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Emma Goldblatt
University of Puget Sound

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Emma Goldblatt

Friends of the Poppy: An Ethical Exploration of Opioid Addiction

The idea of addiction has confounded society since it was first recognized in the early 1800s; we have had many explanations for addiction since then that change with the values of our society. Today, in 2018, certain addictions are viewed as legitimate diseases, some are seen as despicable forms of conscious social deviance and some exist between those two ends of the spectrum. Some argue that opiate addicts are not worthy of rehabilitation; and there is a lot of debate over what can be considered successful rehabilitation. Recently, attention has been drawn to this issue because of the ongoing U.S. “opioid epidemic,” which refers to the growing number of heroin and other opiate users and the associated increase in mortality (Today’s Heroin Epidemic 2015). For example, the number of deaths by overdose rose 43.57% to an average of 89 Americans dying each day just from 2015 to 2016 (Opioid Overdose 2017). The vastness of this addiction is spoken about in medical terms, it warrants medical treatment and yet it is still not fully considered a disease, which prevents many addicts from having access to effective rehabilitation. Opiate addicts deserve access to care, just like everyone else. The expanding medicalization of opiate addiction has been a positive force leading to higher rates of rehabilitation and a decrease in negative social stigma. As a society, we should embrace a rule utilitarianism perspective of addiction. We should establish the rule that addiction ought to be treated as a disease and we should move away from rehabilitating addicts as criminals. From a utilitarian perspective, this will yield the most good for all involved.

Utilitarianism always promotes the action that yields the greatest amount of good for all involved. Rule utilitarianism is one form of this philosophy that is more easily applied as an ethical guide for a group or society. In rule utilitarianism, each action does not need to be judged

on its individual outcome (Simões 2009). When a rule is followed consistently, the most good is produced. As a society, we have approached addiction from many perspectives and with a breadth of treatments. As we will see, the most effective treatment comes when addiction is treated as an illness. I ask that you reconsider our extant paradigm surrounding opioid addiction, which posits that addicts are morally corrupt people who are sick with a criminal disease. Continuing the medicalization of addiction, by increasing access to legal, science-based treatment, will result in more accessible, successful treatment; a concurrent decrease in crime rates and a change in the stigma associated with addiction.

What is addiction?

Society's view of addiction has been evolving for a long time; only recently has addiction been thought of as something other than a reflection of a person's moral character. In the mid 1900s, a radical idea started catching on, that addiction may be as involuntary as a disease, and so began the medicalization of addiction. Medicalization is the process of defining a human behavior or condition, that is typically considered undesirable, as a disease. Diseases are then treated as a medical problem. That disease is defined in medical terms and remedied or changed with medical treatment; examples of medicalized diseases include epilepsy, homosexuality and, more recently, anorexia nervosa (Conrad 1992). Medicalization is a form of social constructionism; it can be a negative force and it can also be used to do social good, but either way it is a form of social control. (Social Constructionism 2017; Conrad 1992). Medical social constructionism can be dangerous because it involves a group of, usually privileged, people defining normality for the rest of society. Their bias and values are tied into decisions of what is

and is not natural and how people should experience their shared world. This allows social deviance to be labeled as a sickness, when historically it had been seen as a sin or crime.

While there is negative social stigma associated with any diagnosis, there can also be extreme positives that come out of medicalization. Once a disease is seen as completely legitimate, patients receive a significant increase in access to helpful resources, social understanding and financial support from insurance companies (Conrad 1992). If addiction is treated as a disease, as my rule proposes, these benefits can be added to the yield of good. Opiate addiction is still not completely medicalized so finding treatment can be difficult. The largest obstacle preventing it from being completely medicalized is its criminalization in the 1910s and 20s. It is difficult for society to accept a condition that is defined as both a crime and a disease because a person who commits a crime is assumed to have done so voluntarily and consciously, but people who are sick do not carry the same responsibility. How can a sick person exist as both a perpetrator and a victim? Opiate addiction's illegality makes it a hotbed for social stigma and paints addicts as people who are not only ill, but morally bankrupt as well (Miller 2012). This sickness is treated and controlled not only by the medical community, but by the criminal justice system as well.

