garcia 2010; Singer, et al. 2017). My participant observation in the study supports this.

It is important to pay attention to how diseases and sickness are categorized (both physically and visually), because “as these systems change the ways people—both healers and sufferers, as well as the larger community—think about health and illness change, and as a result, the ways they respond to sickness changes as well” (Singer and Clair, 2003). For example, if a patient suffering from addiction internalizes stigma and believes they continue to be addicted to opioids because of a moral failing or character flaw, it may be much harder to
achieve sustained recovery than if the person were to accept that addiction is a chronic
relapsing brain disease, and a relapse does not change their motivation or self-worth.

In an excerpt from Angela Garcia’s (2010) work with heroin addicts, participants speak
out about their experiences with stigma and triage:

*Several patients reported that they never mention their addiction when they go to the
hospital for physical problems, because if they do the staff will not treat their pain, and
may not even examine or treat their presenting condition. One man described his
hospitalization for severe phlebitis when he was actively injecting heroin: I learned about
rounds. Rounds is when the head doctor comes in with about 10 other people first thing
in the morning, yanks off my gown, points to a huge boil on my butt and tells them I’m
an addict*” (Garcia 2010: 277).

One of the most important contributions of medical anthropology has been examining the
context of sickness and disease in a sociocultural context (singer and Clair, 2003). Weaving this
methodology into the triage and treatment of opioid addicted patients in acute crisis, through
an examination of stigma and harm reduction has the potential to improve our understanding
of the changes that are needed to the way patients are received in emergency room contexts
and how medical professionals approach the concept of sobriety.
CHAPTER THREE:

METHODS

Gaining Access

In the beginning stages of organizing and refining my research goals, I knew that working with people suffering from opioid addiction was going to be difficult. Due to the illicitness of drug use, people in the grips of addiction tend to be a very insular population, leaving little access for someone who is not already a member of the group in some way. Providentially, previous life experiences of growing up with a mother suffering from addiction, along with a multitude of family and friends who also experienced addiction, marked me as a member of this group via experience and exposure, though it had been a number of years since I had any contact with people actively addicted. Fortunately, the Human Services department at Saint Petersburg College, where I am an employee, put me in contact with professionals already striving to address the needs of a community rocked by opioid addiction. My study prioritized participant observation, for reasons explained below, along with interviews (semi-structured and life history interviews). While spending time with patients undergoing or having recently undergone treatment for opioid addiction in the Hillsborough County/ Pinellas County area, two constantly recurring themes were discussed with me: stigmatized experiences, and the lack of health insurance and treatment options within this population, not only for addiction-related ailments, but for routine health concerns as well. When you’re struggling with poverty and
addiction (which, as discussed above, often go hand in hand due to structural inequalities and the cost/frequency of drug use), what people are really struggling with is a lack of access to resources—one of the most fundamental resources is access to health care.\(^6\)

All of the people I interacted with regarded the emergency room as the only source of care available, as they could not afford a primary care doctor or urgent clinic. In addition, the emergency room is where first responders and police officers take people found in opioid overdose. Therefore, the emergency room became a logical launching point to observe how stigmatized reactions creates barriers to care for patients suffering from opioid addiction. If the emergency room was the first (and often only) access that people had to receive healthcare, how were they experiencing this treatment, and was it conducive to sustained recovery?

**Research Design and Field Sites**

Before beginning research, in order to structure the direction of this project, I developed the following research questions, categorized into two sections:

*Understanding Overdose and Drug-Addicted Experiences*

1. What do IV drug overdose victims/opioid overdose victims experience during healthcare crises?

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\(^6\) Currently, the federal program available to low income households that cannot afford insurance is designated as Medicaid. Medicaid is the health insurance program of last resort that covers 74 million low-income and disabled Americans (Marcus 2017). Jointly funded by the federal and state governments, it is run by the states and tailored to meet differing needs and policies on such things as eligibility (Marcus 2017). Florida did not expand the Medicaid program under the Affordable Care Act, which disqualifies all applications that are not severely disabled or pregnant, essentially making insurance an impossibility for most of this population.
2. How do drug addicted patients experience stigma? What are the challenges those individuals experience in their interactions with healthcare providers, social workers, and other caregivers?

3. What challenges do healthcare providers, social workers, and other caregivers experience in their encounters with drug-addicted people?

4. What gaps in acute care exist for addicted patients?

Applied and Policy Outcomes

1. How can health care workers contribute to reducing stigma and facilitate greater access to care when responding to acute opioid overdose/withdrawal?

2. How can medical professionals and emergency room staff provide better access to substance abuse treatment and mental health care?

3. How can policy changes and social support be utilized for public education regarding substance abuse and mental illness?

To address these questions, I selected the Tampa General Hospital (TGH) emergency department as my field site, in order to observe the process that addicted patients experience, and to understand the nexus of interaction between patients and emergency room staff, and the experiences staff have with treating opioid-addicted patients. TGH is the region’s high trauma and research hospital facility situated in the heart of downtown Tampa and reported an increase of 64 percent in hospital admissions related to overdose from heroin and other opioids in recent years (TGH 2016). TGH is also a teaching hospital, and according to a report from the
Association of American Medical Hospitals (AAMH), teaching hospitals provide significantly
more free care to the poor and uninsured than any other hospitals, stating:

_Teaching hospitals serve critical and unique community services, lead in developing new
cures and treatments, and are continually improving medical education for future
physicians. ... And they are a vital part of America's safety net, providing care to millions
of [America’s] uninsured population (AAMC, 2015)._ 

Figure 4 shows the number of opioid related arrests around the vicinity of the hospital—of
which many are brought to the emergency room in acute crisis over a three-month period. This
highlights the central role TGH plays in mitigating this epidemic. The mapping tool stopped at
1000 arrests and could not display any more results. This represents a snapshot in time and not
all of these arrests may have ended up in TGH emergency rooms, but the map conveys the
extent of the crisis and its geographic relationship to the study site.

Figure 4. Arrest Map of Opioid-Related Offenses around Tampa General Hospital from March
6th-June 6th, 2017. Accessed from hcso.tampa.fl.us
Participant Observation

The research focused on patients who arrived in the TGH emergency department in acute opioid crisis, and the hospital personnel that administered treatment to them. I wanted a first-hand awareness of the struggles of opioid addiction, without upsetting patients by asking questions while they were in acute crisis. Due to the nature of acute crisis that patients are in when receiving treatment in the emergency department, coupled with the multiple vulnerabilities that accompany addiction, I selected participant observation as the primary method for this research project in order to obtain an understanding of the treatment process. “Participant observation is in some ways both the most natural and the most challenging of qualitative data collection methods. It connects the researcher to the most basic of human experiences, discovering through immersion and participation the how’s and whys of human behavior in a particular context” (Bernard 2006: 41). Bernard recalls the description by John Whiting when speaking to a class on participant observation at UC Irvine: “An observer is under the bed. A participant observer is in it” (Bernard 2006). As I collected data for this research project, I had no formal contact with patients in the emergency department, because I did not feel comfortable interrupting treatment while patients during overdose or withdrawal complications.

Semi-Structured Interviews

In addition to participant observation and qualitative analysis, I also conducted 15 interviews with ED staff. Interviews, both open-ended (Miles and Huberman 1984; Spradley
1979; Weller and Johnson 2001) and semi-structured\(^7\) (Ryan and Bernard 2000; Spradley 1979), allowed participants to freely discuss personal struggles, whether suffering from, or treating addiction. With permission, interviews were recorded with a digital recorder and transcribed using Microsoft Word and the playback functions of the .wav audio file of each interview. All excerpts of staff interviews have been assigned a random pseudonym to protect anonymity.

**Life History Interviews**

Pure participant observation in the emergency department did not seem to give a proper voice to patients’ experiences when seeking care, however. To achieve a more reflexive and holistic view of addiction, I conducted three in-depth life history interviews. During these interviews, I worked with each participant to both document their lives generally, and the overarching aspects of addiction that served to shape the course of their lives in multiple ways (often from a young age). The participants all attained an extended length of sobriety and could consent to research participation, while also being able to vividly recall highly personal and traumatic experiences in the emergency department while in acute opioid crisis.

The employment of life history, or life story interviewing promotes a greater understanding of people’s personal experiences with opioid addiction, stigma, and acute care (Wilson, et al. 2013). From a philosophical viewpoint, “Research regarding human experience is not only logical, but responsive and authenticates the experience of the phenomena. This is resonance; more than explanation, it is understanding (Wertz et al. 2011, Risser 1997).”

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\(^7\) Appendix B contains a caregiver interview guide. If an interview did not seem to fit the format of outlined questioning, I let the participant take the conversation in different directions. Whether the interview was semi-structured or open-ended depended on the participant, their comfort level, and adherence to the question guideline.
Narrative is used to understand addicted experiences, and tie together common themes among participants who experience stigma when seeking treatment in the emergency department. Using narratives such as this from a person’s own perspective can broaden knowledge of what the next steps will be to begin removing barriers to care created by stigmatized experiences (Wilson, et al. 2013).

All interviews were transcribed from audio to text for sake of clarity and reference. While analyzing interview transcripts, I looked for common themes and experiences in order to develop the composite narrative focus of this study regarding stigma and emergency room experiences (described in more detail below). Though I worried that a composite narrative would lose the singular voices of my participants, this task proved easier than I anticipated. Unfortunately, many participants’ stories, though varying in individual detail, laid neatly over the same repetitive frame of stigmatized experiences regarding opioid addiction.

**Ethical Considerations**

Ethical considerations may often be like navigating a minefield when working with such a vulnerable population. It was of utmost importance to me that my research project remains ethical from its inception to write-up, and beyond. At TGH, I did not feel comfortable attempting to elicit or use data collected from patients admitted in the acute stages of overdose, as they were not in a lucid mental state that would allow consent. Consequently, I did not have any on-record communications with patients and conducted ethnography at TGH via participant observation. According to James Spradley’s work on participant observation, this was a limited-entry social situation that requires the permission of one (or more) person(s).
Spradley states that “limited-entry social situations can become an excellent place to do your first field study, provided the permission-gaining process goes smoothly” (Spradley 1979).

