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NAVIGATING THE OBTACLES OF THE SUBSTANCE USE EPIDEMICS IN THE UNITED STATES FOR HEATLHCARE PROFESSIONALS

By Valencia Alexandria La'Cour

Project submitted in partial fulfillment of the
requirements for the
Bachelor of Integrated Studies Degree

Murray State University

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ABSTRACT

The purpose of this research is to assist healthcare professionals in the United States in both clinical and non-clinical areas become more informed, identify barriers, and develop an action plan regarding opioid and alcohol addiction crisis. The opioid crisis was declared an epidemic that places the county in a state of national emergency by President of the United States Donald J. Trump in 2018. Alcohol consumption has been steady in America since 1850, except for during the times of prohibition from 1919-1933.

Both the opioid crisis epidemic, and alcoholism continuously manage to aggressively take devasting numbers of lives over due to problematic uses is one that will continue to cause negative impact to the county in terms of public safety, the reliability of healthcare, and revenue losses if prompt and standardized actions are not taken in unison by government, healthcare providers, and patients.

Although the opioid crisis's and alcoholism's current impact in the United States may seem as though it is reversible and manageable by the hope of current funding and improved access, the purpose of this research is to provide education on opioids and alcohol, then identify the barriers that healthcare providers face while attempting to offer the best care to patients, and finally, to assist healthcare providers with developing a standardized action plan to fight the crisis of these diseases as a country.

DEDICATION

This research was completed in dedication to the millions of lives lost to the opioid and alcohol addictions. May we work diligently to heal our county of these epidemics for all of them.

The health care professionals who work tirelessly and thanklessly with the intention to heal those of these devastating diseases with hopes that one day the affects will be reversable. You are of dire importance in this battle. Please keep up your hard work and dedication.

I would also like to dedicate this research to an author of numerous articles regarding the opioid epidemic, Maia Szalavitz. I was struggling to find an article that she published in 2018, and reached out to her personally on Twitter and via email. Not only did she respond immediately, but she also found the article and sent me a direct link to it. I found even more of her work, which turned out to be an invaluable asset to this research. Thanks Maia!

Last, but not least, I would like to dedicate this research to my consumers and coworkers. Working at Centerpoint Recovery Center and gaining the hands-on experience with our consumers, my coworkers, and those who have graduated to be successful men in recovery and in life is motivational. Even those who get lost along the way in recovery, because their experience teaches us what we need to do differently in the future. I pray that this organization and those like it are provided with an overwhelming amount of support to continue the mission to free our people of opioid and alcohol use disorders.

LITERATURE REVIEW

Of the many sources that were used in the completion of researching for this project, I would like to review the three publications that provided the most value to review. The most difficult part of the research process was identifying the barriers to addiction treatment, and providing a detailed explanation for each of them. It is easy to research things that are already in place, but researching what needs to improve is something that we have to go to the ultimate source for: our recovering men and women. A lot of reading through articles of those who are recovering opioid and alcohol addiction, as well and asking those who are currently in recovery programs was the only way to find the most accurate explanations of what people are enduring for their recovery.

“How Can We Stay Sober? Homeless Women’s Experience in a Substance Abuse Center”, an article published in 2014 on the Springer Science and Business Media New York website was an article that discussed the experiences of ten women, seven of them were still in the program, and three were graduates, via interview in efforts to determine areas concern for them maintaining sobriety while being homeless due to a lack of available research for homeless women in recovery and those seeking recovery. The recovery program chosen for this publication was the First Steps for Women program in the Coalition for the Homeless of Central Florida, Inc that assists women for up to six months. The article provided a detailed description of the program’s services offered, the four barriers that the interviews identified, and solutions that would eliminate those barriers. It was an article that was written using an organized method by gathering the point of view from women in different parts of the program, participating

and graduated. Credible sources were used in this publication as well such as the use of information from SAMSHA and the National Institute of Drug Abuse, as well as respected authors and educators like James D. Wright, Thomas Hall Ph.D., and Andrew Baird Ph.D.

In comparison to the “How Can We Stay Sober? Homeless Women’s Experience in a Substance Abuse Center” publication, “Barriers to Addiction Treatment: Why Addicts Don’t Seek Help” that was published on the American Addiction Centers website by Editorial Staff discusses barriers to treatment for noticed by clients who are or have gone through their program. American Addiction Centers has locations in multiple states, therefore the information gathered comes from a larger of individuals, and from a national level versus a local level. The information provided in this source had statistics that involved adults as well as children over twelve and identified four barriers that those who need help are struggling to overcome. There was information about geographic areas and how location affects treatment numbers and success, insurance information such as what is covered and plans that offer the most assistance, and solutions to some of the barriers with statistics that reflect how overcoming those barriers affect treatment numbers and success. In addition, there hope for improvement in the amount of people not receiving treatment, by discussing changes made to improve the numbers of those who are struggling with addiction’s participation in the programs offered. Although the specific names of the staff who completed the publication aren’t listed to see the background of them, it is fortunate to note that the references used to complete the publication are very credible ones such as the Bureau of Labor Statistics, SAMSHA, and the National Institute on Drug Abuse.

The last article to compare was a much longer publication, but it was one of the three that provided the best level of insight through research. “I Am More Than My Addiction Perceptions of Stigma and Access” was composed by Heather D. Henderson, as a graduate thesis for the University of South Florida. It was a publication of much more detail that included graphs, statistics, personal interviews of clients and healthcare professionals. The publication provided true insight on the issues that both health care professionals and clients face daily in the battle to overcome the opioid crisis, as well as provided a more personal feeling to her research method with the use of poetry, direct quotes, and other expressions by clients. Henderson provided lists of resources that would be of assistance to those in addiction but may not have family or friends to assist with things that would trigger relapse due to stress such as lack of food, difficulty paying bills, transportation, etc. The desire to educate and help was made obvious in the publication. Henderson used many resources as well as completed her own surveys and studies for the publication as well, which made it an invaluable asset to my research on this topic. The sources Henderson used were of great credibility including SAMSHA and several publications by authors who are PhD, health care professionals, and those of great experience in working with those in addiction. There was a great variety of media (book, print, personal conversation/interview, and web). The publication also held interest and listed not only the problems and statistics, but also assisted with education, problem resolutions, and humanizing those who are struggling with addiction, rather than referring to them as numbers or as if they are less than those are not struggling with addiction.

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INTRODUCTION

Jamie Lee Curtis, a renowned actress for decades who currently holds recognition for having the best opening lead role for an actress over 55 years old from new Halloween sequel, is also now a public advocate for men and women who struggle with opioid addiction.

It was disclosed in the November 2018 People magazine article written by Johnny Dodd that she finally came out about her addiction in 1999 after confessing to the theft of her sister Kelly's pain medication. It was that moment that Curtis knew that she 'needed help'. Curtis's addiction to Vicodin started in the 80's while continuing to make great movies such as My Girl and True Lies. It came as a shock to many people that she struggled with opioid addiction for ten years silently and independently. (People 2018)

Curtis's story is not shockingly similar to many others who struggle or struggled with addiction. Her addiction has a strong connection to her immediate family, the closest being her father who used heroin, cocaine, and alcohol and her brother who sadly lost his life to heroin overdose in 1994. When Curtis realized that she wanted to get help and end the cycle of addiction that has cursed her family, is when she decided that she would help others in the world as well. Curtis's addiction to opiates began with the prescription of pain killers for plastic surgery for puffiness in her eyes in 1989, over

thirty years ago, which puts Curtis ahead of the opioid epidemic declaration made by the 45th President of the United States, Donald Trump in 2018. Curtis explained the feeling as “crazy great” and “amazing” and continued to chase that feeling by taking medications from her stuntman, friends, and her sister, and other methods for a decade before getting help to become sober again.

Stories such as Curtis’s are what reflect the struggle with opioid addiction that patients in the United States and the world face every day. It also acknowledges that opioid addiction is something that can’t always be predicted, and that addiction doesn’t have a prejudice, it can take over anyone. There is someone working in or frequenting every local police department, hospital, school, grocery store, gas station, restaurant, etc. who is or has struggled with addiction to opioids. The difference between Curtis and some other people is that Curtis had a strong bond with her husband, family, and children, and possessed the ability to not use the medications while working, thus her ability to maintain her success was not in jeopardy as it would have been if she weren’t able to use such discretion. She credited that to the fact that opiate drugs were not as easily available in her times of addictions as they are now. She stated to People that “I believe I’d be dead if, prior to my getting sober, these pills had been available on the internet”.

