



Special Issue on Addictive Behavior

## Stigma Associated with Opioid Use Disorders in Adolescents Limits Naloxone Prescribing

Lydia Carson, BSN, RN, CPEN, CCRN

New York-Presbyterian Morgan Stanley Children's Hospital, NY, United States of America

### ARTICLE INFO

#### Article history:

Received 9 June 2019  
 Revised 9 September 2019  
 Accepted 3 October 2019

#### Keywords:

Opioid use disorder  
 Stigma  
 Adolescents  
 Naloxone

### ABSTRACT

**Theoretical principles:** Parse's theory of humanbecoming describes shame as a sense that one is failing to conform to both personal and societal expectations of high value. Shame and stigma, negative perceptions others hold of an individual based on failure to conform to societal expectations, that surround opioid use disorders are linked to patients not seeking medical treatment due to the social isolation and humiliation brought on by the disease. **Phenomenon addressed:** This article reviews the resistance of some health care providers to discuss the realities of substance abuse with adolescent patients and their families, and identifies how the stigma that some health care providers place on opioid use disorders makes them less likely to discuss and prescribe naloxone, the reversal agent for opioids. When families are prepared to prevent overdose deaths by administering naloxone, lives can be saved, and time can be preserved for developing long-term treatment options.

**Research linkages:** Research should develop curricula that teach how to identify unconscious bias that may exist on the part of the healthcare provider, and to understand the negative effects of stigmatizing opioid use. Bedside nurses and practitioners should be equipped to educate patients and their families about naloxone and its availability, and to explain that it is a safe and effective way to prevent opioid related deaths. When presented in a nonjudgmental way, information about naloxone is a critical component in addressing the opioid epidemic, preventing deaths and providing time for further treatment options.

© 2018 Elsevier Inc. All rights reserved.

### Introduction

Since 2015, the American Academy of Pediatrics reports there has been a 28% increase in opioid related deaths in the United States, and deaths from overdoses have been increasing in adolescents. With, on average, 130 people dying from opioid overdoses every day, an epidemic has hit home for many families (Health and Human Services, 2019). Research suggests that adolescents aged 16–18 are the most vulnerable at-risk population for opioid misuse followed by adolescents aged 13–15 (Cerdá, Santaella, Marshall, Kim, & Martins, 2015). In 2017 alone, 14% of high school students reported having used prescription pain medicines, such as codeine and oxycodone, without a prescription or differently than indicated (Fig. 1) (Kann et al., 2018). Research surrounding opioid use suggests that prior use of opioids for nonmedical purposes is a strong predictor of heroin use when first introduced in adolescence (Cerdá et al., 2015).

Recently, the role of prescription medicine in this crisis was elevated in the minds of the public by an Oklahoma judge who ruled, on August 26, 2019, that Johnson & Johnson helped create the state's opioid epidemic by deceptively marketing opioids to the public without properly

informing patients about the risks (Martin, 2019). In an interview conducted during *Morning Edition*, hosted by Rachel Martin, on *National Public Radio* (NPR), Gary Mendell shared his son's feeling of shame and stigma surrounding opioid addiction, which led to his untimely death at the age of 25, not by overdose but by suicide. (Martin, 2019). His son's story will resonate with many families, as his journey to opioid use started in high school, first with marijuana, then prescription pills like Vicodin (acetaminophen/hydrocodone) and finally heroin. Mendell stated that his son wrote about "the shame that goes along with someone addicted - the waking up every morning feeling like an outcast all day long" (Martin, 2019). Mendell acknowledged that people like his son who struggle with addiction also suffer from the social isolation created from the stigma surrounding opioid use, and often do not seek treatment due to the shame that surrounds it (Martin, 2019).

When someone experiences stigma from not meeting societal norms, they feel ashamed. Those who feel shame may experience a feeling of worthlessness, low self-esteem and social isolation (McFall & Johnson, 2009; Shaughnessy, 2017). Shame, as described by Rosemarie Parse (2010) in the Theory of Humanbecoming is "a deep sense of non-conforming to valued personal expectation and expectations of others" (p. 259). Parse explains that when people feel shamed, they remain silent and choose to disconnect from others so as not to feel additional shame.