My initial role at TGH was purely observational in the emergency department. After several months, I was hired as a clinical research associate through the office of clinical research, though I am still considered an independent contractor. My new role at TGH consists of screening the charts of patients admitted to the ED for inclusion in various research studies conducted at the hospital. Though I now have access to patient charts, this does not in any way correlate with the participant observation conducted regarding this project, and while I have a new direct supervisor in this role I have continued collaborating on opioid research in the ED.

In terms of interviews, no identifying information whatsoever was retained in either recorded or written notes. All recordings and written field notes were de-identified either in the moment or as transcribed, and all data was stored under lock and key (either physically or electronically). Due to the sensitive nature of my research topic, all participants in this study remained completely anonymous, with an additional layer of anonymity applied to life history interview participants via the methodology of collective representation and composite narrative as described in more detail in the next section.

**Collective Representations**

In an attempt to craft an ethnographic account capable of examining the intimate ways people experience the stigma of addiction, it became clear that personal recollections from those who have suffered from opioid addiction would be one of the most powerful ways to convey the desperation of addiction and the desire for dignity. Yet, showcasing individual
stories in detail would have almost certainly compromised their anonymity that was promised when they agreed to take part in this research. For this reason, I chose to recount participants’ experiences as that of a composite (condensing several stories into one story which is representative), following a similar approach used by other anthropologists researching extremely sensitive topics among the most vulnerable (Johnson 2013; Angrosino 1998; Angrosino 2002; Narayan 2012). Use of composite characters in qualitative research has been addressed by several anthropologists, most recently Kirin Narayan (2012) and Michael Angrosino (1998).

I refer to an individual named “Jenny” in the composite narrative in my findings chapter to protect the identity of the private histories with which I was entrusted. Iterations of the composite narrative were written and re-written with active research participant assistance in an attempt to heed Narayan’s caution that use of this ethnographic writing technique must “be done carefully so that these composites remain socially grounded even as they become fictional inventions” (Narayan 2012; Johnson 2013).

Composite Narrative

The name of my composite narrative character is based on the popular song titled Jenny, from American rock group Nothing More. The highly personal song discusses struggles with mental illness and drug abuse, and was written about Jenny, the aunt of lead vocalist Jonny Hawkins, and his sister Jenna, who struggle with schizophrenia and bipolar disorder, respectively (Atlasman 2015). Creation of this composite character involved the careful abridging of several life stories into one master narrative based on particular themes. The
resulting composite is therefore a fictional, yet thoughtfully crafted character involving the real-life narratives collected from fieldwork, and the systematic scrutiny of research participants. I employed the use of a composite character for the life history interviews to ensure total anonymity of participants, reinforce similar experiences, and give voice to a population that is often rendered voiceless.

Participants in the Study

While this research has been thoroughly anonymized, participant demographics are relevant to the study findings. Healthcare providers ran the gamut regarding ethnicity and gender. I discovered that speaking to a variety of staff\(^8\) yielded similar experiences when attempting to provide care to patients in acute opioid crisis. As my presence in the hospital became a regular occurrence, I started getting to know people and share my research goals. Most of the time, staff would volunteer to speak with me without prompting. I met most of my participants through referral—I would give lectured on heroin addiction and be approached afterwards by a participant desiring to have their story heard, or I would attend community events and would be referred to someone who would like to participate by sharing their story.

Regarding research participants that dealt with opioid addiction, I found that (while I did interview males), the majority of participants ended up being female. This could be due to feeling more comfortable with me as a female researcher. All of my life history interviews in this study were white/Caucasian. This could be due to the current epidemic having such a large effect on poor whites, or it could be due to my own status as a white female researcher. I hope

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\(^8\) The staff I mainly spoke to were nurses and patient care technicians. I also had the opportunity to speak to a clinical researcher, a resident, security guard, nurse administration, social workers, and a screen tech.
to include a more varied portrait of how addiction is experienced along ethnic/gender lines in future research.

**Engaging with Applied Approaches for Opioid Addiction**

Along with anonymity, a predominant emphasis from the beginning of the research was making sure results of this project included envisioning meaningful change for participants and the community. With this in the back of my mind, I began to notice a common concern repeatedly arising in the form of an overall lack of resources on many different fronts. Medical professionals struggled with a lack of a list of updated health and other resources targeted to their specific patient populations, while those suffering from addictions struggled with access to affordable resources that fit their particular situation. Working together with community partners, research participants, and service providers I created a comprehensive list of relevant resources for opioid addiction, which can be found in Appendix C. More discussion of the applied outcomes of the study are found in the conclusion.
CHAPTER FOUR: 

RESULTS

Jenny

I drove down a narrow, winding road, squinting in the afternoon sunlight to find a hidden turn for the small rural park where we were to meet. As my tires crunched through the gravel parking lot, I could see a slight woman perched tentatively at a picnic table, across from recently abandoned swings that swayed in the breeze. The screech of children’s laughter met me as I stepped out, and waves of cigarette smoke from a group of teenagers walking passed. I stepped over random bits of garbage that littered the edge of the parking lot and made my way over. Though we had only spoken via email so far, I was convinced that the woman waiting at the table must be Jenny, which was confirmed when she stood up and waved me over.

That breezy Saturday afternoon was the beginning of many interviews as we worked together to unpack Jenny’s life experiences. An endeavor to sort out how opioid addiction comes to fruition, how someone struggling with this addiction navigates periods of active addiction and incarceration, and how stigma affects the recovery process. Because opioid addiction to date has been met with punitive reform, recovery can become much more complicated than people assume due to past criminal convictions. People struggling with opioid addiction can tell you that this disease invariably results in frequent run-ins with law enforcement, and can result in losing children, becoming ineligible to receive financial aid for
high education, lost employment opportunities, losing the right to vote, and in countless other ways. In the next section, Jenny and I discuss exposure to opioids, and the general and persistent stigma surrounding addiction.

**Exposure, Incarceration, and Indignity**

One of the first things we discussed was how Jenny became addicted to opioids. Her mother was an alcoholic who was also plagued with mental health issues, and I asked Jenny if she felt this affected her childhood:

*Oh yeah. I’ve watched my mom have sex with other men besides my father while smoking crack in a hotel room. I was eight years old. I have memories of all of the dysfunction. My friends used to love my house, because we could drink and party. That was my life until about 18 when my mom had her first psychotic break. Then life changed.*

Being exposed to substance abuse and mental health issues from a parental figure as a child definitely leaves scars. People are creatures of habit, and who you subconsciously gravitate towards in teenage and adult years often share the same characteristics with people you have grown up surrounded by. Around the time of her mother’s mental health crisis, Jenny met a friend named Veronica, who introduced her to methadone.

*I started taking methadone, but it was completely social at first. We would only do it when we’d go out. Then I met Mark [child’s father], who introduced me to Roxy’s [Roxicodone]. After that, I went to my doctor and got diagnosed with fibromyalgia so I could go get an MRI and get my own script. It was all-consuming. The prescriptions are*
enough to sell and maintain your habit. We both quit our jobs and went to selling drugs fulltime.

Jenny and Mark were receiving a combined total of 420 Roxicodone 30mg pills per month. We both agree that this is more than any one person needs to manage pain, and she sheepishly smiles. After the birth of her son in 2009, Mark was arrested and sent to federal prison for transporting opioid pills from Florida to Kentucky. During the stress of the arrest, Jenny spiraled deeper into addiction, and the court system awarded custody of her son to her parents. During this time, Jenny was in and out of the court system and drug court after being arrested for possession of opioids with intent to sell. I asked her if being incarcerated and detoxing from drugs helped at all, and was told that even a six-month sentence in the county jail did little to shake the grips of her addiction:

*It changed nothing. I had a bad attitude in jail. I was angry—I hated the world.*

*Everything was everybody else’s fault. I took responsibility for nothing, I think because I got treated like shit. They treat you like the lowest person on earth. And I think that’s when... I never looked at myself any different. Until I was arrested and went to jail, I didn’t realize how I was really viewed.*

Shortly after her release, Mark was also released from prison, and introduced her to injecting heroin. Jenny whispers that after she tried heroin, the drug made her feel like everything would be ok; she became an intravenous drug user for the next four years of her life.

Using drugs intravenously comes with its own set of problems aside from addiction, chiefly the transmission of disease. I ask Jenny if she was exposed to any diseases while actively using:
I have Hepatitis C. Everybody that I grew up with? We all have hepatitis. And we all have hepatitis because we’ve shared [needles]. There’s a whole entire town, right here, that’s grown up together since elementary school. And we all have hepatitis.

Hepatitis C is a viral infection [referred to as HCV] that damages your liver, and can lead to cirrhosis of the liver, and liver cancer. Hepatitis C is transmitted in a variety of ways, but the most common is through intravenous drug use and the sharing of needles among drug users. Though this disease is a common concern for IV drug users, Jenny vehemently conveys that exposure to the disease is often not the result of being careless. People who are in a relationship may share, or someone may use the needle when the owner is not around. Clean needle exchange programs are a proven method of harm reduction but are unfortunately few and far between currently (Ovalle 2017). Jenny does tell me that if you have identification and money, some pharmacies will sell you a single needle:

Some pharmacies in some places will let you get a clean needle if you have an ID and can pay for it. So if you have the money and you’re in the right place you can get a clean needle. I always tried really hard to do that. But sometimes you don’t have money, or you’re nowhere near a pharmacy that does that, and it’s the only needle there. So you just do it because you don’t have access.