It is not a crime to be sick with any other disease; opiate addiction is an illness that immediately invokes the blatant labeling of its sufferers as deviants. The weight of that stigma restricts an addict's ability to recover. Opiate addiction is also unique in that the epidemic started in hospitals and doctor's offices (Berridge 2009). When doctors realized addiction was a problem, it was kicked out onto the street and criminalized so any resources for recovery were few and far between. And even today, if a person asks for help in their recovery, they simultaneously confess to a crime, which brings more consequences and stigma. The

responsibility an addict holds in their condition is dependent upon which institution is “treating” them. Opiate addiction has only recently made its way back into medical territory, where it is mostly seen as a disease and addicts are seen as victims. This change has been beneficial to the amount of recovery from opiate addiction. Adopting my rule will further these benefits.

Where does opiate addiction come from?

It all started in the 1800s, when morphine, a derivative of the opium poppy, was widely available and commonly used clinically as an analgesic and cough suppressant. Morphine’s prevalence became the source of a growing addiction problem worldwide. In response, scientists sought out a solution. In 1890, acetylated morphine was introduced to the market by Bayer as a less addictive version of the pure morphine being used. However, acetylated morphine, also known as heroin, is metabolized more quickly by the body, making it more addictive than morphine. This realization took years, and in the meantime, doctors were unintentionally inducing heroin addictions in many of their patients. The spread of heroin addiction was not curbed until 1914 when the Harrison Narcotics Act was passed in the U.S., which legally restricted the use, prescription and possession of heroin. It took 10 more years for the U.S. Congress to make heroin completely illegal (Governmental Deviance 2014; Berridge 2009). As a result, the portion of the population that was addicted to opiates now had no legal way of feeding their addiction or getting help. This resulted in the social marginalization of addicts.

Opiate addictions used to begin in medical treatment, but after the use of heroin was banned, living with addiction became a form of social deviance. Opiate addicts suffer from the weight of social stigma, the rippling consequences of being labeled a criminal and from economic strain their habit places on their lives. Like any drug, heroin and other opiates cost

money and that cost is not usually balanced by a steady income. Addicts have trouble holding down a job and very rarely work in high-earning professions. When living in the throes of addiction, addicts are usually compelled to use their chosen opiate between 2 and 4 times a day meaning they are committing at least two expensive crimes every single day (Miller 2012). The myriad consequences that come with addiction have bioethicists, doctors, sociologists and psychologists curious as to how and why addiction develops.

In popular opinion, addicts are thought to first start using a drug because they are looking for relief from social friction and want to gain some form of control over their lives (Social Constructionism 2017; McNamee, H.B. et al. 1976). They may seek social capital in the form of acceptance, they may have some sort of internal aggression they are looking to quell, or they may need relief from some form of depression or anxiety (Lindesmith 1938; McNamee, H.B. et al. 1976). Historically, addicts were known as a type of psychopath. These psychopaths were said to need an escape from their social defectiveness and inner conflict, so they turned to drugs. It was their psychopathic condition that predisposed them to a life controlled by addiction (Lindesmith 1938). A person's morality was also brought into question if they were identified as an addict, especially because drug legislation is often the result of societal moral panic (Miller 2012). Up until this point, it was thought that if a "normal" person had enough self-control they would not develop an addiction if they used heroin, but in the early 1900s, doctors began to challenge this idea. In 1894, a doctor wrote a warning to fellow physicians and to patients alike:

Let him not be blinded by an under estimate of the poppy's power to ensnare. Let him not be deluded by an over-confidence in his own strength to resist; for along this line history has repeated itself with sorrowful frequency...(Lindesmith 1938: 595)

Hubris led to many people becoming addicted to opiates. In 1911, a French medical student performed an experiment in an attempt to demonstrate that even a "normal" person could

develop an opiate addiction. The student dosed himself with morphine every day for five days and noted that after three doses, he began to intensely crave his next injection and nearly became irrevocably addicted by the final day (Lindesmith 1938). This was the beginning of a paradigm shift. Healthy, non-psychopathic people were now seen as vulnerable to the development of addiction as well; and if addiction was not a symptom of inherently deviant people, there was a chance that addiction develops and grows in a person like a sickness. The position of the medical community today is that addiction has nothing to do with a person's morality; addiction combines physiological dependency with a psychological need for the drug (Lindesmith 1938).

