The story of the opioid epidemic is ripe for film adaptation. There’s crooked science, hidden agendas, blind-eyed idealists, and an overall breakdown of our fragmented US medical care. Over its course, the opioid epidemic has claimed hundreds of thousands of lives, and forever scarred families across the country.

This isn’t the first time the US has encountered a drug crisis, so why are opioids getting so much attention? One reason is the incredible scale of the problem; in 2016, the Department of Health and Human Services reported that 2.1 million Americans had opioid-use disorder, and 116 people died every day from an opioid-related drug overdose. Another reason is that the initial rise in opioid use broke the nightly news narrative of drug use as an inner-city problem among people of color, as the first spikes in overdose deaths were reported in rurally-residing whites. And finally, the opioid epidemic is unique in that the medical establishment had a clear role in creating the crisis in opioid-related deaths.

The epidemic’s scattered history

In 1995, the American Pain Society pushed physicians to consider pain as a “fifth vital sign.” Society members were justly concerned about the lack of adequate pain treatments, given the complications that can arise from ignoring pain. At the same time, Purdue Pharma was getting ready to release its new miracle pain pill, OxyContin. In 1996, amidst buzz in the medical community about pain, OxyContin hit the market, along with a comprehensive marketing campaign by Purdue Pharma. The company held all-expenses-paid conferences around the US, educating 5,000 physicians about the benefits of prescription opioids as pain treatment. Opioid prescriptions began to rise.

Opioid abuse is far from a new phenomenon in the United States. However, as deaths due to opioid overdose continue to skyrocket, we ask ourselves: Why is the epidemic getting worse, and why are we hearing so much about it now, even though opioids have been impacting communities for decades?

In this issue of A Matter of Spirit, we ask you to join us in learning about opioid abuse in the United States as well as listening with an open heart to the experiences of those who struggle with addiction. Avery Haller provides us with a current overview of the opioid epidemic in the United States, Dr. Fred Rotnike, MD gives us a physician’s perspective, Nancy Granger, RN provides wisdom about how places of worship can address addiction in their communities, Fr. Jim Harbaugh, SJ gives us a glimpse into the 12 Step Program as a spiritual awakening, and Donna Meyer provides an overview of how shareholder advocacy is challenging the systems that allow opioid addiction to flourish.

We are also blessed to share with you three unique stories that give us a rare glimpse behind the staggering numbers of those struggling with opioid abuse in our country. These stories remind us that behind all of the news coverage of this epidemic are real people whom God calls us to embrace.

Join us as we open our eyes to this issue and learn how we might make a difference.
Meanwhile, The Joint Commission, a medical standards accreditor, released new standards for pain treatment. The new standards recommended a number of pain treatments, including an endorsement of prescription opioids. Other medical associations and physicians lauded The Joint Commission for pushing pain management to a central aspect of patient care. With this blessing from the medical community, opioid prescriptions skyrocketed, quadrupling over the next ten years.

Opioids, and OxyContin in particular, addressed demand in a quick, convenient package. Furthermore, at the time of The Joint Commission’s standards, opioid addiction was thought to be rare. An inaccurate study, oft-touted at Purdue Pharma conferences, claimed that the addiction rate in patients prescribed opioids was less than one percent. On the basis of this science, nurses and physicians felt confident that they were doing best by their patients. That confidence led to statements such as the following, written by an RN in 2004.

“Be sure your patient understands that tolerance and physical dependence are expected responses to the continued use of opioids and aren’t necessarily evidence of addiction. Reassure patients that even if they develop tolerance, they’ll still receive enough medication to relieve their pain, and that the symptoms of physical dependence can be avoided or minimized by gradually reducing the dose over several days.”

The claim that patients experiencing withdrawal should calm down and get more pills feels sinister in hindsight.

By the early 2000s, there were plenty of critics dubious of the miraculous opioids. They raised concerns that prescribing practices lacked the oversight necessary to prevent abuse. Critics argued that state-level prescription drug monitoring programs were needed. Without a prescription drug monitoring program, a patient would be free to go from doctor to doctor, getting as many opioid prescriptions as they wanted.

Additionally, some in the medical community doubted the claims that opioids were non-addictive. In 2007, these doubters were vindicated. Purdue Pharma settled a suit in which the company admitted to falsifying safety data. The opioid epidemic was the failure of a scattered system and a population desperate for pain relief.

The epidemic today

While the 2007 Purdue Pharma suit was an enlightening moment for the medical community, it was too late to save lives. By the turn of the decade, heroin overdose deaths had spiked. Heroin is a cheaper, street-available alternative to prescription opioids. At first, it seemed that the new spike in heroin deaths was unrelated to prescription opioid practices—that old study claiming one percent of prescription opioid patients go on to abuse drugs lingered.

However, within a few years, it became clear that the rise in heroin use was almost directly related to the rise in prescription opioid use. Data compiled in 2015 found that 21-29% of patients who were prescribed opioids went on to misuse the drugs. Additionally, data collected from 2011-2013 at the Centers for Disease Control found that 80% of heroin users surveyed had started with prescription opioids. For patients who were vulnerable to developing an addiction, the flowering of prescription opioid availability created an environment where the trusted family physician unknowingly handed over hazardous material.

At first, researchers recorded the highest growth rates in opioid abuse, both prescriptions and heroin, in the rural white population. The narrative became one of a hopeless, jobless landscape outside of US cities. From 2015-2016, however, the rate of opioid overdose deaths among African-Americans nearly doubled, with the rate of over-
dose deaths among Latinx Americans not far behind. Opioid overdose death rates among Native American tribal members have kept pace with white Americans. While the rates of abuse in rural areas begin to steady, urban rates of abuse are rising.