I ask Jenny to share her experiences of finding out she had been exposed to this disease:

When I found out, I was in the hospital. And I was freaking out! Even now, when they [hospital staff] see my track marks, I automatically get “the look.” And my track marks are barely noticeable, these ones [indicates left arm] are almost completely healed. But no matter how long you’ve been sober-- they start feeling around [and feel them] and
then you get the look. And now I have to say I have hepatitis too. Their whole demeanor changes! It makes me not want to say anything. If all the preconceived notions and stigma wasn’t there, then they [healthcare providers] could just see you as a person. See that you are in pain… that you need help. I know I’m an ex-addict, but if my chest hurts it still hurts. There is always that disposition. As soon as you tell them your history, it’s game over.

Stigmatized Experiences in Emergency Care

Based on both my own participant observation and literature reviewed previously, in emergency care, the social stigma associated with opioid misuse can subconsciously prompt encoded notions about the patient that are grounded in assessments of morality instead of medicine. I witnessed this seamless and subconscious passing of judgment during my observations in the ED regarding patients brought in suffering acute opioid crisis. On one occasion, I was asked why a heroin addict deserves treatment, when there could be a grandmother in triage needing treatment for a condition she cannot help. After discussion there was often an acquiescence to the notion that opioid addiction is more complicated than the person initially thought, and that perhaps they were too hasty in their assumptions, but this typically emerged after we had talked and not in the beginning of the conversation. This type of stigma is internalized by people suffering from addiction, and flourishes over time into a “scarlet letter”—carried from one place to the next—whether it is applying for housing, attempting to find employment, or seeking medical care. Though current scientific research has labeled opioid addiction a chronic, relapsing brain disease (HHS, 2016), the stigma that swirls
around this disorder remains pervasive. Jenny’s experiences and those of the others I interviewed suggest that people struggling with addiction dread stigmatized reactions and fear reprisal when seeking care in an emergency setting, which creates very real barriers to care.

Even though Jenny has been in recovery for five years, she relates that any hospital trip [not involving acute crisis] is fair game to experience stigma:

*I had a sore here one time [indicates track mark on right arm] and I had to go [to the emergency room], and I'll never forget the way that woman looked at me. Like I was the epitome... I never felt like scum until that moment. If you go to the hospital...if you go to the hospital even now for certain things, like say if I was to go to the hospital for this [indicates blemish on face] it doesn't matter. I haven't used drugs in almost five years. It's still... I can never escape that persona. That guilt. I feel like I wear the label. The Scarlet Letter will forever remain on my body. No matter how much I change my life, I feel like everybody can see it. And they can't. But it's a constant battle, with myself.*

Additionally, the current system of confronting opioid addiction and overdose with punitive measures continues to stigmatize the detoxification process through arrest and detainment. It can be exceedingly difficult to remain dignified in crisis when chained to a bed. During an episode of detainment, Jenny recounts her experience of being arrested and handcuffed to a hospital bed in the emergency department:

*The stigma...is so hardcore that it affects the level of care that you get. One of the times I was arrested and brought to the emergency department, they couldn't get any IV's into any of my veins, so they needed to make a port in my femoral vein. But they had this doctor who was practicing do it, and I had no say in anything. There was no local
anesthesia, and he kept missing [my vein] and it was the most painful thing I have ever done in my life. And they all acted like I wasn't even a human being at all in that situation. I was handcuffed to the bed, and I was naked [because of the location of the port], and the male officers were there. Everybody was just standing around while the doctor was digging around and I screamed. That was probably the most horrific hospital moment that happened [to me].

Many times, patients in Jenny’s situation are very reluctant to even reveal their drug use/history for fear of reprisal and stigmatized reactions. This often inhibits healthcare professionals from providing efficient care in an emergency. Below, Jenny goes on to describe how the active role of law enforcement, and the stigma of intravenous drug use affected her care in acute crisis:

I got a heart infection from using dirty needles. It started in my blood, and then I got really sick. I was on drug court at the time, so I was supposed to be clean. But eventually I had to go into the hospital, and I wouldn't tell them at first. Because I didn't want it to come out, you know? So, they thought I had spinal meningitis. But I had endocarditis, which you don’t really have nowadays unless you're using dirty needles. I didn't know any of that at the time. I thought it [being sick] didn't have anything to do with that for some strange reason, you know? Then when I did tell them, I ended up being in the hospital for weeks on end. I think it was like 6 weeks that I was in the hospital on IV antibiotics. And it was definitely.... they definitely treat you [pause] they treated me one way when they thought I had meningitis. I was like a normal person, in that moment... then it was more like everyone backed off, and suddenly I was less deserving of care. I
wasn’t there for a legitimate reason. Because I did this to myself. Like, "you are the reason you are here" type of thing. And I did do it to myself, but I was also young and a drug addict.”

Emergency Rooms and the Business of Opioids

Alongside patients suffering addiction, emergency care also faces the challenge of stigma. In “From White Bullets to Black Markets and Green Medicine: The Neureconomics and Neuroracial Politics of Opioid Pharmaceuticals”, authors Hansen and Skinner argue:

"...the current state of opioid treatment in the US can be understood using a biocultural lens, in which the physiological dependence causing properties of opiates and opioids make them ideal commodities from a pharmaceutical corporations perspective, but that the cultural associations of opioids and opiates with racial and class marginalization...reinforces stigma among the urban poor, and enhances the biological, political, and economic dependence of all classes on opioid markets, both legal and illegal (Hansen and Skinner, 2010: 167).

For emergency care, economic dependence is a key factor in patient experiences. The pharmaceutical industry and the institution of emergency medicine are unquestionably intertwined, and all hospitals are stocked with opioids to manage pain. The current opioid epidemic makes the path to treatment more complicated than ever, especially in an acute crisis where the ability to make a quick decision could mean life or death. This can leave healthcare providers in a zero-sum game of wanting to manage their patients’ pain, but not wanting to begin/contribute to an opioid addiction. Additionally, patients in active addiction view the
emergency room as a potential source of obtaining opioids to stave off withdrawal when regular access to opioids has been disrupted. Moreover, funding and administrative constraints leave many in the emergency department feeling frustrated and overwhelmed. In this light, the oath that medical professionals swear to “do no harm” becomes an extremely tenuous ground to stand upon, as noted in the next section.

Healthcare Provider Experiences

In addition to the barriers patients experience, stigma also creates significant challenges for healthcare providers in the emergency department (ED) as well. Patients can be combative, unwilling to share medical histories, or exhibiting drug seeking behavior. Michelle shared her experiences treating patients as an ED nurse:

“We had a lot of patients who were on OxyContin and other prescription opioids, and they either were "abusing" their own prescription, or had purchased them off the street. Often they could be really difficult to take care of, because they could be very unruly and even physically harmful at times. Most of the time they didn't want to be in the hospital, and they would usually be either under arrest or placed under a Baker Act or Stewart-Marchman Act [involuntary or voluntary assessment and stabilization of a person allegedly abusing substances like drugs or alcohol to provide treatment of substance abuse]. So they were being held in the hospital against their will. We didn't have any support at the time as far as extra personnel or even mental health services so it was a huge strain on the nurses trying to care for people that didn't want us to care for them, and they often tried to harm us.
Other care providers corroborate this sentiment, adding that it is “very common to see the same people over and over—called frequent flyers—and it is easy to become jaded because it seems like your efforts to help these patients are in vain as they show up over and over again. (Personal Communication, Field Notes, 2017).”

Perhaps most perplexing is the intense public scrutiny that has been placed on opioid addiction recently in politics and media. While highlighting this issue is critical, such an overwhelming public response has had the unexpectedly deleterious effect of making providers increasingly wary of prescribing opioids at all—

A huge issue that we have in the hospital is that when patients come in with any sort of addiction (drugs, alcohol, smoking, etc.), they are cut off cold turkey, and doctors don’t usually prescribe anything stronger than maybe Tylenol, because they are so afraid of drug abuse allegations. So you are trying to completely detox people that probably aren’t ready to be detoxed. The detox isn’t going to last, and you’re actually causing physical harm to someone by doing that (Personal Communication, 2017).

Combined with these complications is a known shortage of ED healthcare providers (especially nurses). Stacy switched from the ED to pediatric nursing, stating:

After my time as an ED nurse, I left adult nursing altogether because I could feel myself becoming jaded, and I didn’t want to be that way. I didn’t want to be callous to people—but it was a huge emotional strain, and there was no support for either the patients or the staff. I think not having mental health specialists there, or feeling as if the hospital [administration] has your safety in mind makes it difficult to treat patients.
With my research, I felt it was important to analyze the issue of stigma not only from the patient’s perspective, but from the perspective of healthcare providers as well. Only by articulating the needs of both sides is it possible to begin removing barriers to care for patients in acute opioid crisis, with a reduction in stigma being a clear first step in achieving sustainable recovery from addiction. The next section speaks about how all-consuming addiction can be to a person’s identity. Figure 6 highlights common misconceptions about addiction.

**Figure 5. Misconceptions about Addiction and Recovery**

(Creating a Prevention-Ready Sullivan County 2017)

“I Am More than My Addiction”

Stigma reduction is a vital first step to the recovery process. The notions that relapse is connected to a person’s character, willpower, or desire to be sober are now known to be false.
People suffering from opioid addiction are already aware of how they are harming themselves and others and are riddled with shame and humiliation. Everyone around them is telling them to just stop using, so when opioids cannot simply be put down and forgotten these feelings of guilt and inadequacy become internalized, highly damaging motivation and self-worth. When someone is in such a precarious emotional state, experiencing stigmatized reactions when they make themselves vulnerable enough to seek care (in any capacity) sets them on the defensive, with anger the initial response. It is vital to therefore frame addiction as a legitimate medical issue, as opposed to a moral failing. When addiction is regarded as a moral failing, the perceived judgment of a person’s character, willpower, or decision making can exponentially delay the recovery process, resulting in many failed attempts at sobriety. During my time with Jenny, we would often discuss her setbacks on the road to recovery due to stigma, and her earnest desire for society to see past her past—to see her as more than an opioid addict.