Curtis’s story is one that gives those who struggle hope that addiction can be overcome when the effort to become sober is truly taken, and the resources are there and available to them. She described overcoming her personal battle with addiction as her single best and most important accomplishment. Her story also shows how easy it

is to interact with or witness a person with addiction in plain sight or close proximity without knowing.

BETTY FORD 1918-2011

Betty Ford, Former First Lady, Dies at 93

Give this article 190

Former President Gerald R. Ford embraced the former first lady, Betty Ford, at the White House Oval Office in 1974. White House Photograph courtesy of Gerald R. Ford Library

Former First Lady of the United States of America, Betty Ford, spoke out about her addiction to both opioids and alcoholism, and the story was published in an article written by Becky Little on the Biography website. In the beginning phases, the year 1964, Betty Ford was prescribed pain medication for arthritis and joint issues that she developed while she was a dancer before her life in the White House. Later on, she was also prescribed Valium to treat anxiety as an attempt to help her handle the daily challenges that she faced while maintaining some sort of sanity. In the White House she had even more access to medications due to the luxury of having an in-house physician, William Lukash, who would prescribe any medication that was requested without hesitation. When questioned by Ford's assistants and family about the possibility of over prescribing, they were instructed to "mind their business and stay out of it". Before long she was taking medications to give her energy to get through her days, as well as medications to help her sleep at night while still taking pain medications, Valium, and daily drinking. In the midst of that, the pain medications that she was taking did not come with any warning labels as they do today, which help to prevent the use of alcohol with the medications. By the time Ford decided to make her public announcement that

she was going to a rehab facility in 1987, she was on opiates and other mind-altering medications, as well as still having her usual 5:00 PM cocktails daily.

In the New York Times article published in July of 2011, there was a reference to Betty Ford's story of her overcoming her addiction and how it inspired her to found the Betty Ford Foundation located in Rancho Mirage, California in October of 1982, which was known as one of the best rehabilitation centers in the United States. Her success in her recovery journey was not one that came to her alone, or overnight. It started with her denial of her disease. A clear indication of her denial was that when confronted by her family she referred to them as a "bunch of monsters" and although she acknowledged her opioid addiction, the alcoholism wasn't acknowledged until her time in the Long Beach Naval Hospital in California. Her time in recovery is what inspired her desire to help others with addictions. Although she doubted herself by thinking "but what if I relapse, won't that be embarrassing while trying to run a center for addiction?", her support system and determination made her dream a reality that still helps people long after her death in 2006.

Both stories of Jamie Lee Curtis and Betty Ford's struggles with addiction and the overcoming of those struggles serve multiple purposes. The stories relay to the public that addiction can and will consume anyone with no regard to them of socioeconomical status, that more intervention and access to care are needed, and that there is hope for sobriety and healing from both diseases. Both women were in the spotlight of fame, and were in high peaks of their lives. Neither of them saw their addictions as an issue immediately, and there were more limitations and barriers to care than there are today. Both women sufficient income and net-worth along with great

support systems. They both had the ability and resources to help others and motivate change. Not only did they beat addiction for themselves, but they also motivated and provided a means for others to beat addiction as well.

However, what about the person who is in the trenches of poverty or in the middle class living from paycheck to paycheck? What about the person who cannot afford insurance to fund the medical necessities required against fighting opioid addiction? What about the person who lives in a rural area with no transportation and is over 100 miles to treatment? What about the person who lacks support from family and friends after they have wronged their loved ones in search of the next dose of what makes them feel ‘normal’ or ‘better’? The scenarios questioned are all rhetorical and should help people to identify some barriers which make getting the help needed and deserved by so many Americans nearly impossible.

According to an article titled “The United States Opioid Epidemic” included on the Council on Foreign Relations website written by Claire Klobocista (Claire Feltner in 2018, before the updated article published in 2022), “The United States is battling one of its worst drug crises with more than nine hundred opiate drug related deaths per week”. From 1999 to 2017, the number of deaths yearly from opioid overdose related deaths has ranged from just below 10,000, approached 50,000 in 2018, and climbing past 80,000 in 2021 without the expectation of peak for several more years. The staggering statistic is over seven times more than the United States military casualties from post 09/11 tragedies as well as the Iraq and Afghanistan wars. The COVID-19 Pandemic posed another significant threat to the country in the midst of the opioid

epidemic. The disruption to supply chains of currently known and used substances, has led opioid users to look to more unknown opioids. (Klobocista, 2022)

The crisis not only causes a traumatic public health risk, but also a substantial risk to National Security, and the United States economy. More resources to fight the harmful effects of the opioid crisis are of dire need in the United States, and Healthcare Administrators play a major role in the allocation of the resources needed. Despite the major obstacles that they face, Healthcare Administrators and providers collectively all carry the responsibility and obligation to do that is best for patients. The statistics regarding the opioid crisis shared previously, and others to come reflect that United States Healthcare is continuing to fail patients and that affects everyone in all communities, and the same can is said regarding alcoholism, even though there is more discussion on the opioid epidemic.

In the article “Behind the Numbers: Alcohol is Killing More People Than the Opioid Epidemic-Why Aren’t We Talking About It?” by Barbara Krants, the questions at hand were simple: why aren’t we discussing alcoholism to the same extent that we are discussing the opioid epidemic? The explanation, although counterproductive to the mission of healing our citizens who struggle with alcoholism makes sense. Alcohol is legal, accessible, and looked at in a different light than opioids (whether prescribed or illicit). Alcohol’s only legal limitations are that the purchaser of it is of 21 years of age and can show a valid license or state identification if needed. It is made available for purchase in most stores, gas stations, served in restaurants and bars, and due to the range of brands/types, it can be afforded by most who seek it. Alcohol is also associated with having “a good time”. (Krants, 2022)

ALL ABOUT ALCOHOL

It is of great importance for Healthcare Professionals to effectively battle the alcoholism epidemic crisis by gathering the information on what alcohol is, when and why it was declared a United States epidemic, how alcohol affects the body, and what contributed to a crisis of the magnitude that is present.

TYPES OF ALCOHOL

The most common types of alcohol are beer, wine, ciders, and hard liquors. They have all been around for decades. Beer is one of the first alcoholic beverages created, and it is made from fermented nectars such as maize and rice. It is most commonly known for consumption after a long day of work, during sport events, and celebrations. Wine is second, and also known from ancient times. Wine is created by the use of fermented grapes. There are two sorts of wines created: white and red. Wine is usually consumed in finer dining settings or during celebrations such as weddings. Ciders made from fermentation just as beer and wine is, but it is created with the use of fermented apples. It has become a very popular beverage in America in later years. The alcoholic beverage type with the highest alcohol content is hard alcoholic drinks such as Vodka, Rum, Brandy, Tequila, and Whiskey. These are the most intoxicating of the types of alcohol. (Syakira 2019).

HISTORY OF ALCOHOL ADDICTION

The history of alcoholism dates back to thousands of years ago, so far in fact, that the dangers of alcoholism are discussed in some early Greek Literature. It is documented that there have been fermented drinks being made in China back to 7000

BC. In 1933, the United States recognized the dangers of alcoholism to an extent that there was a law passed that prohibited the manufacture, sale, or distribution of anything created with alcohol even if it were for a medicinal purpose. However, despite alcohol being illegal, it was still sold on the black market. Numerous speakeasies were created during that time, and although officials attempted to crack down on them, it seemed like when one was shut-down, another ten took its place. Home brewed beverages such as hard ciders and wines were legal with limitation; however, those were heavily abused as well. During the prohibition is when alcoholism became an epidemic.