New, more potent opioid drugs, such as fentanyl, have hit the illicit drug market in recent years. The opioid epidemic shows few signs of slowing down.

**Racism in the epidemic**

There are several ways in which racism played a role in shaping the opioid crisis and in public response. First, it is well documented that physicians tend to undertreat pain in people of color. People of color are less likely to have their pain taken seriously by doctors and are less likely to have access to prescription services than white patients. In a case of cruel irony, this undertreatment of pain may explain the delayed rise in opioid overdoses among people of color. The drugs provided by the medical establishment simply took longer to get to patients.

Second, many scholars and journalists have noted the distinctly different public discourse surrounding the opioid epidemic compared to the crack cocaine epidemic of the 1980s. In the '80s, African-American drug users were met with a “tough on crime” stance and branded as dangerous criminals. Today, white drug users are met with compassionate calls for safe injection sites as grieving family members share their stories on talk radio.

After the failure of the War on Drugs and the Just Say No campaigns in the '80s and '90s, there has been much self-reflection in public health’s approach to drug use. The change in public discourse is due at least in part to this self-reflection and changes over the last 30 years in how public health organizations attempt to save lives vulnerable to drug overdose, including a much greater emphasis on addiction as a diagnosable medical condition. However, there is almost no doubt that the general public’s readiness to accept this change in narrative was primed by the unexpectedly white face of the opioid crisis.

As rates of opioid overdoses rise in all populations, it will be important for public officials, medical professionals, and news crews to equitably treat and portray all drug users. This crisis truly touches all Americans, and all Americans must have equal access to compassionate, excellent treatment.

**Moving forward**

In March of 2018, the President of the United States declared a public health emergency regarding the opioid epidemic. While a step in the right direction, the public health emergency fund is slim. For an effective mobilization of resources, advocates must continue to fight for the declaration of a national emergency.

Despite a lack of funds from the highest federal office, there are promising policies emerging at the national, state, and local levels. In April of 2018, Medicare ended coverage of long-term opioids, encouraging patients and doctors to use non-addictive strategies for pain management. That same month, the National Institute of Health (NIH) doubled its funding for opioid-related prevention. Most states have now implemented prescription drug monitoring programs, making it harder to obtain unnecessary prescription opioids.

At the local level, cities and counties around the country are considering safe injection sites as well as methadone clinics. Safe injection sites are controversial, because they involve decriminalizing drug use in the clinical setting. Methadone clinics are similarly controversial because they involve clinicians administering opioids to patients in active addiction. However, the promise of both options is that drug users will have a safe entrance to recovery programs, as well as clinical supervision that can quickly save someone who goes into overdose.

If you’re looking for an action step today, call your elected representatives and ask for more funding for drug overdose prevention programs. Given the massive scale of the opioid epidemic, this is going to be a slow recovery. The good news is, learnings from past drug outbreaks have given public health officials and medical staff greater wisdom about how to save lives—but greater public and Congressional support is needed to kick recovery into high gear.

*A Matter of Spirit* 3

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As a faculty physician in Family Medicine and a local educator in Addiction Medicine, this has become my most recent tagline: dead people don’t recover. People must be alive to regain their lives, their relationships, and their ability to thrive. People must be alive to engage in therapy and to develop the strength and resilience to lead opioid-free lives. People must be alive to thrive.

And there’s the rub. Because not everyone who is building back their lives from addiction fell from a place of thriving. Sometimes they fell from a place of existing. Perhaps they never experienced thriving. When we rescue someone from an overdose death with Narcan, or stabilize someone in the emergency department, or refer someone to a treatment program, we are assisting them from detox to treatment. When we find the right dose of a medication to stabilize cravings and brain chemistry or provide psychosocial therapy to help someone gain insight into their behaviors, we are helping them walk from treatment to recovery. Ideally, we all don’t win until we work together towards a state of thriving—positive and healthy relationships, meaningful work and commitments, a rich and reflective mindset—the apex of Maslow’s hierarchy.

But addiction can turn that hierarchy upside down—and people are locked into a survival, rather than a thriving, mode. As we see that with other addictions, we are seeing it with opioids.

The current US landscape of substance abuse is different from past epidemics in several ways.

The supply of opioids is unlike any supply we have seen before. Opioids—both natural, like heroin and codeine, and synthetic, like fentanyl and Oxycodone—have been available for decades on street corners and in physician and dentist offices. Illicit manufacturers and dealers are disguising their products as tablets and capsules. And manufacturing techniques are simpler and distribution networks more extensive than ever. With the conveniences of texting, overnight delivery, and social media, deliveries can be made all over the country. No longer are illicit drugs solely an urban issue; suburban and rural communities are also common markets. Previous addiction epidemics were easy to ignore as “someone else’s problem” and disproportionately affected the poor and those with least access to care.

These drugs are more potent, purer, and cheaper than ever before. People can drop dead from their first use or from what they think is their standard hit when supplies of heroin are laced with other synthetic opioids such as fentanyl—a synthetic opioid 50% stronger than heroin, gram for gram.

These facts are frightening. And more than 60,000 people died in 2016 from overdoses. And the rise continued in 2017, and it continues into 2018.

We need multiple approaches to fighting this epidemic: these include law enforcement—to stem the tide; first responders—to rescue those in crisis and at risk of overdose; and health care providers—to provide the treatment and therapies to help people move from detox to treatment to recovery to thriving. But we also need more efforts looking upstream. Many people call this prevention. But we need more than prevention. We need to understand what is driving so many of our citizens into addiction. We must gain a national understanding of why so many of our relatives, loved ones, and community members are knowingly engaging in addictive and potentially fatal behaviors.