E-mail address: [lyc9022@nyp.org](mailto:lyc9022@nyp.org).

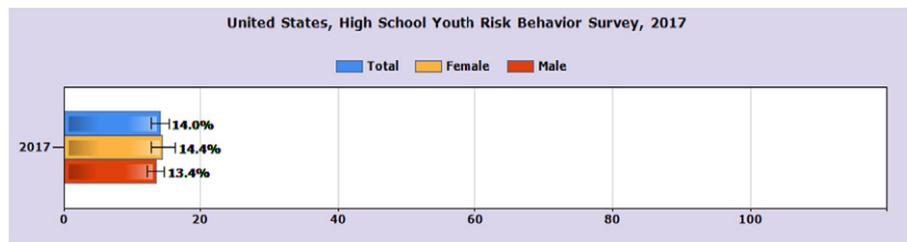


Fig. 1. Percentage of high school students to have misused prescription opioids. <https://nccd.cdc.gov/youthonline/App/Results.aspx> 2018 used with permission.

Breaking down barriers and changing attitudes within healthcare about opioid use disorders and addiction is a first step to shifting culture (Livingston, Milne, Fang, & Amari, 2012). Livingston et al. (2012) state that stigma within healthcare often leads to criminalization of substance use, which leads to system processes that deepen the marginalization of those who use illegal drugs. Research suggests that healthcare providers lack proper education on how to properly treat patients with opioid use disorders which leads to further stigmatization due to unconscious biases held by providers (van Boekel, Brouwers, van Weeghel, & Garretsen, 2013). Negative views that society places on those with addiction hinder progress towards treatment and positive outcomes, and when addiction is not viewed as a chronic illness, but instead as a moral failing, stigma surrounding the disease remains (Saloner et al., 2018). A change in culture and attitudes of healthcare providers is critical, because early intervention and identification of at-risk youth through continuous assessment and screening results in fewer long-term consequences of opioid dependence in adulthood (Bagley, Hadland, Carney, & Saitz, 2017).

Because many adolescents rely on their parents to initiate care, it is also important to decrease parental stigma, whether social or structural, that surrounds the use of naloxone (Wu, Blazer, Li, & Woody, 2011). Decreasing the stigma surrounding the use of naloxone may help adolescents and parents have a more comprehensive conversation about opioids and their dangers, and, with the prescription of naloxone, deaths from opioid overdoses can be prevented. While naloxone won't cure the disease, it will reverse the effects of an overdose, providing time for recovery and allowing the adolescent a future to live a full and productive life (Olsen & Sharfstein, 2014).

### What is a stigma?

Stigma is defined as “a set of negative and often unfair beliefs that a society or group of people have about something” (Merriam Webster, 2019). Stigma that is present in healthcare is often referred to as structural stigma and is influenced by the social stereotypes that surround a certain health condition. These stereotypes are often negative in nature and guide social action, public policy and health-care spending (Livingston et al., 2012). Stereotypes that are formed from past epidemics have shaped public perceptions on how certain people are characterized, and public perceptions of people who misuse opioids are often that of individuals of lower socio-economic status who live in urban settings (Kennedy-Hendricks et al., 2017). These stereotypes can further perpetuate the stigma and shame surrounding opioid use disorders, discouraging people from seeking help when needed.

People who have experienced the shame that surrounds opioid use disorders tend to remain silent, further suppressing the feelings of humiliation and dishonor (Parse, 2010). Living within the silence that stigma and shame bring to an affected person has been shown to be a barrier to critical access to care and treatment for those who have opioid use disorders and other mental illnesses (Livingston et al., 2012; Olsen & Sharfstein, 2014). Stigma related to opioid use disorders has been associated with increased dissatisfaction with treatment provided by healthcare professionals and is correlated with patients being less likely

to complete treatment (van Boekel et al., 2013), delaying medical treatment or experiencing delayed integration back into society after substance use treatment (Livingston et al., 2012).