Due to alcohol being unavailable to the public legally, individuals would seek alcohol by other means, which led to a spike in alcohol poisoning cases. Alcohol poisoning was caused more than likely by improper production with the addition of chemicals to provide more 'punch' for consumers with the intention to gain continued patronage. Medical doctors also chimed in on sales of alcohol during the prohibition by prescribing whiskey to patients. In fact, during the prohibition, over a million gallons per year. By the year 1933, the prohibition came to an end, and the lingering effects of alcoholism remain to the point that over 15 million Americans are currently struggling with some form of alcoholism, despite AA (Alcohol Anonymous) beginning in the year of 1935. (Narnocan Arrowhead 2022)

USE OF ALCOHOL FOR MEDICINAL PURPOSES

An article published on the Medical Daily website discusses the health benefits of alcoholic beverage consumption in contrast to the articles in which discuss the negative affects of the consumption of alcoholic drinks. It is beneficial to understand why a medical doctor would approve the consumption of a such a beverage to the public. The

article identified seven reasons, however, there are three that stand out, which are the prevention of cardiovascular disease, prevention of the common cold, and the increase in libido. It was discovered by studies in the School of Public Health at Harvard University that moderate amounts of alcoholic beverages increased levels of "good cholesterol" which has been known to prevent cardiovascular disease. As far as prevention of the common cold, it was determined with studies by the Department of Psychology at Carnegie Mellon University that moderate amounts of alcoholic beverages led to a decreased amount of common cold diagnosis in non-smokers. The third thing addressed was in the Journal of Sexual Medicine, and it stated that ED, or Erectile Dysfunction cases decreased by twenty-five to thirty percent with the consumption of moderate amounts of alcoholic beverages.

The Stages of Alcoholism

The American Addiction Centers provides a helpful explanation of the three stages of alcoholism (a term commonly used to describe alcohol use disorder that isn't of clinical terms). The three stages of alcoholism are early, chronic and end stage. The early stage of alcoholism is identified by the occasional binge drinking episodes such as holidays, special occasions, or times of stress. The chronic stage refers to daily drinking that is starting to have harmful effects on an individual. Whereas, then end stage describes an individual who is having dangerous withdrawals when not drinking, and at the stage where a healthcare professional must intervene and the patient more than likely requires a treatment program. Diagnosis of alcohol use disorder and its severity is measured using DSM-5.

The use of DSM-5 is important because it helps healthcare professionals to diagnose AUD (alcohols use disorder) and its level of severity in patients. DSM-5 consists of 11 factors, and is measured by how many factors out of the 11 that a patient is experiencing. Some of the factors listed in DSM-5 are of the following: drinking affects work, school, or family lives, the individual misses work or uses alcohol while at work, he or she is having to use more alcohol to experience the same effects, there are withdrawal symptoms after a period of not using alcohol. If a patient is experiencing two or more of the eleven factors, that is enough to diagnose them with AUD. If they are experiencing two to three of the eleven factors, then they are considered a mild case. If the patient is experiencing four to five of the eleven, then they are considered to have a more moderate case. However, anything over six of the factors, the patient is considered a severe case of AUD and intervention is needed most at this stage.

As stated, statistics in 2012 showed that 7.2% of adults had diagnosable AUD, which translates to approximately 17 million people adults. However, adolescents are not immune to AUD, as there were also over 855,000 children in the twelve to seventeen age range as well. Of the 17 million adults, 5.7 million of them were women, but almost double that amount were men at 11.2 million. (American Addiction Centers, 2022)

ALL ABOUT OPIOIDS

Although it is of dire importance to understand alcoholism in its entirety, it is equally important for Healthcare Professionals to initiate work on effectively battling the opioid crisis by first gathering the information on what prescription opioids are, when and why it was declared a United States epidemic, what the original intent was for

prescribing them, how they affect the body, and how the prescribing of them contributed to a crisis of the magnitude that is present.

The first question to answer is simply: what are prescription opioids? As defined on the publication titled “Drug Facts”, provided by the National Institute on Drug Abuse (NIH) website, www.drugabuse.gov, opioids are a class of drug that are naturally found in opium poppy plants. Some of the prescriptions given to patients are made directly from the plant, while others are made by scientists in labs using the same or similar chemical structure.

Examples of prescription opioids which are the most common prescribed are OxyContin, Vicodin, and Percocet, or common street nicknames known best to many individuals who purchase them on the illegally: ‘oxys’, ‘vikes’, and ‘percs’.

Oxycontin

OxyContin, according to Scot Thomas, M. D’s definition on the American Centers for Drug Addiction website, www.amercianaddictioncenters.org, is the specific name brand that has the extended release of oxycodone. Oxycodone is defined as the opiate agonist that is the active ingredient in narcotic pain medications such as are Percocet, Percadon, and OxyContin.

OxyContin, as described on medlineplus.gov, is prescribed in the forms of either liquid or pill, and is used to treat moderate to severe pain caused by cancer and other more serious conditions that may not be effectively treated using other medications. The medication is initially prescribed by a physician at a lower dose, and then is gradually increased as needed if the patient’s pain level is not able to remain under

control using the initial dose. The dose strength may also be decreased should the patient begins to show signs of side effects.

Vicodin

According to the research on the Narconon website, (Narconon, being a center, whose purpose is to provide assistance to overcome addiction), www.narconon.org, Vicodin is one of the most abused prescription opiate drugs. It is a combination of hydrocodone and acetaminophen. Vicodin is a drug that has effects that go beyond opiate addiction, but can cause liver injury and/or failure as well due to the high milligrams of acetaminophen in doses.

Vicodin is the prescription opioid drug that Jamie Lee Curtis, as mentioned in the introduction, was the beginning of Curtis's ten-year struggle with opiate addiction. Vicodin was prescribed to Curtis following a minor oral surgery. In the short time that she was instructed to use the medication, she quickly developed the addiction.

As mentioned previously, Vicodin is a combination of Hydrocodone and Acetaminophen (APAP), and although Acetaminophen is a highly effective agent that is used by people daily, it is also dose dependent and is in over six hundred medications both (OTC) over the counter and prescription. In fact, there are over 60,000 cases of liver injury in the United States, and over 50% of those are due to APAP overdose. (Bari, Fontana 2014).

Percocet

Percocet is a prescription drug that is used for pain and can also reduce fever for patients. It is a combination of an opiate base (oxycodone), and acetaminophen

(APAP), which can also be identified under generic names Endocet, Tylox, or Primalev. Percocet is prescribed to patients with acute intense temporary pain that will correct itself over a short time, and is not intended for long term (chronic) use. (Steppingstone 2019).

As will be explained further in the text, prescription opioids were originally prescribed by healthcare providers with the intention to treat chronic and acute pain. The reasons for prescribing of opiate drugs, as well as other forms of therapies to assist with pain management, has been argued as necessary to improve quality of life of patients effected by acute and chronic pain.

Chronic pain is pain that lasts over twelve consecutive weeks that could be the result of an initial injury, or from an illness. Chronic pain poses limitations to movement and can even reduce strength and stamina in patients.

An example of a patient who would struggle with chronic pain is someone who were in a motorcycle accident and damaged his leg in several places, requiring multiple surgeries to repair. If the patient has suffered nerve damage, fractured or broken bones, and torn ligaments, even if the patient is able to regain function in his/her limb, they might be subject to constant pain over weeks, months, or possibly even the rest of his/her lifetime.

Acute pain is the short-term normal sensation of pain that is a result of possible injury to a part of the body. The next question to answer is: what is the intent of prescribing opioids to patients with chronic and acute pain?

An example of a patient who may struggle with acute pain is one who may have had to have a minor dental procedure, and then experiences pain for a few days after the procedure. The patient would receive a three-day supply of pain medication in the lowest dose possible, or be instructed to use over the counter medications such as Aleve, Tylenol, Ibuprofen, etc.

Cancer pain was the initial use of opioid pain medications, and as explained in the Pain Journal publication, Management of Cancer Pain, due to the diverse symptoms and pain levels of individual cancer patient conditions, when physicians the use of opioid medications, they undergo a process of considering if using the opiate drugs will improve the patient's quality of life. It was stated that about thirty to fifty percent of cancer patients will suffer with chronic pain.

To find the best solution for each patient, their source of their pain must be assessed, and then the pain level must be assessed. Some pain from cancer that physicians must identify are of the following: acute pain, acute post-operative pain, neoplasm or related pathology, chronic pain due to tumors, and neuropathic pain syndromes.

After understanding what prescription opiate drugs are, what the uses are for them, and how they affect the body, it is important to discover the history of the opioid crisis epidemic. Understanding the history of the crisis will assist healthcare professionals in identifying the obvious as well as underlying causes of epidemic, which is the first but most important step to discovering the best solutions to reverse the epidemic's effects.