Addiction has been called a disease of hopelessness. The person struggling with addiction sees the behavior as the best choice—or only choice in light of what they can see in front of them. Hope is gone. There is no opportunity for a better choice than shooting or smoking. Solace for the person in active addiction comes with the solace of numbing and the absence of withdrawal symptoms. There is no euphoria, for that left months or years before when his or her brain chemistry adjusted to all the foreign chemicals in its system. What remains is a memory of that ini-
tial euphoria and a compulsion to chase it—no matter the cost.

Science can teach us the treatments and the interventions. And science can tell us what prevention programs work and what public service announcements have the greatest impact. But even if we are not scientists or practitioners of scientific interventions, we can play a role in fighting the opioid epidemic by our innate ability to form caring relationships with other human beings.

Addiction is not a normal state of being; moreover, it is not an aspirational state. In other words, if someone has an addiction, it is very likely that something has gone terribly wrong in their lives. That “terribly wrong” can be trauma, exposure, or even genetic factors—but almost universally, addiction stems from and develops in social isolation.

Think about how many times in our days we ask others how they are doing. Consider the change we could catalyze if we only used that greeting when we are ready to listen. Every parent I know states that pulling one of their children away from a screen for a walk outside is almost always difficult for both parties, but it is also almost always rewarding. Speaking to a teenager in a tutoring situation can develop into a trusting relationship when adolescent concerns are shared, and the teenager knows they are having a normal reaction to a seeming abnormal stage of life. A conversation at the mailbox or in the lunch line can be a chance to break the isolation of a post-partum mother or an isolated senior. We don't have to commit 30 minutes to every conversation, but we occasionally do have the time and interest for such a conversation. We could challenge ourselves to do so on a regular basis.

The opioid epidemic may seem overwhelming. In fact, it’s the first time in this generation that many of us have firsthand experience of a loved one or acquaintance suffering in an epidemic. But we don't need to stand on the sidelines. Part of the cure for this epidemic is the same as previous epidemics—we must uncover the cause and care for those affected. But we also have a truly powerful tool to help many avoid the epidemic—provide the human connection and fight the isolation that drives someone to a needle or a pill. Put other choices in front of the person who has no hope. Form communities of conversation that honor and support our isolated members. By putting our values into action, we will change our communities and our cultures.

One of the great do-ers of the last century was St. Theresa of Calcutta. Never one to shy away from apparently insurmountable challenges, she found ways to fight epidemics—of AIDS, poverty, and isolated deaths—by serving others, building a workforce, and telling their stories. Her pragmatic approach to faith can inspire us in these times as well.

“I used to pray that God would feed the hungry, or do this or that, but now I pray that he will guide me to do whatever I’m supposed to do, what I can do. I used to pray for answers, but now I’m praying for strength. I used to believe that prayer changes things, but now I know that prayer changes us, and we change things.”

Dr. Rottnek is a Professor and the Director of Community Medicine at Saint Louis University School of Medicine and the Medical Director of the Assisted Recovery Centers of American (ARCA).

A process from the Catholic Health Association to engage leaders around the theme of how the Catholic Healthcare system can address opioid addiction. Designed to be used flexibly by individuals or groups as a reflection. Available to download at www.chausa.org.

America Has the Highest Drug-Death Rate in the World

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<th>Total</th>
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* mortality rate per million persons aged 15-64
Best estimates according to source

@StatistaCharts  Source: UNODC

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1 www.cdc.gov
What if?

By Jim C.

One evening at a dinner party, some friends confessed that their daughter was in drug rehab. I smugly thought, “Of course she was. You guys have let her run wild for the last few years.” My wife and I were the parents who knew where our kids were and even said “No.” But a couple years later, we were the ones putting our son into treatment.

Over the next several years, he worked his 12 Step program and we worked ours in an Al Anon group. I learned a good deal about the disease of drug addiction but also I developed a one-on-one relationship with God for the first time in my life. I learned about hope and trust that God has a plan for me but also has a plan for my son. I also met dozens of other parents with kids in rehab. It didn’t seem to matter whether they were from homes of professionals, blue collar workers or from the farm. Whether the kid was an athlete, a star student or from the farm. Whether the class clown, everyone seemed to be susceptible.

Once my son invited my wife and me to his AA meeting where he was going to give his witness. I had previously heard his drug history but was shocked to hear that he felt he had been in pain mentally for many years, but once he tried drugs for the first time, he felt he had found the answer. So I have to ask myself, what would have been different if I had made the effort to talk to him about why he was acting out or getting angry, instead of using parental authority to shut him down? What if I had made the effort to make sure he felt he was important and loved and that the world would be worse off without him?

The Church’s Response to Addiction

By Nancy Granger

As Christians we are called upon to demonstrate love for our neighbor through actions that make a difference. When it comes to addictions, and particularly the current opioid epidemic, doing whatever we can to lower barriers to getting well is an authentic act of love. We are charged with the responsibility, as a channel of God’s love and compassion, to address this unprecedented epidemic that affects all of us.

First and foremost, letting go of preconceived notions and prejudices allows us to better understand underlying causes of addiction. This can help dissolve tightly held ideas which compromise compassion and perpetuate the lack of development of a sensible, caring response. Do our own personal convictions revolve around the notion that addiction is a choice? Are we blaming pharmaceutical companies for creating opportunities for individuals to ruin their lives? Do we see the opioid epidemic as the responsibility of those who prescribe drugs for pain management? Regardless of where our beliefs lie, the current statistics are staggering, indicating that over 22 million Americans of all walks of life are struggling with addiction, a physically, mentally and spiritually debilitating disease. I challenge the reader who claims they do not know someone who is affected by this illness. Undoubtedly, even the family members and loved ones of those employed by Big Pharma, those health care practitioners who prescribe opioids, and even those who are in the role of helping others with addiction, are themselves suffering the personal pain of the effects of addiction. And most certainly, those reading this article who themselves are addicted know addiction is not a choice.