Although health care providers are educated to understand substance use disorders, much like mental health disorders they are subject to the feelings that have been placed on these disorders by society and as a result may have a negative view of people who have substance use disorders (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014). Negative societal thinking leads down the path of worsening stigma throughout healthcare, and all providers should be aware of these unconscious biases and how they may influence the care they provide. When healthcare providers have an unconscious bias based on common societal stereotypes, they have the potential to miss critical opportunities to discuss opioid use or even miss the signs of opioid addiction because the patient does not fit within the societally accepted stereotypes. For example, a provider seeing a well-educated adolescent from an upper-class, stable family, living in a suburban neighborhood may be less likely to bring up the subject of opioid use during a visit.

### Recognizing opioid use in adolescents

Adolescents are developmentally predisposed to pursue highly stimulating behaviors to gain large rewards, often with little regard for consequences. When opioids are introduced to the developing brain, the feelings of goodwill and euphoria experienced make it more likely for the adolescent to want to take more drugs to recapture the instant reward (Levy, 2019). Opioids are agonists that act at the mu-opioid receptors [MOR] in the brain, which are responsible for pain and reward networks (Volkow, Jones, Einstein, & Wargo, 2019). When opioids are introduced in high doses, respiratory depression can occur which is the leading cause of death among opioid overdoses (Volkow et al., 2019).

Opioid use disorder shares many characteristics with other substance use disorders and addiction; for more key points about opioid use disorders see Table 1. Whether caused by stress, adversity, family use or past nonmedical opioid use, adolescents tend to follow the same pattern of usage, from pill to inhalation to injection (Sharma, Bruner, Barnett, & Fishman, 2016). Therefore, all pediatric providers should discuss opioid safety and the dangers of opioid overdose during each adolescent encounter.

### Evidence based treatment options

The American Academy of Pediatrics (AAP) has found that distribution of naloxone to families and friends of people with opioid use disorders, and also to the general community, has been a safe and effective way to prevent opioid overdose deaths (Korioth, 2018). Naloxone, or Narcan, is an opioid antagonist that works by displacing opioids from their receptor sites in the brain and reverses the effects of opioid based drugs (Volkow et al., 2019). Naloxone reverses the effects of an overdose, especially respiratory depression, which, as previously noted, is the cause of most overdose deaths. When given in time, naloxone provides time for first responders to arrive and appropriate medical

**Table 1**  
Adolescents and opioid use disorder: Key points.  
Adapted from Sharma et al. (2016).

Opioid use disorder influences	The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition criteria of OUD (Mild 2–3 symptoms, Moderate 4–5, Severe 6 or more)	Recognizing OUD in adolescents
<p>Environmental:</p> <ul style="list-style-type: none"> <li>Stress, adversity and exposure to opioids (Sharma et al., 2016).</li> <li>Exposure to opioids for non-medical use by parent, guardian or close peer (Sharma et al., 2016).</li> <li>There has been shown to be a strong correlation between drug use and adolescents' immediate peer group (Eitan, Emery, Bates, &amp; Horrax, 2017).</li> <li>Permissive attitudes of opioid use by parents, guardians or peers (Sharma et al., 2016).</li> <li>Adolescents who report lower socioeconomic status feel discouraged from developing positive relationships that may prevent future drug use. Leading to less social support from peers (Eitan et al., 2017).</li> </ul> <p>Access to drugs:</p> <ul style="list-style-type: none"> <li>Easy access to opioids from friends or family, leads to increased exposure to the drug.</li> <li>Increase in the price of prescription opioids and the decrease of Heroin has led to an increase in Heroin use (Levy, 2019).</li> <li>An increase in Heroin purity has led to a change administration in adolescents (Levy, 2019; Sharma et al., 2016).</li> </ul> <p>Comorbidities:</p> <ul style="list-style-type: none"> <li>Known diagnosis of depression, anxiety disorders or impulsivity disorders or other psychiatric disorder (AAP, 2019)</li> </ul>	<ul style="list-style-type: none"> <li>Taking a large amount or taking opioid over a longer period than intended</li> <li>Persistent desire or unsuccessful efforts to cut down or control opioid use</li> <li>Spending a great deal of time obtaining or using the opioid or recovering for its effects</li> <li>Craving, or a strong desire or urge to use opioids</li> <li>Problems fulfilling obligations at work, school or home.</li> <li>Continued opioid use despite having recurrent social or interpersonal problems.</li> <li>Giving up or reducing activities because of opioid use</li> <li>Using opioids in physically hazardous situations</li> <li>Continued opioid use despite ongoing physical or psychological problem likely to have been caused or worsened by opioids</li> <li>Tolerance (the need for increased amounts)</li> <li>Experiencing withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>Change in mood or demeanor <ul style="list-style-type: none"> <li>Irritability or depression</li> </ul> </li> <li>Failing grades</li> <li>Breaking curfew</li> <li>Arrest or run in with law enforcement</li> <li>Loss of or change in peer group</li> <li>Loss of interest in activities that once brought joy <ul style="list-style-type: none"> <li>Stops attending after school programs</li> <li>No longer goes to work (quits or gets fired)</li> <li>No longer shows interest in family outings</li> </ul> </li> <li>Tolerance (the need for increased amounts of drugs) <ul style="list-style-type: none"> <li>It is important to look for obvious track marks</li> </ul> </li> <li>Withdrawal symptoms <ul style="list-style-type: none"> <li>Irritability</li> <li>Vomiting/diarrhea</li> <li>Sweating</li> <li>Insomnia</li> </ul> </li> <li>Overdose (fatal or non-fatal)</li> </ul>