*One of the most interesting things after getting out of that world was that I couldn’t look people in the eyes for so long. No one. I felt like being that [an addict] for so long, after being that for so many years... that’s all I was. That’s all my jail record says about me! I apply for jobs and I’m like well why am I going to get it? I’m the girl with sales charges, with drug charges. I’m the ex-drug addict. I’ll forever be viewed as the drug addict. What am I supposed to say? I’m just a drug addict, but I’m trying to make my life better? It’s so long before you can look anyone in the eyes, because when you’re an addict you’re not a person. You’re not a normal member of society. [begins to cry] I’m sorry, but it makes me cry when I think of those feelings, because it’s not how I feel today... but I can still remember. Feeling like nothing.*
I asked Jenny what she would say if she had the opportunity to tell people one thing about the how the stigma of addiction stalls recovery, and she immediately says that it would be to tell people that those who are struggling with addiction are more than their addiction:

*Even though I was addicted to opioids, I am still a human being. I deserve dignity and support. If there was more compassion and dignity in the recovery process, getting people clean would be a lot more successful. Everything about recovery makes you feel like you’re being set up for failure. The stress of probation and drug court and all of the expectations while also trying to stay clean—get to meetings, and urine drops, and group therapy sessions seven days a week without a car, and if you don’t do it all perfectly you’re going to go back to jail. They say there is support, but there isn’t. People suffering from addiction need to know that it’s ok. It’s ok that they haven’t been able to get clean yet, but at least they’re trying. Instead of a probation officer screaming at you that you’re going to go back to jail, you need to be taught to reconnect with your body and acquire tools to help you cope with sobriety and the world. I wish people had a clue about recovery. I feel like people look at us like there is no hope. Especially once you’re labeled an IV drug user. People automatically deem you… like there is no hope.*

**Hope**

This chapter focuses on the personal account of Jenny and her experiences of stigma and lack of access when suffering from opioid addiction, along with challenges from the perspective of healthcare professionals when treating patients in opioid crisis. While these pieces are critical to the care process, there is another piece to recovery, however: the support
system of family and friends. One of the chief points made by both with participants who struggled with addiction and the healthcare professionals who provided care was that sustainable recovery is insurmountable without a support system. These are people who are always on call to help navigate the stormy seas of addiction. Without access to care and a communal support system, freedom from addiction is often impossible. Sustained sobriety can be a long and arduous process however, and each relapse takes its toll. Every time a loved one relapses; family and friends share feelings of devastation and helplessness. I want to end this chapter by stressing how important it is to not give up, how vital it is that we view every relapse as a step closer to sobriety.

Singer/Songwriter Johnny Cash, who struggled with drug addiction for most of his professional life, said, "You build on failure. You use it as a stepping stone. Close the door on the past. You don't try to forget the mistakes, but you don't dwell on it. You don't let it have any of your energy, or any of your time, or any of your space." Researchers Rosemary Boisvert et al. 2008 discovered that peer-support and community programs proved to significantly reduce relapse rates among those suffering from substance additions, while fostering increased community affiliation, and increased quality of life (Boisevert, et al. 2008). When speaking with Jenny about her recovery, she says:

*It [recovery] is such a process. I have been to rehab three times, with multiple trips to jail in-between. It took me every single time to gain more knowledge, and more understanding of myself [to get clean]. I made a lot of mistakes, but it took every single time to get me closer to recovery.*
The only constant currency we have in this struggle is hope. With that in mind, I wanted to close with the simple phrase "I know."

I know about waiting by the phone night after night with a tightness in your chest that cuts off your very breath because you have no idea where your loved one is. I know about the indescribable relief of discovering they are in jail, because at least they are still alive. I know about being on a first name basis with every bail bondsman in town. I know about the lies, the missing debit cards and checkbooks, and finding your belongings in pawn shops. I know about attending every group therapy meeting, counseling meeting, and Narcotics Anonymous meeting required by drug court, just to experience the pain of walking in on a loved one with a needle in their arm, starting another cycle of relapse. I know about living on tenterhooks because you have no idea when the mood swings of withdrawal will lead to a violent outburst. I know this is not easy. I know it seems like the only way this will end is with a funeral. I know the toll this takes. But there must be hope. Hope inspires the courage required to weather this storm, becomes a balm to soothe the suffering of family and friends, support when enduring seems impossible, and a message that every person struggling with this disease is more than their addiction.

The aims of this study are to ultimately involve humanize the disease of addiction. The outcome of this could potentially reduce stigma during emergency care while in acute opioid crisis. The stories expressed in this section highlight the increased need for ethnographies of opioid addiction, and sharing the results of ethnographic research to caregivers, to improve communication between patients suffering crisis and healthcare providers who facilitate treatment in emergencies.
CHAPTER FIVE:
DISCUSSION & CONCLUSIONS

What is so vital about qualitative approaches is that they give equal attention to both social and biological aspects of health, and posit, “Epidemics, while biological in form, are fundamentally social processes” (Maher 2002: 312). In this light, a qualitative ethnographic approach offers a “reconceptualization of the social forces and human behaviors that drive public health problems” (Carroll 2014). Researchers of every discipline are beginning to realize that “research into systemic forces [such as poverty] … “must be complemented by qualitative methods to help understand the cultural, social, political, and institutional context within which such problems are rooted” (Bamberger 2000). This is especially true from a medical perspective; exclusively quantitative methods will not yield the lived experiences necessary to elucidate sustainable addiction solutions.

Summary of Key Findings
At the beginning of this project, I assumed I had a relatively good understanding about how stigma damages a person’s ability to achieve sobriety from opioids. Both participant observation and conducting life history interviews with participants in recovery from opioid addiction helped address the way stigma operates and confirmed early suspicions regarding
stigma’s role in recovery\(^9\). What was unexpected, however, was the perceived helplessness of care providers and law enforcement to adequately combat this epidemic. As I began conducting interviews, I admittedly had a very patient-centric focus. Though the more I spoke with treatment providers, and attended opioid summits, and panels on substance abuse, the issue of stigma and opioid addiction became problematized in unexpected ways.

For example, people in active addiction tend to vilify law enforcement and expect every instance of arrest and detainment to play out in the same predictable pattern. Hearing law enforcement speak at various functions uncovered how they too are struggling with a lack of resources, much like patients who suffering addiction and have a complete lack of recovery facilities to bring people to. Healthcare providers voiced similar feelings of helplessness regarding patients seen in the hospital and felt that there was a lack of dependable resources for patients once discharged after a crisis event. These findings illuminate the importance of delving into lived experience through ethnography, which is discussed in the next section—not only for the victims of the opioid epidemic, but also the people doing their best to treat and contain it.

Based on my interviews and participant observation, it is clear that overdose victims experience stigmatized reactions, lack of access to resources, and inadequate follow-up care during healthcare crises. Providers experience constraints regarding time with the patient in crisis, and lack of funding options and pathways to utilize for extended care once discharged from the emergency department. When considered together, I found that improved access to

\(^9\) Such as feelings of worthlessness that became internalized by the patient when addiction was not prioritized as a legitimate disease, which fostered feelings of hopelessness and inadequacy—exacerbating active addiction and preventing patients from seeking out treatment.
resources both for patients and healthcare providers start to close gaps in care for people suffering acute opioid crisis. This research documented gaps in care as far as follow-up, and lack of information on services (such as affordable detoxification, food security, and housing assistance), which led to my development of the applications of the research.

**Contributions to Medical Anthropology**

Though there is a dedicated body of anthropological work regarding stigma and addiction (Jenkins and Carpenter-Song 2008; Hall-Cliffard 2009; Garcia 2010; Page 2011; Hansen and Skinner 2012; Knight, et. al. 2015; Gunn, et. al. 2016; Singer, et. al. 2017) this project is unique with respect to the access I had to conduct participant observation directly in the emergency department (which is typically a very insular space) with a particular focus on subjective and social implications of disease. A study conducted by anthropologist Raminta Daniulaityte and colleagues, who sought to analyze perceptions of risk among pharmaceutical grade opioid users to determine patterns of cultural sharing and intra-cultural variations, found that, “although prescription opioid use and abuse has risen at an alarming rate in the U.S., there remains a relative lack of studies on the meanings that people attribute to their own drug use behaviors and associated harms” (Daniulaityte et al. 2012: 375). Their research revealed that most drug classification and policy laws are more commonly based on socio-cultural, political, and historical influences, rather than scientific evidence.

The authors suggest that a prudent step forward would be to base drug policy on a “rational scale” of drug risk assessment conducted by social and natural scientists, coupled with drug experts, rather than politicians (Daniulaityte et al. 2012: 375). This study further illustrates
the glaring issues with our current “universal approach” to distributing substance abuse
treatment, prevention, and intervention among vulnerable populations, grounded in the fact
that substance use education is experienced differently based on individual users’ drug history
and perceptions of risk. Moreover, it also highlights the extremely individualized way in which
each person experiences acute opioid crisis.

In this respect, the support and mentorship I received while collaborating with TGH was
critical to the success of this project. Conducting both qualitative and quantitative research into
an issue as complicated as opioid addiction is instrumental to finding plausible solutions to the
crisis, and the interdisciplinary partnership of this project respectfully makes space for medical
anthropology in traditionally clinical zones. Ultimately, interdisciplinary research highlights
multiple facets of a singular issue in unexpected ways, and having many minds working
together on the same issue is invaluable. Working directly with medical professionals charged
with the acute care of patients in opioid crisis uncovered the social needs patients bring to the
hospital with them, and how both social and medical science can move forward together to
address those needs.

**Applied Project Outcomes**

This project had specific applied goals from the outset. My main goal was to let applied
components develop organically based on the needs of research participants. A main issue
cited by participants in recovery from opioid addiction, healthcare providers, law enforcement,
public health officials, and politicians is a lack of resources to fight this epidemic. Making
resources more available to my field site became a central focus and has so far been successful,
which I explain in more detail below. Moving forward, future research will extend to focus on the creation and improved access to harm-reduction services. One such service includes access to clean needle exchanges, which is proven to lower rates of infectious disease transfer, cause less individualized complications such as abscesses or infection, and provides a way to connect with people suffering from addiction to offer further harm reduction services such as HIV/HCV testing, STD protection, and overdose prevention medication. The importance of access to resources for opioid addiction is expanded in the next section.