With continued use of any opiate, a user requires higher and higher doses of the drug to feel the desired effect, this is known as tolerance. If use of the drug is discontinued, the body responds as though it is ill, manifesting extreme symptoms collectively known as withdrawal. The presence of withdrawal indicates that the drug has induced chemical dependence (Governmental Deviance 2014). Withdrawal symptoms from heroin include a very runny nose, muscle pain and weakness, nausea, diarrhea, chills, hypertension and anxiety. Luckily, there is an easy, quick cure to withdrawal, the addict just needs to take another dose of their drug. Opiate addicts build up both tolerance and dependence which initiate and maintain the cycle of addiction. Tolerance and dependence together require the addict to constantly increase the amount of the drug they use; this is why opiates are so dangerous. That increasing dosage leads to the 91 American deaths that occur from an opioid overdose every day (Governmental Deviance 2014; Understanding the Epidemic: Drug Overdose Deaths in the United States Continue to Increase in 2015 2015). The first use of an opiate gives no warning or sign of the misery that is to follow. As use continues and tolerance develops, the euphoric feeling dissipates and after a while, the drug serves mainly as withdrawal avoidance (Lindesmith 1938). Opiate use

creates a constant need that an addict must fulfill multiple times a day, every day, unless they want to feel extraordinarily ill. Some people define an addict as a person who no longer wants to, but still compulsively uses a substance (Lindesmith 1938). This cycle seems impenetrable, especially when it is approached in ignorance. Addiction comes with enormous cost. The addict is not able to fully contribute to society in a productive way, they are largely viewed as some sort of parasite on the community, the physical and financial risk is enormous and continued addiction maintains or increases crime rates. A failure to adopt my rule will allow these issues to fester and grow.

What do we do with an opioid addict?

Who is Responsible:

Philosophers and scientists have recently concluded that because addiction is social and physiological, an addict is only partially responsible for their moral actions while they are under its thrall (Liao and O'Neil 2017). They cannot be held completely accountable for their wrongdoing, but they should not be exempt from common social morality. Liao and O'Neil (2017) make the important note that addiction outlives withdrawal. It's been shown in scientific studies that generally, an addict is always an addict (NA Foundation Group 1998a; Narcotics Anonymous 2009). That fact influences the way addiction should be treated. One of the more popular rehabilitation groups, Narcotics Anonymous, has fully embraced the medicalized definition of addiction because it makes recovery easier for addicts to conceptualize. The first step of their Twelve Step program is to admit that you are an addict and that you have lost control of your life (NA Foundation Group 1998a; NA Foundation Group 1998b; Narcotics Anonymous 2009). This surrender is tempered by the diagnosis; it is easier to admit that one has

lost control of their life if said control was taken by the disease rather than surrendered by the individual. Throughout history, addiction patients have gone through all kinds of treatment with varying rates of success.

What works and what doesn't?

During the days when addiction was thought to be caused by moral failing, curing addiction was wildly unsuccessful. Doctors spent 50 years using rehabilitation programs that did not work. It was their failure that originally sparked the idea that the addicts were destined to be addicts and that they were beyond help (Lindesmith 1938). Later came a time when doctors knew what triggered addiction but did not know how to reverse it, so they employed methods to mitigate a patient's risk of developing addiction in the first place. It was thought that if a patient did not know the name or power of a drug, they would be less likely to become addicted to it because in ignorance, they could not consciously desire it. While this is now seen as an obvious and upsetting violation of patient autonomy, all of this occurred in a time when doctor paternalism was the norm and these practices were seen as beneficial.

To veil the use of an opiate, doctors would administer the drug orally rather than intravenously, which was atypical and might mislead the patient. Patients were rarely given opiates to self-administer. And when some patients were given opiates, doctors treated them simultaneously with drugs that yielded uncomfortable, sometimes sickening side effects to create a negative association between the drug and the feeling it induced in the body (Lindesmith 1938). This technique had mild success, but doctors also saw patients becoming addicted who were completely unconscious when they began using opiates. This undercut the value of the smoke and mirror game doctors were playing with their patients. The medical community

realized prevention was not going to stop the epidemic, and that they must figure out how to cure people of their addiction if that was even possible.

Rehabilitation programs were initially based in abstinence because the drug was feared and still poorly understood. As heroin and other opiate addictions started the medicalization process, a more physiological approach was warranted so doctors focused on withdrawal, seeing it as the root of addiction. True addicts understand the cause of withdrawal and use their drug to palliate their symptoms (Lindesmith 1938). If an addict can find an alternative treatment for withdrawal symptoms, they should be on the road to recovery.