Current research tells us that sadly only one in ten people who suffer from addiction seeks help, primarily because they perceive themselves to be thought of by others as weak individuals with no will power. This tremendous shame and stigma can easily overpower the hope to be well. Can you imagine a loved one with the diagnosis of cancer, diabetes or heart disease not seeking treatment because of humiliation? We, the church and body of Christ, must challenge ourselves to open doors to those who feel shamed and unwelcomed.

Pope Francis describes the Catholic Church as a field hospital for the wounded. For me, this reflects current trends in trauma-informed care that teach us to ask not “what’s

Here are a few ways to open your doors to the community

- Offer your space for weekly recovery programs and/or self-help support groups for people with substance-use disorders, as well as their families who may also need support.
- Connect people to existing support in your community.
- Offer free transportation to treatment services and/or recovery support programs.
- Advertise local meetings in your newsletters, community calendars, websites, and social media channels.
- When offering public or congregational prayer—particularly prayers for the sick—please pray for people who are suffering opioid or substance-use disorders.

US Department of Heath & Human Services www.hhs.gov
wrong with you,” but “what’s happened to you”…how were you wounded? Perhaps our message needs to focus on acknowledgement of the deeply rooted link between trauma and addiction. Science tells us that early experiences of trauma have a profound effect on one’s emotional and physical health, and influence the development of inappropriate coping strategies. Traumatic life experiences are not only defined as exposure to horrendous situations such as war combat, natural disasters or sexual and physical assault. Varying degrees of abuse, neglect and household dysfunction including parents who are addicted, impact individuals from a very early age. Too often the use of substances is the only temporary relief from unimaginable life experiences. Divorce, unemployment, car accidents, unexpected illness, or loss of a loved one can be the breaking point for some.

Faith communities frequently do an admirable job of offering hospitality, food, and space to sleep for those experiencing homelessness, possibly driven by addiction, but are we offering acceptance, support and resources for the healing of those who are addicted? Do we offer words of mercy from the pulpit that acknowledge the personal battles that undoubtedly plague many parishioners in the pews and go unspoken because of the undeniable stigma?

When help is eventually sought, it is often church leaders who are the first to be approached by family members or addicts who are hoping for solace, forgiveness and acceptance as a human struggling with this illness. It is known that individuals with an active spirituality in their lives have a better chance of healing from addiction. Are we supporting this spirituality by offering pastoral visits to people with mental illness and addiction the same as we do for those experiencing other illnesses? Being familiar with agencies in the local community who serve those with addiction, such as Catholic Community Services of Western Washington’s CReW Program (Counseling, Recovery and Wellness), is very helpful. Perhaps we are able to identify congregation members who might accompany another church member to an appointment. Are we aware that there are nationwide Catholic residential treatment centers for those with the ability to access those services? Might more Catholic churches provide space for 12 Step programs or other support meetings? Encouraging these gatherings in a church is a beautiful step in breaking down stigma and demonstrating a welcoming community. Indeed, many have come into the church or found their way back, by this introduction.

Places of worship have the tremendous opportunity and power to help reframe the culture of how congregations view the illness of addiction. Key components of a faith filled response are acknowledging addiction as an illness and not a weakness, educating ourselves on current information and showing mercy. As Christians we need to communicate that God offers grace, mercy, love and forgiveness to everyone—including those struggling with active addiction.

▲ Nancy Granger, RN, MSN, CNS-BC is the Parish Mental Health Nurse and director of the Mental Health & Wellness Ministry at St. James Cathedral, Seattle, WA.
I was blindsided when my daughter told me, “I’m a heroin addict.” It was November 16, 2009, at a meeting with her drug counselor at Boston College, where she was a junior in the nursing program. After I uttered a profanity and slammed my keys on the table, Amy said that she wanted to take a medical leave of absence to go to treatment. “You only have a few weeks left in the semester,” I protested. “Can’t you tough it out?” Her counselor shot back, “If your daughter just told you she had stage 3 cancer, would you be asking that? No. You’d get her into the best treatment as fast as you possibly could.” That was the proverbial “two-by-four whack upside the head” that made me realize we were dealing with a disease.

Amy started treatment that week; five weeks later, she died of an overdose at the facility. She left the world her journals: what a gift to help me better understand the six tumultuous years she was sick, and her underlying emotional pain. As author David Sheff says, a “drug problem” is usually a “life problem.”

I knew Amy had used drugs: in 10th grade she was caught showing up high for cross country practice. When she was a junior in high school I found a Vicodin in her purse—and I had no idea what a big red flag that was. We all had plenty of counseling, yet after her death, I was amazed how clueless I had really been.

I sometimes rationalized her behavior as acting out, or going through a phase. Yet we would never say that a person with epilepsy isn’t controlling their seizures so they can annoy us. Or a patient with dementia isn’t remembering our name because they’re trying to aggravate us. Because addiction is a “broken brain,” the disease model helps us humanize those who misuse substances, though addiction can be more complicated because its impacts are usually felt not just in the public health arena but also in public safety. Even so, use of non-stigmatizing language, and trauma-informed care, can make a big difference in how people think about and behave around the disease.