HOW OPIOIDS EFFECT THE BODY

Howard Fields, M.D., Ph.D., author of “Understanding How Opioids Contribute to Award and Analgesia”, explains that opioids acting at the **mu opioid** (MOP) receptor creates a significant analgesic. The reward of the analgesic is one that is so powerful, that it can quickly lead to addiction and dependency, sometimes in matters of weeks. Opioids control the path way of pain transmission through the **dorsal horn** by binding to opioid receptors to stop the transmission of pain signals. The dorsal horn, is one of the three columns of the spinal cord that receives sensory information from the body.

SIDE EFFECTS OF OPIOIDS

The side effects of opiate prescription medications are divided into classifications of both long and short-term effects. Although some of the side effects are seemingly insignificant due to the common nature of the effects, they following effects are all serious and play a role on compromising the overall health and well-being of patients. Some examples of the long-term side effects include nausea and vomiting, abdominal bloating, and constipation, and liver damage, while some examples of the short-term side effects include but not limited to the following: drowsiness, slowed breathing, constipation, and nausea.

According to the opioid special issue in the Pain Physician Journal of 2008, **tolerance** is one of the leading and most difficult complications in opioid treatment. When the pain tolerance is reached and passed by the patient’s body while under the use of opiate drugs, the body doesn’t experience the same rewarding effect of the medication. Therefore, it is inevitable that patients will need to continually have

increases in the doses of such medications, and the probability of further, more severe side effects become an issue.

Another effect identified in the Pain Journal is **Hyperalgesia**, which is defined as an adverse effect in which patients experience a heightened pain sensitivity. Hyperalgesia can present as increasing pain, despite the increase in dosage of pain medications and is most common in long term use of opiate drugs.

Constipation is a very common effect of prescription opioids, which is so common that it effects forty to nine-five percent of patients who are treated with the medications. Although constipation has been accepted as a normal side effect of opiate medications, the long-term effects of constipation are more severe and can eventually lead to morbidity, which adversely effects quality of life. (Pain Journal. 2008)

Opioid-Induced Respriatory Distress an effect that is the leading cause of death in opioid overdose deaths. It is also the cause of death in post-op from the anesthesia. It occurs when the opiate decreases the brain stem's ability to sense increases in CO2 levels. When this occurs, the result is complete respiratory failure. The only cure for an opiate overdose is the administration of Naloxone, hence the importance of quick reaction from EMS and the use of capnography to determine the need for Naloxone. Capnography is used to measure air flow in the lungs. It can be compared to how an ECG measures electrical current in the heart. (Capnoacademy 2018)

ORIGINAL INTENTIONS OF PRESCRIBING OPIOIDS

The opioid crisis has been developing over the past thirty years, which has resulted in shocking statistics of abuse, misuse, and death, but the intentions of prescribers of the first opioids were in efforts to help patients with pain. (Rummans, MD et all 2017). There is a special article published by the Mayo Clinic titled “How Good Intentions Contributed to Bad Outcomes: The Opioid Crisis, which explains that in the times of the Civil War, there were issues regarding the misuse and addiction of opiates following the prescription of morphine for pain relief after serious injuries, which was originally intended to treat acute pain.

It was determined that the United States began setting limitations on the importing of opium for medical use only, however, following times of wars, Veterans were prescribed opiate drugs to help with acute pain from combat injuries. In 1970, opiate drugs for cancer pain and were discovered in addition to the already popular drugs on the market. In the 1980’s, chronic pain (pain lasting more than 12 weeks) was beginning to be taken more seriously by providers and although reluctant due to issues foreseen issues with addiction, providers began to prescribe opiate medications to patients with chronic pain. Soon, sanctions were removed for physicians who chose to prescribe long term use of opioids, which was subsequently followed by an increase from one million to two million prescriptions written in just one year.

OPIOID AND ALCOHOL TREATMENTS

There are multiple means of treating addiction in patients for both alcoholism and those who struggle with opioid addiction. One of the very effective treatments for both is medication assisted therapy, or known to health care professionals as MATs.

MATs (Medication Assisted Therapy): for Alcohol Use Disorder

It was stated in the JAMA August 2018 article “Diagnosis and Pharmacotherapy of Alcohol Use Disorder: A Review”, that the medications available were under prescribed. It was noted that less than 9% of patients who were in need of a medication assisted treatment were prescribed either of the four medications that were made available. It is suggested that a medication assisted treatment (or MAT) would be beneficial along with behavioral/mental counseling/therapy would be most effective for patients. The four available medications are: Disulfiram, Naltrexone, Long-Acting Injectable Naltrexone, and Acamprosate. Although the ideal result is abstinence, realistically, significant progress has been made by simply contributing to the reduction of alcohol consumption as well. The medications below are the four medicated assisted treatments that are FDA Approved and currently recommended for use in patients with AUD. (JAMA 2018)

MATs (Medication Assisted Therapy): for Alcohol Use Disorder-Approved by the FDA)

Disulfiram

Disulfiram was the first to be approved by the FDA for treatment of AUD in 1949. It is designed for the management of chronic alcohol patients who are attempting to remain in the state of enforced sobriety. The suggested dosage is 250-500 mg/d daily by mouth. It was observed by an analysis of 22 studies that disulfiram sustained abstinence, and was associated with a better response than controlled adherence was supervised, however, not when unsupervised. The most commonly reported, yet mild

side effect is listed as drossiness. The more serious, yet rare side effects are neuropathy, neuritis, and psychosis. Disulfiram is not recommended to reduce drinking, but means to sustain abstinence in comparison to other medication such as Acramprostate.

Naltrexone

Naltrexone aims to assist those with AUD in the treatment of alcohol dependence. The FDA approved dosage is 50mg/d by mouth, daily. The analysis of sixteen studies showed that naltrexone is associated with a reduction of binge drinking. The most common side effects of naltrexone are nausea, vomiting and decrease of appetite. Naltrexone can also affect those who are struggling with addiction to opioids as it blocks the effects of opioid analgesics and principates withdrawal.

Long-Acting Injectable Naltrexone

Long-Acting Injectable Naltrexone is for the treatment of patients who are alcohol dependent that are able to abstain from alcohol use in an outpatient setting. The FDA approved dose is 1998 mg/d, by mouth, per day. There was only one placebo-controlled study, which showed a decline of binge alcohol consumption in patients. The side effects are the same as those for the oral version, (vomiting, nausea, decrease in appetite, abdominal pain) in addition to injection site irritation or reactions. Naltrexone is shown to block the effects of opioids and can precipitate withdrawals in someone who is completely dependent on them as well.

Acamprosate

Acamprosate is used to maintain the abstinence in patients from alcohol consumption for those who are dependent. The FDA approved dosage is 1998 mg/d by mouth, daily. It was stated after a meta-analysis of sixteen studies, that acamprosate contributed to the reduction of alcoholic consumption, however, it is not likely to reduce a patient's likelihood to binge drink. The only noted side effect of Acamprosate is diarrhea. Acamprosate can also be used for patients with hepatic disease.

NON-FDA Approved MATS for AUD

In addition to FDA approved medications for the treatment of AUD, there are also some non-FDA approved medications which studies have shown have the ability improve abstinence rates and reduce binge alcohol use. The medications mentioned are Nalmefene, Baclofen, Gabapentin, and Topriamate. The medications listed are commonly known in the United States for the treatment of other medical conditions such as seizures, multiple sclerosis, the reversal of opioid's effects, migraines and even chronic weight loss.

Nalmefene

In the US, Nalmefene is used for the reversal of opiate drug effects but in the European Union it is known to reduce the alcohol consumption in adults who consume more than four drinks daily (for men) or three drinks daily (for women). The approved dosage in the European Union is 18 mg/d on an as needed basis. Doses in clinical trials for AUD are five 80 mg/d in either one dose, or two divided doses. In a meta-analysis of 5 RCTs nalmefene is associated with a reduction in binge alcohol consumption. Side effects are nausea, dizziness, vomiting, and fatigue.

Baclofen

Baclofen is associated with alleviating the symptoms of spasticity in multiple sclerosis in patients. The dosage in trials for AUD is 30-18 mg/d in up to four divided doses. In a meta-analysis baclofen is associated with a greater time to lapse and a greater chance of abstinence during treatment. Patients who consumed alcoholic beverages more heavily than others during the study had a better abstinence rate with baclofen. Side effects with low doses treatment include dizziness, headache, confusion, muscle stiffness, excessive perspiration (sweating), itching, numbness, and slurred speech.