attention to be rendered, preventing death and allowing treatment for opioid use disorder in the future (National Institute of Drug Abuse [NIDA], 2018).

In April 2018, the Surgeon General of the United States made a declaration that recommended early intervention and early prescribing of naloxone as a key step in reducing opioid related deaths (Adams, 2018). The AAP, along with the American Medical Association Opioid task force, provided guidelines to practitioners on how to combat the opioid epidemic among adolescents and children (American Medical Association [AMA], 2019). The opioid task force recommends healthcare providers not only have safer opioid prescribing practices, but also that

they continuously assess adolescents for any behavior that may put them at an increased risk for an opioid use disorder (Korioth, 2018; AMA, 2019). If any risk factors are identified, then prescribing naloxone is recommended.

Naloxone kits have been available through community training programs since 1996, first in Chicago and later in San Francisco (Carrol, Green & Noonan, 2018). These training programs were initially targeted to adult drug users, but then progressed to education of family and friends (Heavey, Burstein, Moore, & Homish, 2018). It was found that family were often the first on the scene during an overdose, and thus the most effective responders (Heavey et al., 2018). Since many overdoses occur in the presence of another person, whether a friend or family member, it is important for the health care provider to train both parties. Research suggests that those who witness an overdose are willing to intervene and help, making education about naloxone available to all parties that much more important (Kirane et al., 2016).

Many times, there are opportunities for naloxone distribution and prescribing in the primary care setting or in the Emergency Department. Wilson, Berk, Adger, and Feldman (2018), in a study of pediatric primary care providers, found that 97% of pediatric providers felt a responsibility to educate patients about overdose risk, but only 42% did. This deficiency of patient and parent education was due to a lack of adequate provider education in harm-reduction or limited knowledge of naloxone as a reversal agent (Wilson et al., 2018). One study likened take home naloxone kits to EpiPen kits and noted that the patient should be treated without bias; training on life saving medication should be made regardless of disease (Holland, Penm, Dinh, Aran, & Chaar, 2019). Treating the patient without bias allows for a more therapeutic relationship between patient and provider, further decreasing the shame and isolation that is often felt with opioid use disorders.

Decreasing stigma by having early conversations about treatment options, including the lifesaving medication naloxone with adolescents, family and friends helps bridge the gap between life and death. With any education, next steps should be discussed, such as the need for further medical help after naloxone administration. This is vital because naloxone is short acting and may not fully reverse an overdose. Naloxone distribution is a safe, reliable way to prevent opioid related overdoses, and should be considered for family members or friends of anyone who is at risk (Korioth, 2018).