Methadone

Around this time, there was a push to shift the paradigm surrounding the use of heroin to be one of a more clinical nature; doctors embraced it as a tool in rehabilitation. Clinics began prescribing controlled doses of injectable heroin as treatment for addicts who were running out of other treatment options (Berridge 2009). Then came a new innovation in the treatment of opiate addiction, it was called methadone. Methadone, like heroin, was developed in the hopes of creating a less addictive opiate to be used in opiate rehabilitation. But, unlike heroin, methadone actually accomplished this goal. It is still addictive, but it does not give any sense of euphoria and is successfully used to prevent severe withdrawal. Methadone started its clinical career in the 1960-70s and was marketed as a legitimate, medical drug. Methadone prescriptions replaced those for heroine in addiction management therapy. Unfortunately, methadone is still not fully embraced by the medical community. This could be due to the fact that methadone prescriptions replaced those for heroine, which led many to view methadone as merely the second coming of heroin and assume that methadone should not be trusted (Berridge 2009).

There are pockets of doctors and patients who fear the idea of replacing one drug dependency for another. Many people still think of methadone therapy as more harmful to the patient than abstinence programs despite the fact that methadone has been shown to be more effective than other opiate rehabilitation programs (Amato et al. 2005). It safely weans addicts off their drug, has phenomenal patient retention rates and is the most successful in preventing relapse and post-rehabilitation death due to overdose (Amato et al. 2005). There have been some bioethical rumblings around methadone; some see it as a form of social control that does not actually benefit the patient; it just switches their dependency from one individual or institution to another. But the truth is that methadone therapy upholds all the bioethical principles.

Nonmaleficence is embodied in methadone's efficacy. Studies have shown time and time again that methadone decreases the strength of addiction, lowers drug-related crime rates, is cost effective, treats patients long term and is safe (Aceijas 2012). Methadone is not dangerous to users and it is certainly much safer than opiates obtained on the street. Opioid replacement therapy is beneficent as well. It is a specific, targeted, proactive program that allows opioid addicts to take control of their life back.

Autonomy, arguably the most highly valued bioethical principle in America, is respected in methadone treatment. The presence of methadone, also known as opioid replacement, therapy gives addicts a choice in how they want to stop using; they can choose their own path to recovery. And although methadone replaces one addictive substance with another, rather than "curing and stopping" the addiction itself, it does not rob the patient of any agency or self-determination.

The issue people take with justice in the context of methadone therapy is that it does not technically get rid of addiction; it is thought that methadone therapy is a form of social control

that does not really change an addict's state of being. However, Aceijas (2012) addresses this, claiming that having accessible, safe replacement treatment that not only lifts the weight of addiction, allowing addicts to stop their use of dangerous opioids, but also provides public health information and resources is good for individuals and society when compared to the alternative. Without methadone or other replacement therapies, addicts could still participate in detox-abstinence programs, but they are less effective, with much higher rates of relapse, are more dangerous, and are sometimes more difficult to approach. Methadone therapy improves the health of individuals, which ripples out and ultimately benefits society (Aceijas 2012). Replacement therapy should not be looked down upon the way it is currently. It should continue to be embraced by the medical community so more addicts can have access to it with minimal stigma.

Both replacement therapy and abstinence rehabilitation are seen as medical treatments for the disease of addiction. These programs are medical in nature but are still not fully medicalized because of the involvement of the criminal justice system. Law enforcement has a large influence on how medical rehabilitation programs are viewed by the public and by addicts.

Crime and Punishment

Many patients being treated for addiction are put into programs as a form of punishment. In 1989, Miami set a new precedent by establishing a drug court meant to try crimes involving narcotics. Those who were seen as nonviolent criminals with a "drug problem" were mandated by the court to complete a rehab program (Miller 2012). Today, drug courts exist in all 50 states, D.C. and Puerto Rico. In 2000, California passed a proposition that required first- and second-time offenders convicted of drug-related crimes be placed in a mandatory rehabilitation program (Miller 2012). These state-run programs have an explicit curriculum of moral fortification,

reinforcing the societal expectation that addicts are inherently bad people (Miller 2012). Using rehabilitation as a punitive measure skews the medicalization of addiction, but when the law is not involved, and treatment is voluntary, addiction looks much more like a disease. Addiction treatment is more successful than addiction punishment. Abusing opiates should still be illegal, but we will benefit the most from emphasizing the medical side of addiction, like my rule suggests.