Gabapentin

Gabapentin (also known as Neurotin, and now classified in the United States as a controlled substance), is known for the management of postherpetic neuralgia (severe nerve pain), and treatment of seizures in patients aged three and older. In trials for AUD use, dosage is 75-300 mg/d in 2 divided doses. There were small to medium level results with gabapentin as a treatment for AUD in terms of abstinence success. The rate of no-binge drinking was 22.5% during the studies. Side effects are dizziness, somnolence (drowsiness), ataxia (impaired coordination) or gait disorder, peripheral edema (leg swelling). There is bias against the use of Gabapentin due to the high rate of treatment non-completion. There will need to be more studies to receive a better understanding of the medication's effects.

Topiramate

Topiramate is monotherapy for partial onset of primary generalized tonic-clonic seizures, and adjunctive therapy for partial onset seizures, as well as seizures with an association to Lennox-Gastraut syndrome and migraine prophylaxis. It is also used in combination with Phentermine for chronic weight management. Topiramate was used in clinical trials for AUD under the following dosage: 75-300 mg/d in two divided doses. In a meta-analysis of 7 RCTs there were small to medium effects on this medication in regard to abstinent days. The most commonly reported side effects associated with Topiramate are anorexia, dysgeusia, concentration issues, and dizziness. It is recommended to reduce the adverse effects to start with a dosage of 25-50 mg/d with weekly increases, as the effects are caused by higher doses.

It has been recommended that the combination of MATs for AUD be combined with a minimum, a brief counseling to improve the effectiveness of the medications. There was evidence that connects abstinence before the start of an MAT can provide longer success of abstinence and better treatment outcomes for patients. If naltrexone isn't deemed a medication that provides the desired effect, then it is recommended that treatment with an alternate drug such as topiramate could be effective. AUD is a chronic course with relapse being inevitable, therefore it is necessary to have ongoing clinical management, even indefinitely if that is deemed necessary. (Kranzler, Soyka)

MATs for Opioid Use Disorder

Addressing OUD (Opioid Use Disorder) can be done in the healthcare setting with a combination of proper screening/assessment, counseling, and medication assisted therapies. In the 2022 SAMHSA Tip Sheet 63, Exhibit ES.1. 'Comparison of Medications for OUD', a complete compare and contrast chart was provided for the

purpose of educating professionals as well as those who are struggling with opioid addiction about the proven effective treatments: Methadone, Naltrexone, and Buprenorphine. The Tip Sheets are developed by a panel of non-federal addiction focused experts in clinical, research, and administrative areas. A description of each medication used to treat OUD is provided with the following details: the mechanism of action at mu-opioid receptor, which phase of treatment it is most likely given and effective, how the medication is administered, side effects that are most common, and the regulations/availability of the medication.

Methadone

Methadone is an antagonist that is used under medical supervision for withdrawal maintenance purposes. The patient would ingest Methadone orally. Some of the most common side effects are: constipation, sexual dysfunction, hypotension, respiratory distress, and syncope. Methadone is classified as a schedule II medication and is only available in an inpatient hospital acute treatment setting, or at a federally certified OTP (Opioid Treatment Program).

Naltrexone

Naltrexone is an antagonist, and is used in the prevention of relapse to misuse. Withdrawal is carefully monitored by medical personnel as well. The method of administration is oral injection, with an extended intramuscular release. Some of the most common side effects of Naltrexone are constipation, nausea, insomnia, anorexia, dizziness. There are also some intramuscular effects such as pain and swelling, and induration. Naltrexone is not classified as a scheduled medication; however, it does

require a prescription and office-based treatment or can be used in specialty substance use programs including OTPs.

Buprenorphine

Buprenorphine is a partial antagonist and is provided with medically supervised withdrawal maintenance. The medication can be administered via sublingual, buccal, and subdermal implant-subcutaneous extend release injection. The methods of administering buprenorphine are oral and extended-release injection.

Buprenorphine: Oral (Sublingual and Buccal)

Sublingual and buccal are solid dosage forms of oral administration. Sublingual administration is when the medication is placed under the tongue to absorb into the tissues there. Buccal is when the medication is placed between the cheeks to absorb the medication in those tissues. Both have the advantages because they release the medications into the bloodstream of the patient quickly. This is extremely helpful and appropriate in times of medical emergency, such as a heart attack for example, because only a small amount of saliva is needed to carry the medication to the bloodstream and can help even when there is a loss of consciousness. The main disadvantage to an oral method of administration is that the dosage form may not be high enough due to the size of the oral cavity. Other disadvantages are the tablets may have an unpleasant taste, might be uncomfortable if accidently swallowed, and it is not effective with medications that require extended release to work. (Chrominfo 2020).

Buprenorphine Extended-Release Injection (Sublocade)

Buprenorphine Extended-Release Injection (known as the tradename: Suboxone) is a monthly subcutaneous (meaning situated or applied under the skin) injectable opioid that is used for patients with a range of moderate to severe opioid use disorder. A minimum of twenty-six days is required between doses due to its long half-life, therefore it should only be administered monthly. This treatment is for patients who have already undergone induction and stabilization on a buprenorphine-containing medication to manage the opioid withdrawal. The equivalent of 8-24mg/day of buprenorphine for a minimal of seven days must be completed before the start of the Sublocade therapy.

Both the oral and injectable therapies for Buprenorphine have the same adverse effects. Some of the most common are constipation, nausea, excessive sweating, insomnia, respiratory depression, and carry the protentional of misuse as a risk factor. As far as the implant, nerve damage during the insertion or removal process can occur. In the subcutaneous injection method, injection site itching or pain can occur. There is also risk of death if the medication is injected intravenously. Buprenorphine is classified as a Schedule III and required a waiver to prescribe it outside of OTPs. If using the implant method, then the provider must be certified in a Probuphine Risk Evaluation and Mitigation Strategy (REMS) Program. For subcutaneous injection, both healthcare settings and pharmacies must be certified in the Sublocade REMS program and only can dispense the medication to a certified provider to administer.

IDENTIFYING THE BARRIERS OF OBTAINING TREATMENT

Illegal Versions of Prescriptions

An example of an opioid that is becoming more popular despite its climbing death toll is Fentanyl. In comparing statistics from 2010 where 14.3 percent of overdose deaths were caused by Fentanyl, in 2017, the percentage has increased to 57, and climbing rapidly. Fentanyl is a prescription medication that is used for severe pain right after surgeries, or when someone with chronic pain has built a tolerance to other pain medications that has decreased or eliminated their effectiveness. Fentanyl is a very powerful synthetic opioid that is similar to morphine, but is 50 to 100 times more potent. The prescription form of Fentanyl is known as Actiq, Duragesic, and Sublimaze. When prescribed by a physician, it can be given as a shot, patch, or lozenge.

When Fentanyl is illegally used, it is created in labs and sold as a powder, put in eye droppers or nasal sprays, or made into pills that look like other commonly used opioids. Drug dealers have found ways to mix fentanyl with other drugs such as heroin, methamphetamine, and MDMA because it doesn't take much of the fentanyl to create a stronger product. The problem with this in buyers of these products are that if a tolerance isn't built to handle the stronger opioid, the result can be an overdose. (NIH 2021)

Insurance/Coverage

To understand the complexity of insurance companies and their direct hinderance in battling the opioid crisis, it is best to use an example from a business aspect. The business of healthcare is profitable for in multiple areas, some of them beyond the areas that patients are directly exposed. Health Insurance companies, such as Blue Cross Blue Sheild, Humana, Aetna, Cigna, Healthlink, and many other commercial and state/federal payees offer health insurance policies to patients, and

although in most cases, the patient pays for insurance, or is covered by a state Medicaid plan, etc., it is noted that it is more profitable for insurance companies to not pay claims. The best way to understand the previously mentioned statement, is to use a strategy that is used by several restaurants who offer an 'all you can eat buffet', or offer 'all you can eat' on a particular menu item at a standard price.

When a person pays for that 'all you can eat' special, they are not limited to how much, or how little they consume in that setting. When the customer rises from the table, he or she might either feel that they received a great deal for the amount of food that they consumed, however, may also be possible that he or she would have done better to just order the items from the menu instead.