After Amy died, I attended a weekly 12 Step meeting for over four years. Since I’d only been to a few meetings before she died, I needed this time in community to understand how other families had been impacted by the disease, and reflect on how it had impacted mine. I also needed to hear the stories of hope. Yet some people said they needed the hope I represented—that even when your loved one dies from this disease, there are ways forward.

One of the wisest phrases I ever heard was, “we heal in community.” Yet when Amy was sick, I never thought to tap my faith community, feeling ashamed, as well as being skeptical whether anyone could really be helpful. Thankfully in recent years, more faith communities have developed ministries to address mental health (which so often overlaps with substance misuse) and more parishes provide education on the epidemic. More healthcare professionals are being educated, though we have a long way to go. I’ve actually heard physicians apologize on behalf of their profession for the mis-prescribing which was the pathway to addiction for some patients—they weren’t trained about the risks, and believed they were doing the right thing to help address pain. Many of them seek forgiveness. However, forgiveness is a much more difficult proposition for those who deliberately tried to profit from the innocent.

As people of faith, we need to stay informed – the epidemic is a moving target, especially the way marketers (legal or illicit) target our young people. We need to build safe and supportive community. And we must pray for everyone, across the generations, who is grieving from this epidemic, whether a loved one(s) is in recovery, actively using, missing, estranged, incarcerated, or has died.

Melissa Weiksnar has been a writer, speaker, and advocate since 2010, using her daughter Amy’s story to educate about how addiction can impact any family. She published “Heroin’s Puppet -Amy (and her disease)” in 2012, and “It’s Not Gunna Be an Addiction: the Adolescent Journals of Amelia F.W. Caruso (1989-2009)” in 2014.
A Spiritual Awakening
The 12 Step Approach to Addiction

By Fr. Jim Harbaugh, SJ

One of the oldest responses to drug addictions is the 12 Step program first outlined in the book *Alcoholics Anonymous*, published in 1939. The book’s title was also the name of the organization that published it. In the years since, AA has helped millions of people find long-term, contented sobriety. The 12 Step program in turn has served as the basis for programs addressing other addictions, both to substances (e.g., Narcotics Anonymous) and to behaviors (e.g., Gamblers Anonymous), as well as for programs for those affected by another’s addiction, like Al-Anon.

In time the Steps also were used to shape professionally staffed treatment programs. These programs, often modelled on Hazelden’s in Minnesota, operated on a for-fee basis, whereas 12 Step programs such as AA never charge for their services. Inpatient treatment, much more expensive than outpatient, was at first supported by health insurance, but in time has become difficult to access, especially for people who are poor—and a drug habit can make you poor in short order.

If opioid abusers are going to be effectively treated, the 12 Step programs may be essential. There is little public will to fund for-fee treatment for addicts who can’t pay for it themselves, so programs that are essentially free are one of the few resources available for now.

I want to argue that the “spiritual” feature of 12 Step programs, far from being a deal-breaker for prospective members, is actually a strong selling point. There is a lot of confusion about just what this feature entails, though, so let me clarify this point.

Consider the last of the Steps, Twelve: “Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.” What is “a spiritual awakening,” and how could one help a person to recover from drug addiction?

In the earlier stages of AA, this Step spoke of “a spiritual experience,” but this language confused people, and it was changed to “awakening.” Bill Wilson, a co-founder of AA, came to understand his own “spiritual awakening” from alcoholism by reading about the conversion experiences described in an American classic, William James’ *Varieties of Religious Experience* (1902).

Incidentally, there were similarities between AA’s 12 Steps and Ignatian spirituality, especially the use of spiritual means to overcome what Ignatius called “inordinate attachments” and AA called “the disease of alcoholism.” But these resemblances were accidental and were only noticed later, when in 1940 a Jesuit from St. Louis, Fr. Ed Dowling, brought them to the attention of Bill Wilson.

First, what does “spiritual” mean here? From its beginning, AA was careful to avoid divisive doctrines: it’s “God as you [the individual member] understand God.” And so it’s “spirit” or “spirituality” as you understand them as well. My own definition of “spirit” would refer to the whole person of the addict: one of AA’s most significant insights was that there was something biological going on in the addict, not
just psychological or emotional. In the 1930s this was a radical idea, but since the enormous advances in brain scanning in the 1970s, it's become a truism. So more effective forms of treatment for addiction address all the features of addiction—and address them in a coherent, holistic way, which I would call “spiritual.” As with most serious pathologies—cancer, heart disease, diabetes—holistic changes in lifestyle are needed, not just fragmented treatment of symptoms.

Then what does “awakening” connote? It’s a better word than “experience,” which is at once too vague and too specific—many prospective AA members thought an “experience” must be a dramatic incident, like St. Paul knocked off his horse. “Awakening” is better precisely because it accurately describes what happens when an addict stops using. Physiologically, all drugs first go to the most evolved part of the brain and impair the functions, like judgment and decision-making that those parts govern. In the case of “downer” drugs like alcohol and opioids, drugs that slow down the system, the brain, and the addict, may literally go to sleep. What kills opioid abusers is that they go so deeply to sleep that their breathing comes to a complete stop. Unless an antidote like Narcan is immediately administered, the breathing stays stopped—the person dies.

If you stop using such drugs, you wake up. But this is not just a physical outcome, with improved alertness and better decision-making. It is also a spiritual result: the outcome of many meditation practices, Western like Ignatian prayer or Eastern like Buddhist meditation, is enhanced attention, becoming more awake. Prayer and meditation screen out distractions and preoccupations, and above all preoccupation with self, allowing one to notice and focus on deeper truths.