**Pragmatic Solutions for Patients in Acute Opioid Crisis**

According to the Society for Mental Health and Substance Abuse (SAMHSA), people suffering from addiction are much more likely to grasp how addiction has taken over their lives during crisis and be receptive to making changes. By analyzing the stigmatization of opioid addiction within the framework of emergency care through ethnography, it is possible to discover how such attitudes affect care during an acute crisis, when patients are most open to the idea of detoxification and sobriety. This information has the potential to lead to new protocols and resources that can aid emergency department (ED) caregivers who treat these patients, better access to resources for patients in crisis, and more follow-up once a patient is discharged after the crisis event.

The most salient benefit from this research thus far exists in the form of an extensive list of cohesive, vetted, immediately available, and affordable resources that can be given when a patient comes to the ED in acute opioid crisis that is made available to emergency room personnel through patient management software. This list (found in Appendix B) was a
collaboration between myself, researchers at USF, social workers in the TGH ED, and participants in recovery who all shared what they thought would be important resources to have access to post-emergency room crisis visit. Having a list of available resources—such as sliding scale detoxification, food banks, or where to obtain utility vouchers—not only help facilitate detoxification and recovery, but also address a broad array of systemic concerns, from housing to food scarcity to bill payment assistance. This goes a long way to encouraging greater access to future care and recovery in an emergency setting, along with greater access to community resources for detoxification, rehabilitation, and sustainable sobriety.

The most cited concern with research participants was a combination of feeling shame for their addiction and not feeling worthy of care due to stigmatized experiences in acute care settings. It is important not to place blame on the patient for their addiction, shifting addiction into the realm disease instead of self-inflicted harm. Having vetted resources available in a single, easy-to-use list conveys to the patient that their suffering is acknowledged, and the hospital is prepared to help them both with addiction management and recovery, but also with systemic issues that exacerbate addiction.

In addition, my research findings suggest that a reduction in stigma in an emergency setting could ultimately lead to better access to care for those suffering opioid addiction, greater follow-up regarding recovery, and less recidivism regarding patients who overdose on opioids. This study did not assess the impact of reducing stigma, so a future research project would need to follow patient outcomes long-term in order to determine the connections between these factors. However, it seems likely that if a patient that receives dignified care, and feels they are being heard regarding what they actually need (even if the hospital cannot
accommodate all treatments/concerns) it could potentially disarm patients who come in
defensive, expecting the usual stigmatized reactions. Empathizing with a patient suffering
either overdose or withdrawal humanizes them and their experiences.

Yes, addiction is a relapsing brain disorder, so it is highly likely that the emergency
department will see this patient in crisis again, but each empathetic interaction has the
potential to chip away at the addiction, instilling patients with the confidence needed to
achieve sobriety. Conceivably this could provide a more substantial level of care to the
patient—one that facilitates recovery in lieu of relapse. Further research is needed into the
impacts a program or curricula for emergency room staff on reducing stigma might have on
patients.

According to one health care provider who participated in this study, conducting
ethnographic research in a clinical setting “really highlights why we add qualitative techniques
to research, and where I think we can go with integrating an anthropological approach into our
work in the ED (Personal Communication, Field Notes, 2017).” While there were limitations to
ethnographic research that involves vulnerable populations, this research project suggests that
observing interactions with staff and patients in the ED is a critical way to uncover how stigma
surrounding opioid users is both created and perpetuated.

Limitations and Potential Future Research Directions

One of the most significant limitations of this research project was being unable to
speak with patients experiencing acute opioid crisis in the emergency department. At the
outset, I chose not to do this so that I could build a strong foundation via observation of how
hospital emergency departments operate, and build rapport by working together with hospital staff. Stigma reduction in acute care is the beginning of a long, multifaceted journey to ensure that people suffering from substance abuse receive dignified and appropriate treatments.

My primary concern in this research project was giving voice to the experience of stigma in acute care, along with extenuating circumstances that exacerbate addiction. This unfortunately also meant I encountered issues that I did not have the space to unpack in this master’s thesis. These include a perception that women have less access to treatment and recovery than men due to the stigma attached to active addiction and motherhood, and how racial discrimination plays a role in the stigma of addiction. My earnest objective moving forward is to continue this research in a dissertation, which will include personal accounts from patients, coupled with how stigma is experienced along the intersections of race, gender, and disease co-morbidity.

**Thoughts on Positionality**

My positionality as both an academic and medical researcher, and a person with intimate knowledge of opioid addiction challenged me during this project in an unexpected way. At the start, I felt distinctly prepared to work with this population given my history. I grew up with extensive exposure to both mental illness and polysubstance abuse. This history was a significant part of why I wanted to research stigma related to treatment for drug abuse, so that I could attempt to give voice to the voiceless. In the past, I experienced abundant stigmatized interactions, along with the punitive machinations of addiction management, though I did not
possess the scholarship necessary to frame addiction within theory, or the access to evoke change.

I grew up witnessing systemic inequality, socioeconomic disadvantage, unequal access to healthcare, and lack of fair representation in the legal system on a daily basis but experiencing these issues through the eyes of my research participants evoked a surprising emotional response. My past life marked me as a member of this community, while my present level of education and shift in economic status (no matter how slight) simultaneously marked me as an outsider. I realized that I was no longer commiserating with someone suffering from addiction from a purely emic perspective, but also empathizing with a research participant from an etic perspective. I walked with one foot in both worlds but fit in neither; I had lost my belonging.

After examining this jarring emotion, I came to the realization that although I feel adrift culturally, I am grateful for both my personal past with addiction, and the knowledge I now have to situate my lived experiences. Having a foothold in each world allows me to be an intermediary, advocating for patients suffering from addiction, as well as healthcare professionals who feel lost in treating them. Closing this gap in communication by first tackling stigmatized interactions, and then bridging acute care with hospital follow-up and establishing communal support are key steps to sobriety, and I am both humbled and changed by the privilege of access to facilitate sobriety in the lives of those struggling with opioid addiction.
Conclusion

Comedian and movie star Russell Brand recently shared his own experiences in his memoir, *Recovery: Freedom from our Addictions* about his years-long struggle with heroin addiction. A manual written with the intention of “helping addicts and their loved ones make the first step towards recovery,” Brand asserts that addiction is not a moral failing, but a public health issue: *this was written not from the mountain but from the mud… my qualification is not that I am better than you but that I am worse* (Brand 2017). Similarly, after experiencing a 44 percent increase in overdose deaths in Pennsylvania in 2017 (second in the nation only to Florida), Governor Tom Wolfe of Pennsylvania went on record to say, “It [opioid addiction] is not a moral or social failing, it’s a medical emergency (Wolfe 2017).” From comedian to governor, more people than ever are speaking out about addiction and the United States’ current public health crisis with opioids.

The present opioid epidemic is comprised of an entire spectrum of people: those actively suffering from addiction, those attempting to navigate life after recovery, medical treatment providers mitigating the symptomatology of the disease of addiction, law enforcement who are trying to facilitate treatment and reduce illicit drug availability (often without adequate funding), politicians trying to legislate change in both treatment and harm reduction, and countless others. This research exposed the obligation advocates have to remember that each member of this crisis brings their own thoughts, feelings, emotions, and lived experience to the table. Even though I discovered that one of the principal barriers to acute addiction recovery was stigma, I also realized that it is not only people struggling with addiction who deal with the fallout of stigmatized responses. The road will be long, but I believe
the solution to the opioid epidemic already exists in the form of compassion, compromise, and a shift away from moral imperatives and punitive measures to a model of harm reduction and public health approaches that encompass increased access to sustainable recovery services, harm reduction, and extended follow-up care after crisis.
REFERENCES


APPENDIX A:

UNIVERSITY OF SOUTH FLORIDA INSTITUTIONAL REVIEW BOARD – STUDY APPROVAL LETTER

October 25, 2017

Heather Henderson
Anthropology
Tampa, FL 33612

RE: Expedited Approval for Initial Review
IRB#: Pro00031903
Title: Perceptions of Stigma and Access to Care in Acute Opioid Crisis

Study Approval Period: 10/25/2017 to 10/25/2018

Dear Ms. Henderson:

On 10/25/2017, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):
Protocol Document(s):
IRB_Protocol_V1_101817.docx

Consent/Assent Document(s)*:
IRB_Adult_Consent_Minimal_Risk_V1_Henderson_1023.docx.pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110. The research proposed in this study is categorized under the following expedited review category:
(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

Mark Ruiz, PhD, Vice Chairperson
USF Institutional Review Board
APPENDIX B:

CAREGIVER INTERVIEW GUIDE

1. How long have you worked in the medical field?

2. How much of it has been in an emergency setting?

3. How often do you encounter patients suffering from opioid addiction?

4. Tell me about a difficult/memorable encounter you’ve had with this type of patient.
   
   *(Probe: How did the encounter make you feel?)*

5. What challenges do you face when caring for patients in acute opioid crisis? *(Probe: What role do you think stigma plays in the treatment of this disease?)*

6. How supported do you feel in caring for these patients? *(Probe: How would you like to be supported in order to do your job?)*

7. Describe anything else you believe would help facilitate care for patients in acute opioid crisis.
APPENDIX C:

OPIOID RESOURCE LIST

Opioid Addiction Resource Guide

DETOX CENTERS THAT ACCEPT MEDICAID/ACCEPT SLIDING SCALE PAYMENT BASED ON INCOME

Phoenix House of Florida | 5501 West Waters Ave Suite 404, Tampa FL 33634 | 813-881-1000 |
Offers Residential Detox, included therapeutic assisted detox, and outpatient treatment | Se Habla Espanol

Riverside Recovery of Tampa | 4004 N Riverside Dr, Tampa FL 33603 | 813-847-0905 | Offers in-patient therapeutic assisted detox, residential treatment, intensive outpatient treatment, and have a specialty in trauma | Se Habla Espanol