Insurance works in the same way. The monthly premium is set, and usually is offered to people in at least standard health conditions, (in other words, primarily healthy individuals), with no complicated health concerns such as cancers, AIDS/HIV, issues with drug addiction (prescription or recreational). When the patient is insured, there is a silent hope that the patient doesn't need to file any claims. Which raises the questions of Americans, why would insurance companies want to deny a claim? Insurance is a business, and it is known from experience in any medical office that if an insurance company can avoid paying a claim, they will avoid paying that claim whether by the creation of difficult to decipher policies, technicalities in coverage for certain diagnosis treatment, deeming services as medically unnecessary, or making the information so overwhelming that policy holders simply just don't understand what policy they are signing up for and investing in.

When a patient pays a monthly or bi-weekly deducted premium for health insurance, but doesn't file claims outside of provided wellness or preventative care and maybe the occasional sick visit to an urgent care or primary care facility, the insurance company does not return that monthly premium. It remains within the company. However, when the patient visits a physician and that physician's office submits a claim to the insurance payer, that organization has to submit their obligated portion (this may depend on the medical facility's providers that the insurance company has credentialed) payment to the provider for services that are billed correctly and are defined as covered under the health insurance policy. There are so many obstacles in filing claims to insurance companies that many claims are denied or only paid partially. As well, there is the harsh reality that many organizations are opting not to accept that insurance, which contributes to the financial burden being placed onto the patient or their families in their dire need of assistance. Typically, at the point of which an individual would reach out for assistance, they are already having financial issues, and/or can't rely on family or friends to assist them depending on the extent that the patient has worn those sources thin.

Financial Concerns

The primary concern in battling the opioid and alcohol addiction crisis, just as any other healthcare epidemic, should be providing the best access and care to the patients, in summary, putting the needs of the patient at the front line, and then allowing revenue and financial allocations to be a reflection of the quality of care that is provided. However, from an administrator's perspective, the business aspect of healthcare must be recognized. Treatment costs money, and battling a crisis of the magnitude that the

opioid crisis and alcohol addiction has continually grown to become. Therefore, it can be expected that a lack of adequate financial resources is a considerable barrier to fighting the crisis.

Combating issues such as insurance policies making it more difficult to submit clean and payable claims, reducing the stigmas associated with opioid and alcohol treatment, educating the public of the severity of the epidemics as well as the importance of feasible and effective options are, will all be significant aids to assist in the overall mission: to get patients the help that they desperately need,

Combination of Barriers: Insurance, Education, Access, Stigma

It goes without saying that for a patient to receive the help that he or she may need when they are struggling with addiction, they need to make the initial effort to identify that they are addicted to opiates, and then turn to a healthcare professional that is equipped to meet their needs. In addition, patients are subject to need rehabilitation services, or to receive medication-assisted therapies and counseling or other resources that in a perfect world would be readily available to patients. However, there are some factors that are to be considered when thinking from a patient's point of view of when the time comes to reaching out for assistance.

There is a plethora of reasons why patients are either unable, or simply don't cooperate with addiction treatment that include, but are definitely not limited to are insurance barriers, lack of access to care, lack of education, the stigmas that come with patients' addiction issues in the community, lack of transportation to treatment centers, shame or guilt, the commute of treatment centers, etc.

Combination of Factors: Insurance, Miseducation, Harmful Policies

A tragic story that is a great example of how a combination of patient cooperation, lack of education, and insurance barriers combined essentially claimed the life of a patient who reached out for help, but was failed by the healthcare system. In the article, "Insurance is Supposed to Cover Addiction Treatment, But It's Still a Nightmare" by Maia Szalavitz, a reporter and author who has published numerous works on public policy, science, and addiction treatment, Szalavitz discusses the story of William, who lost his life to opiate overdose in 2012 at only 24 years old after reaching out for help. The story was told by William's father, Bill Williams, in the December publication in Vice Magazine. Bill told the story that William went to Beth Isreal Hospital in New York City with the intention to sign himself into an inpatient detoxification program. William was failed initially by his insurance company who deemed inpatient care as medically unnecessary, a phrase that is heard by insurance companies by healthcare professionals more often than not, despite his clear chemical dependence on opioids.

William refused to attempt an outpatient methadone program as recommended by the hospital and insurance company because he was under the uneducated assumption and myth that methadone harms the body's bones and teeth. It was stated that a competent counselor would have been able to educate William on the advantages and truth about a methadone program, which could have had a better influence on his decision to possibly give that option a chance to help him. Sadly, William later overdosed in a Starbucks and taken to St. Luke's hospital. William

survived, but he was released immediately after becoming stabilized without any actual care.

Following his overdose in Starbucks, he was in a seemingly similar predicament where in less than a week later, William overdosed, and that incident was the last one. William was placed on life support for six weeks before his family was faced with the decision to stop the life support and William died. In the article, Maia states that the clear irony in the situation was that the insurance company would have paid less in billed claims for the detoxification programs that could have positively impacted William's survival rate than they did for the six weeks that William remained on life support after another overdose.

It was also stated that before his last attempt to obtain help for his addiction, William went through a series in non-effective treatment and programs with a lack of coordination. He was prescribed Vivitrol, but then pushed out of the program due to his refusal to cease his marijuana use. Maia Szalavitz compared that decision to one as such where a physician would stop prescribing insulin to a diabetic merely because he or she doesn't balance their diet per orders. She stated that it is a policy that needs to change. It was also stated that when Vivitrol wears off (typically in 30 days), the opportunity for overdoses increases significantly, which could explain William's series of overdoses, as he has his last injection of Vivitrol about a month before his overdoses.

Combination of Factors: Insurance, Lack of MAT, Assumptions

Another story of how policies determined the untimely fate of a patient seeking addiction help is the story of Sharon Richmond's son Vincent. Vincent died due to a

Fentanyl overdose in 2017 at the age of 25. Sharon pleaded to get Vincent assistance, but was turned away due to ‘having supportive family’. Three days of detox were covered for Vincent, but he was not given the opportunity to use a Medication Assisted Treatment (MAT) such as Methadone or Buprenorphine.

Both stories, and many like it are being used for the good of the battle with opioid addiction because the families have come together to fight for others. Lawsuits against insurers and other involved parties in the lack of attention and care to patients seeking addiction assistance are starting to create better developed policies to prevent deaths due to lack of attention and approval for needed services in the future. (Szalavitz, M 2018)

Stigma

In a Florida Master of Arts graduate’s thesis titled “I am More Than my Addiction”, written by Heather Henderson, the stigmas that patients faced when they would present to the emergency rooms whether in need of pain medication for an injury, or upon their overdose of opiate medications was discussed in great detail. In the theses, it is made known that stigmas have a place that hinders their ability to treat pain in emergency room settings. The goal of the referenced thesis was to identify the stigmas, pinpoint how those stigmas effect the level of patient care received in times of need, and then finally to develop suggestions and methods that will reduce or hopefully eliminate the stigmas to redirect the focus of healthcare professionals to offering the best access to the best care for the patient.

Healthcare professionals are faced with the difficult decision: to prescribe, or not the prescribe? The emergency room is known for being "stocked with opiates" to manage acute pain. Therefore, it is evident that those in active addiction might frequent emergency rooms to obtain a prescription of an opiate due to their usual source of the opiate not being available, not having the funds to purchase it, or other factors. The patient is making the attempt that he or she might know to ease the symptoms of withdrawal. Knowing this, there is the possibility that people who are not in active addiction, or have addiction issues at all, lacking the level of care needed to manage their pain because the emergency department staff may not want to contribute to starting another person on the road to addiction to opiates. The act of not prescribing medications when needed is also harmful because it can cause the injured person to look for relief elsewhere, and more times than not, that involves the use of someone else's medication, or obtaining medications from dealers.

There were other barriers that the publication identified such as patient behavior, willingness to accept treatments, and altered mental status upon arrival. It was noted that patients who are in active addiction can be combative, unruly, or resistant to the care plan set forth by medical professionals due to altered mental status while under the influence. It was stated that the lack of additional nurses, security, and mental health specialists can make that situation even more of a dangerous one because nurses and physicians are put in harm's way with minimal backup. Sometimes patients are forced to be there due to being under arrest, being harmful to themselves or others, but do not actually want the care due to their mental status. This can cause a major hinderance in

the most critical moments for healthcare professionals in times where the best service for the patients is needed.