### Effects of stigma and shame

To dismantle the stigma that surrounds opioid use disorders and treatment options, health care professionals should first view the disorder as a medical illness, and not a moral weakness (Olsen & Sharfstein, 2014; Livingston et al., 2012). As providers, it is important to be aware of the language and tone that is used in practice, so that judgment is not passed to those around us (Saloner et al., 2018; Parse, 2010). Parse (2010), states that healthcare professionals should have solemn regard for human presences, listen and have open dialogue without judgment and be honest with information sharing. Practicing within this dialogue, healthcare providers will be able to accept others without judgment. Stigmatizing language like "junkie" can cause a patient shame, hurting the patient-provider relationship and pushing the patient who feels shame further into silence (Parse, 2010).

Healthcare providers who are aware of the biases present within healthcare and are free from those biases are essential for the identification, patient education and treatment of those with opioid use disorders. Due to social stereotypes and inadequate education of healthcare providers, those with opioid use disorders are often viewed as manipulative, violent and having poor motivation to get better (van Boekel et al., 2013). When healthcare providers have negative attitudes towards patients, they have the potential to be less engaged with their patients and further diminish the sense of trust in the patient-provider relationship (van Boekel et al., 2013).

Pollard, Fitzgerald, and Ford (2015), studied patients that experienced shame and found that those who suffered from shame often wanted to hide perceived shameful behaviors from others. Feeling ashamed of a medical condition, these patients did not seek help from others in order to remain silent (Pollard et al., 2015). Although Pollard et al. (2015) studied older men and women about delirium after a surgical procedure, this could be translated into the shame one may feel when diagnosed with an opioid use disorder. Patients who have experienced stigma from their medical condition may, over time, feel underappreciated within society and feel shame. Patients who have been labeled by society as shameful, i.e. those who use drugs or those with a psychiatric disorder, are more reluctant to seek medical attention in order to avoid feeling the shame associated with the social downfall (Shaughnessy, 2017). Stigma and shame lead to a potential lack of medical attention, failed rehabilitation attempts and relapse, which may lead to further social isolation.

Since patients with opioid use disorders may not disclose their disease due to the stigma and shame that surround it, they often seek treatment for other problems, like headaches or the flu (van Boekel et al., 2013). Therefore, it is important to do a complete history and physical as well as a psychosocial exam for every patient, especially those who are deemed high-risk (Levy and Williams, 2016). Negative attitudes felt by the patient often lead to poor communication, failed identification of the disease and a poor therapeutic relationship between patient and provider (van Boekel et al., 2013).

### Nursing implications

A systematic review conducted by van Boekel et al. (2013) found that healthcare providers, in general, have negative attitudes when taking care of patients with substance use disorders. For example, healthcare providers' attitudes towards patients were higher when patients had diseases like depression and diabetes rather than substance use disorders. Providers had a difficult time empathizing with patients who use illicit drugs, often due to patients not meeting societal norms and stigmatizing attitudes held against them. Another common theme was a lack of appropriate education for the healthcare provider to care for and support the patient who has a substance use disorder (van Boekel et al., 2013).

Adequate training in recognizing at risk adolescents should be made available for all pediatric providers and should include age-appropriate materials and anticipatory guidance for patients across the age spectrum (Wilson et al., 2018). Education should also include how to decrease stigmatizing language by using "person-first language" within the healthcare setting (Kelly, Saitz, & Wakeman, 2016). Person-first language includes teaching providers to use terms like 'a person with opioid use disorder' rather than 'a drug abuser' (Kelly et al., 2016). Changing the language healthcare providers use within their practice shows respect for human dignity, focuses on the medical nature of the disease and subsequent treatment options, promotes the recovery process and helps stop stereotypes that might hinder care (Broyles et al., 2014). Enhanced education for healthcare providers to understand the lived experience of those with substance use disorders has been shown to decrease negative attitudes towards patients, therefore lowering stigma (Livingston et al., 2012).