ISU @ Baycare | New Port Richey, FL | 727-841-6430 | In-Patient therapeutic assisted detox |
Accepts Medicaid, and offers sliding scale fee based on income for patients with no insurance | Se Habla Espanol

CRC @ Baycare | 727-841-4475 | 30-60 day residential treatment facility | Accepts Medicaid, offers sliding scale based on income for patients with no insurance | Se Habla Espanol

Addiction Recovery Care of Tampa | 13719 N. Nebraska Ave. Ste. 101 Tampa, Fl. 33613 | 813-978-1300 | Offers Substance abuse and mental health treatment and outpatient treatment |
Sliding scale based on income
DACCO | 4422 E Columbus Dr, Tampa FL 33605 | 813-384-4000 | Offers residential treatment, outpatient treatment, juvenile services, and prevention services | Accepts Medicaid | Se Habla Espanol

BoardPrep Recovery Center | Tampa FL | 813-600-7929 | Offers in-patient, out-patient, and medical detox, along with youth services | Private Insurance is accepted, and cash pay is discounted-- if cost is too high, the center will work with you | Se Habla Espanol

Operation PAR | Multiple Locations/Counties Serviced | 1-888-727-6398 | Adolescent services, women/men specific services, residential treatment, medication services, detox | Se Habla Espanol

ADULT ADDICTION RECEIVING FACILITY (AARF) | 2214 E Henry Ave, Tampa FL 33610 | 813-367-2317 | Physical assessment, HIV/AIDS risk and substance abuse assessments, medical examination, diagnostic services, counseling, AA meetings, and referral to individuals throughout the Suncoast Region | Available 24/7 | Se Habla Espanol

MAINTENANCE CLINICS / TREATMENT CENTERS

Tampa Metro Treatment Center | 7207 N Nebraska Ave, Tampa FL 33604 | 813-236-1162 | Methadone and Suboxone

Lakeside Methadone Clinic | 13700 58th St N Building 2 Suite 209, Clearwater FL | 727-223-3545 | Methadone

AnewU Recovery Clinic | Tampa Office 813-443-5128 Ext#2 | Clearwater Office 813-443-5128 ext#3 | Weekend Hours | Suboxone
FREE AND DISCOUNTED MEDICAL SERVICES

**Tampa Family Health Center** | 1514 North Florida Ave Suite 300 (3rd floor) Tampa FL 33602 | 813-490-1957 | Accepts Medicaid, sliding scale payment based on income, and offers some charity services, including prescriptions, checkups, and X-rays | Se Habla Espanol

**Center for Family Health** | 912 East Sligh Avenue Tampa Bay Florida, 33604 | (813) 237-6988 | Low cost and free care based on income

**Crosstown Health Center** | 4951 East Adamo Drive Tampa FL, 33605 | 813-307-8058 | Sliding scale healthcare based on income—patients with no income may receive free care

**Family Care Medical Center** | 5802 North 30th St Tampa Bay FL 33610 | Discount/Free physicals for students and children, lab work, specialist referrals, etc

**Hillsborough County Dental Research Clinic** | 2010 East Hillsborough Ave Tampa FL 33610 | 813-238-7725 | Free dental care offered

**North Tampa Health & Dental Center** | 1502 East Fowler Ave Tampa FL 33612 | 813-866-0950 | Both primary care and dental services are offered on a sliding scale based on income

**Community Health Centers of Pinellas** | Multiple Locations | 727-824-8181 | Accepts Medicaid and sliding scale payments | Se Habla Espanol

COUNSELING AND CRISIS

**Crisis Center of Tampa Bay** | 1 Crisis Center Plaza, Tampa FL 33613 | 813-964-1964 | Counseling, Suicide Prevention, Community Outreach, Financial Assistance

**Personal Enrichment through Mental Health Services (PEMHS)** | Multiple Locations | 727-545-6477 | 24-hour suicide hotline, emergency screening and crisis intervention services, inpatient
services for adults and children, residential services for children and community-based programs | Accepts Medicaid and sliding scale payments | Se Habla Espanol

**Pinellas SHARP | 313 18th Ave South Saint Petersburg, FL 33705 | 727-280-7056 |** Free HIV/HEP C testing, free lunch, supports ages 13-24, substance abuse and suicide prevention services | Se Habla Espanol

**NARCOTICS ANONYMOUS**

[https://www.tampa-na.org/meetings/](https://www.tampa-na.org/meetings/) | this website will provide a weekly schedule of all narcotics anonymous meetings available in Hillsborough County along with location and time.| A smartphone app for iPhone and Android is offered | if you do not have internet access there is a printable version available in pdf format

**BILL PAYMENT ASSISTANCE**

**St. Vincent DePaul of Tampa Bay** offers financial assistance in the form of rent assistance, electric/heating/water bill assistance, debt counseling, free health checkups, charity assistance, mortgage help, and more. Listed below are contact locations for receiving aid:

- Corpus Christi, 9715 N 56th St. 33617, Temple Terrace, Tampa, FL 33617, dial 813-988-1593
- St Lawrence - *Note, this particular church only provides free food or groceries as part of the Matthew 25 Outreach.* The days of distribution are the second and fourth Sundays of every month, between the hours of 2pm and 4pm. 5521 N Himes Ave 33607, West Tampa, Tampa Bay, Florida (813) 879-5090.
- St Mark, 1924 Cross Creek Blvd 33647, New Tampa
• St Mary, 15520 N Boulevard 33613, North Tampa Florida
• St Patrick, 4518 S Manhattan 33609, South Tampa, FL
• St Paul, 12708 N Dale Mabry 33618 North West Tampa, Tampa Bay, call (813) 961-3023
• St Peter Claver, 1203 N Nebraska 33602 Downtown East, Tampa Bay Florida, telephone (813) 223-7098
• St Anne, 106 11th Ave N E 33570, Ruskin, Florida 33570 phone (813) 645-1714
• Our Lady of Guadalupe, 16650 US Hwy 301 S 33598 Wimauma

**DOMESTIC VIOLENCE SHELTERS**

*The Spring of Tampa Bay* | 209 N Willow Ave, Tampa FL 33606 | 813-247-7233 | Accepts men and/or women [and children] who are suffering from domestic abuse | Assistance is offered for those in active addiction, and men/women in opioid maintenance programs are welcome | Se Habla Espanol

*Alpha House of Tampa* | 201 S Tampania Ave, Tampa FL 33609 | 813875-2024 | Eligibility Criteria: Women, 18 years of age or older, who are homeless and pregnant or parenting | Women in opioid maintenance programs welcome | Se Habla Espanol

**FOOD BANKS AND FREE FOOD IN TAMPA**

**MONDAY**

• Metropolitan Ministries. 2002 N Florida Ave, Tampa, FL 33602. (813) 209-1000. 9am-5pm. Need photo ID, utility bill and proof of income.

• Metropolitan Ministries. 2310 N. Tampa Ave, Tampa, FL. 9am-5pm.
• Morning Star Church. 5102 W Linebaugh Ave, Tampa, FL – 33624. (813) 960-3030. 10am-12pm.

• St Vincent De Paul Ministries. 12310 N Nebraska, Tampa, FL 33612. 8am – 10am.

• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.

• St. Paul’s Church, 12708 N. Dale Mabry, Tampa, Fl. 9am-12pm.

• San Jose Mission. 3238 San Jose Mission Dr, Tampa, FL. 1pm-3pm.

• Salvation Army. 1603 N. Florida Ave, Tampa, FL. 9am-3pm.

• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.

• Trinity Café. 1603 N. Florida Ave, Tampa, FL. 11:30am-12:30pm.

• Most Holy Redeemer 10110 N Central Ave, Tampa, FL 33612. (813) 933-2859. (Arrive at 6am, distribution at 9:30am)

• Bible Truth Ministries, 4902 N 22nd St, Tampa. Every day after 3:30pm.

• St. Luke AME Church, 2709 North 25th St. Monday and Wednesdays 8am-11am

• Bible Based Fellowship. 4811 Ehrlich Rd. 813-264-4050 (Monday-Friday until 3pm, bring ID and proof of address)

• Manifestations Worldwide. 3703 N 30th St. 813-241-6919. Monday, Wednesday, Thursday, Friday, no Tuesday: 10:30am-430pm. Saturday 12pm-4pm. Shelter service/shower/bed, do not need ID.

• Our Sisters, Our Friends. 1709 E. Genesee St. 813-965-5117 Every Monday 12pm-2pm. Bring ID.
• Mission Tampa. 5306 N. Nebraska Ave. 813-236-6237. Monday 10:00am-11:30am, Thursday 5-6:30pm. 25 ppl max. (Bring ID or SS#)

• New Mt. Zion Missionary Baptist Church. 2511 E. Columbus Dr. 813-248-8101 (10-12pm 5-7pm. Need intake form (call first).

TUESDAY

• Food Not Bombs 263 E Madison St, Tampa, FL 33602. 8am.

• Feeding America, N 40th and E Osborne Ave, Tampa, FL. 9 am. 813 843 2736

• Forest Hills Presbyterian Church, 709 W Linebaugh Ave, Tampa 33612. 10am and 2pm. (813) 932-6149

• Metropolitan Ministries. 2002 N Florida Ave, Tampa, FL 33602. (813) 209-1000. 9am-7:30pm. Need photo ID, utility bill and proof of income.

• College Hill Mennonite Church. 3506 Machado St, Tampa, Florida. 813 247 2798. Need a picture ID.

• Tampa Bay Community and Family. 3101 N 34 St. Tampa, Florida. 813 248 8760. Need an ID and proof of income. Must sign up on Wednesday, Thursday, or Friday the week before. 11:00 am.

• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.

• St. Marks Church. 1924 Cross Creek, Tampa, FL. 3pm-6pm.

• Santa Maria Mission. 14004 N 15th St, Tampa, FL. 10am-12pm.