In emergency department setting where the patient has overdosed, and has been brought in for stabilization and treatment, that is harm's the most crucial time to offer addiction services to patients. It has been stated in the Henderson's research that times of overdose are significant enough to cause someone in active addiction to reflect on how their drug or alcohol use affects them physically. During that time is when change is desired, and the individual may be open to accepting offers of treatment. Although a patient may be loud, combative, or unruly, it is best practice to as safely as possible display empathy, compassion, and be willing to educate patients to provide them with the best outcome possible. It might take multiple attempts, a healthcare professional might see that patient for overdose more than once, however, the stigma of that repeated circumstance should not cause a breakdown in care. A breakdown in care due to stigma gives off the feeling that the healthcare providers do not have a genuine interest in helping that patient, and he or she may not accept care as they would if they felt that they are truly cared for and not looked down upon or shamed during those crucial moments.

HOPE AND MOTIVATION FOR IMPROVEMENT

There are many barriers that stand in the way of people living with addictions to opioids and other substances, however, there is a newly profound hope that help is becoming more available and accessible for those who need and seek it. In the July 2022 publication titled "Barriers to Addiction Treatment: Why Addicts Don't Seek Help" article posted on the American Addiction Centers website, it states that financials,

geographic location, stigma, and co-occurring disorder treatment availability are the most commonly identified barriers to those who should be seeking addiction treatment. It states that in 2018 in excess of twenty-one million people (ages twelve and older) who needed treatment, did not seek it due to reasons such as those listed above.

Insurance has become increasingly higher, stipulations for Medicare and Medicaid have made it to where physicians and centers are reluctant to accept it, and job loss due to COVID-19 or other reasons for unemployment has created a great level of financial insecurity. In addition, there are many patients in need of care who live in rural areas, or in areas where treatment centers are too far for individuals without reliable transportation. However, it can bring a feeling of relief to know that in 2022, there have been changes to make treatment and support more attainable. Some examples of the improvements being made daily are in areas of technology, the restructuring of insurance plans, and improvement in access to care. (American Addiction Centers, 2022)

Insurance (BCBS and the Affordable Care Act)

Although insurance coverage, or lack thereof, is listed as a barrier to care, there is also hope that some insurance companies have improved their coverages to assist in combating the opioid and alcohol addiction crisis. According to an article by James Regan with American Addiction Centers, BCBS (Blue Cross Blue Shield) has improved the ease of finding recovery options that are covered under their insurance, and they are covering more than before. If a patient has purchased the BCBS policy through the marketplace, then they are more than likely covered for treatment in an in-network facility as the ACA has made it a requirement that the essential benefits are covered.

Some services that are approved are medical detox, inpatient treatment, outpatient care, telehealth therapy, and medication-assisted therapies. Patients are now able to search for facilities in network with BCBS in their plan to see where they can go.

The cost isn't completely eliminated with this improvement in insurance coverage, as the amount that a patient would pay out of pocket depends on the specific plan and facility, but the improvements have decreased the burden of cost for patients significantly. Factors that determine cost the to the patient are now more comparable to standard medical office costs such as deductible, copays, coinsurances, and out of pocket maximums. In many cases, BCBS (Blue Cross and Blue Sheild) would require the preauthorization of treatment services before treatment can begin, and the staff of the facility should be able to handle that task on the patient's behalf. Although the burden of cost could still fall onto the patient for their treatment, the development of financial assistance, sliding scales (which are adjusted rates based upon income), and payment plans offered by many recovery centers are an additional resource to those seeking care, but may be underinsured or uninsured.

Telehealth

As far as technology, after COVID-19 revealed a new normal for the people of the United States, and other countries, it has also revealed a new level of care that can be provided. Individuals in need of treatment who may be sick, struggle with a lack of transportation, lack of childcare, or an unforgiving work schedule, now have access to Telehealth, which provides a new level of convenience, yet delivers great quality of care to patients.

By definition of HHS.gov, telehealth-or often called telemedicine allows patients an opportunity to receive care from their healthcare providers without the need for an in-person office visit. There are multiple options for patients and healthcare providers to use telehealth such as live discussion via phone or video chat, the sending and receiving of messages using a secure messaging email or file exchange, and remote monitoring (use of devices or apps to track progress). Through the innovation of technology health care professionals are now able to meet patients where they are, by having the ability to reach patients using platforms that they currently use such as Facetime, Facebook Messenger Chat, Google Hangouts, Zoom, Skype, etc. Many areas of specialized care can be met with telehealth for those who struggle with addiction such as mental health treatment, medication management, and counseling. The benefits of using telehealth for care are that it reduces risk of spreading viral disease, care can be provided regardless of location, reduces need for transportation and childcare, increased access and reduce wait times. (HHS.gov 2022)

Ease in Finding Locations of Resources

SAMHSA has made many improvements to their website over time to make it easier for individuals to find care on their own. In the instance that an individual might not want someone to know that they are struggling with addiction or who might not have a support system to assist them in finding resources, they can go onto the website and use it’s many helpful features. The one that stands out most is the “Find Treatment Tool” By going to www.samhsa.gov and then clicking on “Find Treatment”, an individual could use a zip code, city and state, and be able to find treatment centers (inpatient and out-patient). They can also find that the website provides the most currently available

information regarding their demographics (such as address and phone number), payment accepted, insurance accepted, and a detailed description of the services that the programs offer.

For instance, if someone lived in Paducah, then they could use either zip code 42001 or they could type in Paducah, KY. They would find that a list of 16 facilities in Paducah, KY as well as surrounding areas in Illinois are listed with information. It could also be noted that the smaller the population, or more rural the area, the less resources are available. For instance, if someone lived in Wickliffe, KY and needed to locate treatment, there were only six resources. As of 2022, Paducah has a population of 27,559, while Wickliffe has a population of 813. Considering the difference in population, it can be noted that the larger the population in a designated area, the more resources are available to individuals.

Increased Access to Care

There has been a significant increase of access to care, supportive services, and holistic care for patients in all phases of addiction and recovery of alcohol use disorder, and opioid abuse disorder. Some examples of the increased access to care are in Kentucky such as Centerpoint, Turning Point, Stepworks, and Lifeline. All of those mentioned programs have continued to grow and thrive in their missions to provide the best care available to those in need of the services offered.

Centerpoint

A shining example of access to care is a Recovery Center that focuses on the true needs of those seeking treatment for addiction either independently or through

the correctional facilities is Centerpoint Recovery Center for Men in Paducah, KY which is a non-profit organization. The program is available to people in recovery without regard or restriction based on insurance or financials because the consumers are not billed to complete the program. This allows the residents to focus on their care, and not have to worry about the financial aspect of recovery. Centerpoint in an umbrella of Four Rivers Behavioral Health of Paducah, KY and is currently funded partly by KHC (Kentucky Housing Corporation), the Local Department of the Government, and the Kentucky Department of Corrections. The program for consumers (*consumers is the term that is used to describe clients for this organization*) is designed in phases that ensure success by gradually transitioning them to be self-sustaining while providing life skills and education needed to survive on after living through active addiction of drugs and alcohol. The location allows consumers to be close to their families, although it is a smaller city compared to places like Chicago, Nashville, Louisville, etc. The location is convenient for Paducah residents as well as those who live in the more rural areas such as Wickliffe, KY, Bardwell KY, Arlington, KY, or Southern Illinois, where more rural areas have a smaller population, and the least access to recovery programs.

The program is designed to be completed in five phases, and provides the consumers with hot meals, safety, affordable-or even free (based on income for rooms) shelter, case management, peer mentoring, laundry, privileges, social time, opportunities to show responsibility, exercise and rewards for progress and good behavior, and a graduation ceremony, as well as access to food and other resources after they've completed the program. Consumers have the opportunity to stay in the program after graduation to work on gaining more skills, giving back, saving money

before making the transition to return to family or to live independently. Consumers can also use the time to further prepare themselves mentally for their transition.