The proof that one has in fact awakened spiritually is contained in the rest of the Twelfth Step: the recovered addict will hold on to recovery by carrying the message, telling the story of what he or she has found, and by practicing “principles”—living a life of moral integrity. That moral life will in fact be the best vehicle for the message of recovery. In other words, the recovering person will become “just,” in the rich Jewish-Christian sense of that word, a person who treats everyone and everything else with fairness. To make “just” choices, it’s essential to be awake, not sedated or impaired.

Not every person at a particular 12 Step meeting is perfectly “just,” or for that matter perfect. But there are plenty of people at them who are visibly trying to be just, and not incidentally are drug-free to enable their efforts. This is the “message” for active addicts, opioid abusers included.

Jim Harbaugh is a Jesuit who has worked in parish ministry for some years in Seattle and Tacoma. He has been involved in addiction recovery as a writer, teacher, and giver of 12 Step retreats for many years.
miliar with weapons and completely self-possessed, Tricia fired a warning shot and yelled, “I've got great aim, people! Get the f—off my husband!”

Police later explained that this was a gang initiation, that the fight had been staged to lure bystanders like Josiah whom prospective gang members could brutally, publicly attack.

In the weeks that followed, the couple’s trauma turned into a perpetual nightmare. Josiah struggled holding out-of-town construction jobs; unable to focus and blacking out, he was unaware of (and untreated for) significant brain injuries. Alone with their son for long periods in Anchorage, Tricia would recluse herself in the apartment, cowering, terrified a stranger might intrude at any moment. She couldn’t eat, sleep, or even shower. In her head she re-played her husband’s attack, over and over, and strained to subdue her racing thoughts. Desperate for rest, Tricia tried melatonin, Benadryl, and sleeping pills; her mind wouldn’t shut off. Finally a neighbor’s nephew appeared with a shot of heroin.

For the first time in over a month, Tricia slept deeply. Recounting her descent into full-fledged addiction, Tricia sighs, “I won’t lie: heroin seemed like a godsend. It made me calm.”

By mid-summer, she was shooting up to feel good, but also suffered from kidney stones, and her white blood count had plummeted from using. So she remained in Anchorage, while Josiah and their son joined family in Kodiak. Hunkered down in a homeless shelter, Tricia withstood ureteroscopy (for her kidney stones), and desperate to be well, initiated detox on her own. Eventually she received care at an outpatient health center, where doctors authorized suboxone, a prescription med-

cication that relieves opiate withdrawal. However, because Anchorage’s rehab options were so meagre and the waiting lists so long, Tricia resorted to a secret weapon, her four older sisters. (“You don’t want to mess with these women, two in particular,” Tricia laughs). After rallying on her behalf for countless phone hours, they secured a spot for Tricia in a Washington in-patient clinic and a plane ticket to Seattle.

Unfortunately Tricia’s transition from Alaska to the Emerald City hasn’t been smooth. When she arrived in early February, the esteemed clinic had lost her records and summarily turned her away. For the first time in all of her ordeal, Tricia felt hopeless: in an unknown place, needing treatment, her well-laid plans were completely shot.

Luckily a shelter acquaintance suggested Recovery Café. Tricia approached the antique double doors at 2022 Boren Avenue, got coffee, sat near the front desk, and began to tell her story. Recovery Café staff listened, initiated her as a Member, and started advocating. Jason Fitzgerald, Director of Operations, coached Tricia through drug and detox assessments. Resource Referral Manager Tiffany Turner found Tricia a spot with intensive outpatient therapy. For the last several months, Tricia has engaged in specific drug therapy three days a week, and taken rehabilitative classes through Recovery Café’s School for Recovery (Killian Noe’s “Connecting with the Heart of Love” and Tom Kuebler’s “Addiction Recovery”).

Today Tricia proudly claims over 100 days of sobriety and expects Josiah and their son to join her within days here in Seattle. They intend to re-locate to Washington State and pursue healing programs together, especially brain injury therapy for Josiah. And even though Tricia enjoyed her former career as a dental assistant, in light of this recent year’s events she contemplates other vocations, perhaps drug or mental health counseling. “In my New Member Intro at Recovery Café, Jason said, ‘look around: these are your people, your family.’ I still feel that way. I want to lean into that. I want to help others with this crazy, harrowing journey toward well-being.”

"Tricia sighs, ‘I won’t lie: heroin seemed like a godsend. It made me calm.’"
I
n 2017, the opioid epidemic became the leading cause of death for Americans younger than 50 and may be the most significant contributor to the fall in US life expectancy. Overdoses are merely the most visible and easily counted symptom of the opioid problem affecting more than two million Americans. The 2015 National Survey on Drug Use and Health reports more than 97 million people took prescription painkillers in 2015, with 12 million without a doctor’s direction.1 Opioid abuse is taxing families, communities and healthcare facilities throughout the United States.

As active investors in the companies they own, shareholders are continually considering what issues affect the global community that can be addressed at the corporate level. In 2017, Mercy Investment Services, the socially responsible investing program of the Sisters of Mercy, learned through conversations with a Mercy hospital about the taxing effects of the opioid epidemic on healthcare systems—not to mention the impact on individuals and communities. The US Centers for Disease Control and Prevention reports that, in 2015, at least 1,000 people were treated every day in hospital emergency rooms for prescription opioid misuse.2 As a result of research and conversations with other active shareholders, Mercy Investment Services and the UAW Retiree Medical Benefits Trust formed the Investors for Opioid Accountability (IOA). Launched in July 2017, the IOA has grown exponentially as more shareholders raise the issue of opioid abuse with companies involved in the manufacturing and distribution of opioids and antidotes. The Northwest Coalition for Responsible Investment is a member of the IOA.