• Most Holy Redeemer. 10110 Central Ave, Tampa, FL. 10am-12pm.
• Forest Hills United Methodist. 904 W. Linebaugh Ave. Every other Tuesday. 7am-10pm and 2pm-5pm.

• Metropolitan Ministries. 2310 N. Tampa Ave, Tampa, FL. 9am-5pm.

• New Beginnings. 4100 S. Manhattan Ave, Tampa, FL. 9am-11am.

• Salvation Army. 1603 N. Florida Ave, Tampa, FL. 9am-3pm.

• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.

• Trinity Café. 1603 N. Florida Ave, Tampa, FL. 11:30am-12:30pm.

• Amvets. 1014 Skipper Rd, Tampa, FL 33613. 10:30am. (813) 971-1881.

• Most Holy Redeemer 10110 N Central Ave, Tampa, FL 33612. Arrive at 6am, distribution at 9:30am. (813) 933-2859.

• Bible Truth Ministries. 4902 N 22nd St. Every day after 3:30pm.

• Bible Based Fellowship. 4811 Ehrlich Rd. Monday-Friday until 3pm. 813-264-4050. Bring ID and proof of address.

• Bible Based Fellowship of Temple Terrace. 8718 N 46th St. Tuesday and Thursday 10am-12pm. 813-980-0559. Bring current and “preferably local” ID

• Household of Faith. 2725 N. 46th St. Tuesday and Friday 9:30am-1130am. 813-368-6453. No ID necessary.

WEDNESDAY

• University Area Community Development Center, 14013 N 22nd St, Tampa, FL 33613. 9am-10:30am.

• Forest Hills Presbyterian Church, 709 W Linebaugh Ave, Tampa 33612. Dinner at 6pm. (813) 932-6149
• Metropolitan Ministries. 2002 N Florida Ave, Tampa, FL 33602. 9am-5pm. (813) 209-1000 Need photo ID, utility bill and proof of income.

• Metropolitan Community Church. 408 E Cayuga St, Tampa, Fl 33603. 11:00am-2:00pm.
  813-239-1951.

• St Vincent De Paul Ministries. 12310 N Nebraska, Tampa, FL 33612. 8am – 10am.

• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.

• San Jose Mission. 3238 San Jose Mission Dr, Tampa, FL. 1pm-3pm.

• Resurrection Church. 6819 Krycul Ave, Tampa, FL. 8am-12pm.

• Metropolitan Ministries. 2310 N. Tampa Ave, Tampa, FL. 9am-5pm.

• Salvation Army. 1603 N. Florida Ave, Tampa, FL. 9am-3pm.

• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.

• Trinity Café. 1603 N. Florida Ave, Tampa, FL. 11:30am-12:30pm.

• 22nd St Park. 7801 N 22nd St, Tampa, FL. Every 3rd Wednesday.

• Most Holy Redeemer 10110 N Central Ave, Tampa, FL 33612. Arrive at 6am, distribution at 9:30am. (813) 933-2859.

• New Beginnings of Tampa. 1402 Chilkoot Ave. E. Before and after bible study on Wednesday night and three times on Sunday.

• Bible Truth Ministries. 4902 N 22nd St. Every day after 3:30pm.

• St Luke AME Church. 2709 North 25th St. Monday and Wednesdays 8am-11am

• Bible Based Fellowship. 4811 Ehrlich Rd. Monday-Friday until 3pm. 813-264-4050. Bring ID and proof of address.
• Manifestations Worldwide. 3703 N 30th St. Monday, Wednesday, Thursday, Friday from 10:30am-4:30pm, Sat 12pm-4pm. 813-241-6919. Shelter service/shower/bed, no ID necessary.

• Mount Olive AME Church. 1745 W Lasalle St. Every 3rd Wednesday 10am-12pm. 813-254-6282. Bring current ID.

• Northeast United Methodist. 6400 N. 15Th St. Every 3rd Wednesday. 813-238-4359.


• Metropolitan Community Church. 408 East Cayuga St. 11:00am-2pm. 813-239-1951. Speak to Mia.

• Town Country SDA Church. 4926 Webb Rd. Wednesday 3:30pm-5:30pm. 813-230-2176. No ID necessary, need intake form.

• The House of God. 2909 N. 29th St. Every 3rd Wednesday at 4pm, Can also call to schedule pick up. 813-690-5895.

**THURSDAY**

• Jewish Family Services. 13009 Community Campus Drive, Tampa, FL. First Thursday each month. 10:30am-12:00pm and 4:30pm-6pm .813-960-1848. Call first.

• Metropolitan Ministries. 2002 N Florida Ave, Tampa, FL 33602. 9am-5pm. (813) 209-1000. Need photo ID, utility bill and proof of income.

• Morning Star Church. 5102 W Linebaugh Ave, Tampa, FL 33624. 2pm-4pm. (813) 960-3030.
• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.

• St. Paul's Church, 12708 N. Dale Mabry, Tampa, Fl. 9am-12pm.

• Nativity. 705 E. Brandon Rd, Tampa, FL. 3pm-4pm.

• Metropolitan Ministries. 2310 N. Tampa Ave, Tampa, FL. 9am-5pm.

• The Garden of Eaten. 12114 Boyette Rd, Tampa, FL. 10am-11:30pm.

• Salvation Army. 1603 N. Florida Ave, Tampa, FL. 9am-3pm.

• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.

• Trinity Café. 1603 N. Florida Ave, Tampa, FL. 11:30am-12:30pm.

• Most Holy Redeemer 10110 N Central Ave, Tampa, FL 33612. Arrive at 6am, distribution at 9:30am. (813) 933-2859.

• Bible Truth Ministries. 4902 N 22nd St. Every day after 3:30pm.


• Bible Based Fellowship. 4811 Ehrlich Rd. Monday – Friday until 3pm. 813-264-4050. Bring ID and proof of address.

• Bible Based Fellowship of Temple Terrace. 8718 N 46th St. Tuesday/Thursday from 10am-12pm. 813-980-0559. Bring current “preferably local” ID.

• Manifestations Worldwide. 3703 N 30th St. Monday, Wednesday, Thursday, Friday 10:30am-4:30pm, 813-241-6919. Shelter service/shower/bed, no ID required.

• Mission Tampa. 5306 N. Nebraska Ave. Monday 10:00a-11:30am, Thursday 5pm-6:30pm. 813-236-6237. Bring ID or SS#, 25 ppl max.
• Morningstar Church Inc. 5102 West Linebaugh Ave. Thursday 2:00pm-4:00pm, Sunday 10:30am-12:00pm. 813-960-3030. Bring ID-can be anything.

• VICTORY BAPTIST CHURCH 6202 S. Macdill Ave. Thursday 3pm-4pm. Gather at 2:30pm. 813-837-5343. Gets busy fast, no ID necessary.

FRIDAY

• Feeding America, N 40th and E Osborne Ave, Tampa, FL. 9 am. 813-843-2736.

• Metropolitan Ministries. 2002 N Florida Ave, Tampa, FL 33602. 9am-5pm. (813) 209-1000. Need photo ID, utility bill and proof of income.

• Abe Brown Ministries. 2921 N 29 St, Tampa, Fl 33605. 9am. Last two Fridays of the Month. 813-247-3285.

• Covenant Family Church. 8701 Progress Blvd (Progress Village Park). Tampa, FL 33619. 2pm. 813-671-4673.

• St Vincent De Paul Ministries. 12310 N Nebraska, Tampa, FL 33612. 8am – 10am.

• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.

• St. Stephen’s. 5049 Bell Shoals Rd, Tampa, FL. 11am-1pm.

• San Jose Mission. 3238 San Jose Mission Dr, Tampa, FL. 1pm-3pm.

• Metropolitan Ministries. 2310 N. Tampa Ave, Tampa, FL. 9am-5pm.

• Peninsular Christian Church. 3600 W. Ballast Point, Tampa, FL. 8am-8:30am.

• Salvation Army. 1603 N. Florida Ave, Tampa, FL. 9am-3pm.

• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.

• Trinity Café. 1603 N. Florida Ave, Tampa, FL. 11:30am-12:30pm.
• Amvets. 1014 Skipper Rd, Tampa, FL 33613. 10:30am. (813) 971-1881.

• Most Holy Redeemer 10110 N Central Ave, Tampa, FL 33612. Arrive at 6am, distribution at 9:30am. (813) 933-2859.

• Bible Truth Ministries. 4902 N 22nd St, Tampa, FL. Every day after 3:30pm.

• Bible Based Fellowship. 4811 Ehrlich Rd. Monday-Friday until 3pm. 813-264-4050. Bring ID and proof of address.

• From the Heart Outreach. 10651 Anderson Rd. Friday 11am. 813-964-8500. Bring ID and intake form.

• Higher Hope International Ministry. 5808 Lane Rd. Tampa, FL 33624. Doors open at 10am and lunch is served until 1pm. 813-908-0893. Call number to make reservation for Fridays.

• Manifestations Worldwide. 3703 N 30th St. Monday, Wednesday, Thursday, Friday from 10:30am-4:30pm, Saturday 12pm-4pm. 813-241-6919. Shelter service/shower/bed, no ID required.


• Household of Faith. 2725 N. 46th St. Tuesday and Friday 9:30am-11:30am. 813-368-6453. No ID required.

• Tampa Deliverance Ministry. 2102 E. Columbus Dr. Friday 1pm-4pm. 813 389 1968. No ID required.