As previously noted, if an opioid use disorder is confirmed or suspected, education about opioid dangers should be addressed and naloxone should be prescribed (Korioth, 2018). Having a comprehensive treatment plan in place, with overdose education and reversal options, helps de-stigmatize treatment (Levy, 2019). Providing at-risk youth a safe space to be heard, and allowing a conversation of available treatment options might be the gateway to providing them the help they need. Pediatric providers are motivated by prevention of disease, and when combined with the longstanding relationship with patients and families an ideal environment is created for conversations about opioid safety (Carney, Hadland, & Bagley, 2018). This relationship

allows the adolescent a safe space to speak freely and without judgment, and to be educated about the dangers of opioid use.

Since 2017, every state and the District of Columbia has enacted laws expanding access to naloxone, making it easier for patients, families and friends to obtain and be able to administer it if in a position to prevent an overdose (SAMHSA, 2018). There are civil liability laws, also known as Good Samaritan laws, in place in 46 states and the District of Columbia covering those people who administer naloxone. These laws are in place to encourage people who administer naloxone to an overdose victim to call for help without fear of prosecution (see Fig. 2 for a summary of states with Good Samaritan laws) (SAMHSA, 2018). The ability to call for help without fear of prosecution decreases the stigma surrounding this disease, and allows people to step out of the shadows and into the light and ask for help.

### Conclusion: stop the stigma

There is a critical need to decrease the stigma that surrounds all substance use disorders and their treatment options. Societal norms and embedded stereotypes often shape the thinking for many health care providers, which, even if unconscious, affects the care they provided to a patient with an opioid use disorder. As Gary Mendell stated, his son wanted people to view him "not [as] a bad person... but [as] a good person, with a bad disease" (Martin, 2019). Shifting focus from moral failing to a chronic disease breaks down stereotypes, allowing for a more robust conversation about opioid use and its dangers. Lessening stigma that surrounds opioid use disorders will help lower the social isolation and shame that is associated with the disease, and fewer patients will remain silent about their disease. Shifting the perception among health care providers is essential for breaking down barriers to treatment that frequently exist and allows the provider to engage in a more therapeutic relationship (Saloner et al., 2018; Livingston et al., 2012).

Naloxone co-prescription should be considered in all adolescents at high risk for an opioid use disorder or overdose and who are also prescribed an opioid at discharge (AAP, 2016). Further education is needed for all pediatric providers about how and when to prescribe naloxone to patients and their families. It is essential for all pediatric providers to allow a safe space for adolescents to have an open and honest conversation about opioid use and the risk of overdose (Levy, 2019). The more education that is provided to health care providers and families about naloxone and the risks of opioids, the more opportunities there will be for robust conversations and for further treatment options. This will lessen the stigma surrounding opioid use disorders, increase naloxone distributions from pediatric providers and provide more treatment options for pediatric patients in the future.



Jurisdictions: 46 (AK, AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, HI, IA, ID, IL, IN, KY, LA, MA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OR, PA, RI, SC, SD, TN, UT, VA, VT, WA, WI, WV)

Fig. 2. States that have Good Samaritan Laws in place. [www.pdaps.org](http://www.pdaps.org), 2018 used with permission.

## CRedit authorship contribution statement

**Lydia Carson:** Conceptualization, Writing - original draft, Visualization, Writing - review & editing.

## Declaration of competing interest

None.