Self-diagnosis and the Addict Anonymous path

Voluntary rehabilitation is well represented by the group Alcoholics Anonymous (AA) and the aforementioned Narcotics Anonymous; their model could be very affective for opiate addiction. AA is an organization that was founded in 1935 by two self-identified alcoholics. AA is a group of people struggling with alcohol addiction who provide an inclusive recovery community free of judgement (Alcoholics Anonymous 2009). Anonymity is an incredibly important part of their program because there are no other social outlets that allow addicts to share their experience and commiserate with impunity. AA has done a lot to medicalize alcohol dependence and consequently, other addictions. The World Health Organization and American Medical Association accepted alcoholism as an official disease in the 1950s, which is partially credited to AA because of the way they approach rehabilitation (Miller 2012). AA emphasizes that recovery can only start once a person admits that they are powerless against their addiction (Alcoholics Anonymous 2009). It is noted that most addicts will not join the group until they have hit “rock bottom.” This is usually marked by significant social and usually financial losses, which serve as observable symptoms of one’s disease. Accepting that addiction is controlling you, not the other way around, and acknowledging your symptoms frame addiction as a disease, just like any other. People do not choose to have cancer, they are at its whim. Addiction is not

only physical, it is also a social disease meaning it is caused, exacerbated and healed by a person's community.

Narcotics Anonymous (NA) is a group that splintered off from AA in 1953; it currently serves as a healing community for many opiate addicts. NA adopted the Twelve Steps from AA which are a spiritually-based guide through acceptance of and recovery from the disease of addiction (Narcotics Anonymous 2009). They emphasize equality within their group, because social status should be irrelevant in this process. Again, anonymity provides a safe space for people to open up without fear of judgement or persecution allowing them to take large steps forward in their recovery (Narcotics Anonymous 2009).

Other rehabilitation programs take on the NA approach. Some substance abuse psychologists found that addicts were more successful in their treatment when they did not feel as though their addiction was the result of their personal moral bankruptcy (Coombs, Robert 2001; McAvoy, Brian 2008). The aforementioned psychopath etiology of addiction was designed to find and place blame related to addiction, not to fully understand the condition (Lindesmith 1938). That way of thinking had far-reaching and long-lasting consequences, like the stigma associated with opiate use. Opiate addicts are still viewed as weak people who do not contribute fully to society. Even with everything that we know about withdrawal, tolerance and dependence, some people still think opiate addicts choose their addiction. It is hypothesized that this idea comes from the fact that using opiates initially creates pleasure and euphoria; it feeds the part of the brain that encourages self-indulgence. Generally speaking, our global society values control over hedonistic impulses, so continually using opiates is seen as relinquishing the control necessary to function in a community (Coombs, Robert 2001; McAvoy, Brian 2008). This stigma must be overcome because statistical and anecdotal evidence both show that when

addicts view their condition as a disease, they recover more quickly and completely (Amato et al. 2005; Coombs, Robert 2001).

Conclusion

The medicalization of addiction has improved recovery rates and created a firmer, more easily understood ethical framework within which patients, providers and society can operate. We have come a long way from merely assuming that addicts were deranged people on the fringe of society, who were beyond help. There are many benefits that come from an addict's recovery; not only for the individual, but their community as well. The societal good that comes out of successful addiction treatment include increasing the number of people who can actively participate socially and economically, reducing crime rates and the number of people in prison and reducing deaths by overdose. We have seen marginal success with the past rules we have used to approach addiction, but the most success is seen when addiction is treated like a medical and psychological issue. From a rule utilitarian perspective, the most good will come from emphasizing the medical treatment of addiction rather than the criminal punishment. I do not expect the criminality of inappropriate drug use to be lifted. Laws making opiate abuse illegal signal that it is not socially accepted and that it is a behavior to be avoided, which it should be. Opiate addiction is easy to pick up and miserable to put down. It is physically and socially dangerous; it leads to death by overdose and it causes social isolation and ostracization of people who are in need of help. But we must remember that although addicts are criminals, they are not addicts because they are criminals. In fact, the opposite is true. We must rehabilitate addicts with that in mind; part of that reform needs to be continuation of medicalization. We must also embrace the practices like methadone clinics that successfully treat opiate addicts and reinforce

the notion that addiction is a disease. We are a long way from curing the American opioid epidemic, but the steps we have taken to understand it are finally moving us in the right direction. If American society accepts my rule and promotes medical treatment of addiction, we can avoid unnecessary deaths, recover lost economic potential and solve one of the largest health crises we currently face.

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