During the current shareholder advocacy season, IOA’s coalition of 46 state treasurers, asset managers, faith-based, public and labor funds with more than $2.2 trillion in assets has filed shareholder proposals on board oversight of business risks related to opioids at 21 opioid distributor and manufacturer companies. The IOA, which strongly believes that companies need to consider their role in the epidemic, is asking the companies’ boards of directors to investigate their response to increasing business and reputational risks related to opioids. The IOA considers good corporate governance practices that traditionally are risk mitigators as critical to implement going forward and that strengthened independent board leadership and compensation policies will increase board accountability and deter misconduct. The IOA hopes to change distributors’ normal business practices so that they closely monitor all sales and report unusual sales to appropriate authorities.

IOA has taken a three-pronged approach to engaging companies with an impact on the opioid epidemic:

- Opioid manufacturers about their corporate policies on the marketing of drugs that lead to addiction and how the company can take responsibility for these practices. By responsibly marketing these drugs and clearly communicating the risks involved with taking these drugs, manufacturers can hold themselves accountable for their role in the crisis.

- Opioid distributors about taking responsibility for their distribution of opioids and drugs that lead to addiction. Investors believe distributors should take precautions to ensure excessive amounts of opioids aren’t being directed to a single geographic area, which could indicate misuse or distribution.

- Antidote or treatment manufacturers to press them to offer affordable pricing of their products as they lobby for expanded access to these drugs. As the opioid crisis expands, affordable access to antidotes is crucial to saving lives. The price of many antidotes has risen significantly, making them less readily available when needed in an emergency.

Opioid addiction goes back centuries, but the current crisis started in the 1980s. A few highly influential journal articles relaxed doctors’ long-standing fears about prescribing opioids for chronic pain. With doctors more willing to prescribe opioids, in the mid-1990s pharmaceutical companies began aggressively marketing drugs such as OxyContin. From 1994-2014, sales of prescription opioids in the United States quadrupled. “Pill mills” began appearing around the country as prescription opioids flooded communities. Then, in 2014, large amounts of fentanyl, a deadly synthetic drug, began entering the drug supply. Fentanyl accounts for more than half of all overdose fatalities and is manufactured in China or Mexico as a powder that can be mixed into or made to look like powdered heroin. This potent—and less expensive drug compared to prescription opioids—is also used to produce counterfeit prescription pills.
Prescription opioids have improved the quality of life for millions of cancer patients and those with acute pain, but their efficacy in treating chronic pain is less well-defined, especially when weighed against the risks of overdose and addiction. Experts say the medical system needs to improve how it manages patients’ pain. In the meantime, widespread distribution of naloxone (brand name Narcan), an overdose antidote, is critical to help save lives in acute cases. Antidote manufacturers encourage requirements to stock antidotes for first responders, in schools, etc., creating high demand for the products. Unfortunately, as demand for these products has grown, antidote prices have escalated with one company raising the price for a dose from $690 to $4,500 in one year.

The IOA has specific requests of companies involved in the opioid epidemic:

- For manufacturers and distributors to improve board oversight of opioid sales and distribution. Specifically, investors are asking companies to appoint Board Committees with responsibility to investigate and report to investors how the board is assessing and managing legal, financial, and reputational risks related to the company’s opioid sales.

- To achieve the above, when appropriate, investors are asking that the Board Chair and CEO positions be separated and that the Board Chair be independent—not a company executive.

- Investors are also asking for evidence that that company executives do not receive incentive compensation for opioid sales.

Already, the IOA has made a difference:

- The first resolution to go to vote, at distributor Cardinal Health, earned 36 percent shareholder support, thanks to IOA members’ outreach to investors. Cardinal announced that the company will separate the chair and CEO positions. Investors continue to meet with Cardinal to define the role of the independent board members in oversight of sales.

- Amerisource Bergen, another distributor, was less willing to consider requests for appropriate oversight; the SEC sided with shareholders on all three resolutions filed, and the independent votes were in favor by 62%, 52%, and 48%—all strong numbers, especially for first-time resolutions.

- The third distributor, McKesson, has settled some shareholder requests, and other resolutions will be voted at its upcoming meeting.

Most of the opioid manufacturers are agreeing to adopt clawback policies: if a company executive who should have monitored risk earned pay and then the company experiences significant financial, legal and reputations harm, the pay can be clawed back and disclosed without violating privacy laws. In one case, manufacturer Mallinckrodt settled on clawback and monitoring political spending asks, but divested its opioid business rather than agreeing to an independent director report on opioid business risks. Shareholders consider this a win but will monitor the company’s progress.

While we celebrate several victories, there is more work to do. One of the challenges for next year is to engage private companies and those large manufacturers domiciled outside the US. Also, because lobbying monies pass through the Healthcare Distribution Alliance (HDA), the national organization representing pharmaceutical distributors, the IOA plans to try to understand their goals.

As the opioid epidemic continues to impact families and communities, businesses must take an active role in reducing their role in this crisis. Members of the IOA remain committed to using their voices as shareholders in companies and as stakeholders in impacted communities to advocate for businesses to do their part to stem the growing tide of opioid use.

Donna Meyer, PhD joined Mercy Investment Services as social responsibility consultant in 2012 and became director of shareholder advocacy in 2013; she provides advocacy services for the socially responsible investment program with a focus on health issues, including domestic health, global health, and nutrition.

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2 https://www.cdc.gov/washington/testimony/2017/t20170321.htm
NWCRI: Great News for Gun Safety!

At the Sturm Ruger annual shareholder meeting in Prescott, AZ on May 9 a majority of the company’s shareholders voted for our resolution! In it we ask the Company for a report on its “activities related to gun safety measures and the mitigation of harm associated with gun products.” Majority votes are rare!