## References

- AAP Committee on Substance Use and Prevention (2016). Medication-assisted treatment of adolescents with opioid use disorders. *Pediatrics*, 138(3). <https://doi.org/10.1542/peds.2016-1893>.
- Adams, J. (2018, April 5). Surgeon General's advisory on naloxone and opioid overdose. Retrieved March 14, 2019, from <https://www.surgeongeneral.gov/priorities/opioid-overdoseprevention/naloxone-advisory.html>.
- Addressing the Opioid Epidemic. Retrieved January 25, 2019, from [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Substance-Use-and-Prevention/Pages/addressing-the-opioid-epidemic.aspx\(2019\)..](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Substance-Use-and-Prevention/Pages/addressing-the-opioid-epidemic.aspx(2019)..)
- American Medical Association (2019). Naloxone. Retrieved March 14, 2019, from <https://www.end-opioid-epidemic.org/naloxone/>.
- Bagley, S. M., Hadland, S. E., Carney, B. L., & Saitz, R. (2017). Addressing stigma in medication treatment of adolescents with opioid use disorder. *Journal of Addiction Medicine*, 11(6), 415–416. <https://doi.org/10.1097/adm.0000000000000348>.
- van Boekel, L. C., Brouwers, E. P. M., van Weeghel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, 131(1), 23–35. <https://doi.org/10.1016/j.drugalcdep.2013.02.018>.
- Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., ... Gordon, A. J. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: A recognition and response. *Substance Abuse*, 35(3), 217–221. <https://doi.org/10.1080/08897077.2014.930372>.
- Carney, B. L., Hadland, S. E., & Bagley, S. M. (2018). Medication treatment of adolescent opioid use disorder in primary care. *Pediatrics in Review*, 39(1), 43–45. <https://doi.org/10.1542/pir.2017-0153>.
- Carroll, J. J., Green, T. C., & Noonan, R. T. (2018). Evidence-based strategies for preventing opioid overdose: What's working in the united states. an introduction for public health, law enforcement, local organizations, and others striving to serve their community.&nbsp; Retrieved from <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf>.
- Cerdá, M., Santaella, J., Marshall, B. D., Kim, J. H., & Martins, S. S. (2015). Nonmedical prescription opioid use in childhood and early adolescence predicts transitions to heroin use in young adulthood: A national study. *The Journal of Pediatrics*, 167(3). <https://doi.org/10.1016/j.jpeds.2015.04.071>.
- Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing*, 23(3), 273–284. <https://doi.org/10.1111/inm.12040>.
- Diagnostic and statistical manual of mental disorders: DSM-5 (2013). *Diagnostic and statistical manual of mental disorders: DSM-5 (Fifth edition )*.
- Eitan, S., Emery, M. A., Bates, M. L. S., & Horrax, C. (2017). Opioid addiction: Who are your real friends? *Neuroscience and Biobehavioral Reviews*, 83, 697–712. <https://doi.org/10.1016/j.neubiorev.2017.05.017>.
- Heavey, S. C., Burstein, G., Moore, C., & Homish, G. G. (2018). Overdose education and naloxone distribution program attendees. *Journal of Public Health Management and Practice*, 24(1), 63–68. <https://doi.org/10.1097/phh.0000000000000538>.
- Holland, T. J., Penm, J., Dinh, M., Aran, S., & Chaar, B. (2019). Emergency department physicians' and pharmacists' perspectives on take-home naloxone. *Drug and Alcohol Review*, 38(2), 169–176. <https://doi.org/10.1111/dar.12894>.
- Kann, L., Mcmanus, T., Harris, W. A., Shanklin, S. L., Flint, K. H., Queen, B., ... Ethier, K. A. (2018). Youth risk behavior surveillance - United States, 2017. *MMWR. Surveillance Summaries*, 67(8), 1–114. <https://doi.org/10.15585/mmwr.ss6708a1>.
- Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, substance use disorders, and policy: The need to reach consensus on an "addiction-ary". *Alcoholism Treatment Quarterly*, 34(1), 116–123. <https://doi.org/10.1080/07347324.2016.1113103>.
- Kennedy-Hendricks, A., Barry, C. L., Gollust, S. E., Ensminger, M. E., Chisolm, M. S., & Mcginty, E. E. (2017). Social stigma toward persons with prescription opioid use disorder: Associations with public support for punitive and public health-oriented policies. *Psychiatric Services*, 68(5), 462–469. <https://doi.org/10.1176/appi.ps.201600056>.