SATURDAY

• Food Not Bombs 263 E Madison St, Tampa, FL 33602. 4pm.
• George Bartholomew Center, 8608 N 12th St, Tampa, FL 33604. 9am-10:30am
• University Area Community Development Center. 14013 N 22nd St, Tampa, FL 33613. 9am-10:30am.
• Bethel Temple, 1510 W. Hillsborough Avenue, Tampa FL 33603. 9am-10:30am
• Forest Hills Presbyterian Church, 709 W Linebaugh Ave, Tampa 33612. Lunch at 10am. (813) 932-6149
• Deeper Life Church. 3300 N Nebraska, Ave. Tampa, Fl. 33603. 3 times per day: breakfast, lunch, dinner.
• St. Peter Claver. 1203 N. Nebraska Ave, Tampa, FL. Second and fourth Saturday of the month. 8am-9:30am.
• Corpus Christi. 9715 N 56th St, Tampa, FL. 9am.
• Faith Café. 3702 W. Kennedy Blvd, Tampa, FL. 9am-12pm.
• Bible Truth Ministries. 4902 N 22nd St. Every day after 3:30pm.
• New Hope Missionary Baptist Church. 3005 E. Ellicott St. 813-236-3611. No pantry, you have to be on a list. Sign up 1 month in advance by the 4th Saturday. 1st come/1st serve.
• Manifestations Worldwide. 3703 N 30th St. 813-241-6919. Saturday 12pm-4pm. Shelter service/shower/bed. No ID necessary.
• Faith and Truth Revealed. 5012 E. Broadway Ave. 8am-9am. 813-770-1138. No ID necessary.
SUNDAY

- Deeper Life Church. 3300 N Nebraska, A Ave. Tampa, Fl. 33603. 3 times per day:
  breakfast, lunch, dinner.

- Village Presbyterian Church 13115 S Village Drive, Tampa, FL. 12pm-2pm.

- St Lawrence Church. 5225 N Himes Ave, Tampa, FL 33614. 2pm-4pm. (813) 875-4040.

- New Beginnings of Tampa. 1402 Chilkoot Ave. E. Before and after bible study on
  Wednesday night and three times on Sunday.

- Bible Truth Ministries. 4902 N 22nd St. Every day after 3:30pm.

- Purpose Driven. 4202 N. Hubert Tampa, FL 33614. 813-466-2602. Must go to service
  first at 9:30am and worship at 10:45am and then will be given a meal ticket. No one is
  turned away.

- Morningstar Church. 5102 West Linebaugh Ave. 10:30am-12pm. 813-960-3030. Bring
  ID-can be anything with your name.

- Crossover Community Church. 1235 E Fowler Ave. Any sun after services 10am-
  10:30am, 12pm, 2pm. 813-971-8887. No ID necessary.

OTHER LINKS AND RESOURCES

- Substance Abuse & Mental Health Services Administration Treatment Locator:
  https://findtreatment.samhsa.gov/locator

- Resource Guides for patients and families | https://www.operationpar.org/resources

- 211 Tampa Bay | Dial 211 from your phone or visit http://www.211tampabay.org/

- Agency for Community Treatment Services Locations | http://www.actsfl.org/crisis-care.html
APPENDIX D:

GLOSSARY OF COMMONLY USED TERMS

The following terms are ones that I commonly experienced during research and fieldwork and lend context to opioid addiction.

**Addiction**: The fact or condition of being addicted to a particular substance, thing, or activity; compulsive need for and use of a habit-forming substance (such as heroin, nicotine, or alcohol) characterized by tolerance and by well-defined physiological symptoms upon withdrawal.

**Analgesic**: An drug that produces analgesia: diminished sensation to pain without loss of consciousness.

**Benzos**: Short for benzodiazepine. The benzodiazepines are a class of drugs with hypnotic, anxiolytic, anticonvulsant, amnestic and muscle relaxant properties. Benzodiazepines are often used for short-term relief of severe, disabling anxiety or insomnia. Long-term use can be problematic due to the development of tolerance and dependency. They began to be widely prescribed for stress-related ailments in the 1960s and 1970s. Often used in conjunction with opioids to intensify the effect. Unfortunately, this combination also depresses the respiratory system to critical levels, and often results in overdose.

**Chasing the Dragon**: “This term is a bit more complicated than merely "smoking opium". It starts when you have your first high, the world is peaceful, everything is perfect, you're numb, but in the best way possible. But, soon, it starts wearing off. Fast. Your mind races, you're
pulled out of your dream world. You crave the drug more and more, wanting to feel the same way as you did on your first high. You go to the dealer and buy the same amount you had the first time, and smoke. Still feels good, but not as good as the first time. You go and buy more. Closer, but not quite there. You're stuck, you don't know what to do. You want to go back to that little dream world and stay forever, but your body is already developing a tolerance. You panic. You use all your money to buy more and more and more, but still, not the same as that first time. You realize that you have no more money, so you start selling your things, pawning whatever could get you that next bag. Still, nothing compared to what you had on that first, magical time. So, you're broke and own nothing. But you don't care, all you care about is getting back to the first high. You start stealing, doing "favors", whatever gets you the money for the attempt. Your life becomes a living hell, all in search of a repeat of the first high. That's chasing the dragon.” (Addicted Definition)

Dilaudid: Dilaudid (hydromorphone) is an opioid pain medication. Dilaudid is used to treat moderate to severe pain.

Doctor shopping: Doctor shopping is the practice of visiting multiple physicians to obtain multiple prescriptions for otherwise illegal drugs, or the medical opinion that one wants to hear. A doctor who for a price will write prescriptions without the formality of a medical exam or diagnosis is known as a "writer" or "writing doctor".

Drugs-forum.com: An online forum for addicted persons to anonymously share drug experiences, ways to use drugs, ways to access drugs, etc.

Fentanyl: A fast-acting narcotic analgesic and sedative that is sometimes abused for its heroin-like effect.
**Freebase:** A method of inhaling drugs by holding a flame under a metal spoon filled with cocaine or any crushed pill. One holds a flame under the spoon and collects the fumes from the crushed pills in an empty bottle and then inhales these fumes by taking a hit off the bottle.

**Foily:** The finished preparation used to smoke freebase narcotics. An amount of narcotic is layered somewhat thinly on a foil sheet. A drop of water is added, dried, then smoked in a "chasing the dragon fashion." With prescription pills, water is added to remove the time release coating on the outside before continuing with the method.

**Hillbilly Heroin:** Slang for the prescription painkiller OxyContin, which is very popular with rural white males.

**Hydrocodone:** Hydrocodone, also known as dihydrocodeinone, is a semi-synthetic opioid synthesized from codeine, one of the opioid alkaloids found in the opium poppy. It is a narcotic analgesic used orally for relief of moderate to severe pain, but also commonly taken in liquid form as an antitussive/cough suppressant. Hydrocodone is prescribed predominantly within the United States, with the International Narcotics Control Board reporting that 99% of the worldwide supply in 2007 was consumed in the United States.

**Narcotic:** a drug (such as opium or morphine) that in moderate doses dulls the senses, relieves pain, and induces profound sleep but in excessive doses causes stupor, coma, convulsions, and death.

**On site pharmacies:** Any number of pharmacies that are located on the same site as a pain management clinic and operate as a cash only way to fill prescriptions obtained from the clinic. Often, one of the restrictions of receiving a prescription from a pain management clinic with an on-site pharmacy is that the patient must also fill their prescription on-site.
Opiate: relating to, resembling, or containing opium (natural opium).

Opioid: Opioids are drugs derived from opium that act on the nervous system to relieve pain. An opioid is often referred to as a narcotic. Street names include: Apache, China girl, Dance fever, Goodfella, Murder 8, Tango and Cash, China white, Friend, Jackpot, TNT, Oxy 80, Oxycat, Hillbilly heroin, Percs, Perks, Juice, Dillies.

Oxys: Also referred to as OCs, this is a slang term for Oxycodone (rapid release) or OxyContin (time released), which is a narcotic analgesic.

Oxy cocktail: This is a slang term for one Oxycodone 80mg and one Vicodin 30mg, which is taken together and has a high street value.

Oxydose: Another term for Oxycodone.

Perc: Percocet. A pill that is a mix of Oxycodone and Acetaminophen (Tylenol). This opioid is a very popular choice due to ease of access.

Pill mill: A term for pain management clinics that freehandedly distribute opioid and benzodiazepine prescriptions.

Rig: Term for a needle/syringe and tourniquet used for “shooting up” drugs intravenously.

Roxyes: Roxicodone [Roxies], a narcotic pain reliever. Became a popular alternative to Oxycodone around 2007.

Sedative: a drug taken for its calming or sleep-inducing effect (narcotic, opiate).

Shooting up: Using a syringe to administer drugs intravenously.

Synthetic Opioids: Opioids include opiates, an older term that refers to such drugs derived from opium, including morphine itself. Other opioids are semi-synthetic and synthetic drugs such as
hydrocodone, oxycodone and fentanyl; antagonist drugs such as naloxone; and endogenous peptides such as the endorphins.

**Vicodin**: A prescription narcotic that contains hydrocodone and paracetamol (aspirin). This narcotic is often a prescribing springboard, and a medical gateway into opioid addiction.

**Xanax**: Xanax (alprazolam), also known as Xany, Xany Bar, and Footballs, is a benzodiazepine. Benzodiazepines, sometimes called "benzos", are a class of psychoactive drugs in the drug family of minor tranquilizers. Alprazolam in particular is one of the most popular benzodiazepines and affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders, and anxiety caused by depression. Taking Xanax in conjunction with opioids intensifies the effect, often resulting in accidental overdose.
APPENDIX E:

COMPOSITE NARRATIVE CHARACTER INSPIRATION

Jenny
Nothing More

A little sleep, a little slumber
A little folding of the hands
Left you weak, left you hungry
When there's supply you still demand

You're beginning to drag the ones you love down
Will this phase ever end?
A thousand arms to hold you
But you won't reach for any hands

‘Cause I don't feel like I’m getting through to you
Let me paint this clear, life is short, my dear
See your mother here, her last painful year
I wish you only knew
She stuck around for you

Maybe you should just fall
Leave the world and lose it all
And if that’s what you need
To finally see
I'll be with you through it all

Bring on the pills, roll that dollar bill
Medicating will never heal
Relapse, rehab, repeat
Always thinking about the me, me, me

Self-destruct, spiral down
Until your want becomes your need
Please get up like I know you can
Or forever love the fall...

https://www.youtube.com/watch?v=_TWr2pj6kqM