Faith based shareholders, led by the Northwest Coalition for Responsible Investment and Catholic Health Initiatives, began addressing gun safety two years ago by writing to gun manufacturers Sturm Ruger and American Outdoor Brands and filing shareholder resolutions. But it was the bravery and eloquence of the students and teachers of Parkland that began this momentum that made this majority vote possible.

NWCRI members who hold the gun manufacturers are: Adrian Dominicans, PeaceHealth, Sisters of Providence, Mother Joseph Province, Sisters of St. Francis of Philadelphia, Sisters of the Holy Names of Jesus and Mary, US Ontario Province. We also filed a shareholder resolution with American Outdoor Brands that will be voted on in September.

We plan to continue to collaborate with investors, financial institutions and corporations to make our schools, churches, homes, streets and communities safe. Convinced that gun manufacturers must be a critical player in the solution to gun violence we will continue to make every effort to engage them.

March for Our Lives

On March 24 the IPJC community participated in the Seattle March for Our Lives, a student-led movement in support of gun safety reform. We continue to raise awareness about the impact of gun violence and work to advocate for common sense reform.

What can I do as an individual to end gun violence?

- Vote and encourage young people to vote by helping them to register.
- Support legislation that promotes gun safety.
- Thank companies that support gun safety, such as Delta Airlines and Dick’s Sporting Goods.
- Be aware of your use of violent words and images; use peaceful alternatives.

More about NWCRI’s work on Gun Safety at ipjc.org/issues/gun-safety

Thank you

To all of our friends and supporters who joined us for our 2018 Spring Benefit

Congratulations to those honored with IPJC’s Building Community, Creating Change awards. Pictured with Patty Bowman, Executive Director are: Charlotte and Earl Sutherland, Avery Haller, Judy Byron, OP, Georgia Yianakulis, SNJM, and Senator Rebecca Saldana. The Senator shared with the attendees how IPJC’s Urban Plunge for high school students and our WEavers women’s spiritually program mentored her in social justice.
2018 Just Video Contest Winners

1st Place: FreshDirect in the South Bronx
Natalia, Marin Academy, San Rafael & Kianna, The College Preparatory School, Oakland, California

2nd Place:
Immigration: Dreamers, DACA & Human Rights
Stuart Hall High School, San Francisco, California

3rd Place: The Cape Town Water Crisis
Holy Names Academy, Seattle, Washington

Human Trafficking

Elizabeth Murphy of IPJC had the honor of addressing over 1,000 high school students at Brophy College Preparatory School in Phoenix, AZ at their annual Summit on Human Dignity. This year, the summit focused on the impacts of human trafficking and ways that students can get involved in the effort to end it.

Young Adult Justice Café

Thank you to everyone who participated in the 2017-18 Justice Cafés! Please join us for our tenth year starting in September.

The Burien, WA Justice Café put together hygiene kits for people experiencing homelessness in their community for their April Act for Justice Café on “Solidarity and Charity.”

2018-19 Justice Café Topics:
Season 1: Global Issues, Local Action
☞ September: Poverty Near & Far
☞ October: Sharing the Journey with Migrants & Refugees
☞ November: Violent Conflict & the Need for Peace

Season 2: Justice for Daily Life
☞ January: Spirituality for Social Justice
☞ February: Overcoming Polarization
☞ March: Social Justice as a Vocation

April: Act for Justice!
Find a Justice Café near you or start your own.
Email ipjc@ipjc.org.

Donations

In honor of: Sisters of the Holy Names California Jubilarians; Fr. John Whitney; Judy Byron, OP; Kit McGarry; Linda Haydock, SNJM

In memory of: Anne Heger, OP; Peg Sullivan; Wayne Kirtley Roche

Support IPJC
☞ Let us know if your company matches donations
☞ We accept gifts of stock
☞ Designate IPJC when buying from smile.amazon.com
Reflection

Gather a group together to pray and reflect on this issue of A Matter of Spirit. Invite people to bring symbols of hope for those struggling with opioid addiction and place them on a table or in the center of the room (for example: flowers from your yard, a copy of the 12 Steps, etc.).

Leader: This issue of A Matter of Spirit addresses the opioid epidemic, which we've likely heard about but perhaps we are just learning about its impacts. Before our discussion today, let us call to mind the millions of people who struggle with addiction. [Take turns reading the following prayers.]

- We pray for those suffering from pain of any kind, that they may find effective ways to treat their pain that do not lead to the increased pain of addiction.
- We pray for those who are seeking treatment, and who struggle to maintain recovery, that they may find the care and support they need.
- We pray for families facing substance abuse and those who have lost loved ones to addiction, that they may find ways to strengthen the ties that hold them together.
- We pray for those who seek to bring compassion, treatment and healing to those who struggle with addiction.
- We pray for an end to the stigma of addiction, that we will come to recognize the need for treatment and care.

Leader: With these prayers in our hearts, we move to our discussion in an effort to find hope and talk about actions that we might take.

Consider the following questions for discussion:

- Name one or two ways that you've seen the impact of the opioid epidemic in your community.
- We heard different stories from people whose lives have been touched by addiction in some way. Pick one and consider: what, if anything, surprised you about this story?
- What is one way that you can show compassion to those struggling with opioid addiction?
- Brainstorm some realistic actions that the group can take either to raise awareness about, or to embrace, those struggling with addiction.

Closing Prayer

God of mercy, we know that you walk with those who struggle with addiction of all forms. Guide us in taking compassionate action within our community and remind us to show empathy to all those who suffer from addiction. Amen.