- Kirane, H., Ketteringham, M., Bereket, S., Dima, R., Basta, A., Mendoza, S., & Hansen, H. (2016). Awareness and attitudes toward intranasal naloxone rescue for opioid overdose prevention. *Journal of Substance Abuse Treatment*, 69, 44–49. <https://doi.org/10.1016/j.jsat.2016.07.005>.
- Korioth, T. (2018). Prescribe naloxone to combat opioid overdoses. Retrieved from <http://www.aapublications.org/news/2018/04/27/fynaloxone042718>.
- Levy, S. (2019). Youth and the opioid epidemic. *Pediatrics*, 143(2). <https://doi.org/10.1542/peds.2018-2752>.
- Levy, S. J., & Williams, J. (2016). Substance use screening, brief intervention, and referral to treatment. *Pediatrics*(1), 138. <https://doi.org/10.1542/peds.2016-1210>.
- Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, 107(1), 39–50. <https://doi.org/10.1111/j.1360-0443.2011.03601.x>.
- Martin, Rachel (Host). (2019, August 28). Families impacted by the opioid crisis testified at Johnson & Johnson trial. [Radio Broadcast]. Morning Edition: US: National Public Radio.
- McFall, L., & Johnson, V. A. (2009). Shame: Concept analysis. *Journal of Theory Construction & Testing*, 13(2), 57–63.
- National Institute on Drug Abuse (2018, June). Prescription opioids. Retrieved March 14, 2019, from <https://www.drugabuse.gov/publications/drugfacts/prescription-opioids>.
- National Public Radio (2019, August 28). Families impacted by the opioid crisis testified at Johnson & Johnson trial. Retrieved from <https://www.npr.org/2019/08/28/754962728/families-impacted-by-the-opioid-crisis-testified-at-johnson-johnson-trial>.
- Olsen, Y., & Sharfstein, J. M. (2014). Confronting the stigma of opioid use disorder—And its treatment. *JAMA*, 311(14), 1393. <https://doi.org/10.1001/jama.2014.2147>.
- Parse, R. R. (2010). Human dignity: A humanbecoming ethical phenomenon. *Nursing Science Quarterly*, 23(3), 257–262. <https://doi.org/10.1177/0894318410371841>.
- Pollard, C., Fitzgerald, M., & Ford, K. (2015). Delirium: The lived experience of older people who are delirious post-orthopaedic surgery. *International Journal of Mental Health Nursing*, 24(3), 213–221. <https://doi.org/10.1111/inm.12132>.
- Public Affairs (d). HHS.gov/Opioids: The prescription drug & heroin overdose epidemic. Retrieved March 14, 2019, from <https://www.hhs.gov/opioids/> (n.d.).
- Saloner, B., Mcginty, E. E., Beletsky, L., Bluthenthal, R., Beyrer, C., Botticelli, M., & Sherman, S. G. (2018). A public health strategy for the opioid crisis. *Public Health Reports*(1\_suppl), 133. <https://doi.org/10.1177/0033354918793627>.
- SAMHSA (2018). *Opioid overdose prevention toolkit*. (Revised 2014, 2016, 2018 Ed.) Rockville: MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.
- Sharma, B., Bruner, A., Barnett, G., & Fishman, M. (2016). Opioid use disorders. *Child and Adolescent Psychiatric Clinics of North America*, 25(3), 473–487. <https://doi.org/10.1016/j.chc.2016.03.002>.
- Shaughnessy, M. J. (2017). Integrative literature review on shame. *Nursing Science Quarterly*, 31(1), 86–94. <https://doi.org/10.1177/0894318417741120>.
- Stigma. Retrieved June 8, 2019, from [https://www.merriam-webster.com/dictionary/stigma\(2019\)..](https://www.merriam-webster.com/dictionary/stigma(2019)..)
- Volkow, N. D., Jones, E. B., Einstein, E. B., & Wargo, E. M. (2019). Prevention and treatment of opioid misuse and addiction. *JAMA Psychiatry*, 76(2), 208. <https://doi.org/10.1001/jamapsychiatry.2018.3126>.
- Wilson, J. D., Berk, J., Adger, H., & Feldman, L. (2018). Identifying missed clinical opportunities in delivery of overdose prevention and naloxone prescription to adolescents using opioids. *Journal of Adolescent Health*, 63(2), 245–248. <https://doi.org/10.1016/j.jadohealth.2018.05.011>.
- Wu, L. T., Blazer, D. G., Li, T. K., & Woody, G. E. (2011). Treatment use and barriers among adolescents with prescription opioid use disorders. *Addictive Behaviors*, 36(12), 1233–1239. <https://doi.org/10.1016/j.addbeh.2011.07.033>.