In a recent and very insightful interview with a Four Rivers Behavioral Health employee who works in the Centerpoint office, Amy Allen (Staff Accountant Assistant, HUD Property Manager, COS) it was determined that the facility houses a total of approximately one hundred individuals in different areas which are in dorms broken down as SOS (Safe Off the Streets), Cot City, and then rooms with a roommate that are laid out as a one-bedroom apartment with everything except a kitchen. The length of time consumers who reside in the dorms depend on many varying factors such as their length of stay, progress in the program, behavior and room availability. Although Centerpoint tries to receive as many interested consumers as possible, the wait list as of September 2022 was ranged from six to eight months long. Interested candidates must complete an application, the application must be approved by the director, and once approved, the interested person would need to call weekly to keep their place on the list for admission for when a bed comes open.

One thing that ultimately stood out in the discussion, was the obvious close-knit connection of the staff and consumers, along with their methods of motivating each other to succeed in the program. There is a highly beneficial peer mentor program where peer mentors (who are also consumers in the program as well, but in a higher phase of progress) should spend a minimum of two hours a day to mentor a designated group of consumers in lower phases of the program. They are paid $100, $125, or $150 weekly (depending on if it is their 1st, 2nd, or 3rd term) as an incentive to assist with peer mentoring, and earn special privileges for their efforts as well. These peer mentors are

looked up to by those who are newly admitted as it can show them that they can proceed in the program as long as they are committed to success with the support of each other and the staff. (Personal communication, Centerpoint Housing Coordinator September 7, 2022)

Life Line Recovery Center (Previously Lifeline Ministries and Ladies Living Free)

In September 2022, Jane Kim and Randell Barnes reported on WPSD Local 6 News that Kentucky Governor Andy Beshear extended sincere appreciation, and financial support at the grand opening for The Ranch; a new recovery center for men in Ballard County, KY. The grand opening was hosted by Lifeline Recovery Group, where Kentucky Governor Andy BeShear spoke and presented financial support to the program in the amount of $100,000. Governor Beshear for furthering efforts in recovery for people who are struggling with addiction.

Governor Beshear made this powerful statement; “We’ve lost far too many of our people, and this pandemic has made it tougher. These are our brothers and sisters, so many that have fallen into addiction and this place does such a great job at getting them better, really excited about what we’re going to see at this facility.” The public were finally allowed to see the center for the first time at this event and the support of Kentucky’s leadership has been greatly expressed. They are thrilled with the location of the campus because it’s is away from the distractions, has lots of privacy, and is a very relaxing environment. Ashley Miller, the Executive Director of Lifeline made the statement “It’s like it was built for us, these people to come out from the madness and just get well”. The Ranch is another example of how care, combined with faith, and work can change things for a community struggling with opiate and alcohol use

disorders. The timeline of both Ladies Living Free (for women) and Lifeline Ministries (for men), which is now merged into one organization to have more of an impact is one that should motivate the United States to keep going further to fight the opioid and alcohol addiction crisis.

The timeline of the development of Lifeline serves as a true testimony of determination and hope to heal those in need of assistance in the opioid and alcohol crisis. In 2000, members of the faith-based community were concerned with the way that addiction has harmed the community of Paducah, KY and surrounding areas. In 2002, they rented a house on Kentucky Avenue in Paducah, KY to hold motivational classes such as Anger Management, and Stepping into Freedom once weekly until the classes were filled. In 2004, the founders of Lifeline wanted to purchase an old homeless shelter to expand their efforts toward recovery, but only had $200.00 to put toward the $90,000.00 property. The members had faith that the program would make a difference, therefore, they went to the WPSD news with their story. After the story aired, the organization received $20,000 in donations that they would use to secure the property with the down payment.

Shortly after, in 2005, Ladies Living Free was organized by nine members that wanted to help women in the community as well. They started classes at the Kentucky Avenue location as well as the McCracken County Jail after the men's program relocated. In 2006, Lifeline and Ladies Living Free combined. In 2007, Ladies Living Free accepted their first group of women in their recovery center, and later on, in 2012, a transitional house was built for them as well. In 2015, Ladies Living Free and Lifeline finally obtained full-time staffing in the organizations. In 2017, they started to analyze

success rates, and documented a 67% success rate. In 2020, the first dorm for men was opened and provided treatment for 22 men. The $250,000 in construction costs were made possible completely by donation. Due to the show of excellence that Lifeline Recovery Center has displayed, in 2021 they received their AODE Licensure and CARF Accreditation. They named the two men's dorms Peeler and Hunt Hall. (Lifeline 2021)

Stepworks

Stepworks is a newer program located in Paducah, KY which offered several programs to fit the diverse needs of individuals in the area. Their detox program starts off with a medically supervised detox period that turns into is a 30 day stay. A short stay is for detox and withdrawal management for less severe needs. Intensive Outpatient is care where the individual lives at home and goes to treatment sessions. Sober Living is a program where residents can live in an apartment designed to house four participants together. The apartment is completely furnished and residents are allowed to stay for a six-month timeframe while working more toward recovery and sobriety. MATs are offered with required counseling along with it to increase effectiveness of the MATs. There is a PICC line program as well, which assists those who are on a required PICC line due to infections contracted while in active drug use in order to allow the patient to start their treatment more quickly and increase effectiveness. (Stepworks, 2022)

Stories Of Hope:

Success Through a Recovery Center-Max Grantham

*The stories of the employees were also inspirational, as some of the consumers after completing the program went back to volunteer, teach classes, and eventually earn

gainful employment in very essential roles of the facility. An example of someone who made a complete transformation after going through the program is the site administrator, Max Grantham. Max is a very down to earth individual who takes pride in this work to assist the current consumers of Centerpoint Recovery Center. As a graduate of the program himself, he can provide the best insight to those who are where he once used to be. Max is known for his love of cigars, daily doses of humor, being humble and appreciative, and most importantly-making things happen. He loves randomly surprising his staff with a very nice gesture to provide breakfast and donuts for a push during rough days to his staff.

Max has the perfect balance of being stern, holding the consumers accountable, as well as the ability to identify ways to truly help them in a holistic manner, being kind, and providing second chances as well as opportunity for growth. Max's story started from his life prior to recovery, which although consists of drug and alcohol use, legal issues, and more, continuing to him being in the program as a consumer, then becoming the site administrator. Max Grantham is one that provides many people a hope that one day as a participant in a program, an individual might be lost, but is not a lost cause. He is living proof that while finding the way back to sobriety, one can overcome the struggles of addiction, but they can also become successful in their lives. For men like Max who have graduated the program, and continued to work for the organization, giving back is a show of finding purpose out of a time where they may not have known what their purpose was. Max sees himself in some of his consumers, and has a true desire to see them become who he knows they can be.

Story of Recovery-The Johnny Cash Story

"I was taking pills for a while, and then the pills started taking me."-Johnny Cash

Chris Foy, a manager and webmaster for FHE Health who has years of experience in addiction treatment, wrote a piece about the legendary Johnny Cash, a country singer who is the one of the most recognized names in music. Although a country music star, Mr. Cash is very well known in other genres of music as well. Mr. Cash is known for many hits such as "Ring of Fire" and "Walk the Line". Mr. Cash's struggle with addiction to alcohol, amphetamines, as well as barbiturates started in the same way that addiction overcomes many well-known and very successful entertainers-trying to cope and keep up with the demands of fame. It is common for entertainers to use speed as a performance enhancer for multiple reasons, but one of the most common was to keep up with demand.

In the 2005 film "Walk the Line", Cash is portrayed as addicted to drugs and alcohol. The Film proceeded to show how drugs and alcohol affected his career due to him being seen as sloppy, unpredictable, and hard to work with. He had car accidents and very erratic behavior. Although the negative perception of Mr. Cash was shown, it was also known that Mr. Cash was compassionate and humble. He was known as a loving father by his son John Carter Cash. It was stated the Mr. Cash and his first wife were divorced due to his addiction and the behavior that came with it, but he was in an affair with his second wife, June Carter Cash, who would soon birth his only son.

Following the birth of John, Mr. Cash had a seven-year period of sobriety. He started drinking after that time period along with Mrs. Cash's impulsive shopping and

prescription “pill popping”. After the deaths of Johnny Cash and June Carter Cash, in 2007, John Carter Cash disclosed details of how it was to live with Mr. and Mrs. Cash in their times of addiction in his book titled “Anchored in Love”. It was a biography about his mother, described their family life as difficult at times, but full of love and hope. Later in life, Mr. Cash had found himself in times of recovery and often used the phrase “You Can Be Redeemed” when he discussed his recovery. He credited his recovery to the finding of a higher power.

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